STATE OF WASHINGTON
DEPARTMENT OF HEALTH
SECRETARY OF HEALTH

In the Matter of **VEST SEATTLE LLC (dba SMOKEY POINT BEHAVIORAL HOSPITAL)** License No. BHA.FS.60874194 Respondent	**No. M2021-727** **NOTICE OF INTENT TO SUSPEND**

Pursuant to RCW 43.70.115, the Executive Director of the Behavioral Health Agencies Program (Program), on designation by the Secretary of Health (Secretary), having authority to regulate Behavioral Health Agencies under chapters 71.05, 71.24 and 71.34 RCW, and chapter 246-341 WAC, hereby provides Notice of Intent to Suspend License No. BHA.FS.60874194 and all certifications associated with License No. BHA.FS.60874194 (Notice). This Notice will take effect and become a Final Order, without further notice, twenty-eight (28) days after receipt absent a timely request for an adjudicative proceeding. This Notice is based on the following findings of fact and conclusions of law.

1. FINDINGS OF FACT

1.1 On June 12, 2017, the State of Washington issued Vest Seattle LLC dba Smokey Point Behavioral Hospital (SPBH) license no. BHA.FS.60874194 to operate as a behavioral health agency (BHA). SPBH's BHA license is currently active.

1.2 On or about November 21, 2019, a Program surveyor completed a state licensing investigation at SPBH. On January 9, 2020, the Program issued a Statement of Deficiencies to SPBH detailing the surveyor's observations.

1.3 The observed deficiencies included SPBH's failure to:

A. Release a voluntary patient immediately upon their request in violation of RCW 71.05.050(1).

B. Implement a policy management structure that established procedures to assure the protection of individual rights as described in chapter 71.05 RCW for any person voluntarily admitted for inpatient treatment to be released immediately upon his or her

ORIGINAL

request and to be advised of the right to immediate discharge in violation of WAC 246-341-1126(4)(c).[1]

C. Document that the individual service plan was mutually agreed upon by a patient when it was developed and failed to make a copy available to a patient in violation of WAC 246-341-0620(1)(d).

D. Work with a patient to address the funding of the patient's treatment costs in violation of WAC 246-341-0420(9).

1.4 On January 27, 2020, the Program received SPBH's plan of correction to address the deficiencies described in paragraph 1.3. On February 14, 2020, the Program responded to SPBH that its plan of correction for the deficiencies described in paragraphs 1.3.A and 1.3.B was inadequate. The response was supplemented by a letter from the Program providing, among other things, technical assistance to SPBH on the Program's interpretation of the requirements in RCW 71.05.050 and why SPBH's practices, policies and procedures were considered deficient.

1.5 On February 24 and April 6, 2020, the Program received SPBH's revised plan of correction and requested documentation to address the deficiencies described in paragraphs 1.3.A and 1.3.B. On June 1, 2020, the Program responded to SPBH that the revised plan of correction for the deficiencies described in paragraphs 1.3.A and 1.3.B remained inadequate. This response was supplemented by a letter from the Program providing additional technical assistance to SPBH on the Program's interpretation of RCW 71.05.050 and why the Program still considers SPBH's revised practices, policies and procedures deficient.

1.6 On June 9, 2020, the Program received SPBH's second revised plan of correction to address the deficiencies described in paragraphs 1.3.A and 1.3.B that included a revised "Request for Early Discharge (AMA)" policy. On October 26, 2020, the Program sent SPBH a letter explaining that it was prepared to accept SPBH's overall plan of correction, but it remained concerned about SPBH's ability to comply with RCW 71.05.050 and "considering the scope and severity of the concerns raised during

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[1] The Program adopted, amended, and repealed a significant number of rules in chapter 246-341 WAC that became effective July 1, 2021. WSR 21-12-042. All references to chapter 246-341 WAC in this Notice refer to the administrative rules that were in effect at the time the Program's surveyor made their observations, which were all prior to July 1, 2021.

[the] investigation, the [Program would] conduct an unannounced follow-up compliance visit to verify all deficiencies have been corrected."

1.7 On April 7, 2021, the Program completed the follow-up compliance visit at SPBH. As part of the follow-up compliance visit, the Program's surveyors reviewed clinical records of six (6) patients who had received services from SPBH and observed the following:

Patient #1

A. SPBH failed to ensure Patient #1's individual service plan was mutually agreed upon when it was developed and failed to make a copy available to Patient #1. The individual service plan contained in Patient #1's clinical record was not signed by Patient #1. Additionally, there was no other documentation In Patient #1's clinical record that their individual service plan was mutually agreed upon and that a copy was made available to them.

Patient #2

B. Patient #2 was not discharged immediately upon their parent's request but referred for evaluation by a DCR for possible involuntary detainment despite Patient #2 being an adolescent with no family safety concerns whose parents requested Patient #2 be discharged. Patient #2 was an adolescent admitted to SPBH on January 7, 2021. On January 14, 2021 at approximately 2:40 p.m., Patient #2's parents requested discharge of Patient #2 so they could be taken to a different facility for treatment. Patient #2 was not immediately discharged from SPBH but instead was detained at SPBH until they were evaluated by a designated crisis responder (DCR). The DCR determined Patient #2 did not meet criteria to be detained under chapter 71.34 RCW and Patient #2 was discharged on January 14, 2021, at approximately 7:05 p.m. During an interview with the Program's surveyor, the DCR who evaluated Patient #2 described SPBH's decision to detain Patient #2 for DCR evaluation as "particularly egregious", that Patient #2 "did not in any way meet criteria to be involuntarily detained", and SPBH "tried to

put up every roadblock they could" to prevent Patient #2 from discharging.

C. SPBH did not follow its own policy when discharging Patient #2 at the request of their parents. SPBH's policy requires that staff complete a Columbia-Suicide Severity Rating Scale (C-SSRS) form at the time discharge is requested so the psychiatric provider can consider, among other things, the results of the C-SSRS form when deciding whether to discharge the patient or make a referral to the DCR for evaluation. Patient #2's parents requested discharge of Patient #2 on January 14, 2021, at approximately 2:40 p.m. SPBH staff did not complete a C-SSRS form for Patient #2 until 5:03 p.m. The DCR was called to evaluate Patient #2 for possible involuntary detainment at 2:50 p.m. based on a referral from the psychiatric provider.

Patient #3

D. Patient #3 was referred for evaluation by a DCR for possible involuntary detainment when they did not present, as a result of a behavioral health disorder, an imminent likelihood of serious harm or as gravely disabled. Patient #3 was admitted to SPBH on February 2, 2021. On February 4, 2021, at approximately 9:13 a.m., Patient #3 requested discharge from SPBH because they felt SPBH was not providing the intensive therapy they needed and Patient #3 understood the importance of proper medication management. The DCR was called to evaluate Patient #3 for possible involuntary detainment at 9:35 a.m. based on a referral from the psychiatric provider. SPBH made a referral to the DCR for evaluation despite the fact that, among other things, Patient #3's pre-discharge assessment indicated Patient #3 did not present an immediate risk to self, was not expressing thoughts of harming others, and was not displaying aggressive behavior. Patient #3 then withdrew their request to discharge at 10:05 a.m.

E. On February 5, 2021 at approximately 8:30 a.m., Patient #3 requested discharge from SPBH. Patient #3 was discharged from SPBH on February 5, 2021 at approximately 11:25 a.m. and almost three hours after the original request for discharge was made.

F. Patient #3 explained to the Program's surveyor that they withdrew their original request to be discharged on February 4, 2021 because their request was followed by "a number of horrific things that would happen to me if I went through with my request" including that their request to discharge would be denied, that law enforcement could become involved if they requested discharge, that Patient #3 could be detained for a minimum of two months at SPBH or Patient #3 would be taken to an emergency room psychiatric ward and legally detained.

G. SPBH did not follow its own policy when discharging Patient #3. SPBH's policy requires that staff complete a C-SSRS form at the time discharge is requested so the psychiatric provider can consider, among other things, the results of the C-SSRS form when deciding whether to discharge the patient or make a referral to the DCR for evaluation.

   i. Patient #3 requested discharge on February 4, 2021 at approximately 9:13 a.m. SPBH staff did not complete a C-SSRS form for Patient #3 after this request to discharge was made. The psychiatric provider notified Patient #3 of their determination to refer Patient #3 for evaluation by a DCR at 9:30am.

   ii. Patient #3 requested discharge on February 5, 2021 at approximately 8:30 a.m. SPBH staff did not complete a C-SSRS form for Patient #3 until 10:43 a.m. The psychiatric provider notified Patient #3 of their determination to discharge Patient #3 at 8:50 a.m.

H. SPBH failed to ensure Patient #3's individual service plan was mutually agreed upon when it was developed and failed to make a

copy available to Patient #3. The individual service plan contained in Patient #3's clinical record was not signed by anyone. Additionally, there was no other documentation in Patient #3's clinical record that their individual service plan was mutually agreed upon and that a copy was made available to them.

Patient #4

I. Patient #4 was referred for evaluation by a DCR for possible involuntary detainment when they did not present, as a result of a behavioral health disorder, an imminent likelihood of serious harm or as gravely disabled Patient #4 was admitted to SPBH on February 8, 2021. On February 20, 2021 at approximately 10:35 a.m., Patient #4 requested discharge from SPBH stating they felt great since getting quality sleep and felt they could manage their medications at home. Patient #4 was not immediately discharged from SPBH but instead was detained at SPBH until they were evaluated by a DCR. The DCR determined Patient #4 did not meet criteria to be detained under chapter 71.05 RCW and Patient #4 was discharged on February 10, 2021 at approximately 4:00 p.m. Patient #4 was referred for DCR evaluation despite the fact that, among other things, Patient #4's pre-discharge assessment indicated Patient #4 did not present an immediate risk to self, was not expressing thoughts of harming others, and was not displaying aggressive behavior. During an interview with the Program's surveyor, a SPBH staff member reviewed Patient #4's request for discharge and acknowledged that it appeared Patient #4 should have been released with no DCR contacted.

J. SPBH did not follow its own policy when discharging Patient #4. SPBH's policy requires that staff complete a C-SSRS form at the time discharge is requested so the psychiatric provider can consider, among other things, the results of the C-SSRS form when deciding whether to discharge the patient or make a referral to the DCR for evaluation. Patient #4 requested discharge on

February 10, 2021 at approximately 10:35 a.m. SPBH staff did not complete a C-SSRS form for Patient #4 until 2:55 p.m. The DCR was called to evaluate Patient #4 for possible involuntary detainment at 12:10 p.m. based on a referral from the psychiatric provider.

K. SPBH failed to ensure Patient #4's individual service plan was mutually agreed upon when it was developed and failed to make a copy available to Patient #4. The individual service plan contained in Patient #4's clinical record was not signed by Patient #4. Additionally, there was no other documentation In Patient #4's clinical record that their individual service plan was mutually agreed upon and that a copy was made available to them.

Patient #6

L. SPBH failed to ensure Patient #6's individual service plan was mutually agreed upon when it was developed and failed to make a copy available to Patient #6. The individual service plan contained in Patient #6's clinical record was not signed by anyone. Additionally, there was no other documentation in Patient #6's clinical record that their individual service plan was mutually agreed upon and that a copy was made available to them.

1.8 The Program surveyor's observations related to Patient #1, Patient #2, Patient #3, Patient #4, and Patient #6 as outlined in paragraph 1.7 violated RCW 71.05.050(1) and (2), RCW 71.05.153(1), RCW 71.34.650(7), RCW 71.34.600(1), WAC 246-341-0600(1), WAC 246-341-1126(4)(c), and WAC 246-341-0620(1)(d). The observations related to RCW 71.05.050(1), WAC 246-341-1126(4)(c), and WAC 246-341-0620(1)(d) represent repeat deficiencies from the state licensing investigation completed on October 1, 2019.

2. CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Secretary makes the following Conclusions of Law:

2.1 The Secretary, acting through his designee, has jurisdiction over the licensee, Vest Seattle LLC dba Smokey Point Behavioral Hospital (SPBH) license

no. BHA.FS.60874194, and over the subject matter of this proceeding under chapters 71.05 RCW, 71.24 RCW, 71.34 RCW and 246-341 WAC.

2.2 The findings of fact constitute violations of RCW 71.05.050(1) and (2), RCW 71.05.153(1), RCW 71.34.650(7), RCW 71.34.600(1), WAC 246-341-0600(1), WAC 246-341-1126(4)(c), and WAC 246-341-0620(1)(d).

2.3 The above violations demonstrate that SPBH has failed to comply with chapters 71.05 RCW, 71.24 RCW, 71.34 RCW, and 246-341 WAC.

2.4 SPBH's failure to comply with chapters 71.05 RCW, 71.24 RCW, 71.34 RCW, and 246-341 WAC provides grounds for the Secretary to deny, suspend, revoke, or place on probation SPBH's license or specific program certifications under RCW 43.70.115, chapter 71.24 RCW, WAC 246-341-0335, and WAC 246-341-0605.

2.5 SPBH's failure to comply with chapters 71.05 RCW, 71.24 RCW, 71.34 RCW, and 246-341 WAC provides grounds for the Secretary to assess a fee under RCW 43.70.250, WAC 246-341-0335(5), WAC 246-341-0365(5) and (7), and WAC 246-341-0605(5).

2.6 SPBH has the right to contest a Secretary decision to deny, suspend, revoke, or place on probation its license by requesting an adjudicative proceeding within twenty-eight (28) days of receipt of the department's decision. RCW 43.70.115.

2.7 The Secretary may indicate when and under what circumstances an order may become an effective Final Order. RCW 43.70.115(2) and RCW 34.05.461.

3. NOTICE OF SUSPENSION

Based on the above Findings of Fact and Conclusions of Law, the Secretary, through his designee, enters the following:

3.1 SPBH's License No. BHA.FS.60873329 and associated certifications are **SUSPENDED**. The **SUSPENSION** shall commence when this Notice becomes a Final Order.

3.2 This Notice will become a **FINAL ORDER** without further notice twenty-eight (28) days from the date of receipt absent a timely request for an adjudicative proceeding.

4. REQUEST FOR AN ADJUDICATIVE PROCEEDING

If you wish to contest the Secretary's decision in this matter, you or your representative must, file a written request with the department's Adjudicative Clerk's Office (ACO) in a manner that shows proof of the service on the ACO within

TWENTY-EIGHT (28) days of receipt of this decision. Please use the enclosed form labeled "Application for Adjudicative Proceeding."

The mailing address is:

Department of Health
Adjudicative Service Unit
P.O. Box 47879
Olympia, WA 98504-7879

The physical address is:

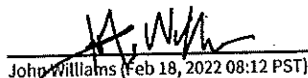
Department of Health
Adjudicative Service Unit
310 Israel Road SE
Tumwater, WA 98501

A copy of the Secretary's decision must be attached to the Application for an Adjudicative Proceeding. **FILING SHALL NOT BE DEEMED COMPLETE UNTIL THE ACO ACTUALLY RECEIVES THE APPLICATION.**

You or your representative's **FAILURE** to submit an Application for an Adjudicative Proceeding within **TWENTY-EIGHT (28)** days of receipt of this decision will constitute a waiver of the right to a hearing; the department may decide this matter without you or your representative's participation and without further notice.

DATED: February 18, 2022

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
BEHAVIORAL HEALTH AGENCY PROGRAM

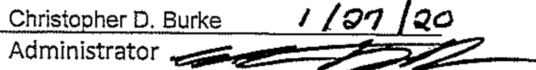

John Williams (Feb 18, 2022 08:12 PST)

JOHN WILLIAMS
EXECUTIVE DIRECTOR
BEHAVIORAL HEALTH AGENCY PROGRAM

Behavioral Health Agency Investigation Report

Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
TEL: 360-236-4732

Smokey Point Behavioral Health, 3955 156th St NE, Marysville, WA 98271
Agency Name and Address

Christopher D. Burke 1/27/20
Administrator 

Investigation	11/21/19	33894
Inspection Type	Investigation Onsite Dates	Investigator Hospital
2019-13786	BHA.FS.60874194	
Case Number	License Number	BHA/RTF Agency Services Type

Please note that the deficiencies/violations/observations noted in this report are not all-inclusive, but rather were deficiencies/violations/observations that were observed or discovered during the on-site investigation.

Deficiency Number and Rule Reference	Observation Findings	Plan of Correction
RCW 71.05.050(1) Voluntary application for mental disorder or substance use disorder treatment—Rights—Review of condition and status—Detention—Person refusing voluntary admission, temporary detention. (1) Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a mental disorder or substance use disorder, either by direct application or by referral. Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request.	Based on interviews and clinical record review, the facility failed to release a voluntarily admitted patient immediately upon his or her request for 1 of 1 patients reviewed (Patient #1). Failure to release a voluntarily admitted patient immediately upon his or her request can result in a patient being improperly involuntarily detained, which is a violation of patient rights and can cause patient harm and trauma. Findings included: Interviews and review of Patient #1's clinical record showed	

4	that the patient voluntarily admitted to the facility on a Friday 04/05/19 because she was feeling increased symptoms of depression and was proactively seeking additional services to see what was available outside of her own community. The patient was told that she would be able to leave whenever she wanted and that she would be able to return to work on Monday. The patient requested to leave multiple times during her stay and was not given permission or assistance to leave based on the following: 1. During an interview on 12/04/19 at 12:00 PM, Patient #1 stated the following: a. Patient #1 stated that she called the facility Friday morning on 04/05/19 to see about going there for the weekend due to increased symptoms of depression related to her work injury, and to receive mental health services she thought might not be available in her own community. When she called the facility she told them the purpose of her inquiry and that she was not in crisis. The staff member on the phone set up an intake appointment for the patient at 2:00 PM that day. b. Patient #1 stated that during the intake process, the intake specialist told her that she was on the cusp of needing inpatient services and suggested she do intensive outpatient services. The patient told her that she could not do outpatient services due to her living too far away and needing to go to work. The intake specialist told Patient #1 that if she checked herself in, she could leave at any time, "that it wasn't like jail, I could leave whenever I wanted to." Patient #1 stated, "The first time I expressed that I wanted to leave was when I was checking myself in and I told the intake specialist that I wanted to leave on Sunday to go to work on Monday. That's when she assured me I could leave whenever I wanted to." c. Patient #1 stated, "The next time I asked about leaving was	

5	when I was talking to the provider [Staff C] who did my evaluation the next morning on 04/06/19. She increased my Zoloft dose and suggested I stay to wait to see what happens. I knew at that point that I didn't want to change my medication because I was concerned it would give them a reason to keep me longer. Also, I was unable to get medication for my work injury pain and started to think that I could be taking better care of myself at home." d. Patient #1 stated, "My outside therapist came to see me during visiting hours on Saturday (04/06/19). I told my therapist what the intake process was and that I wasn't really satisfied with what was going on. After that conversation she called me later and told me about her conversation (with staff) about leaving AMA (against medical advice), that I was voluntary but if I chose to walk out the door I would be leaving AMA and my insurance wouldn't pay anything." e. Patient #1 stated, "Sunday morning I asked them if I would be discharged today. They told me that they didn't have the staff to discharge me today." f. Patient #1 stated, "On Monday morning I spoke with [Staff D, Nurse]. I told her that I didn't want to leave AMA because I didn't want to incur the costs of my stay, and I was afraid it could make me look unstable if I wasn't cooperative. [Staff D] and another man who signed my doctor's note, told me that they almost never do discharges on Mondays." g. Patient #1 stated, "On Tuesday ... each time I asked about leaving I felt like I was bothering the staff. I repeatedly reminded the staff of my pending discharge. Finally [Staff D] took me down to the room with the safe ... while the rest of the unit was at lunch. That's when they showed me the bill, which was the estimated cost and approximately $1200. It was for 5 days, and I asked how it could be for 5 days because I did not get to the unit until after 6:00 PM on Friday and I	

was leaving mid-day on Tuesday, and I had continually expressed that I wanted to leave 3 days ago. I was visibly upset. I think to move it along, they changed it to 4 days, which made the bill approximately $847. I just wanted to leave, so I gave them my credit card. I felt that if I didn't pay, no one was going to escort me out of the facility, and I didn't know how to get out on my own."

h. Patient #1 stated, "I would not put myself in that position again. That was the first time I was hospitalized, and for four days. The fact that I did not get any medical examination concerns me. When I went to see my PCP (Primary Care Provider), she put me on thyroid medication which has done more to alleviate my symptoms than the increase in the Zoloft did. I am back to taking my original dose of Zoloft. Smokey Point did not feel like a safe place. I thought I was going somewhere where I would get help, and ended up feeling like I had to defend myself...I feel like I didn't get what I needed. My experience was not empowering at all. I don't think I could ever go back to some place like that for help again. I think they probably made money off of me. I wish I could have been more informed. I think the best way to describe my experience is that it left me feeling helpless."

2. Psychiatric Evaluation, dated 04/06/19, states that Patient #1 was admitted to the facility with "passive SI (suicidal ideation), increased anxiety and depression, stressors are work situation", "being at hospital increases her anxiety", "she agreed to stay tonight but would like to leave tomorrow", "denies history of suicide attempt", "denies active thought, intent, urge or plan."

3. Provider Note, dated 04/07/19, 3:30 PM, has checked boxes indicating that Patient #1's affect was appropriate, her thought content was appropriate, she denied hallucinations, suicidal thought, plan or ideation. The note states, "She reports improvement in mood, anxiety manageable today,

	denies panic attack. She appears calmer, eye contact better, affect brighter. Enjoyed milieu more, socializing with peers more. Denies side-effects from increased Zoloft, tolerating well. She would like to be discharged tomorrow; encourage to stay until safe discharge in place". 4. Nurse Note, dated 04/07/19, 4:50 PM, states, "Pt requesting to leave and stated 'I'm here voluntarily and not SI'. Advised pt she will meet with provider today and she needs to discuss." 5. Nurse Note, dated 04/08/19, 5:30 AM, states, "Earlier in day she wanted to leave AMA ... She does not feel SPBH is therapeutic place for her. Agreed to stay until Monday." 6. Provider Note, dated 04/08/19, 3:00 PM, states, "SI resolved. Depression has subsided. Anx. (anxiety) Tolerable. D/C tomorrow." 7. Discharge Instructions signed by Patient #1 and Social Worker on 04/08/19 at 4:16 PM. 8. Provider Orders, dated 04/09/19, 9:00 AM, states, "Discharge today – return home meds and possessions". 9. During an Interview on 11/21/19 at 12:25 PM, Investigator #1 asked Staff D, PA-C, why Patient #1 was not discharged on 04/08/19 after he assessed her to be ready for discharge, and instead was discharged the next day on 04/09/19. Staff D stated that it is safer for a patient to leave in the morning and on the day that they have a follow-up outside appointment. Staff D stated that if Patient #1 had asked him to leave it would not have been AMA, and that he would have let her go. He stated that he would have suggested she stay another day for safety, but that Patient #1 would not have met the criteria for a DCR (Designated Crisis Responder) referral.	

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10. During an interview on 11/21/19 at 11:00 AM, Staff B, Director of Clinical Services, stated that patients need an order to discharge and that the order can be a verbal order. She stated that there are three types of discharges, AMA (against medical advice), unplanned discharge which is a discharge that is not planned but the patient is safe and appropriate, and planned discharges where all arrangements and documentation occur 24-48 hours prior to the patient being discharged. She stated that multi-disciplinary meetings where discharges are discussed occur Mondays through Fridays. A "huddle" can occur on the weekend to discuss a discharge as all players are at the facility on the weekend. If a patient is referred for intensive outpatient services, referrals can only be made on the weekdays. When Investigator #1 asked Staff B what patients are told regarding costs if they discharge AMA, Staff B stated that she does not believe patients are told that insurance will not pay if a patient discharges AMA because she believes that insurances do pay.

11. During an interview on 12/04/19 at 8:30 AM, Patient #1's outside therapist stated, "I visited the client on Saturday 04/06/19. The client told me that during the admission process she was led to believe that she could leave whenever she wanted to, and that now she was being told she had to wait. The client told the facility that she needed to go to work on Monday and that she just didn't want to be alone on the weekend. Now she was getting push back and was very anxious and afraid that she was not going to be allowed to leave. The client stated that whenever she asked staff about the process of leaving, they stated that she had to wait until at least Monday and that they couldn't tell her anything else. This was very frightening for my client to not receive clear answers from staff about when she was going to be allowed to leave. She told me that she was fearful they would keep her much longer than she intended to stay if she tried to dispute anything. She told me that if she would have been informed that she would have to stay at least through

	Monday, she would not have admitted herself since she was planning to go to work on Monday. She stated that she would not have checked herself in if she knew she couldn't leave. I asked the front desk to explain the process of leaving and they recommended that I call and ask to speak with a nurse." "On the way home I called and spoke to the nurse who told me ...that there were two ways the client could leave. The client could go AMA. If the client chose to go AMA she would need to let a staff member know as soon as possible. Then someone would be available to talk with her to complete a discharge interview within 24 hours of her notifying staff. Thus she would be able to leave within 24 hours of telling someone, as long as she was deemed to be eligible for discharge. The nurse told me that if she left AMA her insurance would not pay and that the client would be financially responsible for the entire stay. She told me no one would be there over the weekend that could start the discharge process, so it would start on Monday when the rest of the staff was working. The nurse stated that it didn't matter that the client was a voluntary admission, she still had to be discharged with the recommendation of a medical professional who was not working on the weekend. The nurse also confirmed that if the client was at a regular hospital on a 72-hour suicide hold she would be able to leave, but that Smokey Point had different rules to follow. This information was directly in contrast to what the client was told at intake. The client is currently experiencing negative mental health symptoms as a direct result of her time spent at Smokey Point, the lack of information she was provided at intake and throughout her stay, and the lack of care provided while she was there."	
WAC 246-341-1126(4)(c) Mental health inpatient services—Policies and procedures—Adult. In addition to meeting the agency licensure, certification, administration, personnel, and clinical requirements in WAC 246-341-0100 through 246-	Based on interviews and policy and procedure review, the facility failed to implement a policy management structure that established procedures to assure the protection of individual rights as described in 71.05 RCW for any person voluntarily admitted for inpatient treatment to be released	

341-0650, and the applicable inpatient service requirements in WAC 246-341-1118 through 246-341-1132, an inpatient facility must implement all of the following administrative requirements: (4) A policy management structure that establishes: (c) Procedures to assure the protection of individual and family rights as described in this chapter and chapters 71.05 and 71.34 RCW.	immediately upon his or her request and to be advised of the right to immediate discharge. Failure to implement a policy management structure that establishes procedures to assure the protection of individual rights as described in 71.05 RCW for any person voluntarily admitted for inpatient treatment to be released immediately upon his or her request and to be advised of the right to immediate discharge can result in a patient being improperly involuntarily detained, which is a violation of patient rights and can cause patient harm and trauma. Reference: RCW 71.05.050(1) Voluntary application for mental disorder or substance use disorder treatment—Rights—Review of condition and status—Detention—Person refusing voluntary admission, temporary detention. (1) Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a mental disorder or substance use disorder, either by direct application or by referral. Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request. Any person voluntarily admitted for inpatient treatment to any public or private agency shall orally be advised of the right to immediate discharge, and further advised of such rights in writing as are secured to them pursuant to this chapter and their rights of access to attorneys, courts, and other legal redress. Findings included: 1. During an interview on 11/21/19 at 11:00 AM with Staff B, Director of Clinical Services, stated that patients need an order to discharge. 2. Review of facility policy titled, "Request for Discharge AMA", dated 5/2017, states that patients requesting discharge prior to the physician's recommendations will be	

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	discharged AMA. In order for a patient to be discharged AMA, the following steps need to occur: a. The request must be in writing, signed, timed, and dated by the patient. b. Staff must make an effort to assist the patient in identifying their reasons for wanting to leave. c. Staff must notify the house supervisor, director of clinical services and the administrator. d. Staff must conduct a safety analysis which includes reviewing the patient's history and consulting with friends and/or family of the patient. e. Staff must synthesize the information collected to make a decision regarding the patient's safety in light of the AMA discharge. f. Staff have up to 4 hours to notify the attending physician for orders once all of the above steps have been taken. 3. Record review of facility document titled, "Authorization and Assignments for Admission", #18 titled, "Notice of Voluntary Patient's Right to Discharge", signed by patients upon admission, showed that it does not inform voluntary patients that they have the right to be released immediately upon request, or that the facility requires such a request to be made in writing that is signed, timed and dated by the patient. 4. During a phone interview on 11/27/19 at 2:45 PM, Patient #1 stated that when she asked to be released AMA, she was not informed that the request had to be in writing that was signed, timed and dated.	

WAC 246-341-0620(1)(f) Clinical—Individual service plan. Each agency licensed by the department to provide any behavioral health service is responsible for an individual's service plan as follows: (1) The individual service plan must: (d) Document that the plan was mutually agreed upon and a copy was made available to the individual;	Based on clinical record review, policy and procedure review, and interviews, the facility failed to document that the individual service plan (ISP) was mutually agreed upon by the individual when it was developed, and failed to make a copy available to the individual, for 1 of 1 patients reviewed (Patient #1). Failure to document that the ISP is mutually agreed upon by the individual when it is developed, and to make a copy available to the individual, can result in care that is not agreed upon by the patient, which can result in patient harm and poor care outcomes. Findings included: 1. Review of Patient #1's clinical record showed the following: a. The patient's initial treatment plan was signed by the nurse on 04/05/19 at 6:30 PM, day 1 of the patient's stay at the facility. b. The patient's ISP was signed by clinical staff on 04/06/19, day 2 of the patient's stay at the facility. c. The patient's ISP was signed by the patient on 04/08/19, day 4 of the patient's stay at the facility, the same day that she signed her discharge papers. d. Document titled, "Patient Rights and Responsibilities", section titled, "Provision of Care", signed by Patient #1 on 04/05/19 at 4:10 PM, states, "The patient/family has the right, in collaboration with the physician, to be informed about and to make decisions involving his/her health care, including the right of the patient to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal." e. Document titled, "Patient Rights and Responsibilities",	

13	section titled, "Patient and Family Responsibilities", sub-section titled "Compliance with Instruction", signed by Patient #1 on 04/05/19 at 4:10 PM, states, "The patient / family are responsible for following the treatment plan developed with the practitioner and should understand that noncompliance could affect outcome. While the plan is being developed, the patient/family should express any concerns regarding ability to carry out the proposed course of treatment. Every effort should be made to adapt the treatment plan to the patient's specific needs and limitations." 2. Review of facility policy titled, "Treatment Planning", dated 5/2017, states, "Following the Nursing Admission Assessment, the RN will add any medical problems to be addressed to the treatment plan, and discuss this with the patient. The therapist completing the clinical formulation will complete the initial treatment plan and discuss it with the patient." 3. During an interview on 11/21/19 at 11:00 AM, Staff B, Director of Clinical Services, stated that treatment plans are started on the day of admission and are finished within 72 hours of a patient's admission. 4. During an interview on 12/04/19 at 12:00 PM, when Investigator #1 asked Patient #1 if she knew what her individual service plan was, Patient #1 asked if the investigator meant the calendar of group therapy times that she was directed to, or the referral for services on the discharge instructions. Patient #1 was not aware that an individual service plan had been developed for her. She did not remember signing the ISP on 04/08/19, which was the same day that she signed her discharge papers. Patient #1 stated that she did not receive a copy of an individual service plan during her stay at the facility.	
WAC 246-341-0420(9) Agency administration—	Based on clinical record review, policy and procedure review,	

Policies and procedures. Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain administrative policies and procedures to meet the minimum requirements of this chapter. The policies and procedures must demonstrate the following, as applicable: (9) Funding options for treatment costs. A description of how the agency works with individuals to address the funding of an individual's treatment costs, including a mechanism to address changes in the individual's ability to pay.	and interviews, the facility failed to work with an individual to address the funding of the individual's treatment costs for 1 of 1 patients reviewed (Patient #1). Failure to work with an individual to address the funding of the individual's treatment costs can create a financial burden on a patient, which can cause stress and harm to the patient. Findings included: 1. Review of Patient #1's clinical record, document titled, "Patient Rights and Responsibilities", signed by Patient #1 on 04/05/19 at 4:10 PM, states, "The patient has the right to examine and receive an explanation of his/her bill regardless of the source of payment". 2. Record review of the facility's policy title, "Financial Needs", dated 05/2017, showed that all patients are to have their insurance verified before an admission if possible, and that if there is no insurance the Intake Counselor or the Financial Counselor are to inform the patient of their obligations. It states that the Intake Counselors shall verify benefits and certify the admission if the Financial Counselor is not available, and that they will inform the patient of their benefits. 3. During an interview on 12/04/19 at 12:00 PM, Patient #1 stated, "When I arrived, I asked about insurance. I had forgotten my insurance card at home. The staff member told me no worries, they could look it up... On Tuesday ... that's when they showed me the bill, which was the estimated cost and approximately $1200. It was for 5 days, and I asked how it could be for 5 days because I did not get to the unit until after 6:00 PM on Friday and I was leaving mid-day on Tuesday, and I had continually expressed that I wanted to leave 3 days ago. I was visibly upset. I think to move it along, they changed it to 4 days, which made the bill approximately	

15	$847. I just wanted to leave, so I gave them my credit card. I felt that if I didn't pay, no one was going to escort me out of the facility, and I didn't know how to get out on my own. They did not offer to bill me later. They told me I had to sign the bill before I could leave. I felt the social pressure to pay the bill right there or it would be viewed like I was skipping out without paying, like I was stealing. The bill was not itemized." 4. During an interview on 12/04/19 at 8:30 AM, Patient #1's outside therapist stated, "Smokey Point intake staff did not talk with the client about the cost of treatment, even though their website states that the intake assessment includes 'An explanation of insurance benefits and the cost of treatment by a financial counselor'. Their website also states that, 'we will verify your insurance benefits, and we will review them with you at the time of your assessment.' ... The client paid approximately $840 at discharge, and was later sent a bill for $1000 which she is disputing".	