Official Accreditation Report

Western State Hospital
9601 Steilacoom Boulevard. S.W
Lakewood, WA 98498

Organization Identification Number: 1630

Unannounced Medicare Deficiency Survey: 3/17/2015 - 3/17/2015

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)	Survey Date(s)
Hospital Accreditation	03/17/2015-03/17/2015

Hospital Accreditation :

As a result of the accreditation activity conducted on the above date(s), you have met the criteria for Accreditation with Follow-up Survey.

If your organization wishes to clarify any of the standards you believe were compliant at the time of survey, you may submit clarifying Evidence of Standards Compliance in 10 business days from the day this report is posted to your organization’s extranet site.

You will have follow-up in the area(s) indicated below:

- As a result of a Condition Level Deficiency, an Unannounced Medicare Deficiency Follow-up Survey will occur. Please address and correct any Condition Level Deficiencies immediately, as the follow-up event addressing these deficiencies will occur within 30 days of the last survey date identified above. The follow-up event is in addition to the written Evidence of Standards Compliance response.
- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	LD.03.06.01	EP3
	PC.03.05.03	EP1

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	LD.01.03.01	EP2
	LD.04.03.01	EP14
	LD.04.04.01	EP1
	NR.02.01.01	EP2

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(4)(ii)	A-0167	HAP - PC.03.05.03/EP1	Standard

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.23 Condition of Participation: 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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(a)	A-0386	HAP - NR.02.01.01/EP2	Standard

CoP: §482.62 **Tag:** B136 **Deficiency:** Condition

Corresponds to: HAP

Text: §482.62 Condition of Participation: Special staff requirements for psychiatric hospitals.

The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

CoP Standard	Tag	Corresponds to	Deficiency
§482.62(g)(1)	B157	HAP - LD.04.03.01/EP14	Standard
§482.62(g)(2)	B158	HAP - LD.03.06.01/EP3	Condition

CoP: §482.21 **Tag:** A-0263 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

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.

CoP Standard	Tag	Corresponds to	Deficiency
§482.21(e)(1)	A-0309	HAP - LD.04.04.01/EP1	Standard

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Condition

Corresponds to: HAP - LD.01.03.01/EP2

Text: §482.12 Condition of Participation: 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 governing body.

Requirements for Improvement – Detail

Chapter: Leadership

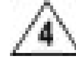
Program: Hospital Accreditation

Standard: LD.01.03.01 ESC 60 days

Standard Text: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Element(s) of Performance:

2. The governing body provides for organization management and planning.



Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.12 - (A-0043) - §482.12 Condition of Participation: Condition of Participation: Governing Body
This Condition is NOT MET as evidenced by:
Observed in Auto Score for CLD at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site.
The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews:§482.62 - (B136), §482.62(g)(2) - (B158), §482.12 - (A-0043)

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.03.06.01 ESC 45 days

Standard Text: Those who work in the hospital are focused on improving safety and quality.

Element(s) of Performance:

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3)
Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 3
§482.62(g)(2) - (B158) - (2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.
This Condition is NOT MET as evidenced by:
Observed in Individual Tracer at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service.
The hospital had not at the time of survey initiated therapeutic group activities in the evenings or on the weekends. Leadership indicated that they are contemplating alternative schedules for staff and plan to implement effective May 1, 2015. Numerous staff on the units and patients indicated that there has been no change in the activities provided to patients on the weekends and evenings.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.03.01

ESC 60 days

Standard Text: The hospital provides services that meet patient needs.

Element(s) of Performance:

14. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities. Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 14
§482.62(g)(1) - (B157) - (1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service.
In discussion with staff, it was noted that the hospital had not provided patients on the forensic units with therapeutic activities in the evenings or on the weekends. Leadership indicated they are contemplating May 1, 2015 to implement. There was no documentation available to support this decision.

Chapter: Leadership

Program: Hospital Accreditation

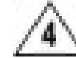
Standard: LD.04.04.01

ESC 60 days

Standard Text: Leaders establish priorities for performance improvement. (Refer to the 'Performance Improvement' [PI] chapter.)

Element(s) of Performance:

1. Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)



Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.21(e)(1) - (A-0309) - (1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service.
There was no documentation regarding performance improvement activities to indicate that monitoring of manual holds and physical holds with appropriate physician orders was taking place.

Chapter: Nursing

Program: Hospital Accreditation

Standard: NR.02.01.01

ESC 60 days

Standard Text: The nurse executive directs the hospital's nursing services.

Element(s) of Performance:

2. The nurse executive coordinates: The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated.
Note: Examples of patient populations include pediatric, diabetic, and geriatric patients.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.23(a) - (A-0386) - §482.23(a) Standard: Organization

The hospital must have a well-organized service with a plan of administrative authority and delineation of responsibilities for patient care. The director of the nursing service must be a licensed registered nurse. He or she is responsible for the operation of the service, including determining the types and numbers of nursing personnel and staff necessary to provide nursing care for all areas of the hospital.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service.
The procedure for Psychiatric Emergency Response Team (PERT) indicated that physical restraint techniques will only be considered as a last resort and must be directed by the nurse in charge. The nurse in charge was defined as the charge nurse on the unit. The nurse executive indicated that she had not seen the revised policy yet her responsibilities included the development of policies and procedure that address how nursing care needs are met.

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.03.05.03 ESC 45 days
Standard Text:	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital uses restraint or seclusion safely.

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements restraint or seclusion using safe techniques identified by the hospital's policies and procedures in accordance with law and regulation.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(e)(4)(ii) - (A-0167) - [The use of restraint or seclusion must be --]

(ii) implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.
This Standard is NOT MET as evidenced by:
Observed in Individual Tracer at Western State Hospital (9601 Steilacoom Boulevard S.W., Lakewood, WA) site for the Psychiatric Hospital deemed service.
The hospital indicated they had investigated the incident of January 16, 2015 when the unit went into a "lock down" due to two patient in an altercation. Leadership indicated that staff had pushed the lock down button and that the whole incident was an error. Leadership indicated that the button was to be disengaged and made inoperable. When asked at the time of survey, leadership indicated that the button had not be disengaged and made inoperable. Consequently no changes had been made and that staff continued to have access to the "lock down" button if they had not been educated to not use.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

As a result of the accreditation activity conducted, there were no Opportunities for Improvement identified.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0