STATE OF WASHINGTON

DEPARTMENT OF HEALTH

NOTICE OF IMMEDIATE STOP PLACEMENT LIMITING OR PROHIBITING ADMISSIONS

DATE: 4/23/2022

Licensee: BHC Fairfax Hospital
Address: 10200 NE 132nd St Kirkland, WA 98034-2899
License No: HPSY.FS.00000004

Re: Case No. 2022-2123, 2022-3363, & 2022-3389

Dear Licensee:

This is notice of a limited stop placement of admissions imposed on your psychiatric hospital license, located at 10200 NE 132nd St Kirkland, WA 98034-2899 pursuant to Chapter 71.12 RCW and WAC 246-322. **The stop placement limiting admissions to your psychiatric hospital is effective immediately upon receipt of this notice.**

Basis for Stop Placement Limiting Admissions

On 4/21/2022 6:00 PM, the Department of Health, Office of Health Systems Oversight (department) conducted an investigation at your facility and found deficient practices or conditions, more fully described below that constitute an immediate jeopardy. On 4/21/2022 the department provided the facility written notification of the immediate jeopardy and the facility had twenty–four (24) hours to develop and implement a department approved plan to address the immediate jeopardy or the facility may be subject to enforcement action.

On 4/23/2022 9:12 AM the department conducted a revisit inspection which verified that the facility did not develop and implement a department-approved plan to address the immediate jeopardy within twenty-four hours. Accordingly, the department is authorized to impose a limited stop placement that takes effect immediately.

Deficient Practices or Conditions

This stop placement is based on the following violations of chapter 71.12 RCW and chapter 246-322 WAC: WAC 246-322-035 Policies and Procedures – Develop and implement policies and procedures to manage assaultive, self-destructive, or out of control behaviors.

Based on observation, interview, and document review, the hospital failed to ensure that staff provided patient care in a safe setting by the failure to identify patients at increased risk for harm, the failure to implement a plan of care for the prevention of sexual aggression or victimization, suicidal behaviors, and self-harm behaviors, and the failure to maintain a safe patient care environment by effectively conducting environmental rounds and patient observations, as directed by the hospital's policies and procedures.

Scope of the Stop Placement

The above noncompliance continues to pose immediate jeopardy as defined in chapter 71.12 RCW and chapter 246-322 WAC:

☐ Stop placement prohibiting all admissions of new patients. The deficient practices or conditions that constitute an immediate jeopardy are not limited to a particular category of patient or section of the hospital. Your facility may not admit any new patients until this stop placement is terminated by the department.

☒ Limited stop placement because the deficient practices or conditions that constitute an immediate jeopardy apply only to the following category/categories of patients or section(s) of your facility as follows: patients under the age of 18. Your facility may not admit any new patients belonging to the above referenced category/categories or to the above referenced section(s) of the facility.

Terminating the Stop Placement:

The department will terminate the stop placement when the department verifies the violation necessitating the stop placement has been corrected, or the department determines that your hospital has taken intermediate action to address the immediate jeopardy; and establishes the ability to maintain correction of the violations previously found deficient. To request an on-site follow-up inspection to verify the above, please complete and submit the enclosed request form.

Request for and Adjudicative Proceeding:

The facility has the right to contest the stop placement by requesting an adjudicative proceeding. To contest the department's decision, your or your representative must file a written request with the department's Adjudicative Service Unit (ASU) in a manner that shows proof of service on the ASU within Twenty-Eight (28) days from receipt of this decision.

The mailing address is:

Department of Health

Adjudicative Service Office

Post Office Box 47879

Olympia, WA 98504-7879

The physical address is:

Department of Health

Adjudicative Service Office

111 Israel Road SE

Tumwater, WA 98501

Email: ACOfax@doh.wa.gov (For filing under the emergency rules)

Dated: 04 | 23|22, 20__

By: Coleen Bann RN

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PSYCHIATRIC HOSPITAL PROGRAM

Enclosures
cc: AAG
OAS
OILS
OCHS
ACO

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	C 05/05/2022

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

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L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety investigation. Onsite dates: 04/06/22-04/07/22, 04/20/22-04/21/22, 04/23/22, 04/27/22-04/29/22 Offsite date: 05/05/22 Case numbers: 2022-3363, 2022-3389, 2022-2123 Intake numbers: 120861, 120854, 120309 Additional Review: Vaccine Mandate The investigation was conducted by: Investigator #15 Investigator #12 Investigator #19 (Orientation) During the investigation, the DOH investigators determined that there was a high risk of serious harm, injury, or death due to the hospital's failure to ensure that there were effective processes in place to identify patients at increased risk for harm to self or others, to ensure that an individualized plan of care was developed and implemented for the prevention of sexual aggression/victimization suicidal behaviors and/or self-harm behaviors, and that staff maintained a safe patient care environment by effectively conducting environmental rounds and patient observations.	L 000	. 1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by 06/07/22. 4. Return the ORIGINAL REPORT via email with the required signatures.	

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 4/15/22

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L 000	Continued From page 1 The state of IMMEDIATE RISK TO PATIENT SAFETY was declared on 04/21/22 at 5:45 PM. Hospital staff created a plan to remove the immediate risk to patients. The hospital's removal plan was approved on 04/27/22 at 2:35 PM. Investigators verified removal of the Immediate Risk to Patient Safety on 04/28/22 at 5:15 PM. Cross Reference: WAC 246-322-035 Policies and Procedures Significant deficiencies remained uncorrected at the time of the investigation exit. Fairfax Behavioral Hospital remains NOT IN COMPLIANCE with the Washington Administrative Code. .	L 000		
L 001	WAC 246-300-001(1-3) Licensed health care facilities and COVID 19 (1) This section applies to all health care facility types licensed by the department of health under chapters 18.46, 70.41, 70.42, 70.127, 70.230, 71.12, and 71.24 RCW. (2) Every facility subject to this rule must comply with state and federal statutes, administrative rules, lawful orders, and other legal requirements relating to the operation of the facility and the control or prevention of the spread of coronavirus disease 2019 (COV-ID-19). (3) Lawful orders include, but are not limited to, orders issued by the governor under chapter 43.06 RCW, by the secretary of health under chapter 43.70 RCW, or by a local board of health or local health officer under chapter 70.05, 70.08, or 70.24 RCW or chapter 246-100 WAC.	L 001		

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L 001	Continued From page 2 This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to adopt and implement policies and procedures that ensure unvaccinated staff receive weekly COVID-19 testing (Item #1) and that ensure unvaccinated staff wear appropriate personal protective equipment (PPE) (Item #2). Failure to adopt and implement policies and procedures for ensuring that unvaccinated staff receive weekly COVID-19 testing and wear appropriate PPE places patients, visitors, staff, and the community at risk for harm, including death. Findings included: Item #1 Weekly Testing for Unvaccinated Staff 1. Review of the hospital document titled, "COVID-19 Mandatory Vaccination, Washington," no policy number, effective 08/21, showed that healthcare workers who have met the requirements for exemption must be tested once weekly for COVID-19. 2. On 04/28/22 between 11:20 AM and 11:55 AM, Investigator #12 interviewed 5 staff members with approved COVID-19 vaccine exemptions. The interviews showed that 1 of 5 staff was not receiving weekly testing for COVID-19 (Staff #1201). 3. On 04/28/22 at 12:30 PM, Investigator #12 interviewed the Chief Operating Officer (Staff #1206), the Human Resources generalist (Staff #1207), and the Regional Director of Risk	L 001		

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L 001	Continued From page 3 Management (Staff #1208) about the weekly COVID-19 testing process for unvaccinated staff. Staff #1207 stated that unvaccinated staff were supposed to submit their test to the lab by Tuesday of each week, and unvaccinated staff who did not submit weekly tests would be suspended. The interview showed that 4 of 14 staff worked without receiving weekly testing (Staff #1201, #1202, #1203, and #1204). Staff #1206 stated that they had identified "gaps in their hiring process," and 3 staff had not been set up for weekly testing since they were hired (Staff #1201, #1203, and #1204). Staff #1207 confirmed that Staff #1202 was set up for weekly testing but had not submitted a test since 03/25/22. Item #2 Personal Protective Equipment (PPE) 1. Review of the hospital document titled, "COVID-19 Mandatory Vaccination, Washington," no policy number, effective 08/21, showed that healthcare workers who have met the requirements for exemption must wear an N95 respirator or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH) at all times while in the building unless actively drinking or eating or within their own private office space. 2. On 04/28/22 between 11:20 AM and 11:55 AM, Investigator #12 interviewed 5 staff members with approved COVID-19 vaccine exemptions. During the interviews, the investigator observed that 1 of 5 staff was not wearing an N95 respirator (Staff #1205) as required by hospital policy. When asked about the hospital's policy for wearing N95 respirators, Staff #1205 stated that the hospital only requires that the unvaccinated staff wear the N95 masks and goggles when they go to the	L 001		

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L 001	Continued From page 4 patient care units. 3. On 04/28/22 at 1:37 PM, during an interview with the Regional Director of Risk Management (Staff #1208), Staff #1208 confirmed the investigator's finding that Staff #1205 was not following hospital policy and should have been wearing an N95 respirator. .	L 001		
L 315	322-035.1C POLICIES-TREATMENT 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: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on policy review and document review, the hospital failed to ensure staff followed policies and procedures to reassess patients for increased risk of suicidal behaviors and, based on the risk formulation, notified the provider of increased risk when indicated, as demonstrated by 6 of 7 records reviewed (Patients #1901, #1902, #1903, #1904, #1905, #1906, and #1907). Failure to complete the suicide risk reassessment and notify the provider of any identified increased suicide risk puts the patient at risk for an unsafe environment for care, psychological harm, and serious injury or death.	L 315		

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L 315	Continued From page 5 Findings included: 1. Document review of facility policy titled "Suicide Risk Assessment and Management," policy number 1000.26, last reviewed 06/21, showed the following: a. All patients admitted to Fairfax Behavioral Health will be assessed for suicidality by the admitting Registered Nurse (RN) using the RN-Columbia Suicide Severity Rating Screen (RN-CSSRS). b. Reassessment of suicidality will occur every waking shift (twice per day) for any patient on suicide precautions or who exhibit a significant change in mental status; these are documented on the nursing progress note. c. This assessment shall contain, at a minimum: i. Current or past thoughts of suicide ii. Recent or past history of suicide attempts iii. Evidence of suicidal planning or intent iv. Risk Formulation including categorization of risk as compared to the general patient population on the inpatient unit (lower, similar, or higher). v. Individualized actions (interventions) initiated to prevent suicide and/or self-destructive behavior. Patient #1901 2. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1901 for the dates of	L 315		

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L 315	Continued From page 6 01/14/22 through 01/27/22. Patient #1901 is a 13-year-old female admitted for suicidal ideation, cutting, and alcohol intoxication. Patient #1901 had a history of a recent suicidal gesture that resulted in an emergency department visit, where she was referred to the facility. She also had a history of sexual assault by a family member. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed the patient using the RN-CSSRS twice per day as directed by hospital policy. In 9 of 34 notes for Patient #1901, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. The RN-CSSRS Risk Formulation shows that a "yes" answer to any 2 or more questions on the CSSRS indicates that the nurse must notify the provider and document the provider's response. b. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed the patient using the RN-CSSRS twice per day as directed by hospital policy. In 2 out of 34 notes for Patient #1901, nursing documented that the patient answered "yes" to the following 3 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? #3-Have you been thinking about how you might do this? Nursing staff documented the patient's level of suicide risk as "moderate" and did not notify the provider as directed by the screening tool and hospital policy.	L 315		

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L 315	Continued From page 7 c. On 01/24/22, in a Daily Nursing Progress Note during day shift, nursing staff documented that Patient #1901 had gone to the staff earlier that day after scratching her arm with broken glass and was tearful and upset throughout the day. No report to the provider was documented. No room search or confiscation of contraband (glass) was documented. No additional CSSRS was completed, as is directed by hospital policy. d. On 01/25/22, in an Addendum Progress Note during evening shift, nursing staff documented that Patient #1901 was found in a male patient's room and ran out of the room to her bathroom in tears. Staff wrote that they went to speak with her and, after they left her room and then returned, the patient was found in their bathroom cutting her wrist and neck with a piece of broken glass from a broken nail polish bottle. Staff wrote that the patient was tearful and said she was cutting because she wanted to die. Staff documented that this was reported to the charge nurse and the provider. An additional CSSRS was not completed, as is directed by hospital policy. e. On 01/26/22, in a Daily Progress Note during day shift, nursing staff documented that Patient # 1901 endorsed suicidal ideation with no intent or plan. The nurse documented that the patient self-harmed yesterday by cutting her neck and wrists and that the patient stated that she tried to kill herself. An additional CSSRS was not completed, as is directed by hospital policy. f. On 01/27/22, in a Daily Progress Note during day shift, nursing staff documented that Patient #1901 endorsed suicidal ideation and verbalized that she wants to kill herself. The provider and case manager were informed. An additional	L 315		

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L 315	Continued From page 8 CSSRS was not completed, as is directed by hospital policy. Patient #1902 3. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1902 for the dates of 01/21/22 through 01/31/22. Patient #1902 is a 13-year-old transgender male (female to male) admitted for depression and suicidal ideation. Patient #1902 had a history of a recent suicidal gesture with a plan to jump off a balcony or cut himself, which resulted in an emergency department visit. The emergency department referred the patient to the facility. Patient #1902 also had a history of sexual assault by a family member. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1902 using the RN-CSSRS twice per day as directed by hospital policy. In 2 out of 22 notes for Patient #1902, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. Patient #1903 4. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1903 for the dates of 01/27/22 through 02/04/22. Patient #1903 is a 15-year-old female referred from the emergency department for depression and suicidal ideation	L 315		

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L 315	Continued From page 9 after attempting to hang herself. She reports the presence of guns in her home. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1903 using the RN-CSSRS twice per day as directed by hospital policy. In 4 out of 18 notes for Patient #1903, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. b. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1903 using the RN-CSSRS twice per day as directed by hospital policy. In 3 out of 18 notes for Patient #1903, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff failed to document the patient's level of suicide risk and did not notify the provider as directed by the screening tool and hospital policy. Patient #1905 5. On 05/04/22, Investigator #19 reviewed the medical record of Patient #1905 for the dates of 01/13/22 through 01/17/22. Patient #1905 is a 14-year-old female admitted for suicidal ideation with a plan, a suicide attempt, and aggression towards her grandmother. She has a history of	L 315		

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L 315	Continued From page 10 sexual assault by her father. a. Investigator #19 reviewed the Daily Nursing Progress Notes for Patient #1905 and found that in 1 out of 10 notes, nursing failed to complete the RN-CSSRS. No nursing staff signed the document and no provider was notified. Patient #1906 6. On 04/28/22, Investigator #19 reviewed the medical record of Patient #1906 for the dates of 04/17/22 through 04/27/22. Patient #1906 is a 16-year-old female admitted as Family Initiated Treatment for depression, a dissociative episode, and suicidal ideation with a gesture involving a kitchen knife to her chest. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1906 using the RN-CSSRS twice per day as directed by hospital policy. In 1 out of 26 notes for Patient #1906, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. Patient #1907 7. On 04/28/22, Investigator #19 reviewed the medical record of Patient #1907 for the dates 04/15/22 through 04/27/22. Patient #1907 is a 15-year-old transgender male (female to male) with a history of depression, anxiety, self-harm	L 315		

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L 315	Continued From page 11 behaviors, suicidal ideation with plans, and homicidal ideation with a plan to burn down his mother's home. He has a history of sexual assault. a. Investigator #19 reviewed the Daily Nurse Progress Notes and found that nursing staff assessed Patient #1907 using the RN-CSSRS twice per day as directed by hospital policy. In 6 out of 26 notes for Patient #1907, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. b. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1907 using the RN-CSSRS twice per day as directed by hospital policy. In 2 out of 26 notes for Patient #1907, nursing documented that the patient answered "yes" to the following 3 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? #3-Have you been thinking about how you might do this? Nursing staff documented the patient's level of suicide risk as "moderate" and did not notify the provider as directed by the screening tool and hospital policy. c. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1907 using the RN-CSSRS twice per day as directed by hospital policy. In 1	L 315		

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L 315	Continued From page 12 out of 26 notes for Patient #1907, nursing documented that the patient answered "yes" to the following 6 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? #3-Have you been thinking about how you might do this? #4-Have you had these thoughts and had some intention of acting on them? #5-Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? #6-Have you done anything, started to do anything, or prepared to do anything to end your life? Nursing staff documented the patient's level of suicide risk as "high" and did not notify the provider as directed by the screening tool and hospital policy. 8. Investigator #19 reviewed all Daily Progress Notes for 7 charts (Patents #1901, #1902, #1903, #1904, #1905, #1906, and #1907) and found that 6 of 7 charts showed failure to use the RN-Columbia Suicide Severity Rating Screen as directed in the screening tool and in hospital policy. Nursing staff frequently did not follow the screening tool directions to document notification of the provider and the provider's response when a patient answers "yes" to any 2 or more questions on the screening tool. .	L 315		
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 320		

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L 320	Continued From page 13 services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Item #1 Compelled Medication - Refusal of Prescribed Antipsychotic Medication and Obtaining Second Opinion Based on interview, record review, and review of hospital policies and procedures, the hospital failed to develop and implement policies and procedures for the administration of chemical restraints, to ensure that patient's rights are protected when the patient refuses their scheduled antipsychotic medication that a second concurring medical opinion is obtained prior to compelling the medication administration, as demonstrated by 3 of 3 records reviewed (Patient #1510, #1518, and #1519). Failure to develop and implement policies and procedures for the administration of compelled involuntary antipsychotic medications that includes the requirement to obtain an additional second medical opinion prior to administration of the compelled medication, puts patients at risk for violation of their right to refuse antipsychotic medications, risk of psychological harm, and loss of personal dignity. Reference: Revised Code of Washington (RCW) 71.05.215 Right to refuse antipsychotic medicine - Rules.	L 320		

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L 320	Continued From page 14 (1) A person found to be gravely disabled or to present a likelihood of serious harm as a result of a behavioral health disorder has a right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication in the best interest of that person. (2) The authority shall adopt rules to carry out the purpose of this chapter. These rules shall include: (b) For short-term treatment up to thirty days, the right to refuse antipsychotic medications unless there is an additional concurring medical opinion approving medication by a psychiatrist, physicians assistant working with a supervising psychiatrist, psychiatric advanced practice registered nurse practitioner, or physician or physician assistant in consultation with a mental health professional with prescriptive authority. (c) For continued treatment beyond thirty days through the hearing on any petition filed under RCW 71.05.217, the right to periodic review of the decision to medicate by the medical director or designee. (e) Documentation in the medical record of the attempt by the physician, physician assistant, or psychiatric advanced registered nurse practitioner to obtain informed consent and the reasons why antipsychotic medication is being administered over the person's objection or lack of consent. Findings included: 1. Document review of the hospital's policy titled,	L 320		

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L 320	Continued From page 15 "Administration of Medication without Formal Consent," policy number 1000.52, last revised 06/21, showed the following: a. Involuntary antipsychotic medications may be administered to a detained/committed patient when it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment that medication in the best interest of that person. b. Only the treating physician or psychiatric advanced registered nurse practitioner may order involuntary medication. c. An attempt must be made to obtain informed consent from the patient prior to administration of the antipsychotic medication. d. The treating provider shall document reason for involuntary medication and request a concurring medical review, within 24 hours, by a psychiatrist, psychiatric advanced practice nurse practitioner, of physician in consultation with a mental health professional with prescriptive authority. e. The provider completing the second opinion shall document in detail the reasons for concurring or not concurring with the treating physicians' opinion. f. Involuntary medication may be administered only if the second opinion concurs with the treatment provider's order for involuntary medication. g. Staff will attempt to administer the medication	L 320		

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L 320	Continued From page 16 without the need for physical restraint. If physical restraint is necessary to safely administer the medication(s), staff shall follow the procedures outlined in Policy PC 1000.53 "Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion." 2. Investigator #15's review of the hospital's policy failed to find evidence guiding clinical staff on a clear process for compelled antipsychotic medications, including clarifying the form used to initiate the provider's order, how to document the request for a consult to obtain a second opinion prior to medication administration, what form is used by the provider completing the second opinion to document their findings, and clarification between the different requirements for compelled antipsychotic medication administration and emergency antipsychotic medication administration. Patient #1510 3. On 04/21/22 at 3:45 PM, Investigator #15 and the Assistant Director of Nursing (ADON) (Staff #1501) reviewed the medical record for Patient #1510, a 17-year-old female admitted on 04/01/22, on an involuntary detainment with a psychiatric diagnosis of Major Depressive Disorder (MDD). Patient #1510 endorsed Suicidal Ideation with a plan to overdose or cut herself. Patient #1510 had recently attempted suicide by overdosing, which led to the Patient's current admission. Review of the medical record showed the following: a. On 04/02/22 at 9:48 PM, nursing staff documented on Seclusion and Restraint documents that Patient was banging her head on the wall and cutting herself with her fingernails.	L 320		

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L 320	Continued From page 17 Patient #1501 refused to take the oral medications offered by nursing staff. b. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 04/02/22. Based on the Patient's imminent danger to self and the refusal to take oral medications, nursing staff contacted the psychiatric provider and obtained a verbal order for a chemical restraint of Haldol (antipsychotic) 10 mg, Ativan (benzodiazepine) 1 mg and Benadryl (anticholinergic) 50 mg. The medications were administered at 10:10 PM via intermuscular injection (IM). c. Investigator #15 found no evidence in Patient #1510's medical record documenting an attempt to obtain a second medical opinion or documentation from a provider detailing the concurring second opinion medical review prior to administration of the antipsychotic medication. Review of the medical record found that the intervention was not clearly identified as the administration of a compelled antipsychotic medication, which would require a request for, and documentation of, a second concurring opinion prior to medication administration. 4. On 04/21/22 at 3:45 PM, during an interview with Investigator #15, Staff #1501 verified that the medication administered on 04/02/22 at 10:10 PM was considered a compelled antipsychotic medication administration. When asked how to determine if the order was for an emergency medication or a compelled medication, Staff #1501 reviewed the medical record and stated that the Medication Administration Records (MAR) showed the patient's refusal to take their scheduled 9:00 PM antipsychotic medication. Additionally, nursing staff documented the Patient's refusal to take their medications on the	L 320		

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L 320	Continued From page 18 Restraint MD Order. Staff #1501 verified that Patient #1510 was given compelled IM antipsychotic medications without ensuring that a second opinion was obtained. Staff #1501 verified that the medical record for Patient #1510 did not contain a request for a second opinion or documentation for a second concurring opinion prior to the administration of the medications given on 04/02/22. Patient #1518 5. On 04/29/22, Investigator #15 reviewed the medical record for Patient #1518, a 34-year-old male voluntarily admitted on 04/22/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD) and Suicidal Ideation (SI). Patient #1510 had recently attempted suicide by attempting to shoot himself, which led to the Patient's current admission. Review of the Patient's medical record showed the following: a. On an Incident Report dated 04/23/22, staff documented an incident categorized as "Patient Out of Control." b. On 04/23/22 at 5:30 PM, nursing staff documented that Patient #1518 was attempting to assault other patients and staff. c. On 04/23/22, nursing staff initiated a Restraint MD Order based on evidence of imminent danger to self (patient) and the Patient's attempt to assault peers and staff. Nursing staff contacted the psychiatric provider and obtained a one-time NOW verbal order for a chemical restraint of Haldol (antipsychotic) 10 mg, Ativan (benzodiazepine) 2 mg and Benadryl (anticholinergic) 50 mg. The medications were administered at 5:40 PM via intermuscular	L 320		

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L 320	Continued From page 19 injection (IM). d. Review of the MAR showed that on 04/23/22 at 9:23 PM, Patient #1518 refused their scheduled 9:00 PM dose of olanzapine (antipsychotic). Investigator #15's review found that the IM medications were given at 5:40 PM, approximately 3 ½ hours prior to the scheduled 9:00 PM olanzapine and the Patient's refusal at 9:23 PM. e. Investigator #15 found no evidence in Patient #1518's medical record documenting an attempt to obtain a second medical opinion or documentation from a provider detailing the concurring second opinion medical review prior to administration of the antipsychotic medication. Investigator #15's review of the medical record found that the intervention was not clearly identified as the administration of a compelled antipsychotic medication and the process and requirements were not followed, as directed by hospital policy and state regulations. 6. On 04/29/22 at 12:15 PM, during an interview with Investigator #15, Staff #1501 verified that the medication administered on 04/23/22 at 5:40 PM was considered a compelled antipsychotic medication administration based on documentation in the MAR noting the Patient's refusal of his olanzapine. Staff #1501 was unable to address the time difference between the compelled medication administration at 5:40 PM and the refusal of the scheduled antipsychotic medication documented at 9:23 PM. Staff #1501 verified that the medical record for Patient #1518 did not contain a request for a second opinion, documentation for a second concurring opinion prior to the administration of the medications given on 04/23/22.	L 320		

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L 320	Continued From page 20 Patient #1519 7. On 04/29/22, Investigator #15 reviewed the medical record for Patient #1519, a 42-year-old male admitted on 03/25/22, on an involuntary detainment with a psychiatric diagnosis of Psychosis, unspecified. Upon admission, Patient #1519 presented with aggression and confusion. Review of the Patient's medical record showed the following: a. On a Physician's Order Form, dated 03/27/22 at 9:30 AM, the psychiatric provider wrote the following order: i. Patient can receive IM antipsychotics if refuses oral antipsychotics. ii. Thorazine 100 mg oral three times daily. Give first dose now. iii. Please obtain 2nd Opinion to obtain order to compel IM antipsychotics if patient refuses oral antipsychotics. b. On a Psychiatric Progress Note - 2nd Opinion Consultation, dated 03/27/22 at 1:00 PM. The second opinion provider documented their agreement with the initial psychiatric providers request. c. During the Patient's admission, staff initiated Incident Reports dated 04/02/22, 04/04/22, 04/05/22, and 04/07/22. Staff categorized each of these incidents as "Patient Out of Control." d. Review of Patient #1519's Seclusion and Restraint documents showed the following:	L 320		

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L 320	Continued From page 21 i. On 04/02/22 at 9:05 PM, nursing staff documented that the Patient "tried to punch staff" by swinging his hand during "second opinion." The psychiatric provider gave a telephone order for physical restraint, which was sustained from 9:03 PM to 9:12 PM. Additionally, the psychiatric provider ordered the administration of Ativan 2 mg IM NOW, which the nursing staff administered at 9:03 PM. ii. Investigator #15's review of the incident on 04/02/22 failed to find evidence that clearly defined the incident as a compelled medication administration or an emergency medication administration. There is an existing order dated 03/27/22 for compelled medications for refusal of antipsychotic medications, with a concurring second opinion, however if the one time IM NOW order was an intervention for an emergency situation, the requirement for a medical review second opinion within 24 hours of the medication administration was not met. iii. On 04/04/22, nursing staff documented that Patient #1519 had court on 04/04/22 and had refused to take his antipsychotic medications prior to the court hearing. (Beginning 24 hours prior to a hearing, the individual may refuse all psychiatric medications. Reference: RCW 71.05.21). iv. On 04/04/22 at 1:50 PM, nursing staff documented that the Patient presented an imminent danger to others. The Patient disrobed and became agitated and assaultive, hitting staff while they attempted to administer IM medications. The psychiatric provider gave a telephone order for physical restraint, which was sustained from 1:50 PM to 2:11 PM, seclusion, which was sustained from 2:11 PM to 2:45 PM,	L 320		

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L 320	Continued From page 22 and chemical restraint. The psychiatric provider ordered the administration of Thorazine 100 mg IM and Ativan 1 mg IM, which the nursing staff administered at 1:50 PM. v. Investigator #15's review of the incident on 04/04/22 failed to find evidence that clearly defined the incident as a compelled medication administration or an emergency medication administration. There is an existing order dated 03/27/22 for compelled medications for refusal of antipsychotic medications, with a concurring second opinion, however staff failed to document that Patient's refusal of his scheduled antipsychotic medications lead to this incident. vi. On 04/07/22 at 6:45 AM, nursing staff documented that the Patient presented an imminent danger to others. The Patient attacked and punched staff. The psychiatric provider gave a telephone order for physical restraint, which was sustained from 6:45 AM to 6:50 AM, seclusion, which was sustained from 6:50 AM to 7:50 AM, and chemical restraint. At 6:40 AM, the psychiatric provider wrote a one-time NOW order for the administration of Thorazine 100 mg IM and Ativan 2 mg IM, for aggressive behavior, the nursing staff administered at 6:45 AM. vii. Investigator #15's review of the incident on 04/07/22 failed to find evidence that clearly defined the incident as a compelled medication administration or an emergency medication administration. There is an existing order dated 03/27/22 for compelled medications for refusal of antipsychotic medications, with a concurring second opinion, however staff failed to document that Patient's refusal of his scheduled antipsychotic medications lead to this incident. If the one-time IM NOW order was an intervention	L 320		

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L 320	Continued From page 23 for an emergency, the requirement for a medical review second opinion within 24 hours of the medication administration was not met. 8. On 04/29/22 at 1:30 PM, during an interview with Investigator #15, Staff #1501 verified that Patient #1519's medical record did include a second concurring opinion consultation dated 03/27/22. Staff #1501 verified that nursing staff failed to document if the IM medications administered on 04/02/22, 04/04/22 and 04/07/22 were compelled medications based on the Patient's refusal of scheduled psychotropic medication or one-time emergency medications. Staff #1501 stated that the second opinion obtained on 03/27/22 should cover the IM medications during the Patient's admission. Item #2 Emergency Medications and obtaining Second Opinion Review within 24 hours Based on interview, record review, and review of hospital policies and procedures, the hospital failed to develop and implement policies and procedures for the administration of chemical restraints, to ensure that patient's rights are protected during the administration of emergency involuntary antipsychotic medications, including a review of the decision and documentation of the second medical opinion review within 24 hours after the administration, as demonstrated by 6 of 6 records reviewed (Patient #1501, #1502, #1503, #1510, #1517, and #1518). Failure to develop and implement policies and procedures for the administration of emergency involuntary antipsychotic medications that includes the second medical opinion review of the decision within 24 hours, puts patients at risk for	L 320		

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L 320	Continued From page 24 violation of their right to refuse antipsychotic medications, risk of psychological harm, and loss of personal dignity. Reference: Revised Code of Washington (RCW) 71.05.215 Right to refuse antipsychotic medicine - Rules. (1) A person found to be gravely disabled or to present a likelihood of serious harm as a result of a behavioral health disorder has a right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration or substantially prolong the length of involuntary commitment and there is no less intrusive course of treatment than medication in the best interest of that person. (2) The authority shall adopt rules to carry out the purpose of this chapter. These rules shall include: (d) Administration of antipsychotic medication in an emergency and review of this decision within twenty-four hours. An emergency exists if the person presents an imminent likelihood of serious harm and medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and in the opinion of the physician, physician assistant, or psychiatric advanced nurse practitioner, the person's condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion. (e) Documentation in the medical record of the attempt by the physician, physician assistant, or psychiatric advanced registered nurse practitioner to obtain informed consent and the reasons why	L 320		

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(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 320	Continued From page 25 antipsychotic medication is being administered over the person's objection or lack of consent. Findings included: 1. Document review of the hospital's policy titled, "Administration of Medication without Formal Consent," policy number 1000.52, last revised 06/21, showed the following: a. Involuntary antipsychotic medications may be administered to a detained/committed patient in an emergency (RCW 71.05.215). b. Definition of an emergency: An emergency exists if the person presents an imminent likelihood of serious harm, and medically acceptable alternatives to administration of antipsychotic medications are not available or unlikely to be successful; and in the opinion of the physician, the person's condition constitutes an emergency requiring the treatment be instituted prior to obtaining a second medical opinion. c. Only a physician or psychiatric advanced registered nurse practitioner may order emergency involuntary medications. d. The format for medication order shall be a one-time NOW order, not an as needed (PRN) order. e. Staff will attempt to administer the medication without the need for physical restraint. If physical restraint is necessary to safely administer the medication(s), staff shall follow the procedures outlined in Policy PC 1000.53 "Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion."	L 320		

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L 320	Continued From page 26 f. The physician will review the decision to administer the emergency medication within twenty-four hours. The review will be documented as part of the authentication of the order. g. If a second medical opinion has not been obtained prior to the use of the emergency medications, the treatment provider will request a concurring medical review within twenty-four hours, by a psychiatrist, psychiatric advanced registered nurse practitioner, or physician. h. The provider completing the second opinion shall document in detail the reasons for concurring or not concurring with the treating physicians' opinion. 2. Investigator #15's review of the hospital's policy failed to evidence guiding clinical staff on a clear process for emergency antipsychotic medications, including clarifying the form used to initiate the provider's order, how to document the request for a consult to obtain a second opinion within 24 hours of medication administration, what form is used by the provider completing the second opinion to document their findings, and clarification between the different requirements for emergency antipsychotic medication administration and compelled antipsychotic medication administration. Patient #1501 3. On 04/06/22, Investigator #15 reviewed the medical record for Patient #1501, a 13-year-old nonbinary born female admitted on an involuntary detention on 02/03/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD), Anxiety, and Post Traumatic Stress Disorder (PTSD). Patient #1501 endorsed suicidal ideation	L 320		

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L 320	Continued From page 27 with an undisclosed plan. Review of the Patient's medical record showed the following: a. On the Psychiatric Progress Note dated 02/09/22, the psychiatric provider documented that due to restrictions to the entire unit related to inappropriate behaviors, Patient #1501 became agitated and began self-harming by head banging, attempting to elope by running at the exit doors. The Patient was not able to redirect. The psychiatric provider wrote a one-time NOW order for 10 mg Zyprexa (antipsychotic) for agitation. b. Review of the Medication Administration Record (MAR) showed that the medication was administered via intramuscular injection (IM) at 1:45 PM on 02/09/22. c. Investigator #15's review of the medical record for Patient #1501 found that staff failed to document a request for a second medical opinion or document that the concurring second medical opinion was obtained within 24 hours of the emergency medication administration. Patient #1502 4. On 04/06/22, Investigator #15 reviewed the medical record for Patient #1502, a 16-year-old female admitted voluntarily on 01/09/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD), Tourette's Disorder (nervous system disorder involving repetitive movements or unwanted sounds), and Post Traumatic Stress Disorder (PTSD). Patient #1502 endorsed Suicidal Ideation triggered by an upcoming court hearing related to the sexual molestation by her biological father between ages 3-14. Patient #1502 had recently attempted suicide by	L 320		

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L 320	Continued From page 28 overdosing on Gabapentin, which led to the Patient's current admission. Review of the Patient's medical record showed the following: a. On a Nursing Progress Note dated 02/05/22, staff documented that that Patient began choking themselves with strings from their mask. The Mental Health Technician (MHT) documented that the Patient was given IM medication. b. Review of the Psychiatric Progress Note dated 02/05/22 at 10:25 PM, showed that the psychiatric provider documented that Patient #1502 continued to endorse suicidal ideation and would not disclose her plan. Investigator #15 found that the psychiatric provider failed to document the Patient's self-harm/suicide attempt or the order for emergency IM medications. c. On 02/05/22 at 7:20 PM, nursing staff obtained a telephone order from the psychiatric provider for Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 25 mg IM NOW. d. Review of the Medication Administration Record (MAR) showed that the medication was administered via IM at 7:20 PM on 02/05/22. e. Investigator #15's review of the medical record for Patient #1502 found that staff failed to document a request for a second medical opinion or document that the concurring second medical opinion was obtained within 24 hours of the emergency medication administration. Patient #1503 5. On 04/21/22, Investigator #15 reviewed the medical record for Patient #1503, a 14-year-old female admitted voluntarily on 01/04/22, with a	L 320		

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L 320	Continued From page 29 psychiatric diagnosis of Mood Disorder, unspecified, Major Depressive Disorder (MDD), and Post Traumatic Stress Disorder (PTSD). Patient #1503 had a reported history of sexual abuse by her biological father, trauma, and neglect. Patient #1503 had recently assaulted her grandmother and endorsed Suicidal Ideation with a plan to overdose, which led to the Patient's current admission. Review of the Patient's medical record showed the following: a. On 01/18/22 at 3:00 PM, the Medication Administration Record (MAR) showed that the psychiatric provider initiated an order for Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 50 mg IM NOW for psychosis. The medications were administered at 1:27 PM via IM. b. On 01/19/22 at 11:00 AM, the Medication Administration Record (MAR) showed that the psychiatric provider initiated on order for Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 50 mg IM NOW for agitation. The medications were administered at 10:53 AM via IM. c. Investigator #15's review of the medical record for Patient #1503 found that staff failed to document a request for a second medical opinion or document that the concurring second medical opinion was obtained within 24 hours of the emergency medication administration. Patient #1510 6. On 04/21/22 at 3:45 PM, Investigator #15 and the Assistant Director of Nursing (ADON) (Staff #1501) reviewed the medical record for Patient #1510, a 17-year-old female admitted on	L 320		

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L 320	Continued From page 30 04/01/22, on an involuntary detainment with a psychiatric diagnosis of Major Depressive Disorder (MDD). Patient #1510 endorsed Suicidal Ideation with a plan to overdose or cut herself. Patient #1510 had recently attempted suicide by overdosing, which led to the Patient's current admission. Review of the medical record showed the following: a. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 04/12/22 at 9:46 PM. Patient #1510 had attempted to break into the nurses' station with the intent to find an object to end her own life. Based on the Patient's imminent danger to self, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint, which was sustained for one minute at 9:43 PM, seclusion, which was sustained from 9:43 PM to 10:17 PM, and chemical restraint. The psychiatric provider ordered the administration of Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 50 mg IM NOW, which the nursing staff administered at 9:55 PM. b. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 04/14/22 at 11:30 AM. Patient #1510 had become agitated and punched a staff member. Based on the Patient's imminent danger to others, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint, which was sustained from 11:26 AM to 11:46 AM, and chemical restraint. The psychiatric provider ordered the administration of Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 50 mg IM NOW, which the nursing staff administered at 11:26 AM. c. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 04/16/22 at 8:15 PM.	L 320		

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L 320	Continued From page 31 Patient #1510 had become assaultive, punching and kicking staff members. Based on the Patient's imminent danger to others, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint, which was sustained from 8:08 PM to 8:28 PM, and chemical restraint. The psychiatric provider ordered the administration of Olanzapine (antipsychotic) 10 mg IM NOW and Benadryl 50 mg IM NOW, which the nursing staff administered at 8:08 PM. d. Investigator #15's review of the medical record for Patient #1510 found that staff failed to document a request for a second medical opinion or document that the concurring second medical opinion was obtained within 24 hours of the emergency medication administrations on 04/12/22, 04/14/22 and 04/16/22. Patient #1517 7. On 05/05/22, Investigator #15 reviewed the medical record for Patient #1517, a 19-year-old female admitted on 02/09/22, on an involuntary detainment with a psychiatric diagnosis of Bipolar Disorder and Post Traumatic Stress Disorder (PTSD). Upon admission, Patient #1517 presented with mania, tangential, pressured speech, sexually inappropriate behavior, and endorsed auditory hallucinations, due to medication noncompliance. Review of the medical record showed the following: a. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 02/09/22 at 7:58 PM. Patient #1517 had attempted to choke a staff member. Based on the Patient's imminent danger to others, nursing staff contacted the psychiatric provider and obtained a verbal order for physical	L 320		

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L 320	Continued From page 32 restraint, seclusion, and chemical restraint. The psychiatric provider ordered the administration of Haldol (antipsychotic) 10 mg IM NOW, Benadryl 50 mg IM NOW, and Ativan 2 mg IM NOW, which the nursing staff administered at 7:58 PM. b. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 02/22/22 at 12:20 AM. Patient #1517 attempted to attack another patient. Based on the Patient's imminent danger to others and danger to self, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint, seclusion, and chemical restraint. The psychiatric provider ordered the administration of Haldol (antipsychotic) 5 mg IM NOW, Benadryl 50 mg IM NOW, and Ativan 2 mg IM NOW, which the nursing staff administered at 12:18 AM. c. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 02/22/22 at 11:24 AM. Patient #1517 had become verbally threatening to other patients and staff members and physically assaulted another patient. Based on the Patient's imminent danger to others, nursing staff contacted the psychiatric provider and obtained a verbal order for seclusion and chemical restraint. The psychiatric provider ordered the administration of Olanzapine (antipsychotic) 10 mg IM NOW, which the nursing staff administered at 11:24 AM. d. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 02/22/22 at 3:40 PM. Patient #1517 had become aggressive, spitting, kicking and attempting to scratch staff members. Based on the Patient's imminent danger to others, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint and chemical restraint. The psychiatric	L 320		

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L 320	Continued From page 33 provider ordered the administration of Haldol (antipsychotic) 10 mg IM NOW, Benadryl 50 mg IM NOW, and Ativan 2 mg IM NOW, which the nursing staff administered at 3:40 PM. e. Investigator #15's review of the medical record for Patient #1517 showed that on 02/10/22 at 11:55 AM, the psychiatric provider initiated the request for a second concurring medical opinion to compel antipsychotic medication administration when the Patient refused their scheduled antipsychotic medication. A second concurring opinion was received and documented on a written order dated 02/10/22 at 12:00 PM. f. Investigator #15's review of the medical record for Patient #1517 found that staff failed to document a request for a second medical opinion or document that the concurring second medical opinion was obtained within 24 hours of the emergency medication administrations 02/09/22, 02/22/22 at 12:18 AM, 02/22/22 at 11:24 AM, and 02/22/22 at 3:40 PM. Patient #1518 8. On 04/29/22, Investigator #15 reviewed the medical record for Patient #1518, a 34-year-old male voluntarily admitted on 04/22/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD) and Suicidal Ideation (SI). Patient #1510 had recently attempted suicide by attempting to shoot himself, which led to the Patient's current admission. Review of the Patient's medical record showed the following: a. Nursing Staff initiated a Restraint Medical Doctor (MD) Order, dated 04/25/22 at 9:58 PM. Patient #1518 had attempted to attack a peer. Based on the Patient's imminent danger to	L 320		

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L 320	Continued From page 34 others, nursing staff contacted the psychiatric provider and obtained a verbal order for physical restraint and chemical restraint. The psychiatric provider ordered the administration of Haldol (antipsychotic) 5 mg IM NOW and Benadryl (anticholinergic) 50 mg IM NOW and Ativan 2 MG IM NOW, which the nursing staff administered at 9:57 PM. b. Investigator #15's review of the medical record for Patient #1518 failed to find evidence of a request for a second medical opinion or evidence documenting the concurring second medical opinion was obtained within 24 hours of the emergency medication administration. 9. On 04/29/22at 1:45 PM, during an interview with Investigator #15, Staff #1501 verified that only one of the medical records reviewed had a 2nd Opinion Consultation for Compelled Medication (Patient #1517) and none of the medical records reviewed for Patients' #1501, #1502, #1503, #1510, #1517, and #1518 contained a request for a second medical opinion or the concurring second medical opinion, which should be obtained within 24 hours of the emergency medication administration. Staff #1501 stated that the facility's interpretation of the requirement for a second opinion for the administration of emergency medication would be met by obtaining a concurring second medical opinion for the administration of compelled medications. Thus, the hospital does not have a clear understanding of the difference between the second medical opinion requirement for emergency medication administration versus compelled medication administration. .	L 320		

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L 340	Continued From page 35	L 340		
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: . Item #1 - Roommate assignments for prevention of sexual aggression or sexual victimization Based on observation, interview, and document review, the hospital failed to provide care in a safe setting by failing to ensure that staff followed policies and procedures that identified patients at increased risk for sexual aggression or sexual victimization and implemented a plan to monitor the room assignments of patients on enhanced precautions to prevent incidents of sexual aggression or sexual victimization. Failure to identify patients at increased risk for harm and to implement a plan for the prevention of sexual aggression or sexual victimization by ensuring that patients identified with sexual aggression precautions will not be roomed with a patient identied with sexual victimization	L 340		

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L 340	Continued From page 36 precautions places patients at risk for serious physical and psychological harm. Findings included: 1. Review of the hospital document titled, "Sexual Aggression/Victimization Precautions," policy number 1000.80, last reviewed 06/21, showed that nursing staff determines if a roommate assignment is appropriate and makes adjustments as needed based on identifiable risk factors. 2. Document review of the hospital's adolescent unit daily census sheet dated 04/23/22, showed 1 patient with sexual aggression precautions (SAP) and 7 patients with sexual victimization precautions (SVP). The document showed that the patient with SAP (Patient #1201) was assigned a roommate with SVP (Patient #1202). 3. On 04/23/22 at 11:30 AM, Investigator #12 Interviewed the charge nurse on the hospital's adolescent unit (Staff #1219). Staff #1219 stated that patients with SAP cannot share rooms with patients who are on sexual victimization precautions. When asked to review the roommate assignment for Patients #1201 and #1202, Staff #1219 stated, "they should not be in the same room." Item #2 - Failure to identify patients at increased risk for self-destructive, assaultive behavior and implement interventions to prevent adverse outcomes Based on interview, record review, and review of hospital policies and procedures, the hospital failed to provide care in a safe setting by	L 340		

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L 340	Continued From page 37 developing and implementing policies and procedures that identified patients at increased risk for sexual aggression/victimization, suicidal behaviors/self-harm behaviors, and assaultive/aggressive behaviors and to implement interventions, such as treatment planning, to prevent incidents related to these increased safety risks, as demonstrated by 8 of 8 records reviewed (Patient #1501, #1502, #1503, #1504, #1507, #1511, #1515, and #1516). Failure of the hospital staff's ability to identify patients at increased risk for harm and to implement a plan of care for the prevention of sexual aggression/victimization, suicidal behaviors/self-harm behaviors, and assaultive/aggressive behaviors to ensure patient care in a safe setting, places the patients at risk for serious physical and psychological harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Suicide Precautions," policy number 1000.24, last revised 06/21, found that the purpose of the policy is to provide a safe environment for all patients by providing guidelines for addressing the immediate safety needs of patients identified as high risk for suicide. All suicide threats, gestures, and attempts are considered serious and are to be responded to immediately. The policy and procedure failed to provide guidelines for staff to implement a consistent process to establish specific goals and targets, document preventative measures and interventions, or record the patient's progress and readiness for discharge, such as a Master Treatment Plan (MTP) and Individual Treatment Plan (ITP), for patients placed on suicide precautions, or that had been	L 340		

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L 340	Continued From page 38 identified at an increased risk for suicidal/self-harm behaviors. 2. Document review of the hospital's policy and procedure titled, "Assault Precautions," policy number 1000.43, last revised 06/21, found that the purpose of the policy is to provide a safe environment for all patients by providing guidelines for addressing the immediate safety needs of patients identified as high risk for assaultive behavior. All verbal and physical threats, and attempts are considered serious and are to be responded to immediately. The policy and procedure failed to provide guidelines for staff to implement a consistent process to establish specific goals and targets, document preventative measures and interventions, or record the patient's progress and readiness for discharge, such as a Master Treatment Plan (MTP) and Individual Treatment Plan (ITP), for patients placed on assault precautions, or that had been identified at an increased risk for aggressive/assaultive behaviors. 3. Document review of the hospital's policy and procedure titled, "Sexual Aggression(SAP)/Victimization Precautions (SVP)," policy number 1000.80, last revised 06/21, found that the purpose of the policy is to provide a safe, therapeutic environment of care for all patients by providing a plan for the prevention of sexually inappropriate behavior, including aggression and the potential for victimization by identifying early warning signs for sexual behavior, monitoring the patient with a suspected potential for sexual aggression/victimization, and implementing intervention steps to minimize the risk of inappropriate sexual behavior. The policy indicated that when nursing staff identifies a	L 340		

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L 340	Continued From page 39 patient with risk factors for Sexual Aggression/Victimization, the patient will be placed on Sexual Aggression Precautions (SAP) or Sexual Victimization Precautions (SVP) and the provider will be notified. When a patient is identified with increased risk factors and SVP and/or SAP precautions are initiated, staff will then develop a Sexually Inappropriate Treatment Plan and update the Master Treatment Plan Problem List. 4. Document review of the hospital's policy and procedure titled, "Suspected or Confirmed Cases of Patient Sexual Activity," policy number 1000.30, last revised 06/21, showed that for cases of suspected or confirmed patient sexual activity the treatment team will initiate a sexually inappropriate behavior treatment plan. 5. On an Incident Report dated 02/11/22, staff reported an incident categorized as "Sexual Intercourse - Patient to Patient." The incident took place on 02/11/22 at approximately 7:00 PM, on the adolescent unit, in the outside courtyard area. A group of adolescent patients were escorted to the outside courtyard area by a nursing staff member. While in the darkened courtyard, two female patients (Patient #1501 and #1504), who had both reported a history of sexual abuse, engaged in sexual intercourse (oral sex) with a male patient (Patient #1507). At the time of the incident, the male patient (Patient #1507) was on Unit Restrictions (UR), which restricted him to the unit only and did not allow access to the outside courtyard area (Unit Restriction-Outside URO). The Investigator's review of the incident's video footage showed that the staff member conducting the observations failed to respond when several adolescent patients were not visible in the blind spot of the darkened courtyard or openly	L 340		

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L 340	Continued From page 40 displayed boundary violations, such as hugging and sexual touch. The staff member was observed sitting on a bench in the middle of the courtyard with his back to the patients hidden in the darkened back corner of the courtyard looking at an electronic device. The following patients were involved in the reported incident: Patient #1501 6. On 04/06/22, Investigator #15 reviewed the medical record of Patient #1501, a 13-year-old non-binary born female involuntary patient admitted on 02/03/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD), Anxiety, Post Traumatic Stress Disorder (PTSD), and Borderline Personality Disorder. Patient #1501 reported a significant history of abuse, including sexual abuse by a family member (grandfather) from age 2 until recently. Review of the medical records showed the following: a. Patient #1501 was placed on SVP upon admission; however, no plan of care was developed at that time to address her significant history of sexual abuse or to prevent sexual incidents during hospitalization. On 02/18/22, staff added "sexual precautions" to the MTP Problem list and initiated a Sexual Precautions Individual Treatment Plan, 15 days after the Patient's admission. b. Prior to the incident on 02/11/22, the psychiatric provider documented Patient #1501 exhibited inappropriate sexual behavior on 3 days, 02/08/22, 02/09/22 and 02/11/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or boundaries on 2 days, 02/03/22 and 02/07/22. Staff failed to document the development of a	L 340		

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L 340	Continued From page 41 plan of care in response to the identified sexually inappropriate behaviors to prevent and minimize the risk of sexually inappropriate incidents. c. After the incident on 02/11/22, the psychiatric provider documented Patient #1501 exhibited inappropriate sexual behavior on 3 days, 02/19/22, 02/20/22, and 02/21/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or boundaries on 5 days, 02/14/22, 02/17/22, 02/19/22, 02/20/22, and 02/21/22. In response to the continued incidents of reported sexually inappropriate behavior, staff failed to document or implement revisions to the plan of care (initiated on 02/18/22) to prevent and minimize the risk of additional sexually inappropriate incidents. Patient #1504 7. On 04/07/22, Investigator #15 reviewed the medical record of Patient #1504, a 15-year-old female voluntary patient admitted on 02/02/22, with a psychiatric diagnosis of Major Depressive Disorder (MDD), Anxiety, Bipolar Disorder, and Post Traumatic Stress Disorder (PTSD). Patient #1504 reported a history of sexual abuse, including sexual abuse by a family member. Patient #1504's father reported that she was currently engaging in risk-taking sexually inappropriate behaviors. Review of the Patient's medical record showed the following: a. Patient #1504 was not placed on SVP upon admission. On the Psychiatric Evaluation the provider documented that the Patient would be placed on SVP based on the Patient's history of sexual abuse. The Patient was not placed on SVP until after the incident on 02/11/22. The MTP was not updated to add Sexually Inappropriate	L 340		

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L 340	Continued From page 42 Behavior to the Problem List and an Individual Treatment Plan was not initiated throughout the Patient's admission. b. Prior to the incident on 02/11/22, the psychiatric provider documented Patient #1504 exhibited inappropriate sexual behavior on 4 days, 02/05/22, 02/06/22, 02/08/22 and 02/11/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or boundaries on 9 days, 02/03/22, 02/04/22, 02/05/22, 02/07/22 (two incidents), 02/09/22 and 02/11/22 (two incidents prior to the reported sexual intercourse incident). Staff failed to document the development of a plan of care in response to the identified sexually inappropriate behaviors to prevent and minimize the risk of sexually inappropriate incidents. c. After the incident on 02/11/22, the psychiatric provider documented Patient #1504 exhibited inappropriate sexual behavior on 3 days, 02/16/22, 02/17/22, and 02/20/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or boundaries on 6 days, 02/13/22, 02/14/22, 02/17/22, 02/18/22, 02/19/22, and 02/20/22. In response to the continued incidents of reported sexually inappropriate behavior, staff failed to initiate and implement a plan of care to prevent and minimize the risk of additional sexually inappropriate incidents. Patient #1507 8. On 04/20/22, Investigator #15 reviewed the medical record of Patient #1507, a 16-year-old male involuntarily detained patient admitted on 12/23/21, with a psychiatric diagnosis of Major Depressive Disorder (MDD), Anxiety Disorder,	L 340		

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L 340	Continued From page 43 and Mood Disorder, unspecified. Patient #1507 reported homicidal thoughts, with a plan to stab 3 random students at school. Patient #1507 denied a history of sexual abuse or aggression. The Patient reported that he had a restraining order against him after he had written a story about a female classmate in 7th grade. Review of the Patient's medical record showed the following: a. Upon admission, Patient #1507 was not identified with an increased risk for SVP or SAP based on clinical information provided and admission assessments. On 02/07/22, nursing staff documented that Patient #1507 would be placed on SVP and SAP. Review of the medical records found that the Patient was placed on SAP on 02/12/22 (5 days later). The MTP was not updated to add Sexually Inappropriate Behavior to the Problem List and an Individual Treatment Plan was not initiated throughout the Patient's admission. b. Prior to the incident on 02/11/22, the psychiatric provider documented Patient #1507 exhibited inappropriate sexual behavior on 3 days, 01/14/22, 02/09/22 and 02/10/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or boundaries on 5 days, 12/24/21, 01/21/22, 02/07,22, 02/08/22 and 02/09/22. Staff failed to document the development of a plan of care in response to the identified sexually inappropriate behaviors to prevent and minimize the risk of sexually inappropriate incidents. c. After to the incident on 02/11/22, the psychiatric provider documented Patient #1507 exhibited inappropriate sexual behavior on 1 day, 02/15/22. In addition, the nursing staff documented that the Patient exhibited inappropriate sexual behavior or	L 340		

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L 340	Continued From page 44 boundaries on 8 days, 02/14/22, 02/15/22, 02/16,22, 02/19/22, 02/22/22, 02/24/22, 02/26/22, and 02/28/22. In response to the continued incidents of reported sexually inappropriate behavior, staff failed to initiate and implement a plan of care to prevent and minimize the risk of additional sexually inappropriate incidents. 9. On 04/07/22 at 11:00 AM, during an interview with Investigator #15, the Nurse Manager (Staff #1503) stated that when a patient is observed displaying sexually inappropriate behavior, the patient is placed on enhanced precautions (SVP and/or SAP) and the treatment team is notified. 10. On 04/20/22 at 10:10 AM, during an interview with Investigator #15 and Investigator #19, the Risk Manager (Staff #1504) stated that when a patient is placed on enhanced precautions, such as SAP or SVP, staff will initiate a supporting treatment plan. 11. On 04/07/22 at 11:15 AM, during an interview with Investigator #15, Nurse Manager (RN) (Staff #1503) stated that during the admission process, patients are assessed for an increased risk for sexual aggression or sexual victimization, based on reports of a history of sexual trauma or abuse or reported incidents of sexual aggression or assault. Once the patients are identified with the need for increased safety precautions (SVP and/or SAP), the treatment team should add this to the MTP and initiate an Individual Treatment Plan. 12. Investigator #15's review of additional medical records for Patients #1502, #1503, #1511, #1515, and #1516 showed evidence of similar findings, including the identification of increased risks and the failure of staff to initiate a plan of care	L 340		

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L 340	Continued From page 45 documented in the MTP and ITP, providing a process to identify interventions, establish goals, track the patients progress during admission and prevent adverse outcomes. 13. On 04/20/22 at 12:55 PM, during an interview with Staff #1501, Investigator #15 asked about the missing behavioral treatment plans and the inconsistencies that were found during the medical record review when staff identified the need for enhanced safety precautions and the initiation of treatment plans and individualized interventions to address those increased risks. Staff #1501 stated that the inclusion to the MTP/ITP would depend on the circumstances. Staff #1501 reported that the treatment team and the provider would review the clinical data, incident, or reported behavior and decide whether to add to the MTP and create an ITP. ITEM #3 Effectively conducting patient observations and ensuring a safe patient care environment Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to provide care in a safe setting by developing and implementing policies and procedures that guide staff to effectively conduct environmental safety rounds and patient observations. Failure to develop policies and procedures that provide a safe patient care environment and protect patients from self-harm or harm from others, places the patients at risk for serious physical and psychological harm. Findings included:	L 340		

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L 340	Continued From page 46 1. Document review of the hospital's policy and procedure titled, "Patient Observation Policy," policy number 1000.5, last revised 06/21, showed the following: a. The Charge Nurse ensures that Patient Observations Rounds are occurring as ordered, 24 hours a day, seven days a week. b. Twice per shift, the Charge Nurse reviews all patient observational rounds and initials the supervisor verification. c. The Mental Health Technician (MHT), Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA) are responsible for reviewing and updating the patient observations records. Any changes in the individual precaution levels, room or bed changes, new admissions and/or discharges will be reflected, as they occur. d. Clearly print employee name and initials in the appropriate section of the patient observations record. e. Observe each patient a minimum of every 15 minutes and/or according to the precaution level and document observation on the patient observation form. f. Document the patient location and behavior when the observation occurs on the patient observation form. g. Visually observe patients when behind closed doors or curtains. h. Staff that is accompanying the patient off	L 340		

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L 340	Continued From page 47 Fairfax grounds (Emergency Department, Social Security or housing appointments) must document observations on the Patient Observation Form. 2. Document review of the hospital's policy and procedure titled, "Level of Observation Orders Policy," policy number 1000.21, last revised 06/21, showed the following: a. Staff will complete the patient observation record as rounds are made, using the coding system described on the record for patient activities. b. Staff will observe the patient and note their behavior, whereabouts, and any other pertinent behavior. c. Staff will initial appropriate documentation in the designated areas. Documentation should occur concurrently with the actual process of performing the physical rounds. d. Staff will be vigilant for potential risk factors identified for specific patients (level of precautions). 3. Document review of the hospital's digital training slides titled, "Rounds and Observation Levels," no policy number, no date of last revision, showed the following: a. You must visually observe the patient's face on each round (even if the patient is in the bathroom). b. If patient is leaving the unit, rounds sheets should go with the staff accompanying the patient.	L 340		

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L 340	Continued From page 48 c. Check environment for safety. Incident #1 - 02/11/22 Patient Observations 4. On an Incident Report dated 02/11/22, staff reported an incident categorized as "Sexual Intercourse - Patient to Patient." 5. Review of the hospital's video of the incident with the hospital's Risk Manager (Staff #1504) confirmed that incident took place on 02/11/22, on the adolescent unit in the outside courtyard area. The video showed that one staff member and approximately 9 patients entered the outside courtyard area at 6:52 PM. At 6:57 PM, all the patients were out of the view of the camera in the darkened corner of the courtyard. While in the darkened courtyard, two female patients (Patient #1501 and #1504) who both had a reported history of sexual abuse, engaged in sexual intercourse (oral sex) with a male patient (Patient #1507). The staff member sat in a chair facing out to the darkened courtyard and appeared to be looking at an electronic device. At 7:01 PM, the staff member moved to a bench in the middle of the courtyard, facing away from the darkened back corner where several of the patients were still out of the view of the video camera and still appeared to be looking at an electronic device. Throughout the review of the video, from 6:52 PM to 7:30 PM, the patients intermittently moved around the courtyard, sometimes visible on the camera, and sometimes moving to the darkened corners of the courtyard out of view. 6. During the investigation of the incident, Investigator #15 found discrepancies in the patient observations/rounding forms for the three patients involved in the incident. Review of the	L 340		

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L 340	Continued From page 49 observation round forms for Patients #1501, #1504, and #1507 showed that staff failed to document that the patients were located in the courtyard between 6:52 PM and 7:30 PM. a. On 02/11/22, staff documented that Patient #1501 was on Suicide Precautions, Unit Restriction Outside Privileges (URO) which meant that the Patient could go to the outside courtyard (with staff supervision). On Patient #1501's Observation Record for Q15 (observations every 15 minutes) Rounds, dated 02/11/22, staff documented the following: 6:45 PM - Location: Day Room 7:00 PM - Location: Hallway 7:15 PM - Location: Hallway 7:30 PM - Location: Bathroom Review of the Observation Records found that the MHT performing rounds inside on the unit was documenting the Patient's location and behavior. Review of the video showed that Patient #1501 entered the outside courtyard at 6:52 PM and returned inside to the unit at 7:30 PM. b. On 02/11/22, staff documented that Patient #1504 was on Suicide Precautions, Unit Restriction Therapy Privileges (URT) which meant that the Patient could go to the outside courtyard and the gym (with staff supervision). On Patient #1504's Observation Record for Q15 (observations every 15 minutes) Rounds, dated 02/11/22, staff documented the following: 6:45 PM - Location: Day Room 7:00 PM - Location: Day Room 7:15 PM - Location: Day Room 7:30 PM - Location: Day Room	L 340		

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L 340	Continued From page 50 7:45 PM - Location: Day Room Review of the Observation Records found that the MHT performing rounds inside on the unit was documenting the Patient's location and behavior. Review of the video showed that Patient #1501 entered the outside courtyard at 6:52 PM and returned inside to the unit at 7:30 PM. c. On 02/11/22, staff documented that Patient #1507 was on Assault Precautions, Unit Restriction (UR) which meant that the Patient could not leave the unit or go to the outside courtyard. On Patient #1507's Observation Record for Q15 (observations every 15 minutes) Rounds, dated 02/11/22, staff documented the following: 6:45 PM - Location: Hallway 7:00 PM - Location: Illegible documentation 7:15 PM - Location: Patients' Room 7:30 PM - Location: Hallway 7:45 PM - Location: Hallway Review of the Observation Records found that the MHT performing rounds inside on the unit was documenting the Patient's location and behavior. Review of the video showed that Patient #1507 entered the outside courtyard at 6:52 PM and returned inside to the unit at 7:30 PM. The investigators failed to observe the staff member documenting observation rounds for the patient in the courtyard. 7. On 04/20/22 at 10:10 AM, during an interview with Investigator #15 and Investigator #19, Staff #1504 verified that on 02/11/22, the staff doing the observation rounds inside on the unit, was	L 340		

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L 340	Continued From page 51 also performing observation rounds for the patients in the courtyard. Staff #1504 verified that review of the video showed that the patients were not visible in the back corner of the darkened courtyard. Staff #1504 stated that the discrepancies in the documentation of the patient's observations is due to the patients coming in and out from the courtyard to the unit. However, Investigator #19's review of the video failed to find evidence to substantiate that the observation rounds documented for Patient #1501, #1504, and #1507 during the times between 6:52 PM and 7:30 PM on 02/11/22 were accurate. Incident #2 - 01/30/22 Environmental Safety-Blind Spots 8. On an Incident Report dated 01/30/22, staff reported an incident categorized as "Sexual Misconduct - Patient to Patient" involving two adolescent patients, Patient # 1506 and Patient #1515. Patient #1506, a 15-year-old female, reported to the psychiatric provider that she had been sexually molested by a peer (Patient #1515). 9. On a Nursing Progress Addendum, dated 02/01/22, nursing staff documented that Patient #1506 reported to the psychiatric provider that Patient #1515, a 13-year-old transgender, female to male patient, pinned her to the wall in the hallway leading to the dayroom and forced kisses on her several times. Patient #1506 reported that Patient #1515 told her that there are no cameras facing that hallway. 10. During a tour of the South Adolescent unit on 04/07/22 at 1:15 PM, with Nursing Manager (Staff #1503), Investigator #15 observed that the chair	L 340		

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L 340	Continued From page 52 positioned facing the hallway leading to the dayroom was empty. The short hallway leading to the dayroom had previously been identified as a blind spot, due to the lack of video monitoring capabilities and no sight lines when staff was conducting observations in the main hallway. Staff #1503 stated that the blind spot should always be monitored, however sometimes their staff is called away respond to a Code called on a different unit. Staff #1503 stated that was why the hallway was not being monitored on 04/07/22. 11. On 04/20/22 at 6:45 AM, during an interview with Investigator #15, Mental Health Technician (MHT) (Staff #1507) stated that sometimes at night, the team will leave the nurses station door open to ensure that the blind spot located near the double doors entering the unit is always monitored. 12. Investigator #15 found that hospital staff reported inconsistencies in the process for performing patient observations off-unit and monitoring identified blind spots within the hospital. Review of the hospital's policies and procedures showed that the hospital failed to develop a policy and procedure to clarify guidelines for staff when performing environmental safety rounds in the exterior courtyard areas or a policy and procedure to safely and effectively monitor identified blind spots within the hospital. Item #4 Reassess patients for increased suicidal risks and notify provider when indicated. Based on policy review and document review, the hospital failed to ensure staff followed policies and procedures to reassess patients for	L 340		

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L 340	Continued From page 53 increased risk of suicidal behaviors and, based on the risk formulation, notified the provider of increased risk when indicated, as demonstrated by 6 of 7 records reviewed (Patients #1902, #1904, #1905, #1906, #1909, #1914, and #1916). Failure to complete the suicide risk reassessment and notify the provider of any identified increased suicide risk puts the patient at risk for an unsafe environment for care, psychological harm, and serious injury or death. Findings included: 1. Document review of facility policy titled, "Suicide Risk Assessment and Management," policy number 1000.26, last reviewed 06/21, showed the following: a. All patients admitted to Fairfax Behavioral Health will be assessed for suicidality by the admitting Registered Nurse (RN) using the RN-Columbia Suicide Severity Rating Screen (RN-CSSRS). b. Reassessment of suicidality will occur every waking shift (twice per day) for any patient on suicide precautions or who exhibit a significant change in mental status; these are documented on the nursing progress note. c. This assessment shall contain, at a minimum: i. Current or past thoughts of suicide ii. Recent or past history of suicide attempts iii. Evidence of suicidal planning or intent iv. Risk Formulation including categorization of	L 340		

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L 340	Continued From page 54 risk as compared to the general patient population on the inpatient unit (lower, similar, or higher). v. Individualized actions (interventions) initiated to prevent suicide and/or self-destructive behavior. Patient #1902 2. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1902 for the dates of 01/14/22 through 01/27/22. Patient #1902 is a 13-year-old female admitted for suicidal ideation, cutting, and alcohol intoxication. Patient #1902 had a history of a recent suicidal gesture that resulted in an emergency department visit, where she was referred to the facility. She also had a history of sexual assault by a family member. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed the patient using the RN-CSSRS twice per day as directed by hospital policy. In 9 of 34 notes for Patient #1902, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. The RN-CSSRS Risk Formulation shows that a "yes" answer to any 2 or more questions on the CSSRS indicates that the nurse must notify the provider and document the provider's response. b. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed the patient using the RN-CSSRS twice	L 340		

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L 340	Continued From page 55 per day as directed by hospital policy. In 2 of 34 notes for Patient #1902, nursing documented that the patient answered "yes" to the following 3 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? #3-Have you been thinking about how you might do this? Nursing staff documented the patient's level of suicide risk as "moderate" and did not notify the provider as directed by the screening tool and hospital policy. c. On 01/24/22, in a Daily Nursing Progress Note during day shift, nursing staff documented that Patient #1902 had gone to the staff earlier that day after scratching her arm with broken glass and was tearful and upset throughout the day. No report to the provider was documented. No room search or confiscation of contraband (glass) was documented. No additional CSSRS was completed, as is directed by hospital policy. d. On 01/25/22, in an Addendum Progress Note during evening shift, nursing staff documented that Patient #1902 was found in a male patient's room and ran out of the room to her bathroom in tears. Staff wrote that they went to speak with her and, after they left her room and then returned, the patient was found in their bathroom cutting her wrist and neck with a piece of broken glass from a broken nail polish bottle. Staff wrote that the patient was tearful and said she was cutting because she wanted to die. Staff documented that this was reported to the charge nurse and the provider. An additional CSSRS was not completed, as is directed by hospital policy. e. On 01/26/22, in a Daily Progress Note during day shift, nursing staff documented that Patient # 1902 endorsed suicidal ideation with no intent or	L 340		

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L 340	Continued From page 56 plan. The nurse documented that the patient self-harmed yesterday by cutting her neck and wrists and that the patient stated that she tried to kill herself. An additional CSSRS was not completed, as is directed by hospital policy. f. On 01/27/22, in a Daily Progress Note during day shift, nursing staff documented that Patient #1902 endorsed suicidal ideation and verbalized that she wants to kill herself. The provider and case manager were informed. An additional CSSRS was not completed, as is directed by hospital policy. Patient #1904 3. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1904 for the dates of 01/27/22 through 02/04/22. Patient #1904 is a 15-year-old female referred from the emergency department for depression and suicidal ideation after attempting to hang herself. She reports the presence of guns in her home. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1904 using the RN-CSSRS twice per day as directed by hospital policy. In 4 of 18 notes for Patient #1904, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. b. Investigator #19 reviewed the Daily Nursing	L 340		

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L 340	Continued From page 57 Progress Notes and found that nursing staff assessed Patient #1904 using the RN-CSSRS twice per day as directed by hospital policy. In 3 of 18 notes for Patient #1904, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff failed to document the patient's level of suicide risk and did not notify the provider as directed by the screening tool and hospital policy. Patient #1905 4. On 04/11/22, Investigator #19 reviewed the medical record of Patient #1905 for the dates of 01/21/22 through 01/31/22. Patient #1905 is a 13-year-old transgender male (female to male) admitted for depression and suicidal ideation. Patient #1905 had a history of a recent suicidal gesture with a plan to jump off a balcony or cut himself, which resulted in an emergency department visit. The emergency department referred the patient to the facility. Patient #1905 also had a history of sexual assault by a family member. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1905 using the RN-CSSRS twice per day as directed by hospital policy. In 2 of 22 notes for Patient #1905, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the	L 340		

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L 340	Continued From page 58 provider, as is directed by the screening tool and hospital policy. Patient #1909 5. On 04/28/22, Investigator #19 reviewed the medical record of Patient #1909 for the dates 04/15/22 through 04/27/22. Patient #1909 is a 15-year-old transgender male (female to male) with a history of depression, anxiety, self-harm behaviors, suicidal ideation with plans, and homicidal ideation with a plan to burn down his mother's home. He has a history of sexual assault victimization. a. Investigator #19 reviewed the Daily Nurse Progress Notes and found that nursing staff assessed Patient #1909 using the RN-CSSRS twice per day as directed by hospital policy. In 6 of 26 notes for Patient #1909, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. b. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1909 using the RN-CSSRS twice per day as directed by hospital policy. In 2 of 26 notes for Patient #1909, nursing documented that the patient answered "yes" to the following 3 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself?	L 340		

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L 340	Continued From page 59 #3-Have you been thinking about how you might do this? Nursing staff documented the patient's level of suicide risk as "moderate" and did not notify the provider as directed by the screening tool and hospital policy. c. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff assessed Patient #1909 using the RN-CSSRS twice per day as directed by hospital policy. In 1 of 26 notes for Patient #1909, nursing documented that the patient answered "yes" to the following 6 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? #3-Have you been thinking about how you might do this? #4-Have you had these thoughts and had some intention of acting on them? #5-Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan? #6-Have you done anything, started to do anything, or prepared to do anything to end your life? Nursing staff documented the patient's level of suicide risk as "high" and did not notify the provider as directed by the screening tool and hospital policy. Patient #1914 6. On 04/28/22, Investigator #19 reviewed the medical record of Patient #1914 for the dates of 04/17/22 through 04/27/22. Patient #1914 is a 16-year-old female admitted as Family Initiated Treatment for depression, a dissociative episode, and suicidal ideation with a gesture involving a kitchen knife to her chest. a. Investigator #19 reviewed the Daily Nursing Progress Notes and found that nursing staff	L 340		

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L 340	Continued From page 60 assessed Patient #1914 using the RN-CSSRS twice per day as directed by hospital policy. In 1 of 26 notes for Patient #1914, nursing documented that the patient answered "yes" to the following 2 questions: #1-Have you ever wished you were dead or wished you could go to sleep and not wake up? #2-Have you ever actually had any thoughts of killing yourself? Nursing staff documented the patient's level of suicide risk as "low" and failed to notify the provider, as is directed by the screening tool and hospital policy. Patient #1916 7. On 05/04/22, Investigator #19 reviewed the medical record of Patient #1916 for the dates of 01/13/22 through 01/17/22. Patient #1916 is a 14-year-old female admitted for suicidal ideation with a plan, a suicide attempt, and aggression towards her grandmother. She has a history of sexual assault by her father. a. Investigator #19 reviewed the Daily Nursing Progress Notes for Patient #1916 and found that in 1 of 10 notes, nursing failed to complete the RN-CSSRS. No nursing staff signed the document and no provider was notified. 8. Investigator #19 reviewed all Daily Progress Notes for 7 charts (Patents #1902, #1904, #1905, #1906, #1909, #1914, and #1916) and found that 6 of 7 charts showed failure to use the RN-Columbia Suicide Severity Rating Screen as directed in the screening tool and in hospital policy. Nursing staff frequently did not follow the screening tool directions to document notification of the provider and the provider's response when a patient answers "yes" to any 2 or more questions on the screening tool.	L 340		

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L 340	Continued From page 61	L 340		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of policy and procedures, Investigator #19 found that the hospital failed to include the patient in the formulation of an individualized treatment plan for 8 of 15 patients reviewed (Patients #1901, #1902, #1903, #1904, #1905, #1911, #1912, and #1913). Failure to ensure patient participation in their treatment care planning can result in	L1065		

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L1065	Continued From page 62 inappropriate, inconsistent, or delayed treatment of patients' needs and may lead to patient harm and lack of appropriate treatment for a behavioral or medical condition. Findings included: 1. Document review of facility policy titled, "Interdisciplinary Patient Centered Care Planning," policy number 1000.81, last approved 06/21, showed the following: a. The patient or representative is to sign the Master Treatment Plan to indicate agreement with and participation in the development of the treatment plan. b. A designated staff member is to discuss the Treatment Plan with the patient/representative if the patient is not present in the Treatment Team meeting. c. If the patient refuses to sign the Treatment Plan, the refusal will be documented. d. The Treatment Team, with the patient/representative, will update the Treatment Plan as clinically indicated, or at minimum every 7 days. e. The patient/representative is to sign the Treatment Plan Update to indicate agreement and participation with review/modification of the treatment plan. f. A designated staff member is to discuss the Treatment Plan Update with the patient/representative if the patient is not present in the Treatment Team meeting.	L1065		

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L1065	Continued From page 63 g. If the patient refuses to sign the Treatment Plan Update, the refusal will be documented. Patient #1901 2. On 04/11/22, Investigator #19 reviewed the medical record for Patient #1901, a 13-year-old female patient admitted 12/03/21 for suicidal ideation with command hallucinations and history of sexual assault, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 12/09/21, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. c. Review of the treatment plan updates, dated 12/16/21, 12/22/21, 12/29/21, 01/05/22, 01/26/22, 02/01/22, 02/16/22, 02/23/22, 03/09/22, and 03/16/22, showed that the patient did not sign the updates confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. d. Review of the treatment plan updates showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1902 3. On 04/11/22, Investigator #19 reviewed the medical record of patient #1902, a 13-year-old female admitted on 01/13/22 with depression, substance abuse, suicidal ideation, self-harm,	L1065		

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L1065	Continued From page 64 and history of sexual assault, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 01/17/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1903 4. On 04/11/22, Investigator #19 reviewed the medical record for Patient #1903, a 19-year-old female admitted on 02/09/22 for psychosis, aggression, mood instability, and history of sexual assault and sexual victimization, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 02/11/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1904 5. On 04/11/22, Investigator #19 reviewed the medical record for Patient #1904, a 15-year-old female admitted on 01/26/22 with suicidal ideation and mood instability, and found the	L1065		

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L1065	Continued From page 65 following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 01/28/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1905 6. On 04/11/22, Investigator #19 reviewed the medical record for Patient #1905, a 13-year-old female admitted on 01/20/22 for suicidal ideation and mood instability, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 01/21/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1911 7. On 04/29/22, Investigator #19 reviewed the medical record for Patient #1911, a 56-year-old male admitted on 04/08/22 for psychosis and aggression, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 04/09/22, showed	L1065		

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

(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
L1065	Continued From page 66 that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. c. Review of 2 of 2 documents titled, "Treatment Plan Updates," dated 04/18/22 and 04/26/22, showed that the patient did not sign the updates confirming that the update had been reviewed with the patient or that the patient had the opportunity to ask questions. d. Review of the treatment plan updates showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1912 8. On 04/29/22, Investigator #19 reviewed the medical record for Patient #1912, a 28-year-old male admitted on 04/07/22 with psychosis, mood instability, and history of assault, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 04/08/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. Patient #1913	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	C 05/05/2022

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

(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
L1065	Continued From page 67 9. On 04/29/22, Investigator #19 reviewed the medical record for Patient #1913, a 15-year-old female admitted on 04/19/22 for psychosis, suicidal ideation, history of assault, and history of sexual assault, and found the following: a. The document titled, "Interdisciplinary Master Treatment Plan," completed on 04/21/22, showed that the patient did not sign the treatment plan confirming that the treatment plan had been reviewed with the patient or that the patient had the opportunity to ask questions. b. Review of the treatment plan document showed that staff failed to document patient participation or the patient's refusal to sign. 10. On 04/20/22 at 12:45 PM, during an interview with Investigator #19 and Investigator #15, the Assistant Director of Nursing (ADON) (Staff #1501) confirmed that medical records reviewed failed to include documentation of the patient's participation in the treatment planning process, patient signatures and documentation of the patient's participation or refusal to sign. Staff #1501 stated that the Case Managers are responsible for meeting with the patients to review their Master Treatment Plans and Treatment Plan Updates. The ADON reported that when the Case Manager meets with the patients to review their treatment plans, staff should be obtaining a signature from the patient. If the patient refuses, or is unable to sign, the Case Manager would document the reason for the refusal. .	L1065		

Fairfax Hospital

Plan of Correction for
State and CMS Investigation
(Case #2022-3363, #2022-3389, and #2022-2123)

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 Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L 001	Item #1 The CEO, COO, Chief Medical Director, Chief Nursing Officer and Director of Risk Management met to review the findings of this survey and review/revised the policies to meet regulatory compliance on 5/31/2022. The *COVID-19 Mandatory Vaccination policy* was reviewed and the Contingency Plan Addendum revised to confirm that healthcare workers who met the requirements for exemption will be tested weekly prior to reporting to work. The revised policy was submitted for review and approval to the Infection Control Committee, Medical Executive Committee and the Governing Board in an ad hoc meeting on 6/7/22. The Human Resources department is responsible for monitoring/obtaining staff vaccination information for compliance upon hire by obtaining their vaccination or exemption status prior to their first day of employment. The HRD will inform any staff who are exempt of the requirement for weekly testing via a signed copy of the Contingency Plan Addendum, ensure they are set up for weekly testing, understand deadline for testing and know where to go for their tests each week. Additionally, the HRD monitors all staff who have met the requirements for exemption and need to be tested once weekly for COVID 19. The Human Resources staff were retrained to the revised and approved COVID 19 Mandatory Vaccination policy by the Human Resources Director. Training will be verified by a signed copy of the revised policy.	Human Resources Director	7/5 c/22	**MONITORING:** Item #1 The Infection Control Preventionist and Human Resource Director (HRD) will maintain the list of all COVID 19 vaccine exempt staff and confirm they are informed of the weekly testing requirement. The HRD will monitor and report testing status weekly to Department Leaders and will follow up with the department managers of all staff who are noncompliant with their weekly testing. Noncompliance with weekly testing will result in immediate suspension. Staff will be permitted to return to work only when compliance is reestablished. Target goal and accepted compliance for testing is 100%. Monitoring is ongoing until otherwise indicated. Aggregated data will be reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly. Item #2 The Human Resource Director (HRD) and Infection Control Preventionist will maintain the list of all COVID 19 vaccine exempt staff and confirm they are

	The Director of Human Resources will set up weekly COVID-19 testing for all staff who meet COVID-19 vaccine exemption requirements to be completed every Tuesday. Results will be obtained from the lab by the HRD/designee by no later than Friday of each week. The HRD/designee will ensure each exempt staff who is scheduled to work has a weekly test done. If a staff member misses their deadline for weekly testing, the HRD will inform the staff members department leader. Testing compliance will be reported weekly to Department Leaders. Staff who are out of compliance for weekly COVID-19 testing will not be permitted to work until they are back in compliance. The HRD will designate another HR staff member to monitor and report compliance weekly should coverage be needed. Training included: • All current exempt staff shall be informed of the requirements as evidenced by a signed copy of the Contingency Plan Addendum in their HR file. New staff shall be informed of the requirements upon hire as evidenced by a signed copy of the Contingency Plan Addendum in their HR file. • Requirement of weekly testing for healthcare workers that met the requirements for exemption • Staff that are not compliant with weekly testing are unable to work and suspended until they are back in compliance with weekly testing. • Human Resources staff are responsible for obtaining the vaccination information or exemption status prior to hire and that it is entered into the Lawson system as soon as possible. • The HRD/designee will report compliance with weekly testing of exempt staff to Department Leaders once a week in the morning Flash meeting Item #2 The CEO, COO, Chief Medical Director, Chief Nursing Officer and Director of Risk Management met to review the findings of this survey and review/revised the policies to meet regulatory compliance on 5/31/2022. The *COVID-19 Mandatory Vaccination policy* was reviewed and the Contingency Plan Addendum revised to remove the requirement of healthcare workers who met the			informed of the weekly testing requirement as evidenced by a signed copy of the Covid 19 Contingency Plan Addendum in their HR file. The HRD will monitor and report Covid 19 testing completion status weekly to Department Leaders and will follow up with the department managers of all staff who are noncompliant with their weekly testing. Noncompliance with weekly testing will result in immediate suspension. Staff will be permitted to return to work only when compliance is reestablished. The Infection Control RN monitors for 100% compliance with staff use of required PPE when assigned to work on the on the Covid unit with positive patients. All staff assigned to the Covid unit are required to use full PPE. All noncompliant staff will be addressed immediately by the CNO/designee. Staff will be directed to comply with use of required PPE. Retraining of staff is completed immediately. Monitoring data for 100% compliance is reported monthly to the Infection Control Committee. Target goal and accepted compliance for testing and staff use of proper PPE is 100%. Monitoring is ongoing until otherwise indicated. Aggregated data will be reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.

	requirements for exemption to wear N95 masks while in the facility. Additional PPE such as eye protection, isolation gowns and N95 masks are available for use by staff who work with patients who are Covid 19 positive, awaiting test results or in the event of an outbreak at the facility. All staff who work in patient care areas are required to have new hire and annual fit testing for proper mask size. The revised policy was submitted for review and approval to the Infection Control Committee, Medical Executive Committee and the Governing Board in an ad hoc meeting on 6/7/22. All Staff will continue to follow standard and transmission based precautions as outlined in the facilities Transmission Based Precautions policy regardless of vaccination status. The Human Resources department is responsible for monitoring/obtaining staff vaccination information for compliance. Additionally, they monitor healthcare workers who have met the requirements for exemption and need to be tested once weekly for COVID 19, see item #1. The Human Resources staff were retrained to the revised and approved COVID 19 Mandatory Vaccination policy by the Human Resources Director. Training will be verified by a signed copy of the revised policy. The HRD will designate another HR staff member to monitor and report compliance weekly should coverage be needed. Training included: • Unvaccinated Exempt healthcare workers are no longer required to wear an N95 mask at all times while in the facility. They will be required to wear a surgical mask as required for all hospital employees while on duty. • All current exempt staff shall be informed of the requirements as evidenced by a signed copy of the Contingency Plan Addendum in their HR file. New staff shall be informed of the requirements upon hire as evidenced by a signed copy of the Contingency Plan Addendum in their HR file. • Requirement of weekly Covid 19 testing for healthcare workers that met the requirements for exemption			

	• Healthcare workers that are not compliant with weekly testing are unable to work until they are back in compliance with weekly testing. • Human Resources staff are responsible for obtaining the vaccination information or exemption status prior to hire and that it is entered into the Lawson system as soon as possible. • The HRD/designee will report compliance with weekly testing of exempt staff to Department Leaders once a week in the morning Flash meeting.			
L315	The CEO, COO, Chief Nursing Officer and DRM met to review the findings of this survey and reviewed the current policies and procedures in place on 5/31/22. Policy *Suicide Risk Assessment and Management 1000.26* was reviewed with no revisions required. The Daily Nursing Progress note was revised to clarify provider notification will occur with any changes in screening results and submitted for review and approved by the Medical Executive Committee and the Governing Board on 6/7/22 and was implemented on 6/8/22. Chief Nursing Officer/designee will confirm all Registered Nurses are current with their training and education in the completion of the RN-CSSRS screening scale. Nursing staff were retrained on the policy Suicide Risk Assessment and Management 1000.26 and trained to the revised Daily Nursing Progress note to include: 1. Reassessment of patients with increased risk of suicidal behaviors or self-harm will occur every waking shift using the RN-CSSRS Rating Screen on the nursing progress note. 2. An additional RN-CSSRS will be completed after any incident of self-harming behavior, results are reported promptly to the provider and providers response is documented in the nursing progress note. 3. Prompt notification of the provider of any identified increased risk from the previous assessment. The CMO educated the providers of the revisions made to the Nursing Progress note RN-CSSRS and expectations that the Nursing staff will call the provider with changes in the RN-CSSRN assessment of a patient during the Medical Staff	Chief Nursing Officer	7/5/22	**MONITORING:** The Chief Nursing Officer and/or designee will audit 100% charts of patients on Suicide Precautions weekly to confirm compliance with risk assessment policy for the following items: 1. Accurate completion of the RN-CSSRS risk screening is being followed for identified patients per policy. 2. Completion of the CSSRS as required based on screening information. 3. Documentation of Provider notification, date and time of notification and the providers response is present when indicated. Target goal for compliance is 90% or greater. The CMO/designee will audit 100% of patients charts, that were identified on the RN-CSSRS as having an increased risk for suicide or self-harm, weekly to confirm documentation of the providers timely reassessment of the patient. Monitoring will be ongoing until compliance of 90% or greater is achieved and sustained for a minimum of 3 months. All deficiencies will be corrected immediately to include staff retraining as needed.

	meeting on 6/16/22. The Providers were informed that Nursing staff are to document on the RN-CSSRS which provider was notified, date and time of notification and the providers response to the notification. Additionally, the provider is responsible for the timely reassessment of the patient for risk of suicide or self-harm and to initiate and order any changes necessary to the patients safety level, observations or precautions.			Aggregated data will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.
L 320	Item #1 Compelled Medication and Obtaining a 2nd Opinion. The CEO, COO Chief Medical Director and Chief Nursing Officer met to review the findings of this survey and reviewed/revised the policies to meet regulatory compliance on 5/31/2022. *The Psychiatric Progress Note-2nd Opinion Form* was reviewed with the following revisions: • Clear process for ordering and obtaining a second opinion for compelled antipsychotic medications • Clarifying the form used to initiate the provider's order • How to document the request for a consult to obtain a second opinion prior to medication administration or within 24 hours for emergency medications • What form is used by the provider completing the second opinion to document their findings • Clarification between the different requirements for compelled antipsychotic medication administration and emergency antipsychotic medication administration. The revised *The Psychiatric Progress Note-2nd Opinion Form* was reviewed and approved by the Medical Executive Committee and Governing Board on 6/3/22. The *Chemical Restraint policy* was also reviewed with no revisions required. The process for obtaining a second opinion for compelled antipsychotic medication administration was reviewed and confirmed with the CMO and is as follows: 1. Ordering Provider will document in the patients medical record an order to request a 2nd opinion for compelled medications and completing the first part of the 2nd opinion form.	Chief Medical Officer	7/5/22	**MONITORING:** Item #1 The Chief Medical Officer and/or designee will review 100% of compelled medications ordered and administered weekly to confirm compliance with revised hospital policy to include: 1. All compelled antipsychotic medications administered have a 2nd opinion form completed prior to the administration of the antipsychotic. Target goal for compliance is 90% or greater. Any identified deficiencies will be corrected immediately to include provider or licensed nursing staff retraining. Providers identified as out of compliance with obtaining a 2nd opinion prior to the administration of a compelled antipsychotic medication will have 1:1 meeting with the CMO to discuss expectations and consequences of further non-compliance. Subsequent violations of this process may result in suspension or termination of employment. Licensed Nursing staff who have administered a compelled antipsychotic medication without ensuring a 2nd opinion form is completed and in the patients medical record will have a 1:1 meeting with the CNO/designee to discuss expectations and consequences of further non-compliance. Subsequent violations of this

	2. That same provider will contact the 2nd provider themselves and request they complete the 2nd opinion and corresponding documentation. 3. After the 2nd provider has completed and documented the requested 2nd opinion in the patients medical record on the 2nd Opinion form, the second provider will put a note in HCS documenting the 2nd opinion has been completed and notify the original, provider who requested the 2nd opinion. 4. After the 2nd Opinion form is completed and documented in the patients medical record, the patients Provider will then write an order in the patients chart for the compel antipsychotic medications and in the PRN section of HCS for the compel antipsychotic medications that will state, "2nd opinion was obtained". 5. Pharmacy will not have an order for these medications prior to the completion of these steps therefore the medications will not be available for administration until the 2nd opinion is obtained, the form is completed, and the provider enters into HCS that the 2nd opinion was obtained. The Medical Staff and providers were retrained by the Chief Medical Officer to the revised code of Washington (RCW) 71.05.215 – Right to refuse antipsychotic medications rules. Training was initiated on 4/22/22 as well as revised *The Psychiatric Progress Note-2nd Opinion Form* and process for compelled antipsychotic medication as listed above during the 6/16/22 Medical Staff meeting. Training included: • A patient found to be gravely disabled or presents a likelihood of serious harm as a result of a behavioral disorder has the right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in serious harm, substantial deterioration or prolong length of involuntary commitment. • For short term treatment up to thirty days, the right to refuse antipsychotic medications unless there is an additional medical opinion approving medication by a psychiatrist, PA or APRN			process may result in suspension or termination of employment. Aggregated data will be reported to the Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly. Monitoring will be ongoing until compliance of 90% or greater is achieved and sustained for a minimum of 3 months. Item #2 The Chief Medical Officer and/or designee will review 100% of the administered emergency antipsychotic medications to include: • All emergency antipsychotic medications administered have a 2nd opinion form completed in the medical record within 24 hours of administration of the emergency antipsychotic. All deficiencies will be corrected immediately to include staff retraining. Providers identified as out of compliance with obtaining a 2nd opinion within 24 hours of the administration of an emergency antipsychotic medication will have 1:1 meeting with the CMO to discuss expectations and consequences of further non-compliance. Subsequent violations of this process may result in suspension or termination of employment. Target goal for compliance is 90% or greater. Aggregated data will be reported to the Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly. Monitoring will be ongoing until compliance of 90% or greater is achieved and sustained for a minimum of 3 months.

	• For continued treatment beyond thirty days through the hearing on petition filed under RCW 71.05.217 – the right to periodic review of the decision to medicate by the medical director or designee • Documentation in the medical record of the attempt by the physician, PA, APRN to obtain informed consent and the reasons why antipsychotic medication is being administered over the person's objection or lack of consent. Additional retraining to the Medical Staff and providers included the revised *Administration of Medication without Formal Consent #1000.52* policy and the *Chemical Restraint hospital policy* by the Chief Medical Officer. Training verified via signed attestation. A Medical Staff meeting was held on 6/16/22 where providers were reeducated on the requirements for documentation and given the opportunity to ask clarifying questions regarding the revised *Psychiatric Progress Note-2nd Opinion Form*. Licensed Nursing staff were educated on: • The revised 2nd Opinion form • The requirement for the nurse who is administering a compelled antipsychotic medication to a patient to ensure a completed 2nd opinion form in their medical record prior to administering the compelled antipsychotic medication. • Documenting in the patients medical record the reason the patient received compelled antipsychotics, i.e., the patients refusal of scheduled medications. Item #2 Emergency Medication and Obtaining a 2nd Opinion Review within 24 hours. The CEO, COO Chief Medical Director and Chief Nursing Officer met to review the findings of this survey and reviewed/revised the policies to meet regulatory compliance on 5/31/2022. *The Psychiatric Progress Note-2nd Opinion Form* policy was revised with the following revisions: • Clear process for ordering and obtaining a 2nd opinion for emergency antipsychotic medications • Clarifying the form used to initiate the provider's order			

	• How to document the request for a consult to obtain a second opinion prior to medication administration or within 24 hours for emergency medications • What form is used by the provider completing the second opinion to document their findings • Clarification between the different requirements for compelled antipsychotic medication administration and emergency antipsychotic medication administration. The revised *Psychiatric Progress Note-2nd Opinion Form* was reviewed and approved by the Medical Executive Committee and Governing Board on 6/3/22. The *Chemical Restraint policy* was also reviewed with no revisions required. The process for obtaining a second opinion for emergency antipsychotic medication administration was reviewed and confirmed with the CMO and is as follows: 1. Ordering Provider will document in the patients medical record an order for a 2nd opinion for emergency medications and completes the first part of the 2nd opinion form. 2. That same provider will contact the 2nd provider and request they give a second opinion within 24 hours. 3. The provider offering the second opinion evaluates the patient and documentation surrounding the administration of the emergency medication and completes the remainder of the 2nd opinion form. They will then put a note in HCS, documenting that the 2nd opinion has been completed, and notify the original provider. 4. After the ordering provider is notified that the 2nd opinion documentation is complete, the ordering provider will then write an order in the patients chart and will state "2nd opinion was obtained". The Medical Staff and providers were retrained by the Chief Medical Officer to the revised code of Washington (RCW) 71.05.215 – Right to refuse antipsychotic medications rules. Training was initiated on 4/22/22. Training included:			

	• A patient found to be gravely disabled or presents a likelihood of serious harm as a result of a behavioral disorder has the right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in serious harm, substantial deterioration or prolong length of involuntary commitment. • For short term treatment up to thirty days, the right to refuse antipsychotic medications unless there is an additional medical opinion approving medication by a psychiatrist, PA or APRN • For continued treatment beyond thirty days through the hearing on petition filed under RCW 71.05.217 – the right to periodic review of the decision to medicate by the medical director or designee • Documentation in the medical record of the attempt by the physician, PA, APRN to obtain informed consent and the reasons why antipsychotic medication is being administered over the person's objection or lack of consent. Additional retraining to the Medical Staff and providers included the revised *Psychiatric Progress Note-2nd Opinion Form* and the *Chemical Restraint hospital policy* by the Chief Medical Officer. Training verified via signed attestation. A Medical Staff meeting was held on 6/16/22 where providers were reeducated on the requirements for documentation and given the opportunity to ask clarifying questions regarding the revised *Psychiatric Progress Note-2nd Opinion Form*.			
L340 Item #1	The CEO, COO, CNO, ACNO and DRM met to review the findings of this survey and reviewed the current policies and procedures in place to meet regulatory compliance. The policies *Sexual Aggression/Victimization Precautions 1000.80 Safety Levels 1000.97* were reviewed and no revisions were made. On 4/22/22 The CNO added to the House Charges' duties that each shift they will review and verify the unit boards to ensure all patients room assignments are appropriate; verify that patients on sexual aggression precautions (SAP) are never sharing a room with patients who are on sexually victimization precautions (SVP). Verify the accuracy of patient	Chief Nursing Officer	7/5/22	**MONITORING:** Charge RN/designee performs chart checks every shift on 100% of patient orders to ensure all patients precautions/safety levels are accurately documented on the observation sheets & the unit census board is updated. Nursing Leadership/designee will monitor the completion of these chart checks by the unit Charge RN.

	rounding sheets; precautions, safety levels and observations ordered are appropriately marked. This was a change in process, not policy. These duties are outlined in the *April 2022 CMS Training*. All House Charges have been trained by the CNO on this responsibility and have signed an attestation of understanding of this requirement. The CNO modified the Charge Nurse's responsibilities as outlined in the *April 2022 CMS Training* to include the responsibility for correct and appropriate room assignments. To meet this requirement, each Charge Nurse reviews the Unit board each shift comparing it with current orders in the patient's medical record as well as each patients rounding sheet to ensure accuracy and appropriateness of monitoring and room assignments. All charge nurses were provided training by the CNO on this responsibility and signed attestations of understanding. The CEO provided direction to all Leadership members who are responsible for performing unit rounds to add "*confirm patient's precautions/safety levels match the provider's order, unit board demonstrates compliance with policies for patient room assignments, and rounding sheet are congruent*". This was added to the Leadership Rounding tool and sent to all members of Leadership who perform these rounds. Leaders responsible for these rounds signed attestation of understanding of these new requirements. Nursing staff training included: 1. Nursing staff will update the unit board as changes in patient observations/precautions occur in real time. SAP/SVP precautions are highlighted as an additional alert. 2. All room assignments require a review of precautions by the RN prior to the assignment. This includes new admissions and patient requests to change rooms. 3. Any addition of SAP or SVP orders for a patient will include a review of the patient's roommates precautions with the understanding that patient's room assignments may be revised to maintain patient safety. 4. *Sexual Aggression/Victimization Precautions 1000.80* which includes appropriate roommate assignment.			The Risk Management Department will monitor all completed Leadership Rounds for compliance with continued documentation of the review of unit boards/provider orders/observation sheets and appropriate room assignments. Leadership Rounds are done once per unit per shift on a weekly schedule. Monitoring of appropriate room assignments will be ongoing until the target goal for compliance of 90% or greater is achieved and sustained for a minimum of 3 months. Any room inappropriate assignments will be immediately addressed to relocate patients to a more appropriate room. Aggregated data will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly. Any non-compliance will be addressed through 1:1 meeting with the CNO/designee any subsequent noncompliance may be met with disciplinary action up to and including termination of employment.

Commented [HJ1]:

Commented [RM2]: shouldn't the RM be using these tools for documentation of correct room assignments? I dont think compliance with leadership and charge rounds is as important as making sure the pts are correctly assigned.

Commented [HJ3R2]: Covered in the charge rn checking each shift for appropriate room assignments and the double check charge rn does when any room assignment is given or changed

L340 Item #2	The CEO, COO, CNO, Interim DCS and Director of Risk Management met to review the findings of this survey and reviewed the current policies and procedures in place on 5/31/22. Policies *Suspected or Confirmed Cases of Patient Sexual Activity 1000.30* and *Sexual Aggression/Victimization Precautions 1000.80* were reviewed with no revisions required at this time. The policies *Suicide Precautions 1000.24* was revised to include a section for Clinical Services: 1. For patients on Suicide Precautions or have otherwise been identified as an increased risk for suicidal or self-harm behavior; 2. Staff will update the patients individual treatment plan to include a problem sheet for self-harm/suicidal behaviors. 3. The problem sheet shall include specific goals and targets, document preventative measures and interventions and record the patients progress and readiness for discharge. *Assault Precautions 1000.43* was revised to include a section for Clinical Services: • For patients on Assault Precautions or have otherwise been identified as an increased risk for suicidal or self-harm behavior. • Staff will update the patients individual treatment plan to include a problem sheet for aggressive/assaultive behaviors. • The problem sheet shall include specific goals and targets, document preventative measures and interventions and record the patients progress and readiness for discharge. The revised policies were submitted for review and approval to the Performance Improvement Committee on 5/31/22, Medical Executive Committee and the Governing Board on 6/7/22. The Clinical Services department staff, to include social workers and group therapists, were retrained on the current and approved revised policies by the Interim DCS to include: 1. Timely documentation on the patients Master Treatment Plan and Individual Treatment Plan/problem sheets for all patients who are identified at risk for sexual aggression/victimization,	Director of Clinical Services & Chief Nursing Officer	7/5/22	**MONITORING:** The Director of Clinical Services/designee will monitor/review 100% charts of those with the identified behaviors to confirm compliance with hospital policy and ensure patients identified as having aggressive/assaultive behaviors, suicidal/self-harm behaviors, are identified as sexually aggressive or identified at risk for sexual victimization, have an individualized treatment plan and master treatment plan and/or update and corresponding problem sheet to include the criteria listed above. Any high-risk behaviors identified during admission are listed on the High-Risk Notification Form and nursing has included appropriate precautions in the Initial Nursing Treatment Plan. These open charts will be reviewed during treatment team daily. Patients will be identified for review by the patients Case Manager via changes on the unit board from the previous day of the patients precautions, safety levels or observation orders. Monthly monitoring and reporting will be ongoing until the target goal of 90% or greater for compliance is achieved and sustained for a minimum of 3 months. All deficiencies will be corrected immediately to include staff retraining and/or disciplinary action as needed. Aggregated data will be reported to Quality Committee and Medical Executive Committee monthly and to the Governing Board quarterly.

Commented [RM4]: any training for Intake staff on identification of SAO risks?

Commented [HJ5R4]: No, there was no specific citation but I will address.

	suicidal behaviors/self harm behaviors and assaultive/aggressive behaviors. 2. Documentation will include specific goals and targets, preventative measures and interventions as well as the patient progress and readiness for discharge. Nursing staff were retrained to the revised and approved policies by the ACNO to include: 1. Immediate Provider notification for any patient exhibiting suicidal behaviors/self harm behaviors and assaultive/aggressive behaviors, sexually aggressive behaviors or identified as at risk for sexual victimization to request appropriate precautions are ordered. 2. Unit board is reviewed and updated each shift and as changes in orders for precautions, safety levels and observations occur. 3. Any identified high risk behaviors are addressed in the initial treatment plan. 4. Policy *1000.6 Broset Violence Assessment* which includes guidance on behaviors used to assess for violence and staff interventions. 5. *Sexual Aggression/Victimization Precautions 1000.80* which includes guidance on behaviors used to assess for potential sexually acting out behaviors and staff interventions.			
L340 Item #3	The CEO, COO, CNO and Director of Risk Management met to review the findings of this survey and reviewed the current policies and procedures in place on 5/31/22. Policies *Level of Observation Orders Policy 1000.21, Safety Levels 1000.97* were reviewed with no revisions required. The *Patient Observation Policy 1000.5* was revised to include: • Identification of "blind spot" monitoring. • Courtyards/outdoor areas. • Areas on the units not covered by video surveillance. • Areas not visible from the nurses station, common hallway monitoring or mirrors. • Blind spots should be assessed frequently during rounding to ensure patients safety.	Chief Nursing Officer	7/5/22	**MONITORING:** The Chief Nursing Officer/designee will audit 5 charts per unit per week, to confirm the Charge Nurse is signing off on the rounds/observation sheets and the round sheets reflect current orders. The Risk Management department will audit Senior Leadership Rounds monthly to ensure observation/precautions, patients current location is accurately documented and reflects current orders, Charge RN oversight is evident, there are no missing entries and that staff can speak to the process if a patient was thought to be increasing in risk.

Commented [RM6]: Add identification of sexually inappropriate behavior and development of ITP or MTP related to SAO behaviors.

Commented [HJ7R6]: Initial tx plan was not cited as an issue. Case management reviews unit board and updates tx plan

Commented [RM8]: Again - policy needs to be changed

Commented [HJ9R8]: done

Commented [RM11]: I think the audit is the senior leadership rounds - but they need modification to observe correct observations, including locations. also need to do some camera observation of staff during outside times

Commented [HJ12R11]: revised

	On 2/11/22, the bushes in the courtyard were trimmed to eliminate the blind spot in the courtyard. Clauson Landscaping is on-site every week to ensure landscaping is maintained. Additionally, patients were no longer allowed outside after dark. On 2/14/22, a staff meeting was held to inform staff of the changes. In April 2022 designated areas for staff to stand while monitoring patients in the courtyard were permanently marked on all unit courtyards to increase visibility while observing patients and eliminate blind spots in these areas. Nursing staff were retrained on Policies *Level of Observation Orders Policy 1000.21, Safety Levels 1000.97* and *Patient Observation Policy 1000.5* by the ADON/designee. Training focused on: 1. The Charge Nurse/designee will ensure patient observation rounds are occurring as ordered at all times via rounding twice per shift. The Charge Nurse/designee will update any/all changes to a patients observation/precaution levels on the unit board in real time. 2. The Charge Nurse/designee will review and initial all patient observation sheets for accuracy twice per shift. 3. Nursing staff observes each patient a minimum of every 15 min or more often as ordered and document appropriately on the patient's observation form. Documentation will include the patient's location and behavior at the time of the observation. 4. Nursing staff will monitor hallways and patient care areas ensuring patients are entering only rooms assigned to them and confirm constant staff supervision in all treatment areas. 5. Nurses round on the unit often during their shift to ensure rounds are being done appropriately by staff. Expectations of nursing staff rounding on their patients and oversight of staff working with them is identical for every shift. There is no set number of expected rounds. 6. Designated spots are marked for staff to stand on all unit courtyards to increase patient visibility and eliminate blind spots. A minimum of 1 staff member will be in the courtyard with patients at all times.			Camera observation rounds will include monitoring of staff timeliness of patient rounding and that nursing oversight is evident while on the unit and in the courtyards. Monitoring of CNO weekly audits, RM monthly audits of Senior Leadership Rounds and monthly camera observation rounds will be ongoing until the target goal of 90% or greater compliance is achieved and sustained for 3 months. All deficiencies will be corrected immediately to include staff retraining. Aggregated data will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.

	7. Prior to taking patients off the unit, staff will check each patient's observation form to ensure they are on appropriate safety levels to leave the unit. 8. The patients rounding form must follow the patient. If a patient is going in and out of the courtyard the rounding sheet must be given to the staff monitoring the area the patient is in. 9. Staff may not use personal devices at any time while providing patient care and should be stored except during staff breaks. 10. If any staff leaves the unit for break/emergencies, the patient observation rounds are assigned to another staff member.			
L340 Item #4	The CEO, COO, Chief Nursing Officer and DRM met to review the findings of this survey and reviewed the current policies and procedures in place on 5/31/22. Policy *Suicide Risk Assessment and Management 1000.26* was reviewed with no revisions required. The Daily Nursing Progress note was revised to clarify provider notification will occur with any changes in screening results and submitted for review and approved by the Medical Executive Committee and the Governing Board on 6/7/22 and was implemented on 6/8/22. Chief Nursing Officer/designee will confirm all Registered Nurses are current with their training and education in the completion of the RN-CSSRS screening scale. Nursing staff were retrained on the policy Suicide Risk Assessment and Management 1000.26 and trained to the revised Daily Nursing Progress note to include: 1. Reassessment of patients with increased risk of suicidal behaviors or self-harm will occur every waking shift using the RN-CSSRS Rating Screen on the nursing progress note. 2. An additional RN-CSSRS will be completed after any incident of self-harming behavior, results are reported promptly to the provider and providers response is documented in the nursing progress note. 3. Prompt notification of the provider of any identified increased risk from the previous assessment.			**MONITORING:** The Chief Nursing Officer and/or designee will audit 100% charts of patients on Suicide Precautions weekly to confirm compliance with this policy/process for the following items: 1. Accurate completion of the RN-CSSRS risk screening is being followed for identified patients per policy. 2. Completion of the CSSRS as required based on screening information. 3. Documentation of Provider notification, date and time of notification and the providers response is present when indicated. Target goal for compliance is 90% or greater. The CMO/designee will audit 100% of the patient charts that were identified as having had Provider notification due to a change in the RN-CSSRS assessment to confirm: 1. Documentation of the providers timely reassessment of the patient. 2. CMO immediate follow up with the provider for any non-compliance with reassessment.

Commented [HJ10]: the citation stated the device was a hospital owned device for playing music for the patients, not a cell phone.

	The CMO educated the providers of the revisions made to the Nursing Progress note RN-CSSRS assessment and expectations that the Nursing staff will call the provider with changes in a patients RN-CSSRN assessment during the Medical Staff meeting on 6/16/22. The Providers were informed that Nursing staff are to document on the RN-CSSRS which provider was notified, date and time of notification and the providers response to the notification. Additionally, the provider is responsible for the timely reassessment of the patient for risk of suicide or self-harm and to initiate and order any changes necessary to the patients safety level, observations or precautions.			Monitoring will be ongoing until the target goal compliance of 90% or greater is achieved and sustained for a minimum of 3 months. All deficiencies will be corrected immediately to include staff retraining as needed. Any non-compliance will be addressed through 1:1 meeting with the CMO. Any subsequent noncompliance may be met with disciplinary action up to and including termination of employment. Aggregated data will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.
L 1065	The CEO, COO, DCS and DRM met to review the findings of this survey and the policies to meet regulatory compliance on 5/31/22. The policy *Interdisciplinary Patient Centered Care Planning 1000.81* was reviewed and no revisions were made. The Director of Clinical Services retrained the Case Managers to the hospital policy. The Group Therapists, with Case Managers support, are the only designated staff to review the plan of care with the patient. Training was initiated on 5/31/22. Training will be verified by signed attestation. Training included: 1. The patient or representative is to sign the Master Treatment Plan to indicate agreement with and participation in the development of the treatment plan. 2. A designated staff member is to discuss the Treatment Plan with the patient/representative if the patient is not present in the Treatment Team meeting. 3. If the patient refuses to sign the Treatment Plan, the refusal will be documented. 4. The Treatment Team, with the patient/representative, will update the Treatment Plan as clinically indicated, or at minimum every 7 days.	Director of Clinical Services	7/5/22	**MONITORING:** The Director of Clinical Services/designee will monitor/review 100% of all open charts that are scheduled for treatment team review, updates or have any additions to the treatment plan, during the daily treatment team meeting ensure the following: 1. Patients participation is evidenced in their treatment plan i.e. the patient has signed the treatment plan or; 2. Documentation of patients refusal to participate is present. 3. Documentation on the treatment plan demonstrates the patients ability to ask questions. Monitoring will be ongoing until the target goal of 90% or greater compliance with the above is achieved and sustained for a minimum of 3 months. All deficiencies will be corrected to include staff retraining as needed. Staff identified as not meeting this requirement will have 1:1 meeting with the DCS to discuss expectations and

Commented [HJ13]: Revised to capture the charts that are brought to tx team daily. Monitoring/auditing 100% of all charts is not manageable.

	5. The patient/representative is to sign the Treatment Plan Update to indicate agreement and participation with review/modification of the Treatment Plan. 6. A designated staff member is to discuss the Treatment Plan Update with the patient/representative if the patient is not present in the Treatment Team Meeting. 7. If the patient refuses to sign the Treatment Plan Update, the refusal will be documented. 8. Failure to properly document the patients participation as evidenced by the patients signature or documentation of their refusal to sign the treatment plan, will result in progressive disciplinary action taken up to and including termination of employment. 9. The Director of Clinical Services will assign a specific staff member to review and follow up on any identified deficiencies should they be out of the office.			consequences of further non-compliance. Subsequent violations of this process may result in suspension or termination of employment. Data will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.

Plan of correction reviewed and approved by:

Christopher West, CEO _____ Date 7/6/22