POC received 10.16.23 DOH
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Mary Drew MSN, BSN, RN

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FORM APPROVED

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: ________ B. WING ________	C 09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

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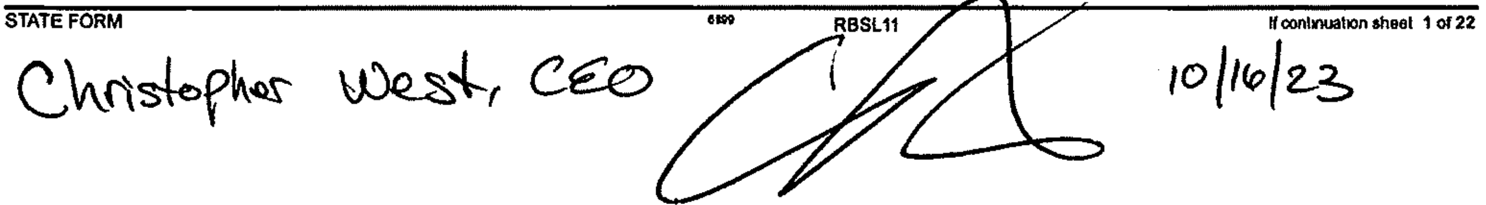
L 000	INITIAL COMMENTS . STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety investigation. On site dates: 08/23/23 to 08/24/23 Off site date/Exit date: 08/25/23 and 09/06/23 Case numbers: 2023-8801 Intake numbers: 132584 The investigation was conducted by: Investigator #1 There were violations found pertinent to this complaint.	L 000	. 1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by 10/15/23. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 325	322-035.1E POLICIES-ABUSE PROTECTION WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 325	Continued on next page	

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE



Christopher West, CEO 10/16/23

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L 325	Continued From page 1 services provided: (e) Protecting against abuse and neglect and reporting suspected incidents according to the provisions of chapters 71.05, 71.34, 74.34 and 26.44 RCW; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to provide a safe environment of care by identifying increased safety risks and implementing interventions to protect patients from incidents of sexual abuse/assault, as demonstrated by record review for 4 of 7 records reviewed (Patient #4, #5, #6, and #7). Failure to initiate interventions to protect patients from incidents of sexual abuse/assault, places the patients at risk for increased physical and psychological harm, violates their right to sexual safety, and to receive care in a safe environment. Reference: Revised Code of Washington (RCW) 71.05.020 Behavioral Health Disorders - Definitions (1) Gravely Disabled - Means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from failure to provide for his or her essential human needs of health and safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated escalating loss of cognitive or volitional control over his or her action and is not receiving such care as is essential for his or her health or safety.	L 325	How Corrected: A motion sensor was installed in the day room on the north unit on 8/22/23 to prevent patients from being in a darkened room unobserved. CEO met with CNO, DCS and CMO to discuss the finding on 10/6/23 and the requirements pertaining to providing a safe environment for patients by identifying safety risks and implementing interventions to protect patients from sexual abuse or assault. All policies noted in this finding were reviewed and did not require revision. Registered Nurses, Case Managers and Providers were re-educated by the Chief Nursing Officer, Director of Clinical Services and Chief Medical Officer on Fairfax policy "Sexual Aggression/Victimization Precautions," policy #1000.80, to include the requirement to identify patients with increased safety risks and implement interventions to protect them from sexual abuse or assault to include, but not limited to, increasing observations, adding precautions, room or unit changes & redirection of the patient. Staff are to document each intervention in the patients medical record and include the patients response to the intervention. Additionally the Chief Nursing Officer retrained all Mental Health Technicians on patient rounding & observation expectations per Fairfax Policies "Level of Observation Orders" policy # 1000.21 and "Patient Observation Policy" policy # 1000.5 to include requirements pertaining to documentation of patients location and definition and expectations of 1:1 patient monitoring. All staff will sign an attestation of completed training via sign-in sheet. The Risk Management department will run a daily report of all patients with identified sexually aggressive or sexually assaultive incidents or that have allegations or incidents of being sexually abused, that have occurred within the	11/5/23

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L 325	Continued From page 2 (2) Mental Disorder - Means any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional function. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Aggression/Victimization Precautions," policy number 1000.80/PolicyStat ID 13426424, effective 06/23, showed the following: a. It is the policy of the hospital to provide safety precautions for a safe, therapeutic environment of care which includes the prevention of patient-to-patient sexual incidents, as well as verbal/physical threats of sexual incidents. b. The purpose of the policy is to provide a plan for the prevention of sexual behavior, including aggression, and the potential for victimization by identifying early warning signs of sexual behavior, monitoring the patient with a suspected potential for sexual aggression/victimization, and implementing intervention steps to minimize the risk of sexual behavior. c. Unit staff will observe patient for specific behaviors/precursors to sexually acting out behaviors, such as boundary violations, sexual aggression and/or victimization. d. Staff will always maintain awareness of the patient's location. e. Separate patients who have been identified as "at increased risk" to engage in such behaviors.	L 325	last 24 hours and will send this report out daily to the Chief Medical Officer, Chief Nursing Officer and the Director of Clinical Services. These leaders will ensure the identified patients are discussed in treatment team and, if indicated, the treatment plan is updated and/ or revised. Who is Responsible: Chief Medical Officer, Director of Clinical Services, Chief Nursing Officer for staff training & Director of Risk Management for auditing and reporting data. Monitoring & Compliance Target: The Risk Management department will audit 30 records a month of patients with sexual behavior incidents to ensure: 1. Documentation demonstrates the identified patients are on SVP/SAP precautions. 2. Documentation demonstrates interventions and patients response to interventions is noted. 3. Documentation demonstrates any incidents of sexual behaviors, assaults or allegations of abuse is captured in Provider and nursing notes. Target for compliance is 90% or greater for the above audits. Audit data found to be out of compliance will be reported to the respective department leader for follow up and corrective action with individual staff. Results of monitoring will be reported to Quality Council and Medical Executive committee monthly and Governing Board Quarterly until compliance goals have been met and sustained for a minimum of 3 consecutive months.	11/5/23

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L 325	Continued From page 3 f. Conduct observation rounds as ordered and check all isolated areas of the unit. Document review of the hospital's policy and procedure titled, "Suspected or Confirmed Cases of Patient Sexual Activity," policy number 1000.30/PolicyStat ID 13426447, effective 06/23, showed the following definitions/terms: a. Definitions of Terms: i. Mental Incapacity - The condition existing at the time of the offense which prevents a person from understanding the nature of the consequences of the act of sexual intercourse whether that condition is produced by illness, defect, the influence of a substance, or from some other cause. ii. Consent - At the time of the act of sexual intercourse or sexual contact there are actual words or conduct indicated freely given agreement to have sexual intercourse or sexual contact. b. If the patient's consent is in question, or if the licensed nurse or provider has reasonable cause to believe that the patient is unable to consent, or is physically helpless and has suffered abuse, he or she shall report such incident. 2. Patient #4 was a 25-year-old female involuntarily admitted on 06/29/23 for grave disability after her mother reported that she was naked and running in and out of her room. Patient #4 was transported to the acute care hospital for medical clearance. The acute care hospital reported that the Patient was impulsive, erratic, and hypersexual and had been observed lying in bed, naked below the waist, exposing her	L 325		

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L 325	Continued From page 4	L 325		

genitalia. Following the Patient admission to Fairfax, she continued to disrobe intermittently, and required constant redirection. Her psychiatric diagnosis was Unspecified Schizophrenia. Review of the medical record showed the following:

a. On the Admission Order dated 06/29/23, the provider initiated the following precautions for Patient #4: Suicide Precautions (SP), Elopement Precautions (EP), Assault Precautions (AP), Sexual Aggression Precautions (SAP), and Sexual Victimization Precautions (SVP).

b. On 07/20/34 at 2:15 PM, nursing staff documented that when the Patient was in the milieu when a male peer (Patient #6) came up to her and started rubbing her shoulders, calling her "my angel." The RN documented that the Patient appeared to have no insight into the situation, could not tell staff what happened, and was not able to tell male peer to stop touching her.

c. Review of the Psychiatric Provider Daily Progress Note dated 07/10/23 at 4:20 PM, found that the provider documented that the Patient was paranoid, delusional, illogical, and internally preoccupied. The provider documented that the patient was being sexually targeted by multiple male patients.

The Investigator's review of the Patient's medical record found that staff failed to implement any additional interventions (other than increasing observation), in response to Patient #4 being sexually targeted.

3. Patient #6, who was involved in the 07/10/23 incident with Patient #4, was a 54-year-old male involuntarily admitted on 07/06/23 for grave

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L 325	Continued From page 5 disability after presenting to the acute care medical hospital with aggression, paranoia, delusions, and hyper religiosity. On 07/07/23 Patient #6 was placed on SAP after exhibiting sexually inappropriate behaviors toward female peers and staff. Review of the Daily Nursing Progress Notes between 07/07/23 and 07/24/23 found that for 14 of 17 days, nursing staff documented that the Patient was sexually inappropriate and aggressive with female staff and peers, including disrobing, touching, and physically/sexually aggressive behaviors. This Investigator's review of the medical record found that staff failed to document the implementation of patient specific interventions to address the Patient's sexually inappropriate/sexually aggressive behavior (other than redirection), or the Patient's response to the interventions, other than the daily documentation of the behaviors observed and multiple attempts to redirect the behaviors. 4. On an Incident Report dated 07/24/23, staff documented a Level 3 - Serious Incident (categorized as a Patient-to-Patient Sexual Intercourse event on 07/24/23), between Patient #7, a 29-year-old female, and Patient #5, a 38-year-old male. According to the Incident Report, a Mental Health Technician (MHT) who was assigned to 1:1 observation for a different patient located down the hallway, heard moaning sounds coming from the dayroom at approximately 12:05 AM. The MHT walked down to the darkened day room, turned on the light and discovered Patient #7 and Patient #5 alone. Patient #5 was standing in front of Patient #7, who was seated in a lounge chair. When the MHT entered the day room, he observed Patient #2 pulling up his pants.	L 325		

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L 325	Continued From page 6 5. Review of Patient #7's medical record showed the following: a. Patient #7, a 29-year-old female, was admitted on 07/23/23 on an involuntary detainment for danger to others and grave disability. Upon admission, it was documented that the Patient was screaming, responding to internal stimuli, and unable to participate in the admission assessment. On the Psychiatric Evaluation dated 07/23/23, the provider documented that the Patient presented with symptoms of psychosis, responding to internal stimuli, delusional, hyperarousal, and reported auditory hallucinations that were telling her to do bad things. Patient #7 had a history of sexual victimization, was sexually abused as a ten, raped after high school, and had become sexually aggressive with her father. The provider documented on the Mental Status Exam (MSE) of the evaluation that the Patient was inattentive, guarded, withdrawn, pacing, hyperverbal, anxious, paranoid, and had impaired judgement. The psychiatric provider ordered that the Patient be placed on SAP and SVP. 6. Review of Patient #5's medical record showed the following: a. Patient #5 was admitted on 06/08/23 on an involuntary detainment for grave disability. The Patient had not been eating or sleeping and was religiously preoccupied. On the Psychiatric Evaluation dated 06/09/23, the psychiatric provider documented that the Patient presented with increased paranoid delusions, a disorganized thought process, responding to internal stimuli (RIS), laughing inappropriately, and unable to participate in the admission assessment. The	L 325		

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L 325	Continued From page 7 provider documented on the MSE of the evaluation that the Patient admitted to auditory hallucinations of magical things but was unable to provide more significant history. b. The Investigator reviewed Patient #5's Daily Psychiatric Provider progress notes between 07/20/23 through 07/23/23 (the days leading up to the incident) and found that the provider documented that the Patient had been isolating in his room, was guarded, internally preoccupied (RIS), had an illogical thought process, with impaired insight and judgment. The Daily Nursing progress notes between 07/20/23 through 07/23/23 documented similar behaviors, including a disorganized thought process, and auditory and visual hallucinations. 7. On 08/24/23 at 1:15 PM, the Investigator met with the Director of Risk Management in Training (Staff #4) to review the video from the incident that took place between the times of 07/23/23 at 11:30 PM to 07/24/23 at 12:05 AM. The video showed the following: a. On 07/23/23 at 11:30 PM the lights in the dayroom were on. Patient #7 was sitting in a lounge chair in the dayroom with another male peer, who was seated at the dining table with his head down. b. At 11:32 PM, staff turned the lights to the dayroom off. c. At 11:35 PM, Patient #5 went to the nurse's station, which was across from the dayroom. d. At 11:40 PM, Patient #5 entered the darkened dayroom, and the other male peer left a few seconds later. At that time, Patient #5 and Patient	L 325		

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L 325	Continued From page 8 #7 were in the darkened dayroom alone. e. At 11:48 PM, the Patients were sitting side by side in lounge chairs. Patient #7 began reaching out and touching Patient #5. f. At 11:49:07 PM, an MHT doing the observations rounds steps into the dayroom and documents that the two Patients are alone in the darkened dayroom. The Patients are not directed to leave the dayroom, and the room remained darkened. g. At 11:49:13 PM, the MHT tasked with observing the hallway and dayroom is called away from the floor to go into the nurse's station. h Between 11:52 PM and 12:05 AM (07/24/23), Patient #5 and Patient #7 engaged in oral and vaginal sexual intercourse. i. At 12:00 AM, the MHT performed the observation rounds and documented that Patient #5 was alone. The MHT could not see Patient #7 because she was kneeling in from of Patient #5 perfoming oral sex. j. At 12:05 AM, the MHT was sitting in the hallway, doing the 1:1 observation for a different patient, heard moaning sounds coming from the hallway. The MHT left the 1:1 patient unattended and walked down to the darkened dayroom, turned on the lights and discovered Patient #5 and Patient #7 engaged in oral sex. The Patients were separated, and the Charge Nurse was notified. 8. Review of the Patient Observation Records showed discrepancies between the timelines established by the video camera review and the staff's documentation on the observation rounds:	L 325		

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L 325	Continued From page 9 a. On 07/23/23 at 11:30 PM, staff documented that Patient #7 was in her room, sleeping in a prone position and Patient #5 was in the hallway awake. However, review of the video from the incident showed that at 11:30 PM, Patient #7 was already in the day room sitting in a lounge chair and appeared to be awake. b. On 07/23/23 at 11:45 PM, staff documented that Patient #7 was awake in the day room. Staff documented that Patient #5 was in his bedroom awake. Review of the video showed that both Patients were in the day room, awake, between 11:45 PM to 12:05 AM (07/24/23). 9. On 08/23/23 at 4:30 PM, during an interview with the Investigator, the Director of Risk Management (Staff #1) stated that she had reviewed the video from the incident between Patient #5 and Patient #7. Staff #1 reported that the MHT had turned the light off in the day room to signal to the patients in the room that it was bedtime. The video showed that the female patient moved closer to the male patient and began performing oral sex, after which she pulled her pants down and immediately began having sexual intercourse. Staff #1 stated that the incident was not a reportable incident to the Department of Health, and that the sexual incident was clearly consensual, not a sexual assault. The hospital had performed a Root Cause Analysis (RCA) after the incident on 07/23/23 (and 07/24/23) and found that the incident was not reportable to the Department of Health, it was not an assault. Staff #1 stated that it was considered an adverse event internally, and their corporate office was notified right away. The hospital's decision was based partially on a review of the patient's mental status at the time of	L 325		

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L 325	Continued From page 10 the incident. The Investigator was unable to verify with Staff #1 what documents were used to substantiate the patient's mental status. 10. On 08/24/23 at 2:50 PM, during an interview with the Investigator, the MHT (Staff #5) stated that when he was trained during orientation and receive refreshers in between on how to handle patients who are placed on Sexual Victimization or Sexually Aggressive/Assault Precautions. The MTH staff ensures that the blind spots on the unit, such as the day room, are always monitored by a staff member. Since there was no door that could be locked for the day room, staff must always physically monitor the room. The MHT stated that the day room is usually closed at 10 PM, and that the staff will turn off the light to indicate it's closed. If the MHTs see patients exhibiting sexually inappropriate behaviors, they would separate and reeducate the patients and notify the Charge Nurse, who will then notify the provider. When the Investigator asked if the protocol is any different if the sexual activity was consensual, Staff #5 reported that the hospital does not allow sexual activity, that is one of the purposes of doing observation rounds. Staff #5 stated that once the patients leave the hospital, then they can have consensual sex. 11. On 08/25/23 at 11:40 AM, during an interview with the Investigator, an RN (Staff #2) stated that if there is an observed or reported sexual incident, staff should immediately notify the Charge Nurse. The Charge Nurse would notify the provider and the House Supervisor. Most of the time the provider will initiate on order to increase the patient's observations level to 1:1, add any necessary safety precautions, and offer to contact the police department. The nurse would create an incident report and document in	L 325		

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L 325	Continued From page 11 the medical records. If it is suspected abuse, they would contact the Department of Health. The Investigator asked the RN if the process would be any different if the sexual incident was consensual. Staff #2 stated that sexual contact is not allowed on the units. It would be reported. Staff #2 stated that as the RN, it's my duty to keep the patients safe and free from incidents. 12. On 08/25/23 at 12:15 PM, during an interview with the Investigator, an MHT (Staff #5) stated that on the North unit, there is always staff in the hallway and at the chair watching the day room. They try to be aware of where a patient with enhanced safety precautions is located to make sure that a patient with Sexual Aggression Precautions is monitored. When patients are in the day room, the lights are always left on. The lights go out at 10 PM and come back on between 6 AM and 7 AM. Staff #5 stated that if he observed 2 patients having sex, or engaged in sexual activity, he would separate the patient and notify the charge nurse immediately. If the patients stated that the sex was consensual, we would still do the same thing, like notify the provider. Staff #5 stated that our patients are not mentally okay, they may say yes and consent to sex, but we still need to notify the state and call the police. When the patient's say yes is not really a yes. It might be okay today, but tomorrow it is rape.	L 325		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and	L1065	Continued on next page	

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BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

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L1065	Continued From page 12 treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff developed, initiated, and updated patient specific care plans, as demonstrated by record review for 6 of 7 records reviewed (Patient #1, #2, #4, #5, #6, and #7). Failure to develop care plans to address patient specific treatment needs and update when indicated, may lead to patient harm and create barriers or delay in receiving appropriate treatments. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Aggression/Victimization Precautions," policy number 1000.80/PolicyStat ID 13426424, effective 06/23, showed the	L1065	How: The CEO met with CNO, DCS and CMO to discuss the finding on 10/6/23. All policies noted in this finding were reviewed and did not require revision. All treatment team staff (Providers, RN's and Case Managers) were re-educated by the Chief Medical Officer, Chief Nursing Officer and Director of Clinical Services on the requirement to develop, initiate and update patient care plans for patient safety incidents to include, but is not limited to, incidents of sexual acting out behaviors or sexual victimization. Documentation on the treatment plan will include, but is not limited to, a description of the incident or behavior exhibited, interventions initiated, change in precautions or observations and the patients response to the interventions. The Treatment team members are to review the patients treatment plan on a weekly basis or sooner if a safety event occurs and revise the treatment plan if the current interventions are ineffective. All training and re-education is verified via staffs signature on the training sign-in sheet at the completion of the training. The Risk Management department will run a daily report of all patients with identified sexually aggressive or sexually assaultive incidents or that have allegations or incidents of being sexually abused, that have occurred within the last 24 hours and will send this report out daily to the Chief Medical Officer, Chief Nursing Officer and the Director of Clinical Services. These leaders will ensure the identified patients are discussed in treatment team and, if indicated, the treatment plan is updated and/or revised. Who is responsible: Chief Medical Officer, Director of Clinical Services, Chief Nursing Officer for staff training and Director of Risk Management for auditing and reporting data.	11/5/23

State of Washington

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L1065	Continued From page 13 following: a. The purpose of the policy is to provide a plan for the prevention of sexual behavior, including aggression, and the potential for victimization by identifying early warning signs of sexual behavior, monitoring the patient with a suspected potential for sexual aggression/victimization, and implementing intervention steps to minimize the risk of sexual behavior. b. Nursing staff will access the patient risk factors for Sexual Aggression/Victimization, and if appropriate, place the patient on Sexual Aggression Precautions (SAP) and/or Sexual Victimization Precautions (SVP). Nursing staff will then initiate a Sexually Inappropriate Behaviors Treatment Plan. Document review of the hospital's policy and procedure titled, "Suspected or Confirmed Cases of Patient Sexual Activity," policy number 1000.30/PolicyStat ID 13426447, effective 06/23, showed that the Treatment Team will initiate a Sexually Inappropriate Behavior Treatment Plan. Document review of the hospital's policy and procedure titled, "Interdisciplinary Patient Centered Care Planning," policy number 1000.81/PolicyStat ID 13804956, effective 06/23, showed the following: a. All therapeutic services that are beyond routine tasks to be provided to the patient are included in the plan and the treatment plans are routinely reviewed to assess the patient's progress and determine if any modifications are needed. b. Within 72 hours of admission, the multidisciplinary treatment team will develop the	L1065	Monitoring & Compliance Target: The Risk Management Department will audit 30 records a month of patients with sexual behavior incidents to ensure: 1. The patients treatment plan updates include information on any safety incidents that have occurred since the last treatment team meeting. 2. The patients treatment plan is reviewed/revised after significant safety events. 3. The patients treatment plan includes interventions to address the identified safety concerns. 4. The patients treatment plan interventions are amended/revised if current interventions are not effective. Target for compliance is 90% or greater on the above audits. Audit data found to be out of compliance will be reported to the respective department leader for follow up and corrective action with individual staff. Results of monitoring will be reported to Quality Council and Medical Executive committee monthly and Governing Board Quarterly until compliance goals have been met and sustained for a minimum of 3 consecutive months.	11/5/23

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L1065	Continued From page 14 treatment plan, including a diagnosis, problem list, and patient assets on the Treatment Plan Cover Sheet. c. Staff will complete an individual problem sheet for each active psychiatric and/or medial problem. The problem sheet will include the problem, patient specific behavioral manifestations, long and short-term goals with target dates, and interventions for each appropriate discipline. d. The treatment team will complete a review of the treatment plan as clinically indicated, or at a minimum every 7 days. Identified problems will be summarized, progress towards goals reviewed, new goals and interventions identified. e. A major change in the patient's clinical condition, a new impairment/problem, or significant information about an existing impairment is identified would be cause for conducting a review of the plan and developing a revision. Patient #1 and Patient #2 2. Patient #1 was a 36-year-old male involuntarily admitted on 06/17/23 for grave disability and danger to others. Upon admission to Fairfax, the Patient was very disorganized, responding to internal stimuli, and openly masturbating. The Patient's psychiatric diagnosis was Schizoaffective disorder. The Patient was placed on Sexual Aggression precautions (SAP). 3. Patient #2 was a 29-year-old female, involuntarily admitted on 07/07/23 for grave disability. The Patient was found naked, running in traffic. Patient #2 was confused, internally preoccupied, and endorsed auditory	L1065		

State of Washington

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L1065	Continued From page 15 hallucinations. The Patient's psychiatric diagnosis was (Rule Out) Unspecified Schizophrenia and Substance Induced Psychosis. Patient #2 was placed on Sexual Aggression precautions (SAP). 4. On 07/08/23, staff initiated an Incident Report for a Level 3 - Serious Incident (categorized as a Patient-to-Patient Sexual Intercourse), between Patient #1 and Patient #2. On 07/08/23, Patient #1 reported that he asked Patient #2 if she wanted to have sex. Patient #2 agreed. Patient #1 then followed Patient #2 into her room at approximately 11:10 AM. According to the Incident Report, less than one minute after the patients had entered the room, a provider entered the room and found Patient #1 undressed, lying in the bed, and Patient #2 undressed from the waist down sitting on the bed. Patient #1 stated that he had taken his clothes off, and he then touched Patient #2's breast as she laid down on the bed. Patient #1 denied sexual penetration. Patient #1 became agitated when staff attempted to redirect him out of Patient #2's room. Patient #1 was placed on a physical hold and taken into the seclusion room. Patient #1 was later transferred to a different unit. 5. Review of the multidisciplinary treatment plans for Patient #1 and Patient #2 showed the following: a. Patient #1 - On the Weekly Treatment Plan Update, dated 07/12/23 (5 days after the incident), staff failed to document the sexual intercourse incident on 07/08/23, the physical restraint and seclusion incident, or the Patient's transfer to a different unit due to the sexual incident. b. Patient #2 - On the Weekly Treatment Plan	L1065		

State of Washington

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L1065	Continued From page 16	L1065		

Update, dated 07/14/23 (6 days after the incident), staff noted that the Patient has been taking clothes off and will continue SVP precautions due to disrobing. On the section of the Weekly Update that documents any significant incidents/behavioral changes nursing staff failed to document the sexual intercourse incident that took place on 07/08/23.

Patient #4 and Patient #6

6. Patient #4 was a 25-year-old female involuntarily admitted on 06/29/23 for grave disability after her mother reported that she was naked and running in and out her room. Upon admission, the Patient continued to disrobe intermittently and was impulsive, erratic, and hypersexual and had been observed lying in bed, naked below the waist, exposing her genitalia. Her psychiatric diagnosis was Unspecified Schizophrenia. Patient #4 was placed on SAP and SVP. On the Psychiatric Provider Daily Progress Note dated 07/10/23 at 4:20 PM, the provider documented that the patient was being sexually targeted by multiple male patients.

7. Patient #6 was a 54-year-old male involuntarily admitted on 07/06/23 for grave disability after presenting to the acute care medical hospital with aggression, paranoia, delusions, and hyper religiosity. Upon admission to Fairfax, Patient #6 was disorganized, manic, and increasingly paranoid. His psychiatric diagnosis was Bipolar 1 disorder. On 07/07/23 Patient #6 was placed on SAP after exhibiting sexually inappropriate behaviors toward female peers and staff.

8. On 07/20/23, staff initiated an Incident Report for a Level 3 Level 1 - Occurrence (categorized as a Sexual Boundary Verbal/Physical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L1065	Continued From page 17 Non-Aggressive Breach), between Patient #4 and Patient #6. On 07/20/23 at 2:15 PM, staff observed Patient #6 approach Patient #4, and began rubbing her shoulders and calling her "my angel, my angel." Staff redirected Patient #6. Staff documented that Patient #4 had no insight into the situation, could not tell staff what happened, or tell the male peer to stop touching her. 9. On a Nursing Progress Note Addendum, dated 07/10/23, staff documented that the Patient was shirtless, wearing only an unzipped sweater. The Patient asked for a towel from the linen closet. The Patient followed the female staff member to the closet, put his foot in the door and cornered her in the closet. The Patient then opened his unzipped sweater to reveal his bare chest and stomach to the female staff. Staff was able to redirect the Patient and the Charge Nurse was notified. 10. Review of the multidisciplinary treatment plans for Patient #4 and Patient #6 showed the following: a. Patient #4 - On the Weekly Treatment Plan Update, dated 07/11/23, staff noted that the Patient was being targeted by multiple male peers and would remain on SVP precautions. Staff failed to document a plan to address the patient's safety or interventions implemented. On the section of the Weekly Update that documents any significant incidents/behavioral changes nursing staff failed to document the sexual incident that took place on 07/10/23. b. Patient #6 - On the Master Treatment Plan dated 07/07/23, staff added Problem #4 Sexual Boundaries on the Master Problem List. An	L1065		

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L1065	Continued From page 18	L1065		

Individual Treatment Plan (ITP) for Sexual Boundaries was created on 07/07/23 based on the Patient's sexually inappropriate behavior towards females. Staff did not amend or initiate any additional interventions between 07/07/23 through 08/08/23. On the Weekly Treatment Plan Update, dated 07/13/23 (3 days after the incident), staff failed to document the sexual incident that took place on 07/10/23.

Patient #5 and Patient #7

11. Patient #5 was a 38-year-old male involuntarily admitted on 06/08/23 for grave disability. Upon admission the Patient presented with increasing paranoid ideation, delusions, and appeared to be responding to internal stimuli. The Patient was very disorganized, was not eating, and had not slept in the past 24 hours. His psychiatric diagnosis was Unspecified Psychosis, Schizophrenia (Rule Out), and Schizoaffective disorder (Rule Out). Patient #5 was placed on EP and AP.

12. Patient #7 was a 27-year-old female involuntarily admitted on 07/23/23 for danger to others and grave disability. Upon admission, Patient #7 presented with symptoms of psychosis, responding to internal stimuli, delusional, hyperarousal, and reported auditory hallucinations that were telling her to do bad things. Patient #7 had a history of sexual victimization, was sexually abused as a ten, raped after high school, and had become sexually aggressive with her father. Her psychiatric diagnosis was Schizophrenia Spectrum and related disorders, Schizoaffective disorder (Rule Out), and Post Traumatic Stress Disorder (PTSD). Patient #7 was placed SAP and SVP.

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L1065	Continued From page 19	L1065		

Continued From page 19

13. On 07/24/23, staff initiated an Incident Report for a Level 3 - Serious Incident (categorized as a Patient-to-Patient Sexual Intercourse event), between Patient #7 and Patient #5. According to the Incident Report, a Mental Health Technician (MHT) who was assigned to 1:1 observation for a different patient located down the hallway, heard moaning sounds coming from the dayroom at approximately 12:05 AM. The MHT walked down to the darkened day room, turned on the light and discovered Patient #7 and Patient #5 alone. Patient #5 was standing in front of Patient #7, who was seated in a lounge chair. When the MHT entered the room, he observed Patient #2 pulling up his pants.

14. Additional review of Patient #5's medical records found the following Daily Nursing Progress Notes/Addendums documenting incidents that occurred before the 07/24/23 incident:

a. On 06/14/23 at 9:15 AM, staff documented that Patient #5 was sitting in the day room laughing to himself when a female peer approached. The patients began talking, then the female peer leaned in to kiss Patient #5 and the two patients began kissing. Staff separated the patients. Patient #5 displayed no insight into the situation, and stated "that's my grandma, bro."

b. On 07/08/23 at 12:45 AM, staff documented that Patient #5's mattress was in the day room on the floor. A female peer was found sitting on the mattress with Patient #5. The female peer resisted redirection but eventually returned to her room.

15. Review of the multidisciplinary treatment plans for Patient #5 and Patient #7 showed the

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L1065	Continued From page 20 following: a. Patient #5 - On the Master Treatment Plan dated 06/08/23, staff added Problem #4 Sexual Boundaries on the Master Problem List on 07/25/23. An Individual Treatment Plan (ITP) for Sexual Boundaries was created on 07/25/23 due to the Patient's sexual intercourse incident on 07/24/23. There were no revisions or updates to the treatment plan or problem list prior to this date that reflected the incidents documented on 06/14/23 and 07/08/23. b. Patient #7 - The Investigator's medical record review found that staff did not amend or initiate any additional interventions between 07/26/23 through 08/21/23 (discharge date). On the Weekly Treatment Plan Update, dated 08/02/23 (9 days after the incident) nursing staff failed to document the sexual intercourse incident that took place on 07/23/23 - 07/24/23. 16. On 08/23/23 at 12:40 PM, during an interview with the Investigator, the Director of Risk Management (Staff #1) stated that often when incidents occur on the units, the staff attending the treatment team meetings are not always aware of the need to update the treatment plans or recent incidents reports. They implemented a new process in July to address these issues. 17. On 08/23/23 at 2:40 PM, during an interview with the Investigator, a RN (Staff #5) stated that when there is significant incident, like a sexual assault or allegation, the nurse would notify the charge nurse, the house supervisor, and the provider. Using the shift report, the information about the incident would be communicated to the next shift. Every day (Monday through Friday), the treatment team meets and reviews incident	L1065		

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L1065	Continued From page 21 reports from the previous day. 18. On 08/23/23 at 3:15 PM, during an interview with the Investigator, the Director of Clinical Services (Staff #3) stated that the treatment team meet daily (Monday through Friday) and determine which patients are up for their weekly review (Treatment Plan Update). Each week, the treatment team should review the patient's treatment plan, and assess their progress towards their treatment goal. The treatment team really relies on the nurses and providers to bring info to the treatment team. Typically, they don't have access to the incident report list until after the treatment team has met for the day. Staff #3 verified that this is probably why the treatment plan updates do not reflect the incidents that have occurred, such as sexual/physical assaults and seclusion and restraint.	L1065		

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

January 9, 2024

Christopher West
Chief Executive Officer
Fairfax Hospital
10200 NE 132nd Street
Kirkland, WA 98034

Re: Complaint #132584/2023-8801

Dear Mr. West,

Investigators from the Washington State Department of Health conducted a state hospital complaint investigation at Fairfax Hospital - Kirkland on 08/23/23 and 08/24/23, exiting on 09/06/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 11/02/23.

Hospital staff members sent a revised Progress Report dated 01/09/24 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Hospital's attestation that it will correct all deficiencies cited in Chapter 246-322 WAC.

We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Mary New

Mary New, MSN, BSN, RN
Nurse Investigator