STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504009	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY A state hospital licensing survey was conducted at Navos Psychiatric Hospital on 1/18/2017 to 1/20/2017 by Tyler Henning ScM, MHS; and Cathy Strauss BSN, RN. ASE #HZP911 RECEIVED FEB 13 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	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 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 2-15-2017 4. Return the ORIGINAL REPORT with the required signatures.	
L 350	322-035.1J POLICIES-INFECTION CONTROL 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 services provided: (j) Infection control as required by WAC 246-322-100; This RULE: is not met as evidenced by:	L 350		

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L 350	Continued From Page 1 Based on observation, interview and review of policies and procedures, the hospital failed to ensure patient care equipment was cleaned between patients. Failure to clean patient care equipment risks cross contamination between patients and staff. Findings: 1. On 1/19/2017 at 8:00 AM, Surveyor #2 observed the medication nurse (Staff Member #1) take a blood pressure (BP) and deliver a medication to Patient #1, then return the portable blood pressure machine to the nurses station without disinfecting after use. 2. On 1/19/2017 at 9:00 AM, Surveyor #2 interviewed with the Nurse Manager, (Staff Member #2) about the hospital's policy for cleaning and sanitizing of the BP cuff and machine between patients. The Nurse Manager was unable to locate a policy. 3. On 1/19/2017 at 11:00 AM, the Chief Nursing Officer/ Infection Control Professional, (Staff Member #3) confirmed the above finding.	L 350		
L 420	322-040.1 ADMIN-ADOPT POLICIES WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients; This RULE: is not met as evidenced by:	L 420		

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L 420	Continued From Page 2 Based on observation, interview and review of policies and procedures the hospital failed to ensure the patient comfort rooms were safe and free from risks of harm in 2 of 2 comfort rooms. Failure to ensure patient areas are safe risks patient injuries and/or death and harm to others. Findings: 1. ON 1/18/2017 at 10:30 AM, Surveyor #2 toured the 3rd floor patient areas with the Charge Nurse, (Staff Member #2). There was a television mounted on the wall in the "Comfort Room" with exposed cables. One of the visible cables sparked when touched. 2. The Charge Nurse stated that the hospital did not have a policy regarding looking at patient areas for specific safety issues, but that the facilities staff did a "monthly walk through". Review of the last 2 months of the monthly "walk through" by the facilities staff indicated that floor 2 and floor 3 were "OK". The specific "comfort room" was not identified on the form. 3. The Chief Nursing Officer reported that the clinical staff do monitoring of all patients every 15 minutes and that the Administrative staff do a monthly "Infection Control Rounding Log", which included infection control observation as well as environmental and equipment checks. Logs were reviewed for the last 2 months without notations of ligature risks or other safety issues.	L 420		
L 545	322-050.6A ORIENTATION-ORG WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training	L 545		

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L 545	Continued From Page 3 for all staff, including: (a) Organization of the hospital; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented to the organization of the hospital. . Failure to orient contracted staff to the organization of the hospital places patients at risk for inadequate care. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding the organization of the hospital. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 545		
L 550	322-050.6B ORIENTATION-PHYSICAL LAYOUT WAC 246-322-050 Staff. The licensee shall: (6) Provide and document	L 550		

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L 550	Continued From Page 4 orientation and appropriate training for all staff, including: (b) Physical layout of hospital, including buildings, departments, exits, and services; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to ensure that contracted staff were oriented to the physical layout of the hospital. Failure to orient contracted staff to the physical layout of the hospital places patients at risk for inadequate care. Reference: Washington Administrative Code 246-324-010 (43), " 'Staff ' means permanent employees, temporary employees, volunteers, and contractors." Findings: 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding the physical layout of the hospital. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 550		

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L 555	Continued From Page 5	L 555		
L 555	322-050.6C TRAINING-DISASTER PLANS WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (c) Fire and disaster plans, including monthly drills; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on the fire and disaster plan of the hospital. . Failure to orient contracted staff on the fire and disaster plan of the hospital places patients and staff at risk during emergency situations. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff ' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training on the hospital fire and disaster plan. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the	L 555		

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L 555	Continued From Page 6 hospital.	L 555		
L 560	322-050.6D TRAINING-INFECT CONTROL WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (d) Infection control; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on infection control. . Failure to orient contracted staff on infection control places patients and staff at risk for infection. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff ' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding infection control. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No	L 560		

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L 560	Continued From Page 7 files for these employees were kept on site at the hospital.	L 560		
L 565	322-050.6E ORIENTATION-DUTIES WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (e) Specific duties and responsibilities; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on specific duties and responsibilities. . Failure to orient contracted staff on specific duties and responsibilities places patients at risk for inadequate care. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff ' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding specific duties and responsibilities. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains	L 565		

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L 565	Continued From Page 8 these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 565		
L 570	322-050.6F ORIENTATION-P&P WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (f) Policies, procedures, and equipment necessary to perform duties; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented to policies, procedures, and equipment necessary to perform duties. . Failure to orient contracted staff to policies, procedures, and equipment necessary to perform duties places patients at risk for inadequate care. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff ' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding policies, procedures, and equipment necessary to perform duties. 2. During the review, the human resources	L 570		

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L 570	Continued From Page 9 assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 570		
L 575	322-050.6G ORIENTATION-PATIENT RIGHTS WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (g) Patient rights according to chapters 71.05 RCW and 71.34 RCW and patient abuse; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on patient rights and abuse. . Failure to orient contracted staff on patient rights and abuse places patients at risk for inadequate care. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding patient rights and abuse.	L 575		

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L 575	Continued From Page 10 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 575		
L 580	322-050.6H ORIENTATION-PATIENT BEHAV WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (h) Managing patient behavior; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented on managing patient behavior. . Failure to orient contracted staff on managing patient behavior places patients and staff at risk of harm if disruptive behavior occurs. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training regarding	L 580		

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L 580	Continued From Page 11 managing patient behavior. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 580		
L 585	322-050.6i ORIENTATION-APPROP TRAINING WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (i) Appropriate training for expected duties This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that contracted staff were oriented with appropriate training for expected duties. . Failure to orient and train contracted staff on expected duties places patients at risk for inadequate care. . Reference: Washington Administrative Code 246-324-010 (43), " 'Staff' means permanent employees, temporary employees, volunteers, and contractors." . Findings: . 1. On 1/19/2017 between 9:09 AM and 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the 6	L 585		

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L 585	Continued From Page 12 staff members, a contracted housekeeper (Staff Member #4), did not have documentation of orientation and appropriate training for expected duties. 2. During the review, the human resources assistant (Staff Member #5) stated that contracted staff are not oriented and trained in the same manner as staff employed by the hospital. S/he also stated that the contracted company maintains these staff members' human resources files. No files for these employees were kept on site at the hospital.	L 585		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This RULE: is not met as evidenced by:	L 615		

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L 615	Continued From Page 13 Based on policy and procedure review, document review, and interview, the facility failed to ensure that staff members received annual tuberculosis testing for 1 of 6 staff members reviewed. Failure to perform annual tuberculosis testing for staff members placed patients and staff at risk of exposure to infection. Findings: 1. The hospital policy titled, "Tuberculosis Testing - Employee/Health Care Worker (Rev. 4/2016)" states in part, "II. All HCW(health care workers) will be required to have an annual TB test. A HCW is defined as any employee who has any contact or shared space with patients. Non-HCW do not need to have an annual TB test." The policy also states, " Who is considered to be a HCW? Maintenance Staff ... " 2. On 1/19/2017 from 9:09 AM to 12:00 PM, Surveyor #1 reviewed human resources documents for six staff members. One of the staff members, an information technologist (Staff Member #7), did not have a documented tuberculin skin test within the last year. The last recorded test was from 3/2014. 3. On 1/19/2017 at 2:34 PM, Surveyors #1 and #2 conducted an infection control committee interview. The Chief Nursing Officer (CNO) (Staff Member #3) indicated that information technology staff perform maintenance work on patient care floors and should have annual tuberculosis testing.	L 615		

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L 670	Continued From Page 14	L 670		
L 670	322-050.12G RECORDS-PERFORM EVALS WAC 246-322-050 Staff. The licensee shall: (12) Maintain a record on the hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to: (g) Annual performance evaluations. This RULE: is not met as evidenced by: . Based on document review, the hospital failed to ensure that annual performance evaluations were performed and retained for 1 of 6 staff members reviewed. . Failure to conduct annual performance evaluations limits the facility ' s ability to ensure that staff members are satisfactorily performing required job duties. . Findings: . On 1/19/2017 from 9:09 AM to 12:00 PM, surveyor #1 reviewed human resources files for 6 staff members. One staff member, an information technologist (Staff Member #7) did not have documentation of an annual performance evaluation from the past year. The last performance evaluation on file was from 9/2013.	L 670		
L 675	322-060.1 HIV/AIDS TRAINING WAC 246-322-060 HIV/AIDS Education and Training. The licensee shall: (1) Verify or arrange appropriate education and training of staff within thirty days of employment on the prevention, transmission, and	L 675		

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	504009	A. BUILDING _____ B. WING _____	01/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 675	Continued From Page 15 treatment of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) consistent with RCW 70.24.310; This RULE: is not met as evidenced by: . Based on document review, the hospital failed to ensure that staff members had documentation of required HIV training for 2 of 6 staff members reviewed. . Failure to ensure that staff have HIV training places patients and staff at risk for infection. . Findings: . On 1/19/2017 from 9:09 AM to 12:00 PM, Surveyor #1 reviewed human resources documents for 6 staff members. Two staff members, an information technologist and a mental health specialist (Staff Members #7 and #8), did not have documented HIV training in their personnel files.	L 675		
L 715	322-100.1E INFECT CONTROL-PROVISIONS WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (f) Provisions for: (i) Providing consultation regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation	L 715		

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L 715	Continued From Page 16 and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This RULE: is not met as evidenced by: . Based on interview, the hospital failed to ensure that the infection control committee was providing consultation regarding procedures and products for contracted environmental services. . Failure to provide consultation regarding procedures and products for environmental services risks inadequate housekeeping practices and places patients and staff at risk of infection. . Findings: . 1. On 1/19/2017 at 2:30 PM, surveyors #1 and #2 conducted an interview with members of the infection control committee regarding infection control practices in the facility. Surveyor #1 asked the Chief Nursing Officer (CNO) (Staff Member #2) if the facility conducted observations or rounding of the contracted environmental services staff to ensure that housekeeping functions meet best practice and guidelines. The CNO stated that the environmental services company has a supervisor that observes housekeeping staff, but the facility has not been performing direct observations. 2. During the meeting, surveyor #1 asked the CNO if the infection control committee reviewed and approved the cleaning products that the contracted service used. S/he stated that the	L 715		

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L 715	Continued From Page 17 contractors provide their own products and that the committee did not perform a thorough review prior to allowing their use in patient care areas.	L 715		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: . Based on observation, the facility failed to provide a safe environment for patients. . Failure to provide a safe environment places patients at risk of injury or death. . Findings: . On 1/18/2017 at 9:00 AM, Surveyor #1 conducted a tour of the facility. During the tour, the surveyor inspected the bathroom in room 208. An old outlet receptacle or opening located on the ceiling above the toilet and sink was covered with a metal plate. This area protruded approximately 2 inches from the ceiling. The metal cover plate was too large for the opening it was covering, creating a noticeable rim on all sides of the protruding area. This rim was large enough to support an item tied around the protruding area for a ligature and could be easily accessed by an individual standing on the bathroom fixtures.	L 780		
L 815	322-120.7 MAINTENANCE P&P WAC 246-322-120 Physical Environment. The licensee shall: (7) Implement current, written policies, procedures, and schedules for maintenance and	L 815		

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L 815	Continued From Page 18 housekeeping functions; This RULE: is not met as evidenced by: Based on observation, the hospital failed to ensure that staff members properly performed housekeeping functions. Failure to properly perform housekeeping functions places staff and patients at risk of infection. Reference: Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). 2004. Pg 134. "E. Recommendations - Environmental Services. I. Cleaning and Disinfecting Strategies for Environmental Surfaces in Patient-Care Areas. G. Avoid large-surface cleaning methods that produce mists or aerosols or disperse dust in patient-care areas." Findings: 1. On 1/18/2017 at 9:38 AM, Surveyor #1 observed a daily cleaning of a patient room on the third floor. Two housekeepers (Staff Members #4, #6) sprayed disinfectant from a spray bottle onto the surfaces of the room, bathroom, and furniture, which is a large-surface cleaning method. This same cleaning procedure was observed during a discharge room cleaning on the third floor at 12:50 PM. 2. On 1/18/2017 at 12:50 PM, Surveyor #1 observed a discharge cleaning of a patient room on the third floor. A housekeeper (Staff Member #6) placed a mattress on the floor and cleaned the bed frame. S/he then returned the dirty mattress to the recently cleaned bed frame in order to clean the mattress. Placing dirty items onto recently	L 815		

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L 815	Continued From Page 19 cleaned items has the potential to reintroduce contaminants to the cleaned items.	L 815		
L 985	322-150.3B EXAM ROOM-LIGHT WAC 246-322-150 Clinical facilities. The licensee shall provide: (3) One or more physical examination rooms, with or without an exterior window, equipped with: (b) Examination light; This RULE: is not met as evidenced by: . Based on observation, the hospital failed to provide an examination light in the examination room on the second floor. . Failure to provide an examination light in the examination room places patients at risk from suboptimal care. . Findings: . On 1/18/2017 at 2:00 PM, Surveyor #1 toured the examination room on the second floor of the facility. No examination light was present. The Chief Nursing Officer (CNO) (Staff Member #3) confirmed the finding.	L 985		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen	L1145		

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L1145	Continued From Page 20 minutes, intervening as necessary, and recording observations and interventions in the clinical record; This RULE: is not met as evidenced by: . Based on observation, interview and review of medical records, the hospital failed to provide evidence that staff monitored patients in seclusion and restraints according to hospital policy for 4 of 4 patients reviewed (Patient #2, #3, #4, and #7.) Failure to do so places these patients at risk of injury or other decline in status. Findings: 1. The hospital policy titled "Seclusion and Restraint", (Policy #3024739, Rev. 4/2016) states in part: "C.4 ...monitor the patient in seclusion or mechanical restraint and document per flow sheet every 15 minutes." 2. Review of the medical records of 4 patients restrained or secluded revealed the following: a. Patient #2's record indicated s/he was placed in seclusion and 4-point restraints on 12/7/2016 at 09:45 AM. The S/R flow sheet directed staff to document observations at 15 minute intervals. There was no documentation in the record to indicate the staff members completed patient monitoring at 12:00 PM, 2:30 PM or 10:15 PM, as outlined in the hospital ' s policy. b. Patient #3's record indicated s/he was placed in S/R on 10/3/2016 at 1:00 PM. The S/R flow sheet directed staff to document observations at 15 minute intervals. There was no documentation in the record to indicate the staff members completed patient monitoring at 2:00 PM, as	L1145		

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L1145	Continued From Page 21 outlined in the hospital's policy. c. Patient #4' s record indicated s/he was placed in S/R on 9/25/2016 at 10:45 AM. The S/R flow sheet directed staff to document observations at 15 minute intervals. There was no documentation in the record to indicate the staff members completed patient monitoring at 12:30 PM, as outlined in the hospital's policy. d. Patient #7's record indicated s/he was placed in S/R on 8/8/2016 at 7:30 AM. The S/R flow sheet directed staff to document observations at 15 minute intervals. There was no documentation in the record to indicate the staff members completed patient monitoring at 8:30 AM, on 8/9/2016 at 11:00 PM and on 8/10/2019 at 9:00 AM, 9:15 AM, and 9:30 AM, as outlined in the hospital's policy. e. The Charge Nurse, (Staff Member #2) confirmed the above findings.	L1145		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This RULE: is not met as evidenced by: . Based on record review and review of hospital policy and procedures, the hospital failed to	L1150		

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L1150	Continued From Page 22 ensure staff released patients from seclusion at the earliest possible time in 2 of 5 records reviewed (Patient #2 and #7). Failure to release patients from seclusion and restraint at the earliest possible time places patients at risk for loss of dignity and personal freedom. Findings: 1. The hospital policy titled " Seclusion and Restraint " (Policy #3024739, Rev. 4/2016), states in part: "Seclusion and Restraint shall be used only to protect patients from harm to self and others, and only after less restrictive alternatives have been attempted and found to be ineffective. Seclusion and restraint shall be discontinued at the earliest possible time." 2. On 1/19/2017 between 10:00 AM and 5:00 PM, Surveyor #2 reviewed 5 records of patients that had been in seclusion or restraints (S/R) and noted the following: a. On 12/7/2016 at 10:00 AM, Patient #2 was placed in restraints at 10:00 AM following an assault on another patient. The patient remained in restraints until 8:45 PM when the chart note states "in locked seclusion" [a form of restraint]. Patient behavior was noted as "Quiet" on the S/R flow sheet, the patient had not been released from seclusion until 10:00 PM. b. On 8/10/2016 at 6:14 PM, Patient #7 was placed in restraints for an attempt to assault the staff during manual escort of the patient to the restraint and seclusion room at 5:45 PM. At 7:15 the S/R Flow sheet notes "remaining restraints removed", no further behavior was noted to harm self or others. The patient remained in locked	L1150		

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L1150	Continued From Page 23 seclusion [a form of restraint] until release at 9:45 PM.	L1150		
L1155	322-180.1E SECLUSION EXAM WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (e) A physician shall examine each restrained or secluded patient and renew the order for every twenty-four continuous hours of restraint and seclusion; This RULE: is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure staff obtained an order for locked seclusion in 2 of 5 records reviewed, (Patient #2 and #7). Failure to obtain physician orders for a new restrictive seclusion places patients at risk for loss of dignity, personal freedom and violation of patient rights. Findings: 1. The hospital policy titled "Seclusion and Restraint" (Policy #3024739, Rev. 4/2016), states in part: "Seclusion and Restraint shall be used only to protect patients from harm to self and others, and only after less restrictive alternatives have been attempted and found to be ineffective. Seclusion and restraint shall be discontinued at the earliest possible time."	L1155		

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L1155	Continued From Page 24 2. On 1/19/2017 between 10:00 AM and 5:00 PM, Surveyor #2 reviewed 5 patient records that had been placed in seclusion or restraints (S/R) and the following was noted: a. On 12/7/2016 at 10:00 AM, Patient #2 was placed in restraints following an assault to another patient. The patient was in restraints at 10:00 AM and released from restraints at 8:45 PM. The documented behavior on the flow sheet was described as "Quiet" after 6:45 PM and no further behavior is noted to justify the patient being placed in "locked seclusion" [a form of restraint] from 8:45 PM to 10:00 PM. There was no evidence in the chart of a physicians' order placing the patient in locked seclusion. b. On 8/10/2016 at 6:14 PM, Patient #7 was placed in restraints for attempt to assault a hospital staff member during the manual escort of the patient to the S/R room. The patient remained in restraints from 5:45 PM until 7:15 PM. The documented behavior on the S/R flow sheet was described as "Quiet" after 6:45 PM and no further behavior is noted to justify the patient being placed in "locked seclusion" [a form of restraint] from 7:15 PM to 10:00 PM. There was no evidence in the chart of a physicians ' order placing the patient in the locked seclusion.	L1155		
L1220	322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records. (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking,	L1220		

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L1220	Continued From Page 25 processing, indexing, filing, and retrieval of records; This RULE: is not met as evidenced by: . Based on interview and record review, the hospital failed to develop an effective process to ensure medical records were accurate, complete, and timely, as demonstrated by 4 medical records reviewed (Patients #2, #3, #4, and #6). Failure to ensure medical records are accurate and complete risks omissions in patient care, medical errors and potential for patient harm. Findings: 1. Review of medical records revealed the following: a. The hospital policy titled "Seclusion and Restraint" (S/R) (Policy #3024739, Rev. 4/2016) states in part: "Part ?. E. Patients will be reintegrated into the milieu as soon as they are deemed by the LIP/Charge Nurse/ trained RN to be clinically ready ..." b. On 10/3/2016 at 1:00 PM, Patient #3 entered S/R room for " aggressive, hostile, threatening and assaultive behavior as noted on the face to face sheet. The Patient debriefing form states the time of release was 2:00 pm. The S/R flow sheet indicates observation of the patients' behavior as "quiet" between 1:15 PM and 2:00 PM; there are no chart notes indicating a trained RN, Charge RN or LIP determined the patient was clinically ready to be reintegrated into the milieu. 2. On 9/25/2016 at 10:45 AM, Patient #4 was in 4 point restraints for hostile, agitated, paranoid and disorganized behavior. The flow sheet indicates the 4 point restraints and the above behavior	L1220		

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L1220	Continued From Page 26 continued at 11:00 AM, 11:15 AM, 11:30, 11:45, 12:00 and 12:15 checks when the patient was released from all restraints and seclusion. There are no chart notes indicating a trained RN, Charge RN or LIP determined the patient was clinically ready to be reintegrated into the milieu.	L1220		

RECEIVED

FEB 17 2017

DEPARTMENT OF HEALTH
Office of Investigation and Inspection

Navos
Plan of Correction for
State Licensing
1/17/2017-1/20/2017

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC
L350	1. A hospital policy will be developed for the cleaning and sanitizing of medical equipment between patient uses. 2. All nursing staff will receive education on the new policy and procedure 3. Managers or designee will observe blood pressure checks once weekly X 4 weeks for disinfecting and sanitizing between uses.	Hospital Administrator	3/1/17	95%	90%
L420	1. TV and wires were immediately removed from the area. The room is closed to patient use until all changes have been made. 2. Implement policy requiring a monthly walkthrough with Facilities Manager and Nurse Manager to identify patient safety issues including ligature risk. 3. Implement policy to ensure that all newly installed equipment is assess for risk and approved by Facility Manager and Nurse Manager	Marlene Love Facility Manager	3/24/17	100 %	90%
L545	1. All housekeeping staff received orientation on the organization of the hospital. 2. All staff including contract staff will receive orientation at the time of employment.	Thom McKeon Facilities	2/8/17	100%	98%
L550	1. All housekeeping staff received orientation on the physical layout of the hospital. 2. All staff including contract staff will receive orientation at the time of employment.	Thom McKeon Facilities	2/8/17	100%	98%
L555	1. All housekeeping staff received orientation on fire and disaster plans and monthly drills. 2. All housekeeping staff will receive orientation at the time of hire.	Thom McKeon Facilities	2/8/17	100%	98%
L560	1. All housekeeping staff received infection control training 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	1/26/17	100%	98%

Plan of correction received 2/14/17
Plan of correction approved 2.17.17 CStrauss RN

L565	1. All housekeeping staff received training on their specific duties and responsibilities 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	1/26/17	100%	98%
L570	1. All housekeeping staff received training/orientation on policies , procedures and equipment 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	1/26/17	100%	98%
L575	1. All housekeeping staff will receive training/orientation on patient rights 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	2/16/17	100%	98%
L580	1. All housekeeping staff will receive training/orientation on managing patient behaviors. 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	2/16/17	100%	98%
L585	1. All housekeeping staff received training/orientation on expected duties to be performed. 2. All housekeeping staff will receive orientation at the time of hire	Thom McKeon Facilities	1/26/17	100%	98%
L615	1. Infection control committee will review the list of staff that is required to have yearly TB testing to ensure it includes all staff that may perform duties in patient care areas and update the policy. 2. All IT staff that performs duties in patient care areas will have TB testing completed. 3. HR will send electronic monthly notifications to staff needing TB testing to maintain compliance.	Human Resources	3/1/17	100%	98%
L670	1. HR will send electronic monthly notifications to supervisors of staff needing performance evaluations 2. The supervisors will be responsible for ensuring the employee evaluation is completed.	Human Resources	3/1/17	100%	98%
L675	1. All required staff will complete or provide evidence of HIV training at the time of hire.	Human Resources	3/1/17	100%	98%
L715	1. All cleaning products currently being used will be presented to the infection control committee for approval.	Thom McKeon Facilities	2/28/17	100%	98%

	2. All new cleaning products will be approved by the infection control committee prior to use. 3. Monthly walk through of the units completed by the nurse manager or designee will include monitoring of housekeeping staff to ensure practices meet best practices and guidelines				
L780	1. The outlet receptacle in room 208 was repaired and no longer has a protruding rim creating a ligature risk. 2. Facilities will complete a monthly walk through of the units assessing environmental risk factors and repair needs	Thom McKeon Facilities	3/1/17	100%	98%
L815	3. All housekeeping staff received education on cleaning including the proper use of spray chemicals and bed cleaning. 4. All housekeeping will receive orientation at the time of hire	Thom McKeon Facilities	1/26/17	100%	98%
L985	1. A new exam room light was ordered 2. During the monthly walkthrough by the manager or designee the exam room will be checked to ensure a light is in place and in working condition.	Hospital Administrator	3/1/17	100%	95%
L1145	1. All staff responsible for observing and documenting observations of patients in seclusion or restraint will receive training on documenting every 15 minutes. 2. The nurse manager or designee will review 100% of documentation for accuracy and compliance	Hospital Administrator	3/1/17	100%	98%
L1150	1. All Staff responsible for observing and documenting observations of patients in seclusion or restraint will receive training on releasing patients when they no longer present as an eminent risk of harm to self or others. 2. The nurse manager or designee will review 100% of documentation for accuracy and compliance	Hospital Administrator	3/1/17	100%	98%
L1155	1. All licensed Nursing staff will receive training on obtaining an order for seclusion or restraint at the start of the episode, every 4 hours or when a patient is moved from seclusion to restraints and restraints to seclusion. 2. The nurse manager or designee will review 100% of documentation for accuracy and compliance	Hospital Administrator	3/1/17	100%	98%
L1220	1. All licensed Nursing staff will receive training on assessing	Hospital	3/1/17	100%	98%

	and documenting the patients clinical readiness to be reintegrated into the milieu. 2. The nurse manager or designee will review 100% of documentation for accuracy and compliance	Administrator			

Rcvd 5.1-17

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Plan of Correction for ~~State Licensing~~

1/17/2017-1/20/2017

See next title Page.

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC	Progress
L350	1. A hospital policy will be developed for the cleaning and sanitizing of medical equipment between patient uses. 2. All nursing staff will receive education on the new policy and procedure 3. Managers or designee will observe blood pressure checks once weekly X 4 weeks for disinfecting and sanitizing between uses.	Hospital Administrator	3/1/17	95%	90%	Completed the nurse managers monitored with 92.5 % cleaned between usage will continue to spot check and provide feedback as needed
L420	1. TV and wires were immediately removed from the area. The room is closed to patient use until all changes have been made. 2. Implement policy requiring a monthly walkthrough with Facilities Manager and Nurse Manager to identify patient safety issues including ligature risk. 3. Implement policy to ensure that all newly installed equipment is assess for risk and approved by Facility Manager and Nurse Manager 4. Mental Health staff to receive education and competency testing on assessing ligature risks during 15 minute rounding checks.	Marlene Love Facility Manager	3/24/17	100 %	90%	Completed 3/21/17 The TV was enclosed behind plexiglass to eliminate ligature risk
L545	1. All housekeeping staff received orientation on the organization of the hospital. 2. All staff including contract staff will receive orientation at the time of employment.	Thom McKeon Facilities	2/8/17	100%	98%	Completed 2/3/17

Revised 2/23/17

Progress Report received date 5.1.17

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CStevens