Received 5/19/21 11:30 AM
Barbara Ble... -Edwards

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/07/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504014	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) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint investigation. Onsite dates: 04/20/21, 04/21/21, and 04/22/21 Case numbers: 2020-16014, 2021-2227 Intake numbers: 107480, 110171 The investigation was conducted by: Investigator #13 Investigator #3 The DOH investigators found violations pertinent to the complaints.	A 000		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to protect patient rights for care in a safe environment by: 1. Not implementing its policies and procedures for investigating and reporting sexual behavior between patients for 2 of 6 records reviewed (Patients #1302 and #1306).	A 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorothy L. Sawyer — TITLE: CEO — (X6) DATE: 5-17-21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 144	Continued From page 1 2. Not implementing observation alerts based on history, observation and interview of patients upon admission to the hospital for 1 of 6 patients reviewed (Patient #1301). 3. Not ensuring a portion of the Noisy Activity Room on the adolescent unit is visible on camera or by staff unless they enter the room. Failure to ensure that staff members follow policy and procedure for investigating and reporting sexual activity on the unit or failing to include appropriate observation alerts in the patient record puts patients at risk for physical and psychological harm. Failure to be able to observe patients in activity rooms 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," dated 01/18/21 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.	A 144		

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A 144	Continued From page 2 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. 2. Review of Patient #1302's medical record by Investigator #13 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. During an interview with Investigator #13 on 01/29/21 at 2:25 PM, 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. During an interview with Investigator #13 on 02/05/21 at 10:00 AM , the Director of Quality/Interim Risk Manager (Staff #1303):	A 144		

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A 144	Continued From page 3	A 144		

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 the two involved patients told Staff #1303 where the encounter took place and that the patients were aware that it was not visible on the video cameras.

5. Observation by Investigator #13 on 04/21/21 of the Noisy Activity Room on the Adolescent Unit showed an angled wall that prevents direct observation from the hall or nurse's station.

6. During an interview with Investigator #13 on 01/29/21 at 10:30 AM, a mental health technician (Staff #1301) stated there are a couple of corners in the activity room that are not visible.

7. During an interview with Investigator #13 on 02/05/21 at 10:00 AM stated that during the investigation, all video tapes were reviewed and nothing was seen.

8. During an interview with Investigator #13 on 04/22/21 at 9:45 AM Staff #1305 verified that a portion of the Noisy Activity Room on the Adolescent Unit is not visible without entering the room.

9. Document review of the hospital's policy, "Sexual Aggression and Sexual Victimization: Prevention and Response at & Notification Plan," number 500.05F,dated 01/18/21 showed that:

a. Action Steps included early identification by Intake/Admission staff for patients with potential

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A 144	Continued From page 4 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 SA)O- Victim Precautions. 10. 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. 11. The psychiatric evaluation dated 11/08/20 at 8:34 AM describes the history of sexual abuse and victimization. 12. Patient #1301's medical record does not include Sexual Victimization precautions. 13. Patient #1301's medical record does not include Sexual Victimization as part of the treatment plan. 14. During an interview on 04/21/21 at 9:00 AM with the Medical Director, 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. .	A 144		

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A 145	Continued From page 5	A 145		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on record review and interview, the hospital failed to protect patient rights by ensuring that all team members are aware of patient's need for specialized observation based on history, observation and interview with the patient. Failure to ensure clear communication of patients need for specialized observation, i.e., sexual aggression or sexual victimization precautions, may cause serious physical or psychological harm to patients. Findings included: 1. Hospital policy titled, "Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan" number 500.05F dated 01/18/21 showed that: a. Early identification by intake/admission staff assesses patients for history of being sexually abused/assaulted, using historical data from the patient, family/guardian, previous hospitalizations/placements, referral/custodial agencies, and available medical, social and legal history. b. Intake/admission staff/Unit nurse completes the high risk visual notification alert and identifies	A 145		

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A 145	Continued From page 6 either sexual aggression of sexual victimization, as appropriate, then conducts a hand-off with the RN accepting the admission on the unit. c. The nursing staff assess patient risk factors for sexual aggression/victimization and places patient on SAO-Aggression or SAO-Victim Precautions. 2.. 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. 3. The psychiatric evaluation dated 11/08/20 at 8:34 AM describes the history of sexual abuse and victimization. 4. Patient #1301's medical record does not include Sexual Victimization precautions. 5. Patient #1301's medical record does not include Sexual Victimization as part of the treatment plan. 6. During an interview with investigator #13 on 04/21/21 at 9:00 AM with the Medical Director, Staff #1311, the doctor 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. 7. On 11/10/20 at 8:35 PM the Spokane Police visited the hospital regarding a police report taken from Patient #1301 being bitten on the breast and pinned to a chair by afoot in her crotch during her hospitalization. The alleged perpetrator was Patient #1302. No charges were filed.	A 145		

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A 145	Continued From page 7 8. Hospital policy titled "Suspected or Confirmed Cases of Patient Sexual Activity" policy #500.43 dated 10/01/18 showed that: a. information regarding continued risk of sexual activity with another patient will be communicated by instituting Sexual Agggression and/or Victimization Precautions. b. Treatment team to initiate sexually inappropriate behavior treatment plan; the plan could include discharge. 9. Six medical records were reviewed by Investigator #13 (Patients #1302, #1306, #1309, #1310, #1311 and #1312). 3 of 4 were not put on sexual familiarity or sexual aggression or sexual victimization precautions after sexually acting out (Patients #1309, #1310 and #1312). 10. Five of 6 medical records reviewied by Investigator #13 showed that the treatment plans were not updated after sexualy acting out behavior (Patients #1302, #1309, #1310, #1306, and #1312). 11. During an interview with Investigator #13 on 04/22/21 at 12:45 PM, the Director of Quality, Staff #1303 verified that not updating observation precautions and treatment plans after sexually acting out did not follow hospital policy.	A 145		
A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be--	A 166		

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A 166	Continued From page 8 (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on record review and review of hospital policy and procedures, the hospital failed to modify the patient's plan of care after placing patients in restraints or seclusion for 3 of 3 records reviewed (Patient #301, #302, #303). Failure to modify care plans for patients are in restraints or seclusion puts patients at risk of 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 04/22/21 at 12:45 PM, the restraint and seclusion record review findings were discussed. Staff #1303 verified that hospital policy was not followed.	A 166		

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A 166	Continued From page 9 .	A 166		
A 286	. PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: . Based on document review and interviews, the hospital failed to fully develop and implement its Performance Improvememt Plan related to preventing sexual acting out behavior among	A 286		

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A 286	Continued From page 10 patients. Failure to include all members of the treatment team and ensure all members are educated may lead to physical or psychological harm to patients. Findings included: 1. The Performance Improvement Project (PIP) titled "Prevention of Sexual Acting Out Behaviors Action Plan" dated 11/17/20 included educating patients using "STOP, THINK, TALK". The plan included only educating Mental Health Technicians (MHTs) on "STOP, THINK, TALK". 2. The plan did not include all members of the treatment team to be educated about "STOP, THINK TALK". 3. A printed outline of the course content was provided to Investigator #13 that had a hand written note in the upper right corner stating that all social workers had been educated on 01/14/21. 4. During an interview with Investigator #13 on 04/20/21 at 9:10 AM, the Director of Clinical Services,Staff #1305 stated that the Social Workers had been trained on "STOP, THINK, TALK". 5 There is no sign in roster for the training. There is no evidence in the electronic education tracking system that education was provided. 6. During an interview with Investigator #13 on 04/22/21 at 9:42 AM, a Registered Nurse, Staff #1309 stated she was aware of the "STOP, THINK, TALK" program, but had been educated	A 286		

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A 286	Continued From page 11 at her previous employer. Staff #1309 had received no training at this hospital on the program.	A 286		

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Spokane Plan and - Edwards

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State of Washington

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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 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		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorothy L. Sawyer	CEO	5-17-21

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L 325	Continued From page 1	L 325		

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.

State of Washington

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L 325	Continued From page 2	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

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 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		

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

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

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

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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 pollicy was not followed.	L 340		

Received 5/17/21 4:40PM, Barbara Richard-Edwards Accepted.

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.	

	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 Training was initiated immediately and completed by 5/31/2021. Evidence of training is filed in staff's personnel file. **STAFF RESPONSIBLE**: Director of Quality and Risk Manager **MONITORING:** 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. 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 5/31/2021
Tag # A 166	**PATIENT RIGHTS: RESTRAINT OR SECLUSION** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review the policy titled, Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion. No revisions required at this time. 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 Training was initiated immediately and completed by 5/31/2021. Evidence of training is located in the personnel file.	5/31/2021

	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

Tag # L 325	**POLICIES-ABUSE PROTECTION** **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.	
Tag # L 340	**PROCEDURES-BEHAVIOR** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review the policy titled, Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion. No revisions required at this time. 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:	

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<td>• 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.</td>
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Facility Name: Inland Northwest . ıavioral Health
Case/Intake Number: 2020-16014/107480

Investigative Report
Off-site State Investigation

Facility Address: 104 W. 5th Ave. Spokane, WA 99204
Laboratory Director: N/A
CLIA Number: N/A
Credential Number: 60882652
Medicare Number:
Shell Number: ZBBNW11
Date(s) of Investigation: 12/28/20-03/03/21
State Licensing Priority: B
Federal Certification Priority: N/A

Intake Details: *(List of concerns reported in the original complaint.)*

A 14 y/o female was sexually assaulted by another adolescent in the facility; experienced bullying and threats regarding her sexuality and religion without staff intervention; was not supervised nor counseled when she cut her arms with metal and cardboard and was provided no first aid for those cuts.

Allegation/s: *(The allegation/s listed below is what the department has jurisdiction and authorization to investigate. An allegation is considered an assertion of improper practice or condition that could result in a violation of facility law or rule.)*

1. Allegation: The facility failed to provide care in a safe environment as required in WAC 246-322-170 Patient Care Services [provide adequate care by admitting only patients for whom the hospital has adequate staff, services and equipment].

2. The facility failed to develop and/or implement policies and procedures regarding abuse of patients under WAC 246-322-035 Policies and Procedures.

3. The facility failed to educate and supervise staff providing care in the adolescent unit as required in WAC 246-322-050 Staff.

Investigative Process Included: *(This is what the investigator did in terms of methods employed to conduct inquiry.)*

1. The investigator interviewed the complainant by telephone on 11/25/20 at 11:30 AM to clarify complaint and gather additional information.