STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

(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 COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital regulations, conducted this health and safety investigation. Administrative review dates: 12/28/20-03/03/21 On Site Investigation dates: 04/20/21, 04/21/21, 04/22/21 Case Numbers: 2020-16014, 2021-2227 Intake Numbers: 107480, 110171 Investigators # 13 and #3 There were violations found pertinent to this complaint.	L 000		
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 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 and document review, the	L 325		

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L 325	Continued From page 1 hospital failed to implement its policies and procedures for investigating and reporting sexual behavior between patients on the Adolescent Unit of the hospital for 2 of 5 patients reviewed (Patients #1302 and #1306). Failure to ensure that staff members follow policy and procedure for investigating and reporting sexual activity on the unit puts patients at risk for physical and psychological harm. Findings included: 1. Document review of the hospital's policy, "Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan," last review dated 05/05/20 showed that: a. The Charge Nurse and facility leadership immediately separate patients upon discovery of sexual behavior or who are alleged to have engaged in sexual behavior. b. The Charge Nurse or designee will notify the parents/guardians as applicable. Most sexual allegations will need to be reported to the parents or guardians of those clients involved. c. Risk Manager or designee notifies the Local/State Police in all sexual assault, intercourse cases that involve a minor. d. Risk Manager or designee notifies State Agencies, i.e.: Child Protective Services (CPS) as required by state statutes. e. Risk Manager or designee oversees documentation in the medical record re: the alleged incident, notifications, staff interventions, and patient response.	L 325		

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	013250	A. BUILDING: _____ B. WING _____	C 04/22/2021

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L 325	Continued From page 2 2. Review of Patient #1302's medical record showed that on 12/02/20 at 5:00 PM the patient reported to a social worker (Staff #1304) that he had sex with another patient (Patient # 1306) on 11/15/20 at 8:30 PM in the noisy activity room. Patient #1302 was afraid Patient #1306 might be pregnant. 3. On 01/29/21 at 2:25 PM, an interview with Staff #1304 showed that: a. Staff #1304 interviewed both Patient #1302 and Patient #1306 together about the sexual encounter. b. Staff #1304 did not notify parents of either Patient #1302 or #1306, as they had declined to have their parents called. c. Staff #1304 did not notify CPS or police of the incident because she believed age 13 was the age of consent. One patient involved in the incident was 16 years old and the other patient was 14 years old. 4. On 02/05/21 at 10:00 AM during an interview with Investigator #13, the Director of Quality/Interim Risk Manager (Staff #1303): a. Verified that the parents were not called, nor were CPS or police notified of the incident. Staff #1303 stated that the hospital's policy was not followed. b. Staff #1303 stated that during the investigation, all video tapes were reviewed and nothing was seen. c. Staff #1303 stated that during the investigation	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013260	A. BUILDING: _____ B. WING _____	C 04/22/2021

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L 325	Continued From page 3 the two involved patients told Staff #1303 where the encounter took place and that the patient were aware that it was not visible on the video cameras (Patients #1302 and #1306). 5. Document review of the hospital's policy, "Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan," last review dated 05/05/20 showed that: a. Action Steps included early identification by Intake/Admission staff for patients with potential for sexual aggression and potential for sexual victimization. b. The Intake/Admission staff/Unit Nurse completes the high risk visual notification alert and identifies either sexual aggression and/or sexual victimization and conducts a hand off with the RN accepting the admission on the unit. c. The Nursing Staff assesses patient risk factors for sexual aggression/Victimization and places patient on SAO- Aggression or SAO- Victim Precautions. 6. On 11/07/20 patient #1301 was admitted to the adolescent unit with suicidal ideation. The Intake Assessment dated 11/07/20 documents sexual molestation by family members and current legal process underway. 7. The psychiatric evaluation dated 11/8/20 at 8:34 AM describes the history of sexual abuse and victimization. 8. Patient #1301's medical record does not include Sexual Victimization precautions. 9. Patient #1301's medical record does not	L 325		

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L 325	Continued From page 4 include Sexual Victimization as part of the treatment plan. 10. During an interview between Investigator #13 and the Medical Director, (Staff #1311) on 04/21/21 at 9:00 AM, Staff #1311 stated that the patient should have been placed on precautions and the sexual victimization should have been included in the discussion with the treatment team.	L 325		
L 340	322-035.1H PROCEDURES-BEHAVIOR 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: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policy and procedures, the hospital failed to implement its policies and procedures for the use of restraints/seclusion by not modifying the patient's plan of care for 3 of 3 records reviewed (Patient #301, #302, #303). Failure to modify care plans for patients in restraints or seclusion puts patients at risk of	L 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 340	Continued From page 5 harm by not meeting their physical and emotional needs. Findings included: 1. Document review of the hospital's policy and procedure titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," policy # 300.22, last reviewed 09/20, showed that a review and modification of the treatment plan is indicated when an episode of restraint/seclusion occurs. The registered nurse will review and update the treatment plan within 8 hours. 2. On 04/21/21, Investigator #3 conducted a clinical record review of 3 patients who were placed in seclusion or restraints. In 3 of 3 patient records reviewed (Patient #301, #302, #303), staff failed to update the patient's care plans to reflect seclusion/restraint interventions. 3. During an interview with the Director of Quality, Staff #1303 on 0422/21 at 12:45 PM, Staff #1303 verified that the hospital policy was not followed.	L 340		

INLAND NORTHWEST BEHAVIORAL HEALTH

CMS PLAN OF CORRECTION

May 17th, 2021

	By submitting this Plan of Correction, the Hospital does not agree that the facts alleged are true or admit that it violated the rules. The Hospital submits this Plan of Correction to document the actions it has taken to address the citations.	
Tag # A 144	**PATIENT RIGHTS: CARE IN SAFE SETTING** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review the findings of this survey and reviewed the policy titled, Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan with no revisions required. All nursing staff including RNs and MHTs were retrained to the Sexual Aggression and Sexual Victimization policy immediately. Training focused on: • Appropriate investigation and reporting of sexual behavior • The need to separate patients upon discovery of sexual behaviors or who alleged to have engaged in sexual behaviors • Notification of parents/guardians per policy • Notification of local/state police in all sexual assault, intercourse cases that involve minors • Notification of Child Protective Services (CPS) as required by state statutes Training was initiated and completed by 5/31/2021. Evidence of training is filed in staff's personnel file. **STAFF RESPONSIBLE**: The Director of Quality and Risk Manager **MONITORING:** Monitoring of 100% of patients placed on Sexual Acting Out (SAO) precautions to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	5/31/2021
Tag # A 145	**PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review policies on Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan, and Suspected or Confirmed Cases of Patient Sexual Activity. No revisions required at this time.	

	STAFF RESPONSIBLE: Director of Quality and Clinical Educator **MONITORING:** Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	
Tag # A 286	**PATIENT SAFETY** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review the Performance Improvement Plan titled "Prevention of Sexual Acting Out Behaviors Action Plan dated 11/17/20. The PIP Plan was updated to state that all members of the treatment team will be educated on the "Stop, Think, Talk" Group and handout. The revised Plan was reviewed and approved by the Quality Council Committee on 5/17/2021. All members of the treatment team including nursing staff, therapists, medical staff and extenders were educated about "Stop, Think, Talk" by the Director of Quality and Risk Manager. Training was initiated immediately and completed by 5/31/2021. Evidence of staff training is filed in staff's personnel file. Training included emphasis on the patient behaviors that are not allowed and the Group content of "Stop, Think, Talk". **STAFF RESPONSIBLE**: Director of Quality and Risk Manager. **MONITORING:** Monitoring of 100% of Group notes on "Stop, Think, Talk" will be reviewed to confirm compliance with the group occurring. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	5/31/2021

	• Required review and modification of the treatment plan when an episode of seclusion/restraint occurs • The RN reviews and updates the treatment plan within eight hours of the seclusion/restraint intervention Training was initiated immediately and completed by 5/31/2021. Evidence of training is located in the personnel file. **STAFF RESPONSIBLE**: Director of Quality and Clinical Educator **MONITORING:** Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	

Received and accepted
9/15/21 4:30PM
Barbara Blanchard-Edwards

Inland Northwest Behavioral Health
Progress Report for Complaint # 107480/2020 and #110171/2021-2227

Tag Number	How Corrected	Date Completed	Results of Monitoring
# A 144 - **PATIENT RIGHTS: CARE IN SAFE SETTING**	All nursing staff including RNs and MHTs were retrained to the Sexual Aggression and Sexual Victimization policy immediately. Training focused on: • Appropriate investigation and reporting of sexual behavior • The need to separate patients upon discovery of sexual behaviors or who alleged to have engaged in sexual behaviors • Notification of parents/guardians per policy • Notification of local/state police in all sexual assault, intercourse cases that involve minors • Notification of Child Protective Services (CPS) as required by state statutes	5/31/2021	Monitoring of 100% of patients placed on Sexual Acting Out (SAO) precautions to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed. June: 100% July: 100% August: 100% September:
# A 145 - **PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT**	All direct patient care staff, including Intake/Admission staff were trained to the Sexual Aggression and Sexual Victimization Prevention and Response, Notification plan. Training focused on: • Early identification by intake/admission staff via assessment of patient history for being sexually abused/assaulted • Completion of a high risk visual notification alert by the intake/admission staff that identified either sexual aggression or sexual victimization • Proper hand-off of patient's assessment and high risk visual notification with RN accepting the admission on the unit • Nursing staff responsibility for assessing patient risk factor for sexual aggression/victimization and • Patient placed on appropriate SAO precautions	5/31/2021	Monitoring of 100% of patient's on SAO precautions reviewed to confirm compliance with hospital policy. Monitoring is ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining June: 90% July: 100% August:100% September:

# A 166 - **PATIENT RIGHTS: RESTRAINT OR SECLUSION**	All Registered Nurses, Providers and Social Workers were retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion with key focus on: • Required review and modification of the treatment plan when an episode of seclusion/restraint occurs • The RN reviews and updates the treatment plan within eight hours of the seclusion/restraint intervention	5/31/2021	Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. June: 90% July: 90% August:95% September:
# A 286 - **PATIENT SAFETY**	All members of the treatment team including nursing staff, therapists, medical staff and extenders were educated about "Stop, Think, Talk" by the Director of Quality and Risk Manager. Training was initiated immediately and completed by 5/31/2021. Evidence of staff training is filed in staff's personnel file. Training included emphasis on the patient behaviors that are not allowed and the Group content of "Stop, Think, Talk".	5/31/2021	Monitoring of 100% of Group notes on "Stop, Think, Talk" will be reviewed to confirm compliance with the group occurring. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. We lost multiple MSW's in June due to Director of Clinical Services leaving. We offered bonuses for extra shifts and sign on bonuses for new MSW's and we got the Groups done along with the notes to meet 95% in August. June: 80% July: 85% August: 95% September:
# L 325 - **POLICIES-ABUSE PROTECTION**	All nursing staff including RNs and MHTs were retrained to the Sexual Aggression and Sexual Victimization policy immediately. Training focused on: • Appropriate investigation and reporting of sexual behavior • The need to separate patients upon discovery of sexual behaviors or who alleged to have engaged in sexual behaviors • Notification of parents/guardians per policy • Notification of local/state police in all sexual assault, intercourse cases that involve minors	5/31/2021	Monitoring of 100% of patients placed on Sexual Acting Out (SAO) precautions to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed. June:100% July:100% August: 100% September:

	• Notification of Child Protective Services (CPS) as required by state statutes		
# L 340 - **PROCEDURES-BEHAVIOR**	All Registered Nurses, Providers and Social Workers were retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion with key focus on: • Required review and modification of the treatment plan when an episode of seclusion/restraint occurs • The RN reviews and updates the treatment plan within eight hours of the seclusion/restraint intervention	5/31/2021	Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. June: 90% July: 90% August: 95% September:

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

May 17, 2021

Dorothy Sawyer, CEO
Inland NW Behavioral Health
104 W. 5th Avenue
Spokane, WA 99204

Re: Complaint #107480/2020-16014, 110171/2021/2227

Dear Ms. Sawyer,

Investigators from the Washington State Department of Health] conducted a state and Medicare complaint investigation at Inland NW Behavioral Health onsite April 20-22, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on May 17, 2021.

A Progress Report is due on or before July 21, 2021 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please send a scanned copy of this progress report to me at the following email address:

barbara.blanchard-edwards@doh.wa.gov

Please contact me if you have any questions. I may be reached at (360) 489-5697. I am also available by email.

Sincerely,

Barbara Blanchard-Edwards MS, RN
Nurse Consultant