Washington State Department of Health

Adverse Event Contextual Information Form (Optional)

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Complete the following information and return by:

- Email to: AdverseEventReporting@doh.wa.gov, or
- Mail to: DOH Adverse Events, PO Box 47853, Olympia, WA, 98504-7853, or
- Fax to: Adverse Events (360) 236-2830

Facility Name:	Kindred Hospital Seattle - First Hill
Facility Contact:	Ryan Hosken, RN (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred-hospital-seattle-first-hill
Date of Event Confirmation:	12/28/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility Information:	Submitting aggregate RCA for 4F events (8/14/2019 through 12/28/2019) by 12/31/2019. ←
Event Information: →	4F event reported on 12/30/2019: Patient E (below) was assessed as having a Stage 3 wound to the occiput on 12/28/2019. Patient E was admitted on 9/21/2019. Context for pending RCA: 4F events reported on 12/18/2019: Patient G was assessed as having an unstageable wound to the left nare on 12/13/2019. Patient G was admitted on 8/12/2019. Patient H was assessed as having an unstageable wound to the right posterior head on 12/15/2019. Patient H was admitted on 10/31/2019. 4F events reported on 12/5/2019: Patient A was assessed as having a Stage 3 wound to sacrum on 8/14/2019. Patient A was admitted on 7/17/2019. Patient B was assessed as having a right heel wound that evolved to Stage 4 on 9/1/2019. Patient B was admitted on 2/15/2019 (vs 8/31/2019). Patient C was assessed as having a Stage 3 wound to left buttock on 9/12/2019 and a Stage 3 to sacrum and coccyx on 10/2/2019. Patient C was admitted on 9/1/2019. Patient D was assessed as having a Stage 3 wound to coccyx on 9/28/2019. Patient D was admitted on 8/19/2019. (next page)

Washington State Department of Health

Adverse Event Contextual Information Form (Optional)

	Patient E was assessed as having a Stage 3 wound to rectal area and perineum on 11/28/2019. Patient E was admitted on 9/21/2019. Patient F was assessed as having a Stage 3 wound to sacrum and right ischium on 11/28/2019. Patient F was admitted on 11/15/2019.

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Facility Name:	Kadlec Regional Medical Center
Facility Contact:	Debra Langston
Facility web site:	www.kadlec.org
Date of Event Confirmation:	12/20/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	337
Other Facility Information:	
Event Information:	On admission 11-20-2019 patient [redacted] had stage 3 PI to coccyx. 11-23-2019 wound care nurse documented stage 2. 11-28-2019 notes show the wounds with epithelization. 12-5-2019 wounds continue to heal 12-19-2019 (per record) significantly larger has progressed to unstageable. Lapse in wound care approx 2 weeks.

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Facility Name:	Kindred Hospital Seattle
Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred-hospital-seattle-first-hill
Date of Event Confirmation:	12/13/2019 and 12/15/2019 - both submitted on 12/18/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility Information:	LTAC
Event Information:	Continuing A-Z letter designations from the previous Contextual Information Form: Patient G was assessed as having an unstageable wound to the left nare on 12/13/2019. Patient was admitted on 8/12/2019. Patient H was assessed as having an unstageable wound to the right posterior head on 12/15/2019. Patient was admitted on 10/31/2019. RCA(s) will include a review of and revisions to our internal reporting processes (already in progress) in order to comply with DOH requirements.

Washington State Department of Health

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Facility Name:	Monroe Correctional Complex
Facility Contact:	Areig Awad
Facility web site:	https://www.doc.wa.gov/corrections/incarceration/prisons/mcc.htm
Date of Event Confirmation:	12/04/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	24 beds in infirmary-step down unit, with low-medium acuity
Other Facility Information:	Minor procedures done such as toe nail removals, minor suturing, joint injections, skin biopsy.
vent Information:	Patient was admitted for observation post operative and to regain strength. He is very competent and ask nursing for help with any movement. He had a falls and mainly mechanical and has not informed nursing when instructed to on multiple occasions. He was sent to the hospital due to a recent back surgery and they noted, " MRI does show postsurgical changes and some impingement of the cord that is unclear if this is an acute process or simply changes from surgery." Surgery was conducted anyway due to persistent symptoms that were there before the fall. It is not clear whether the fall caused any additional injury, but based on notes it does not appear that way. This was sent just to be cautious in case it does need to be reported. Additional information can be requested upon request.

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Facility Name:	Garfield County Hospital District
Facility Contact:	Jayd Kreener RN DNS Co-CEO
Facility web site:	
Date of Event Confirmation:	12-3-19
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25
Other Facility information:	NA
Event Information:	Patient alarm went off, Staff responded found Patient walking to bathroom, pt was assisted to bathroom, pt fell forward while going to sit on toilet, fell on walker. ~~Hair line fracture to~~ Found to have positive findings of (R) wrist that include 1. mildly comminuted intra-articular fracture of the distal radius of Rarm 2. possible nondisplaced ulnar styloid fracture of (R) wrist Investigation with plan to follow Jayd Kreener

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Facility Name:	Kindred Hospital Seattle (First Hill)
Facility Contact:	Ryan Hosken (Director of Quality)
Facility web site:	https://www.kindredhealthcare.com/locations/transitional-care-hospitals/kindred-hospital-seattle-first-hill
Date of Event Confirmation:	Multiple - please see below
Facility capacity: (e.g., # of beds, rooms, procedures per year)	50
Other Facility information:	LTAC
Event Information:	'Several 4F adverse events were not reported for September through November of 2019 based on our Wound Care Coordinator having taken another position on 9/13/2019 and my own absence as Director of Quality between 5/29/2019 and 10/29/2019. While wound care continued, our reporting was not happening. These events are as follows: Patient A was assessed as having a Stage 3 wound to sacrum on 8/14/2019.Patient was admitted on 7/17/2019. Patient B was assessed as having a right heel wound that evolved to Stage 4 on 9/1/2019. Patient was admitted on 2/15/2019. Patient C was assessed as having a Stage 3 wound to L buttock on 9/12/2019 and a Stage 3 to sacrum and coccyx on 10/2/2019. Patient was admitted on 9/1/2019. Patient D was assesses as having a Stage 3 wound to coccyx on 9/28/2019. Patient was admitted on 8/19/2019. Patient E was assessed as having a Stage 3 wound to rectal area and perineum on 11/28/2019. Patient was admitted on 9/21/2019. Patient F was assessed as having a Stage 3 wound to sacrum and right ischium on 11/28/2019. Patient was admitted on 11/15/2019. Our collective RCA is in progress. Please advise.

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Facility Name:	EvergreenHealth Monroe Recovery Center
Facility Contact:	Eric Britt (Program Director)
Facility web site:	www.recoverycentermonroe.com
Date of Event Confirmation:	10/11/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	Licensed for 40 beds (withdrawal management/detox and intensive inpatient/residential).
Other Facility Information:	
Event Information:	- 28-year-old female patient in our Intensive-Inpatient/residential treatment program was transferred to a higher level of care after a reported suicide attempt (in the evening of 10/11/2019). - Patient was admitted to detox on 10/3/19 - She was transferred into the residential program on 10/5/19. She had been placed on a "no self-harm" contract at time of admission due to a history of suicidal ideation and "cutting" - She was not actively suicidal at time of admission. - On 10/8/19 patient reported having thoughts of cutting herself. Staff removed patient's shaving razor from her bedroom, and she was placed on "30-minute checks" (staff conducts visual checks on patient every 30 minutes). The next day (10/9/19) patient reported feeling better and denied having any SI. - On 10/11/19 a different patient reported to staff that this patient had shared that she was experiencing SI. Upon receiving that report, staff (lead counselor & program director) entered patient's room and met with her at bedside. She disclosed that she had just (moments before we entered her room) attempted to hang herself from the shower curtain in her bathroom. She was rubbing her neck and her voice was somewhat hoarse. She reported that she had moved a chair into her bathroom - stood on the chair - tied the shower curtain around her neck - stepped off the chair for a moment - then changed her mind and stepped back onto the chair. - Patient was immediately placed on "one-to-one" status (a staff member with her at all times). The lead counselor stayed with patient in her bedroom, to monitor patient and complete a suicide risk assessment. Program Director (this writer) left the room and informed all staff working on the unit of the incident & that patient was now on one-to-one status. This writer then spoke with intake staff at Smokey Point Behavioral Hospital, and they confirmed that they could accept this patient immediately. - Patient was then transferred to the EvergreenHealth Monroe Emergency Department for medical clearance, to have her neck evaluated, and for appropriate transportation to be arranged from Evergreen Monroe to Smokey Point Behavioral. Patient was evaluated in the ED, and several hours later was transferred, via ambulance, to Smokey Point Behavioral Hospital.

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Facility Name:	Seattle Children's
Facility Contact:	Jackie Valentine, Director of Patient Safety
Facility web site:	www.seattlechildrens.org
Date of Event Confirmation:	9/26/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	407 licensed beds
Other Facility Information:	
Event Information:	patient-on-patient, ages 9 and 10.

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Facility Name:	Fairfax Behavioral Health - Monroe
Facility Contact:	Beckie Shaulnger, CEO ph: 425-284-1547, email: beckie.shauinger@uhsinc.com
Facility web site:	www.fairfaxhospital.com
Date of Event Confirmation:	9/25/19
Facility capacity: (e.g., # of beds, rooms, procedures per year)	34
Other Facility information:	
Event Information:	On 9/24/19 at approximately 11:30 PM, a 60 year-old male patient was found unresponsive, in his room, with scrub pants tied tightly around his neck. The ligature was removed, 911 was called, the AED was applied and EMS arrived. Rescue efforts continued until approximately 12:19 AM on 9/25/19 when the patient was declared deceased.

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Facility Name:	Tri-State Memorial Hospital
Facility Contact:	Kim Pospychalla, RN Director of Quality
Facility web site:	tristatehospital.org
Date of Event Confirmation:	9/19/19
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25 bed Critical Access Hospital
Other Facility Information:	
Event Information:	Patient was scheduled for an epidural injection at the Interventional Pain Clinic. The injection was supposed to occur in the left L5-S1 epidural space, but the injection was given in the right L5-S1 epidural space. No harm or ill effects to the patient, and the correct injection was given right after the error was discovered.

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Facility Name:	Gateway Surgery Center
Facility Contact:	Michelle Cornwell
Facility web site:	
Date of Event Confirmation:	8-6-19
Facility capacity: (e.g., # of beds, rooms, procedures per year)	2 Bed OR, 1900 - 2100 procedures per year
Other Facility Information:	
Event Information:	wrong site pain injection received Right sided injection instead of Left side. Catherine Yee - MD

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Facility Name:	Cascade Behavioral Health Hospital
Facility Contact:	Janet Huff, RN, Director of Risk and Quality
Facility web site:	www.cascadebh.com
Date of Event Confirmation:	7/18/19
Facility capacity: (e.g., # of beds, rooms, procedures per year)	137
Other Facility Information:	Acute Psychiatric and Substance Use Disorder hospital serving inpatients and outpatients.
Event Information:	Female patient alleged she was inappropriately touched by another male patient. After reviewing the records and interviewing staff and the female patient I came to the following conclusions: 1. Neither patient was on 1:1 monitoring, the male patient was seen "hovering" around the female patients room and was told to leave. Staff walked away from the female patients room to attend to another patient on the unit and the male patient entered the female patients' room. 2. The female patients roommate stated in writing that she saw the male "lay down beside her" and put his arm around her. She then told him to get out of the room, after he left she went to tell staff that he was in there. 3. The female patients recounting of the incident to floor staff, outside hospital staff, police and her own written statement have inconsistencies. The only consistently stated event that multiple witnesses recount is that the male patient went into her room and laid on the female patients bed with her. The female patients story sometimes included touching of her private area, sometimes touched over the blankets, sometimes only laid an arm around her over the blankets. 4. The male patient was too disorganized to interview by the Director of Risk or the police. 5. The male patient should not have been in the female patients room regardless of what occurred after he entered. Since this event, the units have been split into male and female sides with 2 staff consistently monitoring the hallways and patient rooms. Nursing staff have received additional education regarding precautions relating to sexually acting out or sexual victimization.

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Facility Name:	Monroe correctional Complex
Facility Contact:	Areig Awad.MD/ Billy Heinsohn
Facility web site:	https://doc.wa.gov/
Date of Event Confirmation:	06/29/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	24 inpatient beds 20 rooms
Other Facility Information:	
Event Information:	Patient was diagnosed with metastatic renal cell carcinoma on a hospital visit for suspected pneumonia on 05/06/2019. Notes from a CT scan chest during that ER visit noted "interval enlargement of the previously noted right renal mass, previously measuring 3.5 cm, currently measuring 9.0x6.5x5 cm malignant in appearance." This was mentioned along with metastasis throughout patients body. Unfortunately, we do not have EMR and due to this report noting "previously measuring," we looked back on any visits to that hospital. On 01/27/2019 patient was sent for right total knee replacement and was admitted for surgery. Due to symptoms that occurred post operative he had a CTA chest done for pulmonary embolism. This is the first time it was noted that the patient had a mass, but no written evidence that this was relayed to provider on discharge. It was also not mentioned on discharge papers from hospital. It was just noted in the CTA report.

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Facility Name:	Skagit Valley Hospital
Facility Contact:	Sarah Place
Facility web site:	www.skagitregionalhealth.org
Date of Event Confirmation:	4/16/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	137 Beds
Other Facility information:	Acute Care Hospital
Event Information:	**8/11/18 -** Pt. seen in another hospital ED with Right pyelonephritis and renal colic. No imaging done. **8/13/19** returned same ED with worsening symptoms. CT done showing Right side stone. Admitted, then transferred to Skagit Valley Hospital to the Hospitalist service, urology consulted. **8/14/18** – Urologist documents CT revealed mild right ureteral stranding and mild hydronephrosis on the right and an obstructing 8 mm left ureteropelvic junction calculus. Urologist scheduled pt. for cystoscopy, placement of Left ureteral stent. Patient signed informed consent for Left Ureteral Stent after informed consent discussion with Provider. To OR for a Left ureteral stent placement. Timeout with staff for Left sided stent. Fluoroscopy done during the procedure. 8/16/18 – Patient discharged. **8/31/18** – Patient returned to ED with abdominal pain. ED Provider documented that per CT, pt. still had Right side stone but it was no longer obstructing the Right Ureter. Recommends the patient return to Urologist for non-urgent treatment of right renal stone and removal of left stent. The patient was informed at the time of this discovery on 8/31/18. ED Provider recommended pt. follow-up with a different urologist. Error was documented in record, but Provider did not notify the hospital management of this discovery nor enter it into the event reporting system. The organization was not able to report the event due to lack of awareness of event. **4/16/19** - The event came to the attention of hospital management and the event was confirmed and reported to the State of WA.

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Facility Name:	Astria Sunnyside Hospital
Facility Contact:	Stephanie A. Macias, BSN, RN, Director of Quality and Risk Management
Facility web site:	www.astria.health
Date of Event Confirmation:	3/18/2019
Facility capacity: (e.g., # of beds, rooms, procedures per year)	Critical Access Hospital; 25 inpatients beds
Other Facility information:	NA
Event Information:	Event reported upon completion of thorough review. Event entails a term fetal death prior to delivery in a high risk mother and fetus.

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Facility Name:	Garfield County Hospital District
Facility Contact:	Jayd Keener, RN DNS
Facility web site:	www.Pomeroymd.com
Date of Event Confirmation:	1/01/2019 at 2045
Facility capacity: (e.g., # of beds, rooms, procedures per year)	25
Other Facility Information:	
Event Information:	Patient was sitting in a chair in his room, had been compliant with using his call light since admit. Staff walked by and he was found laying on the floor by the end of his bed with call light pendant with in reach but he had not pressed it for assistance. patient was determined to have a broken hip and was sent to a higher level of care for surgical intervention.