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 _____	C 05/18/2017

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 000	INITIAL COMMENTS FEDERAL COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-320 WAC Hospital Licensing Regulations, conducted this health and safety complaint investigation. Onsite dates: 5/8/2017 to 5/10/2017 Examination date number: N/A Intake number: 72756 The investigation was conducted by: Diane Sanders, RN, MN, NEA-BC and Deborah Barrette, RN, BSN There were CONDITION LEVEL DEFICIENCIES found.	A 000		
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: Based on observation, interview, and record review the facility failed to provide a safe environment for a patient (Patient #1) following an investigation of a staff member (Staff A) entering the shower/tub room when Patient #1 was showering. Failure to implement security protections for patient safety puts patients at risk for possible continued harm, abuse and /or exploitation.	A 144	**Plan of Correction for each specific deficiency cited:** (A 144) The hospital failed to provide a safe environment for the patient and to implement security protections for patient safety. To ensure the patient has the right to receive care in a safe setting, the following corrections will be made: • Policy 7.03 "Abuse and Neglect Program" will be updated to provide guidance on minimizing the psychological impact to the patient during and after an investigation is concluded. This includes notifying the physician to assess the patient's mental status to determine if patient care has been impacted and make recommendations to mitigate risk for any negative impact to the patient. • The staff will not be returned to the area where the original allegation occurred until it has been reviewed by the Management Review Team. • Training will be developed via	

Chief Executive Officer

7/11/17

			educational memorandum for Supervisors and Physicians and include the requirement of the annual all staff Abuse and Neglect training on policy 7.03 "Abuse and Neglect Program" procedures. **Procedure/process for implementing the plan of correction:** • Updated policy 7.03 "Abuse and Neglect Program" to provide guidance on minimizing the psychological impact to the patient during and after an investigation is concluded. • Supervisors and Physicians will receive training on the revised policy 7.03 "Abuse and Neglect Program" procedure training. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Human Resources will maintain a log of staff reassignments and return to duty. • Human Resources will notify the Chief Clinical Officer when staff is ready to return to duty. • The Chief Clinical Officer or designee will monitor the HR log and ensure physician recommendations occur regarding minimizing negative impact of patient before staff's return to duty, if patient care has been impacted. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • Investigation Department will perform a quarterly audit to ensure that staff will not be returned to the area where the original allegation occurred until it has been reviewed by the Management Review Team. This will be included in the Clinical Risk Management dashboard and reported to Patient Care Quality Council and Governing Body until 100% compliance has been reached for two consecutive quarters. **Individual Responsible:** • The Chief Clinical Officer **Date completed:** • August 10, 2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Chief Executive Officer — (X6) DATE 9/11/17

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 144	Continued From page 1 Findings include: 1. Observations of the shower/tub room revealed all staff could enter the shower/tub room from the staff hallway. 2. Review of Staff A's job description revealed they provided counseling for mental health issues. Staff A did not provide care for patients' personal care needs for activities of daily living (ADL's) which would include showers. 3. On 1/11/2017 it was reported by another staff member Staff A entered the shower/tub room while Patient #1 was in the area. The incident was reported to the investigation department the same day the allegation was reported. The investigation was started on 1/11/2017. Staff A was removed that day from direct patient care. 4. Review of Patient #1's record revealed they were being treated for a mental health condition at the time of incident. The patient was scheduled to be transferred to another ward in the facility as result of their improvement prior to the allegation. After the allegation/incident the patient became suicidal and was put on a 1:1 watch with a staff member for several weeks. The record showed the patient making statements "it's all my fault" and "I do not want to talk about it now." When the patient was asked about if someone was in the shower with them, the patient replied "no" but indicated someone might have been in the tub room area. 5. On 5/9/2017 at 1:25 PM Staff B a licensed nurse was interviewed. Staff B provided care to Patient #1 before and after the incident. Staff B stated that Patient #1 became suicidal after the	A 144		

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A 144	Continued From page 2	A 144		

incident investigation involving Staff A. Staff B stated, Staff A did not provide care for ADL's and should not have been in an area where this would occur.

6. On 5/8/2017 at 1:10 PM Staff C a physician was interviewed. Staff C stated the patient began to decompensate after the incident on 1/11/2017. The patient became less verbal and began to express wanting to harm themself. The patient was put on 1:1 monitoring with a staff member to prevent self harm. The patient would only say about the incident they would talk "when the time is right". Staff C had concerns about what may have occurred between Staff A and Patient#1. Staff C was not consulted about allowing Staff A to return to the same ward as Patient #1 at the conclusion of the investigation. Staff C felt the patient's behavior change was a direct result of the alleged incident with Staff A.

7. On 5/9/2017 at 3:45 PM Staff D a physician was interviewed. Staff D stated they were not consulted about allowing Staff #A to return to the ward at the conclusion of the investigation. Staff D indicated they had contacted administration about the allegations involving Patient #1 and Staff A but they were not included in the decision to allow Staff A back on the ward.

8. On 5/10/2017 at 1:10 PM the above information was reviewed with Staff E the Deputy Director of Operations. Staff E stated changes were going to be made to include physicians in the investigative process. The decision to return an employee to the ward would not rest with the staff member's manager but with an independent review in the future.

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A 144	Continued From page 3 9. On 5/18/2017 at 8:00 AM, the Center Director for Forensic Services (Staff M) was interviewed about the decision to return Staff A to the unit. Staff M made the decision to return Staff A since the allegation was not substantiated despite the fact the patient had decompensated directly after the alleged incident. Staff M did not consult with the patient's physicians about the return of Staff A to the ward.	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 interview, record review and review of facility policies and procedures the facility failed to adequately protect a patient (Patient #1) from an incident of possible exploitation in the shower/tub area of the patient's (Patient #1) care ward. Failure to immediately assess the situation when brought to the attention of the staff places patients at risk for further exploitation. Findings include: 1 .The facility policy "Abuse and Neglect Program", policy 7.03 read in part, "WSH (Western State Hospital) has a program to detect and prevent the occurrence of abuse and neglect to include: Prevention, Screening, Identification, Training, Protecting, Investigating and Reporting and Responding" 2.. Review of Patient #1's record revealed on	A 145	**Plan of Correction for each specific deficiency cited:** (A 145) The hospital failed to adequately protect the patient from an incident of possible exploitation in the shower/tub area and immediately assess the situation when brought to the attention of the staff. To ensure the patient's right to be free from all forms of abuse and harassment, the following corrections will be made: • Policy 7.03 "Abuse and Neglect Program" will be updated to address protecting the patient from exploitation, including immediately ensuring the patient is safe and reporting to prevent future incidents. • Training will be developed to include updated training on policy 7.03 "Abuse and Neglect Program." **Procedure/process for implementing the plan of correction:** • The updated policy 7.03 "Abuse and Neglect Program" will be updated to include protecting the patient from exploitation, including immediately ensuring the patient is safe and reporting to prevent future incidents. • Training will be developed via educational memorandum for Nursing staff regarding updated	

			Policy 7.03. • The required annual Abuse and Neglect training will be updated to include protecting the patient from exploitation, including immediately ensuring the patient is safe and reporting to prevent future incidents. **Monitoring and tracking procedures to ensure the plan of correction is effective:** • Organizational Development will provide competency evaluation as part of the Abuse and Neglect Training. All staff must pass the competency in order to provide patient care. • Organizational Development will track competency and 90% testing compliance will be met. **Process improvement: actions incorporated into its Quality Assessment and Performance Improvement (QAPI) Program:** • Organizational Development will report the results and actions taken to Patient Care Quality Council and the Governing Body on a quarterly basis. **Individual Responsible:** • Director of Organizational Development **Date completed:** • August 31, 2017	

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A 145	Continued From page 4 1/11/2017 it was reported Staff A had entered the shower/tub area while Patient #1 was in the shower. The charge nurse (staff B) went to the door to ask Patient #1 if they were ok and if anyone was in the shower with them. The patient replied no one was in shower with them. The charge nurse then called the nursing supervisor about the incident. 3. On 5/9/2017 at 1:25 PM, Staff B was interviewed. Staff B stated they remembered asking the patient if anyone was in the shower with them. The patient peeked their head out of the shower room and said no one was with them. Staff B went on to say they should have inspected the shower area and tub room area immediately when the allegation was made. 4. On 5/10/2017 at 11:00 AM, the above events were reviewed with the nurse manager (Staff F). Staff F stated Staff B should have done an immediate search of the area when the allegation was made.	A 145		