State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC) Chapter 246-322 Private Psychiatric and Alchoholism Hospitals conducted this health and safety survey. The Washington Fire Protection Bureau conducted the fire life safety inspection. Onsite dates: 03/03/20 to 03/06/20 and 03/10/20 to 03/11/20 Examination number: 2020-137 The survey was conducted by: Surveyor #4 Surveyor #5 During the course of the survey, Surveyors investigated issues related to Intake #97559. Surveyors also identified potential violations of CMS regulations that could contribute to serious patient safety issues. These issues were investigated under Intake #98124.	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 days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be scanned and sent by May 21, 2020. 4. Return the ORIGINAL REPORTS with the required signatures on the first page of the Health and Fire/Life/Safety Reports.	
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;	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 1 This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to develop and implement policies for assessment, reassessment, and treatment of wounds for 4 of 4 patients with wounds reviewed (Patients #501, #502, #510 and #511) (Item #1), failed to assess patients prior to as needed (PRN) medication administration for 3 of 3 patients reviewed (Patients #501, #508, and #509) (Item #2), failed to reassess patients after PRN medication administration for 3 of 3 patients reviewed (Patients #501, #508, and #509) (Item #3), and failed to ensure that staff documented care consistent with provider orders for 2 of 2 orders for Patient #501 (Item #4). Failure to follow the hospital's assessment and medication policies place patients at risk of psychological and physiological deterioration that may not be detected and risks poor patient outcomes and death. Findings included: Item #1- Wounds Assessments, Reassessment, and Care 1. On 03/04/20, at 9:00 AM, Surveyor #5 requested the hospital's nursing assessment and reassessment policy. The hospital provided a policy for the Initial Psychosocial Assessment. The hospital did not provide the Surveyor with a policy that directed nursing staff on assessment and reassessment during the patient's hospitalization or in response to changes in condition. On 03/04/20 at 11:30 AM, surveyor #5 requested	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 2 a wound care policy. At the time of the surveyor's exit, hospital staff had not provided the requested policy. Patient #501 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder, Bipolar Type, and Obsessive-Compulsive Disorder. The review showed the following: a. The patient had a history of Asthma, Chronic Dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), Sleep Apnea, and Hypertension. b. On 08/05/19, a provider ordered Aquaphor (a topical (for the skin) emollient used to treat or prevent dry skin) every 6 hours as needed for dry skin due to the patient's excessive rigorous handwashing. c. The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient was diagnosed with a Retropharyngeal Abscess (an abscess located in the tissues in the back of the throat behind the posterior pharyngeal wall), Streptococcal Pharyngitis (an infection of the back of the throat including the tonsils caused by group A streptococcus), Sepsis, and Pneumonia. d. The patient was readmitted to the hospital on 02/20/20. e. On 02/20/20 at 6:39 PM, the initial Registered Nurse admission assessment showed that	I. 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 3 Patient #501 had a surgical incision. 3. During the review, Surveyor #5 observed there was no evidence in the record that clinical staff had reassessed the patient's hands or skin since the patient's admission (a period of approximately 7 months). The surveyor also observed in the patient's medication administration record that the patient had not received any administrations of the Aquaphor. Following the patient's readmission to the hospital, the surveyor also found no evidence in the patient's record that clinical staff completed a wound assessment or wound care related to the patient's surgical incision. 4. At the time of the observation, Surveyor #5 asked Staff #505 about the lack of documentation of wound care assessments. Staff #505 confirmed the findings, and conducted an additional review. He was unable to locate any additional information related to the documentation of the surgical wound and stated it might be an error. Staff #505 confirmed that nursing staff had not documented skin assessments or administrations of Aquaphor. He stated that he had not assessed the patient's skin and did not know if it was still a problem. He also stated that Medication Nurses administered the medications, documented wound and skin assessments, and provided treatment. 5. On 03/04/20 at 8:00 AM, Surveyor #5 interviewed a Licensed Practical Nurse who was the Medication Nurse for the shift (Staff #506) related to the patient's skin condition and administration of Aquaphor. Staff #506 verified the medication order for Aquaphor and stated that she had not administered any medication	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 4 because the patient had not asked for it. She also stated that she had not assessed the patient's skin and did not know the current condition of the patient's hands. Patient #510 6. On 03/04/20 at 11:00 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #510 who was admitted on 02/05/20 from jail on a 72-hour hold for grave disability and danger to self and others. The review showed the following: a. The patient had a history of Schizoaffective Disorder, Poly-Substance Abuse, Bipolar Mania, and Psychosis. b. Prior to admission, the patient attempted suicide during his incarceration, by strangling himself. c. The patient received a colostomy and reversal procedure on 01/20/20 after perforating his colon with a needle. d. The patient was discharged to an acute care hospital on 02/18/20 for the treatment of Clostridium-Difficile and Sepsis. e. The patient was readmitted to the hospital on 02/24/20. f. The review showed that nursing staff did not complete an assessment (including a skin assessment) at the time of the patient's hospital readmission on 02/24/20. g. On 02/27/20, a provider note showed that the	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 5 patient had an intergluteal cleft (buttock) abscess and the provider ordered warm packs to the site 4 times daily. 7. During the review, Surveyor #5 found no evidence that nursing staff provided wound care treatment as ordered by the provider from the date recorded as the discovery of the wound on 02/27/20 through the date of the record review (a period of 6 days). The surveyor also found no evidence in the record that nursing staff assessed the wound initially or at any time, leading up to the time of the record review (a period of 6 days). 8. At the time of the review, Surveyor #5 asked Staff #503 about the lack of documentation for assessment of the patient's wounds and treatment. Staff #503 stated that the order was not entered into the electronic record in a way that it would be communicated to the Medication Nurse and therefore nursing staff were unaware of the wound and the treatment orders. Staff #503 also stated that the hospital did not have a wound assessment tool in the current electronic documentation system for staff to document an assessment of a patient wound. Staff #503 also stated that the Medication Nurse documents wound care and treatment on the Medication SBAR (Situation, Background, Assessment, and Recommendation) Form. 9. On 03/11/20, Surveyor #5 and Staff #505 completed an additional review of the patient's medical record. The review showed the following: a. On 03/06/20, a provider ordered daily wound checks of the buttock abscess and for staff to cover the wound with a bandage daily and as needed.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 6 b. Further instruction showed that staff might want to alert the primary care provider at the time of wound assessment and dressing change, so the provider could assess the wound at the same time. c. The order had a stop date of 03/10/20 at 11:45 PM. 10. On 03/11/20 at 9:00 AM, Surveyor #5 re-reviewed the medical record for Patient #510. The surveyor found no evidence in the medical record that clinical staff had completed an assessment or provided wound care. 11. At the time of the re-review, Surveyor #5 asked Staff #505 about the lack of documentation regarding the patient's assessments and wound care. Staff #505 stated that it was a problem with the electronic documentation system that sometimes the system "automatically" puts in end dates so the order appears completed and "drops off" then staff are not aware of the ordered treatment. Patient #502 12. On 03/04/20 at 2:00 PM, Surveyor #5, a Registered Nurse (RN) (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #502 who was admitted on 01/09/20 for the treatment of Schizoaffective Disorder and Bipolar Disorder. The review showed the following: a. The patient's medical history included Hypothyroidism, Leukocytosis (high white blood cell count), and Intertrigo (a type of inflammatory rash of the superficial skin) that occurs within a person's body folds where the skin rubs together	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 7	L 315		

or where it is often moist. The rash is caused by fungus or bacteria. The patient's rash was under the breast and abdominal pannus.

b. The Medical History and Physical dated 01/13/20 showed that the patient had a large area of erythema with satellite lesions at the right underside of the pannus and on the left underside of the pannus and the right breast. The plan stated that it had been a long-standing issue so there was no determined end date for the patient's medication.

c. The medication administration record (MAR) dated 02/09/20 showed a provider ordered Miconazole (an antifungal drug used to treat fungal skin infections) to be applied twice daily to the affected areas.

d. Document review of the MAR showed that from 02/09/20 to 03/03/20, the patient refused 29 applications of the Miconazole Cream and received 19 applications of the Miconazole Cream.

13. Surveyor #5 reviewed the medication nurse SBAR documents and found no evidence staff assessed the patient's wounds.

14. At the time of the review, Surveyor #5 asked Staff #503 if the Intertrigo had resolved under the patient's breast and pannus. Staff #503 stated that she had not assessed the patient and did not know.

Patient #511

15 On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 8 admitted on 11/14/19 for the treatment of Psychosis. The record review showed the following: a. On 03/09/20 at 10:40 PM, a Mental Health Specialist (an agency affiliated counselor) (MHS) documented that the patient punched a wall during medication pass that resulted in a bloody knuckle. Surveyor #5 found no evidence that a nurse assessed the patient's hand. Surveyor #5 found no evidence that staff notified a provider of the injury. b. On 3/10/20 at unknown time, a provider note stated: i. The patient had repeatedly punched the wall and that the entire dorsal of the hand was erythematous, swollen, and warm. ii.The patient would not allow much palpation due to pain. iii. The patient had cellulitis but could not rule out a fracture. iv. The patient would be sent to the emergency room and antibiotics would be initiated. c. On 03/10/20 at 1:45 PM, the hospital transferred the patient to an acute care hospital emergency room. d. On 03/10/20 at 9:46 PM, the patient returned to the hospital. 16. Surveyor #5 found no evidence in the patient record that a nurse assessed the patient or the patient's hand on return to the hospital.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 9 17. At the time of the review, Surveyor #5 asked Staff #502 about the missing assessment documentation. Staff #502 confirmed the surveyor's assessment during her review. Item #2- Assessment Prior to "As Needed" Medication Administration 1. Document review of the hospital's policy and procedure titled, "Monitoring of Patients Response to Medication," policy number 6891279, approved 10/19, showed that clinical staff will monitor patients' response to medication to determine the effectiveness and safety of their pharmacotherapy. The policy did not specifically address patient assessment of symptoms prior to PRN medication administration. Document review of the hospital's policy and procedure titled, "Medication Orders," policy number 6319768, revised 05/19, showed that PRN anti-anxiety and psychotropic medication order should identify the principal sign(s) or symptom(s) being targeted or addressed by the medication. Document review of the hospital's policy titled, "Medication Administration and Documentation: General Guidelines," policy number 7412027, revised 12/19, showed that documentation of PRN medications shall include the complaints or symptoms for which the medication was given, the results achieved from giving the dose, and the time the results were noted. Patient #501 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 10 admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder Bipolar Type and Obsessive-Compulsive Disorder. The review showed the following: a.The patient had a history of asthma, chronic dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), sleep apnea, and hypertension. b.On 02/15/20, the patient was discharged to an acute care hospital for difficulty breathing and swelling of the tongue and pharynx. c. The patient was diagnosed with a Retropharyngeal abscess, Streptococcal pharyngitis, Sepsis, and Pneumonia. d. On 02/20/20, the patient was readmitted to the hospital on 02/20/20. e. Review of provider orders and the medication administration record showed PRN medications including: -Cepacol Throat Lozenge, 1 Lozenge as needed every 2 hours for a sore throat, medication order number 0055. f. Patient #501 received 13 administrations of the throat lozenge from 02/12/20 at 11:26 AM through 02/15/20 at 6:21 AM. 3. At the time of the record review, The Registered Nurse (RN) (Staff #505) and the Chief Administrative Officer (Staff #502) were unable to locate any nursing assessment prior to the PRN medication administration in the patient's medical record.	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 11 Staff #502 stated that she could provide a copy of a report that she received. The report showed pain assessment for Medication Order #0004. 4. Surveyor #5 found no evidence in the patient's record that staff completed an assessment for 13 of the 13 administrations documented on the medication administration flow record. 5. At the time of the review, Surveyor #5 asked Staff #502 about the missing documentation. Staff #502 verified that he was unable to locate any documentation of nursing assessment prior to the PRN medication administration. Patient #508 6. On 03/04/20 at 8:00 AM, Surveyor #5 and a Licensed Practical Nurse (Staff #506) reviewed PRN medication administration for Patient #508. The review showed that a provider ordered PRN medications that included: -Diphenhydramine 50 mg every 8 hours (an antihistamine medication used to treat allergies, insomnia, symptoms of the common cold, tremor in parkinsonism, and nausea) as needed for Extrapyramidal Symptoms (EPS) (also known as extrapyramidal side effects which if drug-induced, are movement disorders, which include [acute and long term symptoms. These symptoms include dystonia (continuous spasms and muscle contractions), akathisia (may manifest as motor restlessness), parkinsonism (characteristic symptoms such as rigidity), bradykinesia (slowness of movement), tremor, and tardive dyskinesia (irregular, jerky movements)]. -Lorazepam 1 mg every 4 hours (a benzodiazepine medication used to treat anxiety	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 12 disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy-induced nausea and vomiting) for agitation. -Haldol 10 mg by mouth every 8 hours as needed for agitation and psychosis (an anti-psychotic medicine used to treat mental and mood disorders, including schizophrenia and acute psychosis). The record review also showed that a Licensed Practical Nurse administered the following medications: - Diphenhydramine 50 mg by mouth and Haldol 10 mg by mouth on 02/27/20 at 1:19 PM, 02/29/20 at 9:42 AM, 03/02/20 at 9:11 AM and 03/03/20 at 11:00 AM. - Lorazepam 1 mg by mouth on 03/01/20 at 3:45 PM and again on 03/03/20 at 3:15 PM. 7. Surveyor #5 found no evidence in the review of medications that a nurse assessed the patient for Extrapyramidal Symptoms (EPS) prior to the administration of the Diphenhydramine and Haldol and no evidence in the patient's record that a nurse assessed the patient for agitation prior to the administration of the Lorazepam. 8. At the time of the review, Surveyor #5 asked Staff #506 about patient assessments prior to administration of PRN medications. Staff #506 stated that the nurses do not document an assessment; they give the medication when the patient asks for it. 9. On 03/06/20 at 11:00 AM, Surveyor #5 and a Registered Nurse (Staff #507) completed the	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 13 medical record review for Patient #508. The medical record review showed that a Licensed Practical Nurse administered Diphenhydramine 50 mg by mouth and Haldol 10 mg by mouth on 03/05/20 at 11:21 AM. 10. At the time of the review, Surveyor #5 asked Staff #507 if staff assessed the patient for EPS prior to administration of the PRN medication. Staff #507 stated that they do not document assessments for EPS. Patient # 509 11. On 03/10/20 at 3:27 PM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medication administration record for Patient #509 who was admitted on 02/14/20 for the treatment of Unspecified Psychosis. The patient's medical history showed that the patient had prior diagnosis of Post-Traumatic Stress Disorder, a Mood Disorder, and Traumatic Brain Injury because of an automobile accident. The review showed that a provider ordered PRN medications that included: -Lorazepam 1 mg every 6 hours by mouth as needed for agitation The medication administration record showed that on 03/10/20 at 3:53 AM, a Registered Nurse administered Lorazepam 1 mg by mouth. Surveyor #5 found no evidence a nurse assessed the patient for agitation. 12. At the time of the review, Surveyor #5 found no evidence in the record that a nurse assessed the patient for agitation prior to the medication	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 14 administration. The surveyor asked Staff #508 about the patient assessments prior to delivery of PRN medications. Staff #508 verified that an assessment had not been documented and stated that he did not know if the Medication Nurses documented assessments before administration of PRN medication. Patient #511 13. On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was admitted on 11/14/19 for the treatment of Psychosis. The record review showed the patient received 3 "as needed" (PRN) medication administrations including: Lorazepam 2 mg on 02/07/20 at 12:26 AM, on 02/23/20 at 11:55 PM, and on 03/11/20 at 12:50 AM. Surveyor #5 found no evidence that nursing staff assessed the patient's symptoms prior to the administration of the PRN medication. 14. At the time of the review, Surveyor #5 interviewed Staff #502 about the patient's assessment prior to administration of the medication. Staff #502 confirmed that the patient wasn't assessed prior to medication administration. Item #3- Reassessment after "As Needed" Medication Administration 1. Document review of the hospital's policy and procedure titled, "Monitoring of Patients Response to Medication," policy number 6891279, approved 10/19, showed that patients' response to medication will be monitored to determine the effectiveness and safety of their pharmacotherapy. The policy did not specifically	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 15 address patient reassessment of symptoms after PRN medication administration. Document review of the hospital's policy and procedure titled, "Medication Orders," policy number 6319768, revised 05/19, showed that PRN anti-anxiety and psychotropic medication order should identify the principal sign (s) or symptom(s) being targeted or addressed by the medication. Document review of the hospital's policy titled, "Medication Administration and Documentation: General Guidelines," policy number 7412027, revised 12/19, showed that documentation of PRN medications shall include the complaints or symptoms for which the medication was given, the results achieved from giving the dose, and the time the results were noted. Patient #501 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder Bipolar Type and Obsessive-Compulsive Disorder. The review showed the following: a.The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient was diagnosed with a Retropharyngeal abscess, streptococcal pharyngitis, sepsis, and pneumonia. b. Review of provider orders and the medication administration record showed PRN medications including:	I. 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 16 -Cepacol Throat Lozenge, 1 Lozenge as needed every 2 hours for a sore throat, medication order number 0055. c. Patient #501 received 13 administrations of the throat lozenge from 02/12/20 at 11:26 AM through 02/15/20 at 6:21 AM. The Registered Nurse (RN) (Staff #505) and the Chief Administrative Officer (Staff #502) were unable to locate any nursing reassessment for symptom resolution after the PRN medication administration in the patient's medical record. 3. Surveyor #5 asked Staff #502 about the missing reassessments in the patient record. Staff #502 stated that she could provide a copy of a report that she received. The report showed pain assessment for Medication Order #0004. Surveyor #5 found no evidence in the record that staff completed a reassessment for 13 of the 13 administrations documented on the medication administration flow record. 4. At the time of the review, Staff #502 verified that he was unable to locate any documentation of nursing re assessment for symptom resolution after the PRN medication administration in the patient's medical record. Patient #508 5. On 03/04/20 at 8:00 AM, Surveyor #5 and a Licensed Practical Nurse (Staff #506) reviewed PRN medication administration for Patient #508. The review showed that a provider ordered PRN medications including: -Diphenhydramine 50 mg every 8 hours (an antihistamine medication used to treat allergies,	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 17	L 315		

insomnia, symptoms of the common cold, tremor in parkinsonism, and nausea) as needed for Extrapyramidal Symptoms (also known as extrapyramidal side effects which if drug-induced, are movement disorders, which include [acute and long term symptoms. These symptoms include dystonia (continuous spasms and muscle contractions), akathisia (may manifest as motor restlessness), parkinsonism (characteristic symptoms such as rigidity), bradykinesia (slowness of movement), tremor, and tardive dyskinesia (irregular, jerky movements)].

-Lorazepam 1 mg every 4 hours (a benzodiazepine medication used to treat anxiety disorders, trouble sleeping, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy-induced nausea and vomiting) for agitation.

-Haldol 10 mg by mouth every 8 hours as needed for agitation and psychosis (an anti-psychotic medicine used to treat mental and mood disorders, including schizophrenia and acute psychosis).

The record review also showed that a Licensed Practical Nurse administered the following medications:

-Diphenhydramine 50 mg by mouth and Haldol 10 mg by mouth on 02/27/20 at 1:19 PM, 02/29/20 at 9:42 AM, 03/02/20 at 9:11 AM and 03/03/20 at 11:00 AM. Surveyor #5 found no evidence of any nursing reassessment for symptom resolution after the PRN medication administration in the patient's medical record.

-Lorazepam 1 mg by mouth on 03/01/20 at 3:45 PM and 03/03/20 at 3:15 PM. Surveyor #5 found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 18 no evidence of any nursing reassessment for symptom resolution after the PRN medication administration in the patient's medical record. 6. At the time of the review, Surveyor #5 asked Staff #506 about nursing reassessments prior to administration of PRN medications. Staff #506 stated that the nurses do not document a reassessment; nurses give the medication when the patient asks for it. 7. On 03/06/20 at 11:00 AM, Surveyor #5 and a Registered Nurse (Staff #507) completed the medical record review for Patient #508. The review showed that a Licensed Practical Nurse administered Diphenhydramine 50 mg by mouth and Haldol 10 mg by mouth on 03/05/20 at 11:21 AM. 8. At the time of the review, Surveyor #5 asked Staff #507 about patient reassessments of EPS prior to administration of PRN medication. Staff #507 stated that they do not document reassessments for EPS resolution. Patient #509 9. On 03/10/20 at 3:27 PM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medication administration record for Patient #509 who was admitted on 02/14/20 for the treatment of Unspecified Psychosis. The patient's medical history showed that the patient had prior diagnosis of Post-Traumatic Stress Disorder, a Mood Disorder, and Traumatic Brain Injury because of an automobile accident. The review showed that a provider ordered PRN medications that included:	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 19 -Lorazepam 1 mg every 6 hours by mouth as needed for agitation The medication record showed on 03/10/20 at 3:53 AM, a Registered Nurse administered Lorazepam 1 mg by mouth. Surveyor #5 found no evidence of any nursing reassessment for symptom resolution after the PRN medication administration in the patient's medical record. 10. At the time of the review, Surveyor #5 asked Staff #508 about reassessment prior to administration of PRN medications. Staff #508 verified that a reassessment for symptom resolution had not been documented and stated that he did not know if the Medication Nurses documented reassessments after PRN medication administration, but that they document that patients receive PRN medications on the SBAR (Situation, Background, Assessment, Recommendation) report. Patient #511 11. On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was admitted on 11/14/19 for the treatment of Psychosis. The record review showed that the patient received 3 "as needed" (PRN) medication administrations including: Lorazepam 2 mg on 02/07/20 at 12:26 AM, on 02/23/20 at 11:55 PM, and on 03/11/20 at 12:50 AM. Surveyor #5 found no evidence that nursing staff reassessed the patient for symptom resolution after the PRN medication administration. 12. At the time of the review, Surveyor #5 asked	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 20 Staff #502 about patient reassessment after medication administration. Staff #502 confirmed that the patient wasn't reassessed after medication administration. Item #4- Documenting Provider-Ordered Treatment/Assessments 1. Document review of the hospital's policy and procedure titled, "Medical Staff Documentation," policy number 7498423, revised 03/19, showed that when admitted to the hospital, all patients will be under the care of a primary care and psychiatric independent practitioners who have the responsibility for directing and supervising the care and treatment of the patient. Patient #501- Oxygen Saturation Monitoring 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical records for Patient #501 who was initially admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder Bipolar Type and Obsessive-Compulsive Disorder. The record review showed the following: a. The patient had a history of asthma, chronic dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), sleep apnea, and hypertension. b.The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient was diagnosed with a Retropharyngeal abscess, Streptococcal pharyngitis, sepsis, and pneumonia. c.The patient was readmitted to the hospital on	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2800 SOUTHWEST HOLDEN SEATTLE, WA 98126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 21 02/20/20. d. On 02/21/20 at 2:40 PM, a provider treatment summary stated that the patient appeared to be having intermittent apneic events with an oxygen saturation of 89%. e. On 02/21/20 at 4:50 PM, a provider ordered hourly oxygen saturation monitoring. The order stated, "Send to Harborview Medical Center (HMC) if oxygen saturation falls below 89%." It also stated, "Often patient refuses vital signs. Oxygen saturation takes priority over other vitals if patient refuses. If he refuses more than twice, he needs to be sent out." f. The patient's vital sign flow record from 02/21/20 at 4:45 PM through 02/24/20 at 6:39 PM showed that the patient's oxygen saturation was only obtained on 02/24/20 at 9:40 PM and on 02/24/20 at 6:39 PM (2 times over a period of 74 hours and 54 minutes). Surveyor #5 found no evidence in the record that clinical staff obtained the patient's oxygen saturation hourly as ordered by the patient's provider. g. The patient refused vital signs on 02/22/20 at 9:57 AM, 02/23/20 at 11:00 PM, and 02/23/20 at 6:05 AM. Surveyor #5 found no evidence that the clinical staff contacted the provider related to the patient's refusal or that the hospital transferred the patient to HMC as directed in the provider order. h. A nursing note entered on 02/22/20 at 7:26 AM, stated that the patient agreed to oxygen saturation monitoring overnight for 6 hours (each shift is 8 hours). During this time, the patient's saturation ranged from 90% to 96% drifting up and down and that the patient's saturation did	L 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 22 read at a low of 89% but was infrequent and lasted about a second before going up into the 90%. Surveyor #5 found no evidence of the hourly oxygen saturation or documentation for the additional hours in the shift. Patient #501- Weekly Weights i. On 08/05/19, a provider ordered staff to weigh Patient #501 weekly. j. The vital sign and weight flow record showed that the patient was weighed twice from 08/05/19 through 03/02/20 (a period of 6 months and 26 days). The patient weighed 228.1 pounds on 08/07/19 and weighed 252 pounds on 01/13/20. Surveyor #5 found no evidence in the record that the patient was weighed weekly as directed by the provider order, or that staff documented that the patient refused weekly weights. 3. At the time of the review, Surveyor #5 asked Staff #505 about documentation of vital signs and weights in the patient charts. Staff #505 confirmed the findings, and conducted additional review. He stated that the patient frequently refused vital signs and weights, but that he did not know why the order was not followed.	L 315		
L 325	322-035.1E POLICIES-ABUSE PROTECTION WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (e) Protecting	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 23 against abuse and neglect and reporting suspected incidents according to the provisions of chapters 71.05, 71.34, 74.34 and 26.44 RCW; This Washington Administrative Code is not met as evidenced by: Based on interview, and document review, the hospital failed to develop and implement an effective system to ensure a safe environment that prevented patient sexual incidences between patients (Patient #509, #511, #512, #513, and #515) (Item #1), failed to ensure that staff understood and implemented the policy and procedure for patient rights surrounding abuse to include reporting of suspected incidences (Patient #513 and #514)(Item #2), and failed to implement action plans to ensure a safe environment in response to a patient sexual assault (Item #3). Failure to develop and implement effective policies and procedures to prevent patient-to-patient sexual incidences, protect victims of sexual abuse, investigate allegations of sexual abuse, and implement action plans to reduce patient-to-patient sexual incidences risks psychological harm, physical harm, and an unsafe therapeutic environment. Findings included: Item #1- Providing a Safe Environment Free from Abuse and Harassment 1. Document review of the hospital's policy and procedure titled, "Sexually Inappropriate Behavior Precautions," policy number 5784668, revised 12/18, showed that patients exhibiting sexually inappropriate behaviors such as: touching,	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 24	L 325		

fondling, or kissing others; making lewd or personal comments; or publicly masturbating, will be referred to the Licensed Independent Practitioner (LIP) and/or the interdisciplinary team for evaluation for placement on Sexually Inappropriate Behavior (SIB) Precautions.

Patients whose behavior is persistent, aggressive, and/or offensive enough to cause significant discomfort to other patients or staff may be placed on any level of SIB immediately by any licensed staff, pending evaluation by the LIP. SIB precautions may include 15-minute checks, Line of Sight, or Arm-Length Line of Sight. The Charge Nurse or designee will contact the LIP to inform him/her of immediate actions taken and request an order to continue, change the intensity of, or discontinue SIB Precautions.

If two patients on SIB continue to focus on inappropriate behaviors with each other, they may also be placed on opposite schedules. For example, one patient is directed to remain in his/her room for 30 minutes while the other patient is out in the milieu; then the second patient is directed to remain in his/her room for 30 minutes while the first patient participates in milieu activities.

Patient #513

2. On 03/06/20 at 9:15 AM, Surveyor #5 and a Registered Nurse (Staff #507) reviewed the medical record for Patient #513 who was admitted on 03/05/20 for the treatment of Bipolar Affective Disorder with Psychosis. She had been managed on Lithium and had been weaning off Lithium related to renal impairment. She had a history of Congestive Heart Failure and Thyroid Impairment, and early onset dementia. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 25 review showed the following: a. The Medical History and Physical completed on 03/05/20 at 3:00 PM showed that the patient was morbidly obese, had joint pain in the knees, and used a walker for ambulation. b. On 03/05/20 at 10:56 PM, an Evening Shift Daily SBAR (Situation, Background, Assessment, recommendation) stated that the patient "was concerned about the poor boundaries of one of her peers with her." 3. At the time of the review, Staff were arranging for Patient #513 to change rooms. Surveyor #5 asked Staff #507 about the patient's room change, Staff #507 stated that the room change was because there was an incident the evening prior (03/05/20) with the patient in the adjoining room (rooms are adjoined by a communal bathroom). The patient in the adjoining room was sexually inappropriate with Patient #513 in the bathroom. Because of the incident, Patient #513 did not want to use that bathroom. 4. Surveyor #5 asked Staff #507 about the other patient involved in the incident. Staff #507 stated that Patient #514 was the patient who was sexually inappropriate with Patient #513. Surveyor #5 and Staff #507 reviewed the medical record of Patient #514. The review showed a nursing note dated 03/05/20 at 10:21 PM that documented that Patient #513 had reported that Patient #514 "follows her into the bathroom and has rubbed against her." Patient #513 stated that Patient #514 tried to kiss her." The review also showed that on 01/28/20, staff placed Patient #514 on Sexually Inappropriate Behavior Precautions (SIB).The patient was on	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 26 SIB Precautions (which required staff members check on the patient every 15 minutes) at the time of the SIB incident. Surveyor #5 found no evidence in the record that the clinical staff increased or modified the level of observation for this patient after the sexually inappropriate behavior incident. 5. At the time of the review, Surveyor #5 interviewed Staff #507 about the patient's SIB precautions. Staff #507 confirmed that Patient #514 was on SIB precautions and that no additional measures to keep other patients on the ward safe were implemented following the incident of SIB. Patient #515 6. On 03/06/20 at 1:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #515 who was admitted on 02/26/19 for the treatment of Psychosis, Homicidal Ideation, Paranoid Schizophrenia, and Polysubstance Abuse. The review showed the following: a. On admission, the patient was sexually preoccupied, had inappropriate sexual behavior toward staff and patients, and was exposing his erect penis to staff. The patient had a criminal history of armed robbery, arson and assault. b. On 02/26/19 at 6:58 AM, the clinical staff placed the patient on Sexually Inappropriate Behavior (SIB) Precautions and every 15-minute monitoring. The details of the order showed, "Patient has been making aggressive sexual propositions to staff and peers and has been	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 27 exposing his erect penis to SW staff." The patient remained on continuous SIB Precautions from admission until his discharge from the hospital to jail. c. On 04/20/19, the weekly Registered Nurse Assessment showed that the patient was socially and sexually inappropriate, on Elopement Precautions, and on SIB Precautions. d. On 04/22/19 at 12:31 PM, the Psychiatric Provider (Staff #510) noted that Patient #515 was observed kissing another patient. Surveyor #5 found no evidence that a Registered Nurse assessed the patient for increasing SIB or documented the incident in the patient's medical record. e. On 04/22/19 at 1:03 PM, the Day Shift Daily Mental Health Specialist (MHS) SBAR report stated that the patient's interactions with the MHS were more appropriate than previous encounters from weeks prior, however Patient #515 was "engaging in SIB with another staff member at a later point in the morning." Surveyor #5 found no evidence that a Registered Nurse assessed the patient for increasing SIB or documented the incident in the patient's medical record. Surveyor #5 found no evidence the staff increased their monitoring of the patient. f. On 04/22/19, a Mental Health Specialist note stated that at approximately 6:00 PM, the patient entered another female patient's room, staff told the patient to leave the room, and the staff reported the incident to the Charge Nurse." Surveyor #5 found no evidence that a Registered Nurse assessed the patient for increasing SIB or documented the incident in the patient's medical record. Surveyor #5 found no evidence the	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 28 patient was placed on any enhanced precautions or monitoring. Surveyor #5 found no evidence that the staff notified the patient's provider about his escalating SIB. g. On 04/22/19 at approximately 8:15 PM, Patient #515 sexually assaulted (forcing another person to have sexual intercourse with the offender against his or her will) a female patient (Patient #512). h. On 04/22/19 at 11:22 PM, Patient #515 was discharged to jail. 7. At the time of the review, Surveyor #5 asked Staff #502 about the incidents described in the chart. Staff #502 stated that the observations of SIB should have been documented in the chart; the RN should have assessed the patient for escalating behaviors. Surveyor #5 asked Staff #502, #504 and #509 how the hospital ensures a safe environment, free of abuse and harassment for other patients. Staff #502 stated that in retrospect, Patient #515 should have been placed on enhanced precautions. Patient #512 8. On 03/06/20 at 2:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #512, who was admitted on 04/14/19 at 7:17 PM for the treatment of Unspecified Psychosis, with a first onset of mania and delusions. The review showed the following: a. The patient's history showed risk factors that included removal from her home and placement	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 29 in foster care at age 10, related to sexual, physical, and emotional abuse. The patient was involved in a significant traumatic event in 2017. The provider stated that recent events relating to her past trauma precipitated her decompensation. Prior to her admission at the hospital, the patient engaged in Sexually Inappropriate Behaviors (SIB) in an acute care hospital's Emergency Room. The behaviors included masturbating and requesting sexual contact from hospital staff. The patient continued to exhibit SIB on admission to the hospital. b. A Mental Health Specialist (MHS) note recorded on 04/14/19 at 10:43 PM, described the patient as engaging in multiple incidents of sexually inappropriate behaviors involving a peer patient, between 8:33 PM and 9:38 PM of the same date. The note also stated that the patient continued to require redirection from pursuit of the peer patient. Surveyor #5 found no evidence that the clinical staff placed the patient on enhanced monitoring or precautions, or that staff notified the Charge Nurse of the patient's SIBs. The surveyor also found no evidence that the peer patient received increased or protective monitoring. c. On 04/14/19 at 10:30 PM, the record showed that clinical staff placed the patient on Sexually Inappropriate Precautions. d. On 04/15/19 at 2:34 AM, a nursing note showed that on 04/14/19 at approximately 10:45 PM, staff found Patient #512 having sexual intercourse with a male peer and that the patient was placed on line-of-sight monitoring. Surveyor #5 found no documentation in the patient's record	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 30 that showed staff initiated line-of-sight monitoring. e. On 04/15/19 at 1:56 PM, a provider note stated, "After arriving to the unit, the patient has been presenting with hypersexual behavior. She was masturbating with a toothbrush, entering a male patient's room. Climbing on top of him, attempting to engage him in a sexual act. The patient has now been placed on line-of-sight for safety". Surveyor #5 found no evidence the patient was placed on line-of-site precautions. 9. At the time of the review, Surveyor #5 asked Staff #502 and #504 why the patient was not placed on SIB Precautions upon admission, related to the Emergency room report, and observed behaviors. Staff #502 and #504 stated that they did not know why and were unsure if staff had the Emergency Room information. Surveyor #5 noted that the sexual activity was documented as "consensual" and asked how the hospital keeps patients safe from themselves or others. Surveyor #5 also asked if the patient and the peer were able to give consent based on their psychiatric diagnosis and involuntary admission to the hospital. Patient #512 specifically was diagnosed with Psychosis, inability to care for herself, and exhibiting a hypersexual state, which were not baseline behaviors. Staff #504 stated that although Patient #512 showed impaired judgement and was manic, the patients were not incompetent. Patient #511 10. On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was admitted on 11/14/19 for the treatment of Psychosis. The record review showed the	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 31 following: a. On 11/27/19 at 3:27 PM, clinical staff placed Patient #511 Sexually Inappropriate Behavior Precautions and remained on precautions at the time of the review (03/11/20). b. On 01/03/20, a Treatment Summary note stated, "Consensual inappropriate sexual behavior (possible both anal and vaginal), per report (although specifics not mentioned in PRN notes) soon after admission of peer. Although found together with pants down, patient denies intercourse ...of note, peer is unable to discuss any of this in a meaningful way due to disorganization, lack of insight, lability, and irritability status post event". Surveyor #5 found no evidence in the record that clinical staff placed Patient #511 on any increased monitoring or provided alternative interventions to ensure a safe environment for himself and other patients on the unit. Patient #509 11. On 03/10/20 at 3:27 PM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medication administration record for Patient #509 who was admitted on 02/14/20 for the treatment of Unspecified Psychosis. The patient's medical history showed that the patient had prior diagnosis of Post-Traumatic Stress Disorder, a Mood Disorder, and Traumatic Brain Injury because of an automobile accident. The medical history also showed the patient was a victim of sex trafficking. The review showed the following: a. On 02/14/20, the Initial Psychiatric Evaluation showed that the patient's case manager shared	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 32 that the patient may be a victim of human trafficking and reported that the patient had reportedly been drugged and raped at homeless camps. b. On 02/17/20, the patient's Medical History and Physical Assessment and Plan showed that the patient had a history of sex trafficking. Per her case manager, "The patient was too disorganized at the time of the assessment to discuss, but that when the patient compensates, the provider will consider offering Sexually Transmitted Infection testing." Surveyor #5 found no evidence in the record that clinical staff placed the patient any sexual victimization precautions. 12. At the time of the review, Surveyor #5 asked Staff #508 about protection for patients who have been the victim of previous sexual abuse. Staff #508 confirmed the finding and stated that he was not aware of any policy for patients who have been victims of sexual abuse. Item #2- Reporting of Sexually Inappropriate Behavior Incidents 1. Document review of the hospital's policy and procedure titled, "Resolution of Grievances-Hospital," policy number 6173739, revised 03/19, showed that grievances that involve suspected patient abuse are to be immediately addressed through the appropriate hospital policies and procedures. Document review of the hospital's policy and procedure titled, "Risk Management-Inpatient Investigation and Reporting of Abuse," policy number 7420934, showed that when there is an	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 33 allegation of abuse by a patient the following will occur: -The Charge Nurse will notify the patient's attending physician and the Nurse Manger. -The attending physician or designee will interview and examine the patient as appropriate. -The patient will be informed of their right to report the abuse to police and will be assisted in the process. -The Nurse Manger will enter the event into the incident reporting system that will trigger the Quality department to begin the process of internal review. -The Nurse Manger or Nursing Administrator on call is responsible to facilitate an immediate follow-up investigation of the incident. 2. On 03/06/20 at 9:15 AM, Surveyor #5 and a Registered Nurse (Staff #507) reviewed the medical record for Patient #513 who was admitted on 03/05/20 for the treatment of Bipolar Affective Disorder with Psychosis. She had been managed on Lithium and had been weaning off Lithium related to renal impairment. She had a history of Congestive Heart Failure and Thyroid Impairment, and early onset dementia. The review showed the following: a. The Medical History and Physical completed on 03/05/20 at 3:00 PM showed that the patient was morbidly obese, had joint pain in the knees, and used a walker for ambulation. b. On 03/05/20 at 10:56 PM, an Evening Shift Daily SBAR (Situation, Background, Assessment,	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 34 recommendation) stated that the patient "was concerned about the poor boundaries of one of her peers with her." 3. At the time of the review, staff were arranging for Patient #513 to change rooms. Surveyor #5 asked Staff #507 about the patient's room change, Staff #507 stated that the room change was because there was an incident the evening prior (03/05/20) with the patient in the adjoining room (rooms are adjoined by a communal bathroom). The patient in the adjoining room was sexually inappropriate with Patient #513 in the bathroom. Because of the incident, Patient #513 did not want to use that bathroom. Surveyor #5 found no evidence staff documented the incident in the medical record. The surveyor also found no evidence that staff contacted the patient's provider, or that staff completed an incident report and no evidence that the hospital investigated the incident. 4. At the time of the review, Surveyor #5 also asked Staff #507 about the other patient involved in the incident. Staff #507 stated that Patient #514 was the patient who was sexually inappropriate with Patient #513. Surveyor #5 and Staff #507 reviewed the medical record of Patient #514. The review showed a nursing note dated 03/05/20 at 10:21 PM that documented that Patient #513 had reported that Patient #514 "follows her into the bathroom and has rubbed against her. Patient #513 stated that Patient #514 tried to kiss her." 5. Surveyor #5 asked Staff #507 if the incident had been reported and investigated consistent with hospital policy. Staff #507, the Quality and Compliance Manager (Staff #504), and the Chief Administrative Officer (Staff #502) stated that the	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 35 incident had not been reported to the provider or the Nurse Manager, staff had not completed an incident report, and the incident had not been investigated. Patient #514 1. On 03/06/20 at 9:15 AM, Surveyor #5, a Registered Nurse (Staff #507), a Quality and Compliance Manager (Staff #504) and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #514 who was admitted on 01/28/20 for the treatment of Schizo-Affective disorder bipolar type. The review showed that on 03/05/20 at 10:21 PM, a nursing note stated, "She (Patient #514) gave a Unit Coordinator a SIB note referencing SIB touching/oral sex between them." 2. At the time of the review, Surveyor #5 requested to review the note referenced in the patient's record. Staff #507 stated that it was not in the chart, but that it had been placed in a provider box for the provider to review when he comes into the hospital today (03/06/20). 3. Document review of a form titled, "Navos Inpatient Services Patient Grievance Form," showed that Patient #514 documented on the form that a receptionist touched her inappropriately. Surveyor #5 found no evidence that the hospital notified the provider of the alleged incident. The surveyor also found no evidence that staff notified administrative personal of the alleged incident, and no evidence that staff completed an incident report. The surveyor found no evidence the patient was placed on any additional safety precautions.	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 36 4. At the time of the review, staff #507 confirmed the lack of notification. Staff #502 and #504 stated that staff had not reported the incident and staff had not completed an incident report. Staff had not reported the incident to the patient's provider, or the Nurse Manager, and there had been no initiation of an investigation. Item #3 -Protecting Patients from Abuse: Implementing Action Plans related to Patient Sexual Abuse 1. Document review of the hospital's policy and procedure titled, "Resolution of Grievances-Hospital," policy number 6173739, revised 03/19, showed that grievances that involve suspected patient abuse are to be immediately addressed through the appropriate hospital policies and procedures, and showed that grievance information will be reported to the Quality Improvement Committee, where trends will be identified, in present and Performance Improvement Plans will be implemented. Document review of the hospital's policy and procedure titled, "Risk Management-Inpatient Investigation and Reporting of Abuse," policy number 7420934, showed that when there is an allegation of abuse by a patient, documentation and completed internal investigations findings will be discussed at the Inpatient Risk Review Meeting and recommendations of follow-up actions will be addressed. 2. On 03/06/19 at 2:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed a root cause analysis (RCA)	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 37 developed in response to an incident of sexual assault that occurred at the hospital. The review showed the following: a. The hospital identified the root causes of the sexual assault as a lack of physician engagement in treatment team meetings and the contents of the hospital's special precautions policy. The hospital's action plan included education of providers on attendance at treatment team meetings to address special precautions and review and revision of the hospital's Special Precautions policy. b. During the review of the RCA, Surveyor #5 asked what changes were made to the Special Precautions policy. Staff #504 stated that that policy was reviewed, but no changes were made. Surveyor #5 noted that the policy was identified as a root cause, and asked Staff #504 why there have been no changes made to the policy since the hospital is still experiencing incidents related to patients' sexually inappropriate behavior. The surveyor also asked Staff #504 if the current policy addressed the types of patients and interventions needed to provide a safe environment free from abuse and harassment for all patients. Staff #504 stated that they would be reviewing the current policy. c. Surveyor #5 also asked Staff #509 if there was documentation of the provider education described in the hospital's action plan. Staff #509 stated that she was unable to locate any evidence of provider training as required in the hospital's process improvement plan and this might be attributed to a gap in the Medical Director change. 3. Surveyor #5 also reviewed the Quality	L 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 325	Continued From page 38 Improvement Committee (QIC) Minutes for the prior 12 months. The review showed no evidence that the QIC addressed the Process Improvement plan or identified that the QIC team failed to implement its plan, collect and analyze data, and reassess the plan for effectiveness. At the time of the review, Staff #504 confirmed the finding and stated that they failed to close the loop.	L 325		
L 355	322-035.1K POLICIES-STAFF ACTIONS 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: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to ensure that staff took appropriate action when patients experienced changes in condition for 3 of 3 patients reviewed (Patient #504, #510, and #511). Failure to act on changes in a patient's condition	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 39 leads to delays in care and poor patient outcomes. Findings included: 1. On 03/04/20 at 9:00 AM, Surveyor #5 requested the hospital's nursing assessment and reassessment policy. The hospital provided a policy for the Initial Psychosocial Assessment. The hospital did not provide the Surveyor with a policy that directed nursing staff on assessment and reassessment during the patient's hospitalization. Patient #504 2. On 03/04/20 at 8:10 AM, Surveyor #5 observed Staff #506 as they administered medication to Patient #504. The observation showed Patient #504 presented to the Medication window. Patient #504 reported to a Licensed Practical Nurse (LPN) (Staff #506) that she felt tired and weak and believed that she was experiencing side effects from her medication, Zyprexa. The patient reported to Staff #506 3 times, that she felt weak and tired. The observation also showed that the nurse documented in the medication administration record that the patient refused her medication. Staff #506 informed the patient that she would need to discuss the side effects with her provider. At the time of the observation, during interview with Surveyor #5, Staff #506 stated that the patient had been getting intramuscular administrations of medication for refusing her medications, but that she had not previously complained of an adverse reaction to the medication. Surveyor #5 asked Staff #506 if she was going to notify anyone. Staff #506 stated that	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 40 she would notify the provider after her medication pass was complete. 3. On 03/04/20 at 8:30 AM, during interview with Surveyor #5, a Registered Nurse (RN) (Staff #503) stated that the medication nurses complete an SBAR (Situation, Background, Assessment, Response) report at the end of their shift. In this report, they will document refusals and administration of "as needed" (PRN) medications. She also stated that if patients have adverse symptoms, the staff will verbally report to the RN. During the same interview, Surveyor #5 asked Staff #503 about the patient's statement regarding side effects of her medication. Staff #503 stated that, at the time of the interview, Staff #506 had not reported any adverse symptoms. The surveyor then asked Staff #503 if there were any time expectations for reporting of adverse reactions to medications. Staff #503 stated that it would depend on the severity of the reaction. Patient #510 4. On 03/04/20 at 11:00 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #510 who was admitted on 02/05/20 from jail on a 72-hour hold for grave disability and danger to self and others. The patient had a history of Schizoaffective Disorder, Poly-Substance Abuse, Bipolar Mania, and Psychosis Prior to admission, the patient attempted suicide during his incarceration, by strangling himself. The patient received a colostomy and reversal procedure on 01/20/20 after perforating his colon with a needle. The patient was discharged to an acute care hospital on 02/18/20 for the treatment of Clostridium-Difficile and Sepsis. The patient was	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 41 readmitted to the hospital on 02/24/20. The review showed the following: a. On 02/05/20 at 10:51 PM, a mental health specialist (an agency affiliated counselor) (MHS) note stated, "Patient has not exhibited any remarkable behavior of the challenging type. He did, however, recently vomit a large amount in his room all over the floor." Surveyor #5 found no evidence the emesis was reported to a nurse or that a nurse assessed the patient after the emesis. Surveyor #5 also found no evidence that staff notified the patient's provider of the emesis. b. On 02/07/20 at 10:51 PM, a mental health specialist (an agency affiliated counselor) (MHS) note showed that the patient "slept mostly through the night but took a shower as he threw up in the middle of the shift." Surveyor #5 found no evidence a nurse assessed the patient following the emesis. Surveyor #5 found no evidence staff notified the patient's provider of the emesis. c. On 02/08/20, a provider ordered Imodium (a medication indicated for the control and symptomatic relief of acute nonspecific diarrhea and of chronic diarrhea associated with inflammatory bowel disease.) 4 mg times one dose and Imodium 2 mg every hour as needed (PRN) not to exceed 8 mg in 24 hours. Surveyor #5 found no evidence in the medical record that staff assessed the patient for diarrhea. d. Document review of the patient's medication administration record showed the patient refused the Imodium. Surveyor #5 found no evidence that staff notified the provider about the patient's refusal to take the medication.	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 42 e. On 02/10/20 at 3:24 AM, a nursing note showed that the patient "continues to have diarrhea on almost every shift since his admit. Refuses to take Imodium tablet. Patient has had no lab draws since admit." Surveyor #5 found no evidence in the medical record that nursing staff notified the provider that the patient was having continued diarrhea or refusing medication. Surveyor #5 found no evidence that the hospital staff placed the patient under any enhanced monitoring or restrictive measure related to the unknown source of the patient's diarrhea. f. On 02/10/20 at 3:50 AM, a MHS note stated, "Patient visible in milieu for shower due to diarrhea and about 2 hours later to pace and check time." Surveyor #5 found no evidence the staff notified the provider of the patient's continued diarrhea. 5. At the time of the review, Surveyor #5 asked Staff #503 about how the hospital staff communicated the patient's change in condition. Staff #503 confirmed that the medical record did not show evidence that the provider was notified. He also stated that there is a "message bucket" that staff put messages into for the provider to review the next day, but that this is not part of the patient's medical record and that he had no way to retrieve this information. Patient #511 6. On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was admitted on 11/14/19 for the treatment of Psychosis. The record review showed the following:	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 43 a. On 02/03/20 at 9:29 PM, a provider ordered Permethrin 1% liquid to be applied topically for lice. b. On 02/05/20 at 10:10 PM, a provider ordered Permethrin 1% liquid to be applied topically for lice related to "suboptimal application" of the prior dose. Nursing staff documented on the medication administration record that this dose was not given and stated, "Several nurses worked with the patient to facilitate compliance; patient is 'slippery' and finds it difficult to honor commitments." Surveyor #5 found no evidence that staff notified the provider that the patient had refused the lice treatment. c. On 02/23/20 at 5:10 PM, a provider ordered Permethrin 1% liquid to be applied topically for lice. The provider gave directions to alert the primary care provider if the patient refused the treatment. Surveyor #5 found no reassessment of the patient's head lice, no notification to the provider and no application of the mediation from 02/05/20 to 02/23/20 (a period of 18 day without treatment of the lice). d. On 02/24/20 at 9:34 AM, a progress notes stated that the patient received lice treatment the day prior on evening shift. The patient's bed and the roommates' beds were stripped and cleaned. The roommates' heads were checked for lice and none were found. The patient still had a few visible nits, but no adult lice were observed. 7. At the time of the review, Surveyor #5 observed that the patient had been a patient in the hospital since 11/14/19. The surveyor asked Staff #502 about the possible source of the patient's infestation. Staff #502 verified the finding and stated that they had several patients with	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 355	Continued From page 44 head lice and that he could have gotten it from another patient or from someone that came into the hospital. She also stated that she did not know that the patient had refused the treatment on 02/05/20.	L 355		
L 390	322-035.1R POLICIES-PATIENT TRANSFER 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: (r) Transferring patients to other health care facilities or agencies; This Washington Administrative Code is not met as evidenced by: Based on interview and document review the hospital failed to ensure staff implemented its policy and procedure for patient transfers for 3 of 4 patient transfers reviewed (Patient #505, #506, and #507). Failure to ensure staff members provide complete and accurate patient information to a receiving facility risks delayed or inappropriate care and risks patient harm. 1. Document review of the hospital's policy and procedure titled, "Transfer of Medically Compromised Patients," policy number 6039042, revised 02/19, showed that the Emergency Room Transfer form will be completed and added to the transfer envelope. Document review of the hospital's form titled,	L 390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 390	Continued From page 45 "Certification of Patient Transfer, Emergency Room Evaluation," form number MR60, revised 7/26/08, showed that the original copy of the Emergency Transfer Form is placed in the patient's medical record and a copy of the form is sent with the patient. The form certifies: a. The patient has been screened and stabilized and that it is reasonably and medically probable that the transfer will cause no material deterioration. b. Medically appropriate transportation has been arranged. c. The patient's family has been notified. d. A physician has requested the transfer and the Emergency room has been contacted and informed of the transfer. e. Appropriate records and information will accompany the patient. f. The patient or legally responsible person has requested or consented to the transfer. g. Documentation of the reason for transfer, major medical problems, current medications including last dose, and the most recent vital signs. 2. On 03/05/20 at 11:00 AM, Surveyor #5, the Quality and Compliance Manager (Staff #504), and the Chief Administrative Officer (Staff #502) reviewed the medical records for Patient #505, #506, and #507. The review showed the following: a. On 11/27/19, the hospital transferred Patient	L 390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2800 SOUTHWEST HOLDEN SEATTLE, WA 98126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 390	Continued From page 46 #505 to an acute care hospital for lower quadrant abdominal pain. Surveyor #5 found no evidence that staff completed the transfer form. b. On 12/15/19, the hospital transferred Patient #507 to an acute care hospital for altered mental status. Surveyor #5 found no evidence that staff completed the transfer form. c. On 12/21/19, the hospital transferred Patient #506 to an acute care hospital to remove a ring that was too tight, causing finger tissue damage. Surveyor #5 found no evidence staff completed the transfer form. 3. At the time of the review, Surveyor #5 asked Staff #502 and #504 about the missing forms. Staff #502 and Staff #504 confirmed the missing documentation and stated that the form should have been completed and scanned into the patient's medical records, prior to transport.	L 390		
L 440	322-040.5 ADMIN-MEDICAL DIRECTOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day; This Washington Administrative Code is not met as evidenced by: Based on record review and interview, the Governing Body failed to formally appoint a medical director to oversee the medical staff.	L 440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 440	Continued From page 47 Failure to appoint a medical director to oversee medical treatment risks patients receiving inadequate or substandard care. Findings included: 1. Document review of the Governing Body meeting minutes taken between January and December 2019 showed no evidence that the Governing Body approved the appointment of the hospital's acting Interim Medical Director. Document review of the hospital's July 11, 2019 Medical Executive Committee minutes referred to provider Brian Coleman as the facility's acting Interim Medical Director in the announcements of the meeting. 2. On 03/05/20 at 10:05 AM, Surveyor #4 interviewed the Governing Body President (Staff #401) about the interactions between the board and the hospital. Surveyor #4 asked Staff #401 if the board had formally appointed the hospital's acting Interim Medical Director. Staff #401 stated that they did not formally appoint the Medical Director, but he thought the appointment was announced ahead of the meeting.	L 440		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial	L 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From page 48 infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, policy review, and record review, the hospital failed to develop, implement and maintain active surveillance to prevent and control exposure to infectious diseases (Item #1) and failed to ensure that staff performed appropriate hand hygiene during environmental cleaning in patient rooms (Item #2). Failure to develop and implement an active and appropriate hospital surveillance program and staff failure to perform appropriate hand hygiene puts patients, staff, and visitors at risk of harm from infections. Findings included: Item #1- Active Surveillance 1. Document review of the hospital document titled, "Infection Control Plan", last reviewed 08/19 showed that the hospital targets conditions that are easily transmitted in shared spaces for additional attention. 2. On 03/11/20 at 1:52 PM, Surveyors #4 and #5 interviewed the hospital's Infection Preventionist and Primary Care Physician (Staff #407) about infection control surveillance in the hospital. Staff #407 stated that patients receive evaluation during nursing intake and that providers see their patients within 24 hours. Staff #407 also stated that other providers do not always notify her if patients have communicable illnesses.	L 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From page 49 The surveyors asked how the hospital tracked healthcare acquired infections (HAI). Staff #407 stated that reports go into a general primary care "bucket" for communication to the provider. Staff #407 also stated that she could not provide any data analysis of HAIs in the hospital for 2019. 3. On 03/04/20 at 11:00 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #510 who was admitted on 02/05/20. The patient's medical record included nursing reports of the patient's ongoing diarrhea and bouts of emesis (vomiting). The patient's record showed no evidence that the hospital placed the patient in isolation. On 02/18/20, the patient discharged to an acute care hospital for the treatment of Clostridium difficile and Sepsis. 4. On 03/11/20 at 1:52 PM, Surveyors #4 and #5 interviewed hospital's Infection Preventionist and Primary Care Physician (Staff #407) about the hospital's actions to prevent Patient #510 from infecting his roommate and other patients in the hospital. Staff #407 stated that she instructed staff to check on the other patients, and acknowledged there was no documentation. Item #2- Hand Hygiene 1. Document review of the contractor's document titled, "Kelly Maintenance, Inc., Environmental Services Cleaning Guidebook," no effective date, showed that staff are to use hand sanitizer after removing gloves, and use soap and water if hands are visibly soiled. 2. On 03/05/20 at 9:30 AM, Surveyor #4	L 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 690	Continued From page 50 observed a member of the contracted Environmental Services Staff (Staff #408) as she cleaned patient room #320. The observation showed that Staff #408 changed her gloves, but failed to first perform hand hygiene. On 03/05/20 at 10:05 AM, Surveyor #4 observed a member of the contracted Environmental Services Staff (Staff #409) as she cleaned patient room #206. The observation showed the staff member failed to perform hand hygiene prior to donning gloves to begin cleaning the room. 3. At the time of the 2nd observation, Surveyor #4 interviewed the Environment of Care (EOC) Safety Officer (Staff #410) about the availability of hand sanitizer on staff cleaning carts, since there were no sanitizers on the observed carts. He stated that the expectation is for staff to use the wall mounted non-alcohol based hand sanitizers consistent with their company's policy.	L 690		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the	L 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 710	Continued From page 51 hospital failed to develop and implement a water management plan designed to prevent spread of water-borne pathogens in the facility. Failure to develop and implement an appropriate water management plan puts patients, staff, and guests at risk of harm from exposure to water borne pathogens. Findings included: 1. Document review of the hospital's policy titled, "Water and Waste Water System Plan", last revised 08/19, showed a heading called "Tests for Legionella". The text contained instructions for emergency procedures in the event of a water system failure, but contained no information about prevention or testing for Legionella. The policy also does not provide a prevention strategy for water-borne pathogens consistent with the American Society of Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) industry standard and the CDC toolkit on "Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings". 2. On 03/03/20 at 1:00 PM, Surveyor #4 interviewed the Facilities Manager (Staff #402) about status of the hospital's water management plan. Staff #402 stated that they haven't completed mapping identified areas of risk, but had water filters on ice machines.	L 710		
L1050	322-170.2B TREATMENT PLAN-INITIAL WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge	L1050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1050	Continued From page 52 planning for each patient admitted or retained, including but not limited to: (b) An initial treatment plan upon admission incorporating any advanced directives of the patient; This Washington Administrative Code is not met as evidenced by: Based on interview and document review the hospital failed to ensure that staff members developed an initial treatment plan for all patients as demonstrated by 4 of 5 initial treatment plans reviewed (Patients #509, #510, #512 and #513). Failure to develop an initial treatment plan of care risks inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nursing Psychosocial Admission Assessment," policy number 5788831, revised 12/18, showed that the Initial Treatment Plan identified the problems to be addressed during the hospitalization, problems anticipated at discharge, the patient's strengths and weaknesses, and patient goals and staff interventions. Document review of the hospital's policy and procedure titled, "Hospital Interdisciplinary Treatment Planning Process," policy number 6242431, revised 04/19, showed that Navos Hospital Services recognizes that patients have the right to competent assessment and individualized treatment planning with continual evaluation of identified strategies. An intervention is how the team will ensure that goals are being addressed. The Registered Nurse will utilize	L1050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1050	Continued From page 53 information received from the Pre-Admission Screening, referring agency, and the patient interview to develop the Initial Treatment Plan. Clinical staff will evaluate the patient's response to treatment and progress on a continual basis, through a formal review of the individual treatment plan, at least every 7 days. The Master Treatment Plan form will be used for initial and reassessment evaluations. Clinical staff will review and update the treatment plan with changes in the patient's status/condition. Updates may include seclusion and/or restraint, medical condition, precaution changes (Fall, Inappropriate Sexual Behavior, Suicide Ideation or Attempt, Elopement), and Discharge Planning. Patient #509 2. On 03/10/20 at 3:27 PM, Surveyor #5 and a Registered Nurse (Staff #508) reviewed the medication administration record for Patient #509 who was admitted on 02/14/20 for the treatment of Unspecified Psychosis. The patient's medical history showed that the patient had a prior diagnosis of Post-Traumatic Stress Disorder, a Mood Disorder, and Traumatic Brain Injury because of an automobile accident. The medical history also showed the patient was a victim of sex trafficking. 3. Surveyor #5 found no evidence in the medication administration record that staff developed or implemented an initial treatment plan. 4. At the time of the review, Surveyor #5 asked Staff #508 about the patient's plan of care. Staff #508 confirmed the surveyor's observation and stated that staff should have completed an initial	L1050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1050	Continued From page 54 treatment plan. Patient #510 5. On 03/04/20 at 11:00 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #510 who was admitted on 02/05/20 from jail on a 72-hour hold due to grave disability and danger to self and others. The patient had a history of Schizoaffective Disorder, Poly-Substance Abuse, Bipolar Mania, and Psychosis. The review showed the following: a. Prior to admission, the patient attempted suicide during his incarceration, by strangling himself. b. The patient received a colostomy and reversal procedure on 01/20/20 after perforating his colon with a needle. c. The patient was discharged to an acute care hospital on 02/18/20 for the treatment of Clostridium-Difficile and Sepsis. d. The patient was readmitted to the hospital on 02/24/20. 6. Surveyor #5 found no evidence in the patient's medical record that the clinical staff developed an initial treatment plan for the patient after readmission to the hospital. Patient #513 7. On 03/06/20 at 9:15 AM, Surveyor #5 and a Registered Nurse (Staff #507) reviewed the medical record for Patient #513 who was	L1050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1050	Continued From page 55 admitted on 03/05/20 for the treatment of Bipolar Affective Disorder with Psychosis. The review showed the following: a. She had been managed on Lithium and had been weaning off Lithium related to renal impairment. b. She had a history of Congestive Heart Failure Thyroid Impairment, and early onset dementia. The patient was morbidly obese, had joint pain in the knees, and used a walker for ambulation. 8. Surveyor #5 found no evidence in the medical record that clinical staff addressed the patient's altered mobility and use of a walker in the initial plan of care. 9. At the time of the review, Surveyor #5 asked Staff #507 about the patient's initial plan of care. Staff #507 confirmed the observation and stated that the care plan should address the patient's mobility difficulties. Patient #512 10. On 03/06/20 at 2:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #512, who was admitted on 04/14/19 at 7:17 PM for the treatment of Unspecified Psychosis, with a first onset of mania and delusions. The review showed the following: a. The patient's history showed risk factors that included the patient's removal from her home and placement in foster care at age 10 related to sexual, physical, and emotional abuse.	L1050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1050	Continued From page 56 b. The patient was involved in a significant traumatic event in 2017 . The provider stated that recent events relating to her past trauma precipitated her decompensation. c. Prior to her admission at the hospital, the patient engaged in Sexually Inappropriate Behaviors (SIB) in an acute care hospital's Emergency Room. The behaviors included masturbating and requesting sexual contact from hospital staff. d. The patient continued to exhibit SIB on admission to the hospital. 8. Surveyor #5 found no evidence in the patient's record that the clinical staff addressed the patient's Sexually Inappropriate Behaviors (SIB) in the initial treatment plan. 9. At the time of the review, Surveyor #5 asked Staff #504 about the patient's treatment plan. Staff #504 confirmed the surveyor's observation.	L1050		
L1055	322-170.2C EXAM & MEDICAL HISTORY 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: (c) A physical examination and medical history completed and recorded by a physician, advanced registered nurse practitioner, or physician	L1055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	087470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1055	Continued From page 57 assistant within twenty-four hours following admission, unless the patient had a physical examination and medical history completed within fourteen days prior to admission, and the information is recorded in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, hospital staff failed to complete a history and physical exam, and place it in the medical record within 24 hours of admission for 1 of 5 patients reviewed (Patient # 501). Failure to perform an assessment on all patients within 24 hours of admission puts patients at risk of harm from unidentified and untreated medical conditions. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient History and Physical Exam," policy number 62002421, revised 04/19, showed that an acceptable history and physical must be in the medical record within 24 hours of admission. If a patient has been admitted to the hospital within the previous 30 days, a new and complete history and physical examination is not necessary. However, an interim history and physical must be dictated to include the reason for admission, all additions to the history, and any subsequent changes in the physical findings. 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially admitted to the hospital on 08/05/19 for the	L1055		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1055	Continued From page 58 treatment of Schizoaffective Disorder, Bipolar Type, and Obsessive-Compulsive Disorder. The review showed the following: a. The patient had a history of asthma, chronic dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), sleep apnea, and hypertension. b. The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient was intubated and diagnosed with a Retropharyngeal abscess, Streptococcal pharyngitis, Sepsis, and Pneumonia. c. The patient was readmitted to the hospital on 02/20/20. 3. Surveyor #5 observed that the patient's history and physical was completed on 08/06/19. Surveyor #5 also observed that the provider did not complete a new history and physical until 02/24/20 (a period of 4 days after readmission). 4. At the time of the review, Surveyor #5 asked Staff #502 about the delayed completion of the patient's history and physical. Staff #502 confirmed the observations and stated that clinical staff should have completed a new history and physical as it was more than 30 days since the patient's initial hospital admission.	L1055		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 59 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 and document review, the hospital failed to ensure that staff developed, initiated, and updated patient care plans for 7 of 8 patients reviewed (Patients #501, #502, #510, #511, #512, #513 and #517). Failure to keep patient care plans current risks inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Hospital Interdisciplinary Treatment Planning Process," policy number 6242431, revised 04/19, showed that Navos hospital Services recognizes that patients have the right to competent assessment and individualized treatment planning with continual	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 60 evaluation of identified strategies. An intervention is how the team will ensure that goals are being addressed. The Registered Nurse will utilize information received from the Pre-Admission Screening, referring agency, and the patient interview to develop the Initial Treatment Plan. The treatment team will continually address and evaluate the patient's response to treatment and progress through a formal review of the individual treatment plan that will occur at least every 7 days. Clinical staff will use the Master Treatment Plan form for initial and reassessment evaluations. Clinical staff will review and update the treatment plan with changes in the patient's status/condition. Updates may include seclusion and/or restraint, medical condition, precaution changes (Fall, Inappropriate Sexual Behavior, Suicide Ideation or Attempt, Elopement), and Discharge Planning. Patient #501 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder, Bipolar Type, and Obsessive-Compulsive Disorder. The review showed: a. The patient had a history of asthma, chronic dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), sleep apnea, and hypertension. b. The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAVOS	2800 SOUTHWEST HOLDEN SEATTLE, WA 98126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 61 was intubated and diagnosed with a Retropharyngeal abscess, Streptococcal pharyngitis, Sepsis, and Pneumonia. c. The patient was readmitted to the hospital on 02/20/20. 3. Surveyor #5 reviewed the patient's Master Treatment Plan problem list and interventions and found the following: a. No evidence that clinical staff added an altered oxygen saturation problem to the patient's plan of care after return from their acute care hospitalization b. No evidence that clinical staff added a medication or treatment non-compliance problem to the patient's plan of care c. No evidence that clinical staff addressed an Obsessive-Compulsive Disorder problem in the patient's plan of care 4. Surveyor #5 noted a problem of chronic dermatitis however; Surveyor #5 found no documentation that clinical staff added interventions associated with the problem to the patient's plan of care. The surveyor also noted that staff placed the patient on Sexually Inappropriate Behavior, "Cheeking" (medication avoidance), and Assault Precautions, but found no problems, goals, or interventions associated with these identified issues. 5. At the time of the review, Staff #505 confirmed the surveyor's observations. Patient #510	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 62 6. On 03/04/20 at 11:00 AM, Surveyor #5, a Registered Nurse (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #510 who was admitted on 02/05/20 from jail on a 72-hour hold due to grave disability and danger to self and others. The patient had a history of Schizoaffective Disorder, Poly-Substance Abuse, Bipolar Mania, and Psychosis. The review showed: a. Prior to admission, the patient attempted suicide during his incarceration, by strangling himself. b. The patient received a colostomy and reversal procedure on 01/20/20 after perforating his colon with a needle. c. On 02/14/20, the patient's Master Treatment Plan showed the patient continued to have emesis and diarrhea and that a stool sample was submitted for laboratory testing. The surveyor found no evidence that gastrointestinal alterations were added to the problem list and the plan contained no identified interventions including patient isolation. d. The patient was discharged to an acute care hospital on 02/18/20 for the treatment of Clostridium-Difficile and Sepsis. e. The patient was readmitted to the hospital on 02/24/20. Clinical staff utilized the care plan developed for the prior admission for the patient's readmission from the acute care hospital. 7. Surveyor #5 noted that the care plan was not updated to include the patient's recent Clostridium difficile diagnosis and current	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 63 antibiotic needs until 02/26/20 (a period of 2 days). 8. At the time of the review, Staff #503 stated that the nursing staff does not update care plans and that updating care plans requires input from the entire care team. Staff #503 also stated that care plans are updated weekly unless a significant event occurs such as restraint/seclusion or a patient fall. If a significant event occurs, then the care team meets to update the care plan. Patient #502 9. On 03/04/20 at 2:00 PM, Surveyor #5, a Registered Nurse (RN) (Staff #503), and the Quality and Compliance Manager (Staff #504) reviewed the medical record for Patient #502 who was admitted on 01/09/20 for the treatment of Schizoaffective Disorder and Bipolar Disorder. The review showed the following: a. The patient's medical history included Hypothyroidism, Leukocytosis (high white blood cell count), and Intertrigo under the breast and abdominal pannus (a type of inflammatory rash of the superficial skin that occurs within a person's body folds where the skin rubs together or where it is often moist. The rash can be bacterial or fungal). b. The Medical History and Physical dated 01/13/20 showed that the patient had a large area of erythema with satellite lesions at the right underside of the pannus and on the left underside of the pannus and the right breast. The plan stated that it had been a long-standing issue so there was no determined end date for the patient's medication.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 64 c. The medication administration record (MAR) dated 02/09/20 showed a provider ordered Miconazole (an antifungal drug used to treat fungal skin infections) to be applied twice daily to the affected areas. d. Document review of the MAR showed that from 02/09/20 to 03/03/20, the patient refused 29 applications of the Miconazole Cream and received 19 applications of the Miconazole Cream. 10. Surveyor #5 reviewed the medication nurse SBAR documents and found no evidence staff assessed the patient's wounds. 11. Surveyor #5 asked Staff #503 if the Intertrigo had resolved under the patient's breast and pannus. Staff #503 stated that she had not assessed the patient and did not know. 12. Surveyor #5 found no evidence the patient's plan of care was updated to include wound assessments or the patient's noncompliance with wound care and assessment. Patient #517 13. On 03/05/20 at 9:00 AM, Surveyor #5 and the Quality and Compliance Manager (Staff #504) reviewed the discharged medical record for Patient #517 who was admitted on 10/13/19 for the treatment of Unspecified Mood Disorder and Danger to Self and Danger to Others. The review showed that staff placed the patient in seclusion on 10/11/19 at 6:45 PM and placed her in restraints on 10/11/19 at 8:00 PM. The patient's plan of care was not updated to reflect the patient's behavior, seclusion, and restraint until 10/14/19 (3 days later).	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 65 14. At the time of the review, Surveyor #5 interviewed Staff #504 about the delay in updating the patient's plan of care. Staff #504 stated that if a patient is placed in restraints on a Friday, the plan of care is not updated until the following Monday when the treatment team meets. Patient #512 15. On 03/06/20 at 2:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #512 who was admitted on 04/14/19 at 7:17 PM for the treatment of Unspecified Psychosis, with a first onset of mania and delusions. The review showed the following: a. The patient's history showed risk factors that included the patient's removal from her home and placement in foster care at age 10 related to sexual, physical, and emotional abuse. b. The patient was involved in a significant traumatic event in 2017 when 2 individuals came to the home and killed the patient's aunt while she was there babysitting 3 children. The provider stated that recent events relating to her past trauma precipitated her decompensation. c. Prior to her admission at the hospital, the patient engaged in Sexually Inappropriate Behaviors (SIB) in an acute care hospital's Emergency Room. The behaviors included masturbating and requesting sexual contact from hospital staff. d. The patient continued to exhibit SIB on	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 66 admission to the hospital. e. On 04/14/19 at approximately 10:45 PM, Staff found Patient #512 having sexual intercourse with a male peer. f. A nursing note dated 04/15/19 at 2:34 AM showed that staff placed the patient on line-of-sight monitoring. g. On 04/16/19 (a period of 2 days after admission and sexual activity incident) the Master Treatment plan showed a short-term goal of not exhibiting any sexually inappropriate behavior as evidenced by keeping appropriate boundaries with other patients and following staff direction. 16. Surveyor #5 found no documentation in the patient's treatment plan that indicated the patient received line-of-sight monitoring. 17. At the time of the review, Surveyor #5 asked why staff failed to update the treatment plan immediately to reflect the patient's extreme hypersexual behaviors and hypersexual focus on another peer patient. Staff #502 stated that the treatment plans are updated during the Multidisciplinary Treatment Team meetings. Patient #511 18. On 03/11/20 at 11:00 AM, Surveyor #5 and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #511 who was admitted on 11/14/19 for the treatment of Psychosis. The record review showed the following: a. On 02/03/20 at 9:29 PM, a provider ordered Permethrin 1% liquid to be applied topically for	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 67 lice. b. The patient received the medication sub-optimally and on 02/05/20, a provider ordered an additional application. The patient refused the medication and was untreated for the head lice for 18 days. 19. Surveyor #5 found no evidence in the record to indicate that staff updated the patient's care plan to reflect the change in the patient's condition, the change in the provider orders, and the patient's continued non-compliance and ongoing lice infestation. Patient #513 20. On 03/06/20 at 9:15 AM, Surveyor #5 and a Registered Nurse (Staff #507) reviewed the medical record for Patient #513 who was admitted on 03/05/20 for the treatment of Bipolar Affective Disorder with Psychosis. She had been managed on Lithium and had been weaning off Lithium related to renal impairment. She had a history of Congestive Heart Failure and Thyroid Impairment, and early onset dementia. The review showed the following: a. On 03/05/20 at 10:56 PM, an Evening Shift Daily SBAR (Situation, Background, Assessment, Recommendation) stated that the patient "was concerned about the poor boundaries of one of her peers with her." b. Additional review showed that the patient was the victim of Sexually Inappropriate Behavior from another patient that included rubbing against her and trying to kiss her, which resulted in a fear of using the bathroom.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 68 21. Surveyor #5 found no evidence in the record that staff updated the patient's care plan to reflect the patient's sexual victimization. 22. At the time of the review, Surveyor #5 asked Staff #507 if the hospital had a policy or procedure to address sexual victimization. Staff #507 stated that the hospital did not have a policy on Sexual Victimization Precautions.	L1065		
L1220	322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records. (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records; This Washington Administrative Code is not met as evidenced by: Based on interview and document review the hospital failed to maintain and organize an effective system for the clinical record service. Failure to maintain and organize patients' medical records puts patients at risk of harm from medical errors, which can misdirect caregivers and result in patient harm. Findings included: 1. On 03/10/20 at 1:30 PM, Surveyor #5 requested the hospital's policies for medical	L1220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1220	Continued From page 69 records and requested to meet with the manager (or lead) of the Medical Records department. Surveyor #5 requested to interview the manager of the Medical Records department to discuss identified deficiencies in the hospital's system for patient medical records. Deficiencies identified during the survey included: - Accessibility of a complete medical record related to missing round forms for 7 of 7 patient medical records reviewed - Missing transfer forms for 3 of 3 patient medical records reviewed -Issues with the hospital's electronic patient record that resulted in provider orders receiving inaccurate, pre-populated "end dates" - Inaccurate admission dates printed on patient labels for all charts reviewed and inaccurate or unidentifiable times for orders entered as they are standard time and do not denote AM or PM At the time of the request, the Sr. Quality and Compliance Manager (Staff #509) stated that the hospital did not have a Medical Records Director, but that there was a person at the system level. She also stated that the hospital recognized that they had issues in the medical records department and had a lot of work to do. She stated that the hospital was currently focusing on things with the highest risk. 2. Surveyor #5 asked Staff #509 if the Medical Records Department was collecting any data or had any process improvement plans in place related to timely completion of medical records or any other process improvement data or plans. Staff #509 stated that the medical records	L1220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1220	Continued From page 70 department did not but provided Surveyor #5 with data collected by the Medical Staff Office. Document review of the data collected by the Medical Staff office provided by Staff #509 showed that for 10 of 12 of the previous months, the hospital was not meeting target for compliance with discharge summaries. 3. Staff #509 stated she was not aware of any process improvement plans related to the non-compliance. Cross Reference: Tag 0495	L1220		
L1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that the ordering provider authenticated orders for 2 of 3 patients reviewed (Patient #512 and #516).	L1260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1260	Continued From page 71 Failure to authenticate orders consistent with hospital policy puts patients at risk of harm from improper care and medical error. 1. Document review of the hospital's policy and procedure titled, "Medical Staff Documentation," policy number 7498423, revised on 03/19, showed that orders dictated over the phone shall be authenticated by the independent provider or physician assistant certified (PA-C) within 48 hours of the order. Orders must include the date and signature of the independent provider or PA-C. 2. On 03/06/20 at 9:00 M, Surveyor #5 and the Quality and Compliance Manager (Staff #504) reviewed the discharged medical record for Patient #516. Surveyor #5 reviewed 4 episodes of seclusion, which occurred on 10/23/19 and 10/24/19. Surveyor #5 found no evidence that a Licensed Independent Provider (LIP) authenticated any order for the seclusion. 3. At the time of the record review, Staff #504 confirmed the finding and stated the telephone orders should have been signed within 48 hours. 4. On 03/06/20 at 2:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #512 who was admitted on 04/14/19 at 7:17 PM for the treatment of Unspecified Psychosis, with a first onset of mania and delusions. The review showed that a nurse entered an order for Sexually Inappropriate Behavior Precautions on 04/14/19 at 10:36 PM. The provider did not authenticate the order until 04/20/19 (a period of 6 days).	L1260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1260	Continued From page 72 5. At the time of the review, Staff #502 and #504 confirmed that the authentication was outside the hospital policy's timeframe.	L1260		
L1290	322-200.3K RECORDS-NURSE SERVICES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (k) Nursing services; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to include nursing documentation of patient 15-minute and special precaution checks in the medical record for 7 of 7 patient records reviewed (Patients #501, #502, #508, #512, #513, #514, and #515). Failure to have complete medical records that contain all patient information risks unsafe care due to lack of complete, accurate, and timely information. Findings included: 1. Document review of the hospital's policy titled, "Special Precautions," policy number 7416242, revised 12/19, showed that for patients on Level 1 observation, staff persons are to visually observe the patient every 15 minutes. The staff person assigned to complete the rounds should document the 15- minute checks on the Patient Round Form.	L1290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1290	Continued From page 73 2. Document review of the medical records for Patients #501, #502, #508, #512, #513, #514, and #515 showed that the medical records did not contain evidence of every 15- minute monitoring or evidence of special precaution monitoring as ordered by the patient's provider. 3. On 03/03/20 at 11:19 AM, during review of the medical record for Patient #501, Surveyor #5 asked a Registered Nurse (Staff #505) how to find the documentation of patient monitoring in the patient's medical record. Staff #505 stated that the round form documentation was not part of the patient's medical record because the form contained the rounding documentation for every patient on the unit and it would be a HIPPA (Health Insurance Portability and Accountability Act) violation to place the information in each patient's chart. 4. On 03/06/20 at 1:30 PM, Surveyor #5, the Quality and Compliance Manager (Staff #504), the Sr. Quality and Compliance Manager (Staff #509), and the Chief Administrative Officer (Staff #502) reviewed the medical record for Patient #515 who was admitted on 02/26/19 for the treatment of Psychosis, Homicidal Ideation, Paranoid Schizophrenia, and Polysubstance Abuse. The review showed the following: a. On 02/26/19 at 6:58 AM, clinical staff placed the patient on Sexually Inappropriate Behavior (SIB) Precautions and every 15-minute monitoring. The details of the order showed, "Patient has been making aggressive sexual propositions to staff and peers and has been exposing his erect penis to SW staff." The patient remained on continuous SIB Precautions from admission until his discharge from the hospital to	L1290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1290	Continued From page 74 jail. b. On 04/22/19 at approximately 8:15 PM, Patient #515 sexually assaulted (forcing another person to have sexual intercourse with the offender against his or her will) a female patient (Patient #512). Surveyor #5 found no evidence in the medical record of the patient's SIB Precaution or every 15-minute rounding as ordered by the patient's provider. 5. At the time of the review, Surveyor #5 asked Staff #502 and Staff #504 about documentation showing staff completed patient monitoring. Staff #502 and #504 confirmed that rounding documentation was not included in the medical record because the form utilized by the hospital included every patient on the unit. She also stated that the Nurse Managers kept the rounding forms and after delay, they were able to provide the Surveyor with a copy of the rounding log for the unit.	L1290		
L1295	322-200.3L RECORDS-PROGRESS NOTES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (I) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities;	L1295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1295	Continued From page 75 This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital failed to ensure that staff documented Adjunctive Therapy group and individual notes in the medical record for 2 of 3 patient's reviewed (Patient #501 and #518). Failure to document Adjunctive Therapy notes in the medical record risks patient harm from unrecognized or unmet care needs and inconsistent and unsafe care due to lack of a complete medical record. 1. Document review of the hospital's policy and procedure titled, "Adjunctive Therapies Scope of Services," policy number 6839106, approved 09/19, showed that the objective of Adjunctive Therapies department is to provide patients with individualized care that meets the unique therapeutic needs of each individual patient in a way that respected their basic human dignity. All group and individual notes are kept in the electronic medical record in order to support the treatment team. 2. On 03/03/20 at 11:19 AM, Surveyor #5 and a Registered Nurse (RN) (Staff #505) reviewed the medical record for Patient #501 who was initially admitted to the hospital on 08/05/19 for the treatment of Schizoaffective Disorder Bipolar Type and Obsessive-Compulsive Disorder. The patient had a history of asthma, chronic dermatitis (related to excessive rigorous handwashing from Obsessive Compulsive Disorder), sleep apnea, and hypertension. The patient was discharged to an acute care hospital on 02/15/20 for difficulty breathing and swelling of the tongue and pharynx. The patient was intubated and diagnosed with a	L1295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1295	Continued From page 76 Retropharyngeal abscess, Streptococcal pharyngitis, Sepsis, and Pneumonia. The patient was readmitted to the hospital on 02/20/20. The Master Treatment Plan showed that the patient was to attend Art Therapy, Creative Community, Music Therapy, Expressive Arts, Nutrition, and Process Group. Surveyor #5 reviewed Adjunctive Therapy notes for 02/21/20 through 03/02/20 (a period of 9 days) and found no evidence that staff documented Adjunctive Therapy group or individual notes for Patient #501 including: -Art Therapy on 02/25/20, 02/28/20 -Creative Community on 03/01/20 -Process Group on 03/01/20 -Music Therapy on 02/21/20 Nutrition on 03/02/20 3. At the time of the review, Staff #505 confirmed the lack of documentation of the therapies and stated staff should have documented group attendances or individual therapy if the patient refused to attend group. 4. On 03/04/20 at 9:48 AM, Surveyor #5 and a Registered Nurse (Staff #505) reviewed the medical record for Patient # 518. The Master Treatment Plan showed the patient was to attend Art Therapy, Creative Community, and Music Therapy. Surveyor #5 reviewed Adjunctive Therapy notes for 02/25/20 through 03/03/20 (a period of 7 days) and found no evidence that Staff documented Adjunctive Therapy group or individual notes for Patient #501 including: -Creative Community on 03/01/20	L1295		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1295	Continued From page 77 5. At the time of the review, Surveyor #5 asked Staff #505 about the lack of documentation for patient therapies, Staff #505 confirmed the surveyor's review.	L1295		
L1370	322-210.3B PROCEDURES-MED ORDERS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (b) Assuring orders and prescriptions for medications administered and self-administered include: (i) Date and time; (ii) Type and amount of drug; (iii) Route of administration; (iv) Frequency of administration; and (v) Authentication by professional staff; This Washington Administrative Code is not met as evidenced by: - Based on observation, interview, and review of the hospital's policy and procedure, the hospital failed to ensure staff implemented the hospital's policy for handling hazardous medications during the medication administration process. Failure to implement policies to protect and minimize exposure to hazardous drugs during patient medication administration risks staff and patient harm.	L1370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1370	Continued From page 78 Findings included: 1. Document review of the hospital's policy and procedure titled, "Hazardous Pharmaceutical Management-Handling and Waste," policy number 6101610, revised 02/19, showed that hazardous drugs are only handled using the appropriate personal protective equipment (PPE). All PPE used to handle hazardous pharmaceuticals will be discarded in the designated red biohazard bins found in each Medication Administration room. Valproic Acid (Depakote®), An anticonvulsant medication used to treat certain types of seizures and mania [(episodes of frenzied, abnormally excited mood) in people with bipolar disorder (manic-depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods)] is listed as a Hazardous drug. Document review of the hospital's policy titled, "Medication Administration and Documentation: General Guidelines," policy number 7412027, revised 12/19, showed that preparation for administering medication shall include knowledge of the medication's actions, safe dose ranges, purpose of administration, potential adverse effects, any hazardous medication handling requirements, and any special considerations. 2. On 03/04/20 at 7:55 AM, Surveyor #5 observed as a Licensed Practical Nurse (Staff #506) administered medication to Patient #503. The observation showed that Staff #506 removed Valproic Acid (Depakote®) from a drawer in the automated drug-dispensing machine that was labelled "HAZARDOUS." The observation also showed that the medication administration record	L1370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1370	Continued From page 79 stated, "Hazardous Medication, Personal Protective Equipment (PPE) required." Surveyor #5 observed that Staff #506 removed the medication from the packaging with her bare hands. 3. During an interview with the Surveyor #5 at the time of the observation, Staff #506 confirmed the medication was labelled hazardous and that she should have used personal protective equipment (PPE). Surveyor #5 asked what kind of PPE the hospital required. Staff #506 responded that she should have washed her hands. 4. On 03/04/20 at 2:00 PM, Surveyor #5 interviewed the Quality and Compliance Manager (Staff #504) about the observation. Staff #504 verified that Staff #506 should have worn gloves when handling the hazardous medication.	L1370		
L1490	322-230.2A FOOD SERVICE-24-HR MANAGER WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (a) Incorporating ongoing recommendations of a dietitian; This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital failed to designate an individual responsible for managing and supervising dietary/food services twenty-four hours a day.	L1490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1490	Continued From page 80 Failure to provide oversight of dietary services puts patients at risk of harm from inadequate nutrition and improper diet. Findings included: 1. Document review of the hospital's contract with "Dietitian Consulting Service (DCS), LLC" (agreement date 02/01/12) showed that the client's (Hospital) Chief of Inpatient Child & Family Services shall be the person whom DCS personnel shall deal with in all dietary matters and DCS activities within the facility. It also showed that the hospital shall retain professional and administrative responsibility for all dietary services provided by the hospital to its patients/residents and others. 2. On 03/04/20 at 10:00 AM, Surveyor #4 interviewed the hospital's contracted Registered Dietician (Staff # 403) about the management and supervision of the hospital's dietary services. Staff #403 stated that she visits on Mondays and Thursdays and consults as needed, but was not aware of which hospital staff person had responsibility for the management of the program. She also stated that she thought it might be someone in the purchasing department. 3. On 03/04/20 at 4:15 PM, Surveyor #4 interviewed the hospital's Inpatient Administrator (Staff #404) about the management of dietary services in the hospital. Staff #404 stated that Nurse Managers have responsibility for dietary services, but added that they only deal with food temperatures. She also stated that if the food temperatures are out of appropriate temperature range, then the food is discarded and they order pizza.	L1490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1490	Continued From page 81	L1490		
L1525	322-230.2H FOOD SERVICE-MENU PLANNING WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (h) Ensuring all menus: (i) Are written at least one week in advance; (ii) Indicate the date, day of week, month and year; (iii) Include all foods and snacks served that contribute to nutritional requirements; (iv) Provide a variety of foods; (v) Are approved in writing by the dietitian; (vi) Are posted in a location easily accessible to all patients; and (vii) Are retained for one year; This Washington Administrative Code is not met as evidenced by: Based on observation, document review and interview, the hospital failed to provide menus that listed all foods (breakfast, lunch and dinner) that contributed to patients' complete nutrition. Failure to have complete menus for patients' nutritional needs puts patients at risk of harm from inadequate nutrition. Findings included: 1. Document review of the Dietary Menu titled, "FareStart Community Meals Menu: March 2020", showed daily meals for Lunch and Dinner.	L1525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	03/11/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1525	Continued From page 82 Because the contracted food service vendor only provides Lunch and Dinner, the patient menu does not contain the breakfast or snack options. 2. On 03/04/20 at 5:20 PM, Surveyor #4 observed staff as they began working in 2nd Floor nutrition room. The observation showed the posted menu contained only Lunch and Dinner selections. The Staff corrected the menu omission prior to the survey exit. 3. On 03/04/20 at 10:00 AM, Surveyor #4 interviewed the contracted dietician (Staff #403) about menu planning for the hospital. Staff #403 confirmed that the hospital provides breakfast and snacks, and that she works with the contracted food service provider on menu planning.	L1525		

Received & Approved 10/14/20

Psychiatric Hospital
Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
Phone: 1-360-236-4732

Date: 5/21/2020

Navos Hospital, 2600 SW Holden Street Seattle WA 98126			Angie Naylor
Agency Name and Address			***CNE/QO***
Ongoing – Routine & Complaint	March 3, 2020 to March 10, 2020		Lisa Mahoney
Inspection Type	***Inspection Onsite Dates***		***Inspector***
007470	HPSY.FS.00000019		Mental Health
Inspection Number	***License Number***		***Service Types***

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
L315 WAC 246-322-035	**Treatment Planning:** 1) The Medication Treatment note has been revised to include PRN medications given, active patient symptoms and the reassessment for effectiveness. If an LPN or MHS completes the Medication SBAR note, the supervising RN on that shift will review and co-sign the Medication Treatment note. a. The LPNs and Charge RNs have been educated on 6/1/20 to 2/26/20) on this new process; job descriptions and policies have been reviewed to assure alignment. 2) The MHS SBAR note has been revised to replace assessments with observation. The MHS and Charge RN staff will be educated on this new process and the practice aligns with job descriptions and Navos policies.	• Beginning 7/6/20 weekly chart audits (via Tracer tool) will be conducted on 50% of all patients. • Staff will be provided 1:1 feedback and re-education (as appropriate) for any records found to be out of compliance with assessment/ reassessment. • Once compliance is maintained at >=95% for 3 consecutive months, chart audits will decrease to 20	Cameron Livingston, Nurse Mgr And Jay Sumalbag, Nurse Mgr	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	3) Pharmacy has reviewed the eMAR system and verified that patient assessments and reassessments are able to be documented and that reports can be generated in the system. a. Training on the Pharmacy's medication management system will be completed by Nurse Management and Charge Nurses (RNs). 4) Policies addressing patient assessment and reassessment for treatment of wound care, other medical issues and the effectiveness of PRN medications have been reviewed and update as needed.	chart audits per week via Tracer tool.		
L325 WAC 246-322-035	**Abuse Protection:** a. When significant incidents (assaults, sexual assaults, medical events, and accusations of abuse and neglect) occurs the following actions will be taken: b. Nursing will assess the situation immediately and develop a safety intervention as appropriate. c. Nursing will notify Leader on duty/on call after the situation is controlled. d. Nursing will notify the provider of record or attending during business hours or, if after business hours call the provider on-call. e. Nursing will document the event in the involved patient(s) charts as soon as possible, and before the end of the shift that the event occurred on. f. Nursing will complete an incident report, in Navos' reporting system, by the end of shift that the incident occurred. g. The Hospital Quality Manager will report all reportable Incidents, including sexual assaults, to the DOH within one business day, and will report all Adverse Events to the DOH within 48 hours of confirmation. **Prevention:** a. Potential patients are now screened for risk of sexually inappropriate behavior (SIB) and risk for sexual victimization (SV) with evaluation of risk related to current patient population, vulnerability, acuity and	• 100% of reported incidents will be reviewed for appropriate intervention(s). Once 100% compliance has been sustained for 12 consecutive weeks, audits will be reduced to a weekly review 5. • The Shift-to-shift Huddle Report will be monitored daily during the business week by the Hospital Nurse Managers or their designee for completion and appropriate intervention, as well as reporting; Incidents on the Shift-to-shift Huddle Report will be compared with incidents reported in the incident reporting system weekly at Risk Review, an interdisciplinary hospital team meeting. Any	Angie Naylor, CNE/QO Cameron Livingston, Nrs Mgr Jay Sumalbag, Nrs Mgr Amy Forbes, Quality Mgr	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	capacity to monitor for prevention of resident right violations and promotion of patient safety. Questions regarding ability to maintain safety with admissions are elevated to the hospital leader on call and, if needed, the psychiatric provider on call for consultation. h. Each new patient evaluated at admission by admitting RN for risk of SIB or SV. Admitting nurse escalates to provider/treatment team evaluation of need for increased monitoring i.e. line of sight or arm's length, room assignment i. Staff received education, including the expected steps to follow and the policy "Sexually Inappropriate Behavior Precautions", via verbal education, printed material and teach back by 6/26/2020 regarding the policy, reporting and interventions. Staff was not allowed to work on the units until they received the training. j. The charge nurse, in collaboration with the staff on shift, will complete an end of shift cover report that includes any critical events that occurred on the shift prior. o The cover report will be reviewed with the oncoming shift and signed by the Nurse Manager daily. If any omissions or variance are identified, the Nurse Manager will follow up immediately. On the weekends the on-call Nurse Manager will call and verbally review if there were critical events and follow up accordingly. **Response** k. If a patient(s) reports that they have been assaulted by a patient or a staff member, in addition to the steps that occur when a significant event occurs, the following steps will be taken: l. If a staff person is named in the incident, an investigation will be conducted. The staff member will be removed from the schedule until the investigation is complete. o Nurse Management will immediately interview the involved patient(s) and the implicated staff member(s) separately. o Nurse Management will review all video footage within the timeframe of the alleged event.	variances in data will be resolved immediately Incidents or trends of noncompliance will be addressed with prompt, documented one-on-one nurse education • 1:1 re-education / coaching will be conducted by the Nurse Mgr in the event any incidents are found to be missing from the incident reporting system. • Initial assessment completion and implementation of related appropriate action/precaution for each new admission will be monitored weekly by nurse manager or designee to ensure treatment planning and interventions to reduce risks related to risks related to unsafe behaviors • Weekly review of serious adverse events and related follow up occurs in Safety Action Review (SAR) meeting. Events classified as significant are reviewed to identify trends, preventative measures, and need to elevate for Root Cause		

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	○ Nurse Management will document the investigation in the incident reporting system and notify HR of the outcome of the investigation. ○ The Hospital Quality Manager will lead the completion of a Root Cause Analysis (RCA), as appropriate and as required in accordance with reporting an identified Critical Incident or an Adverse Event policy. **Sexual Victimization:** m. A Sexual Safety Precautions form has been created and added to the Nursing Admission Assessment Packet to identify patients who are to be placed on Sexually Inappropriate Behavior (SIB) precautions and/or Sexual Victimization Precautions (SVP). n. Sexual Safety Precautions of SIB and SVP will be discussed during treatment planning and in the treatment plan, if appropriate. o. Policies addressing precautions have been review and updated to include procedures around SIB and SVP precautions. p. Nurse Management will provide education to RNs on completing the Sexual Safety Precautions form and provide education to all staff on the updated policy and procedures for SIB and SVP precautions by 6/26/2020.	Analysis (RCA) or other recommended action • Based on severity of events, Quality initiates a Root Cause Analysis to assess gaps and develop a plan of correction to mitigate risk for recurrence. RCA lessons learned are reported in SAR (Safety Action Review) & RCA summaries are reported in QIC including potential recommendations for modifications of processes, policies and/or practices • Plans of corrections for compliance and quality variances are monitored at the weekly Hospital Operations meeting for resolution and desired improvement of care and services quality and safety. • "Sexually Inappropriate Behavior Precautions/Sexual Safety Precautions" policy training requirement compliance to be monitored ongoing by Clinical Trainer and completion of NEO monitored by Navos HR with automated tracked through Bamboo (Navos HRIS)		

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
L355 WAC 246-322-035	**Staff Response to Patients Changing Conditions:** 1) To assure Nurses are responding to and consulting with Providers on a patient's change in condition, the Medication SBAR note has been revised to include documentation of Provider notification. a. Nursing will verbally inform the Provider during business hours; if after hours, the Nurse will add the information to the Providers Rounding boards. b. In case of an emergency, the Provider on call will be called by the Charge Nurse. c. If an LPN completes the Medication SBAR note, the supervising RN on that shift will be responsible for reviewing and co-signing the SBAR note. d. The LPNs and Charge RNs staff will be educated by 6/26/2020 on this new process and the practice aligns with job descriptions and Navos policies. Providers will be educated on this process of reviewing the Medication SBAR note by the Medical Director on 5/21/2020. 2) Pharmacy will consult with META regarding the eMAR system to determine if a report of patient refusals can be generated so that it could be used to support the monitoring plan. 3) Nurse Management and Charge Nurses (RNs) will complete a mandatory training on the Pharmacies medication management system by 6/26/2020. 4) The policies "Provision of Nursing Care, Treatment and Services for Navos Hospital" has been reviewed and updated. 5) Patient changes of condition can only be assessed by an RN. LPN's function in their role with RN shift oversight.	• Beginning 7/6/2020 weekly chart audits will be conducted on 100% of all Medication SBAR notes by the Hospital Administrator. Once compliance is sustained for 3 consecutive months at >=95%, the rate of chart audits will decrease to 10 SBAR notes a week. • Staff will be provided feedback, coaching and re-training, as appropriate, if documentation related to change in condition is found to be out of compliance on the SBAR notes.	Angie Naylor, CNE/QO Cameron Livingston, Nrs Mgr Jay Sumalbag, Nrs Mgr	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	6) RN's are present and available for urgent and emergent assessments or reassessments-both routine and life-threatening. Abnormal vital signs, significant changes in function, behavior, or condition will necessitate nursing judgment or an RN assessment for both LPN and MHS report of possible change of condition. 7) The RN will provide these assessments and LPN oversight as needed throughout the shift and document this oversight and assessment by the end of the shift in which the oversight occurred. 8) Routine Assessment and reassessment of long-term resident will be informed and triggered by Nursing Care Plans.			
L390 WAC 246-322-035	**Patient Transfers:** 1) To assure safe handoff of necessary patient information to the next provider of care, a completed Certificate of Transfer form will be sent with the transporting staff any time a patient is transferred to another facility. a. Upon the initiation of a transfer to another facility, the Charge RN or nurse designee will complete and sign the transfer form, a copy will be given to the transporting staff, and the signed form is scanned into the EMR. 2) The Medical Director educated the Providers of the new process on 5/21/2020; Providers will no longer complete/sign the transfer form, instead Nursing will be responsible to complete this documentation going forward. 3) RN education to this new process will be completed on 6/26/2020. 4) Policies "Certification of Transfer" and "Transfer of Medically Compromised Patients" have been review and updated as of 5/18/2020.	• Beginning 7/6/2020 weekly chart audits will be conducted on 100% of all patient charts that transferred to other facilities by the Hospital Administrator. Once compliance is sustained for 3 consecutive months at >=95%, the rate of chart audits will decrease to 50% of transfers weekly. • Nursing will be provided feedback, coaching and re-training, as appropriate, if documentation related to change in condition is found to be out of compliance on the SBAR notes.	Angie Naylor, CNE/QO Cameron Livingston, Nrs Mgr Jay Sumalbag, Nrs Mgr	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
L440 WAC 246-322-040	**Medical Director – Board Approval:** 1) To assure that the appointment of the position of Medical Director is approved by the Board, the following changes to the Medical Staff Bylaws will be amended as follows: a. To Article III –Organized Medical Staff Membership, Section 2 – Qualification for Membership, add: D) *The Governing Board will appoint a psychiatrist as Medical Director for Inpatient Services. The Medical Director will be responsible for directing and supervising medical treatment and patient care twenty-four hours per day.* b. Once a Medical Director candidate has been identified for the position, he or she will be presented to the Medical Executive Committee and then to the Governing Board for appointment as Medical Director prior to starting in the position. c. If a current member of the Medical Staff is appointed as Medical Director, a letter specifying the appointment will be added to the Medical Staff Office file. d. If the appointee will be a new member of the Medical Staff, their initial appointment letter will specifically include their appointment as Medical Director in addition to appointment to the Medical Staff. e. The Credentialing Manual section of the Bylaws will be updated to reflect this procedure.	• Subsequent appointments of a Medical Director will be monitored by the Medical Staff office to assure the appointment is sent to the Board for approval. • The Medical Staff office and the Hospital Quality Mgr will be notified when the process is completed.	Dr. Monica Strope, Medical Director	7/10/2020
L690 WAC 246-322-100	**HAI Surveillance Program to prevent spread of HAI's.** 1) A surveillance program for multi-drug resistant organisms will be implemented based on the results of an Infection Control Risk Assessment, and in conjunction with the Infection Control Committee. 2) The surveillance program will contain the necessary elements to identify MDRO infections in a targeted fashion to include:	**HAI Surveillance:** • Beginning 7/6/2020 a weekly Infection report reviewed by IC Lead. Any identified infections will be handed off to the Hospital Administrator. Documentation in EMR to be verified via chart audit to assure documentation	**HAI:** Dr. Rebecca Richardson, Physician & IC Lead Dr. Monica Strope,	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	a. Provider to staff handoff communication and documentation expectations when an HAI is suspected and identified. b. Protocols to initiate when an HAI is identified. c. Education of RN's and providers regarding treatment for common HAI's. Plan to isolate a patient with a suspected HAI. 3) The Primary Care Lead/Infection Control Lead, the Medical Director and the Hospital Administrator, will develop and provide the Provider and staff education to the above expectations. 4) Data from this surveillance program is reported to the Infection Control Committee. Recommendations made by the Infection Control Committee members as needed to address findings and provide staff education. Data, including infection rates, from the MDRO Surveillance Program will be compiled using evidence-based metrics. The basis for this data collection is based on the IC Risk Assessment in collaboration with published Infection Control guidelines. 5) Education regarding the MDRO program and infection rates is provided quarterly to hospital staff and licensed independent practitioners by the Infection Control Committee. **Staff performs hand hygiene during environmental cleaning of patient rooms.** 6) All housekeeping staff will be re-educated to the proper hand hygiene procedure for donning and doffing gloves, and the use of proper hand hygiene product (following the current Navos "Hand Hygiene" policy and Kelly Maintenance Inc. Environmental Cleaning Services Guidebook) by 6/15/20 by their Supervisor. 7) During this survey, all EVS staff received in-house education on hand hygiene processes, including the use of hand sanitizing between donning and doffing gloves.	expectations met. This will be conducted by the Hospital Administrator or designee, and in coordination with the Infection Control Lead, on 100% of all patients noted in the IC report. • Missing documentation will generate a one on one education with staff or Provider. If specific staff/Provider continues to be non-compliant, it may trigger a Performance Improvement Plan (PIP). • Monitor weekly IC report and review 100% of chart documentation for 3 months. If 100% for 3 months, then move to 1wk/month review. • Audit performance will be reviewed at weekly hospital meetings to address opportunities for improvement. • Trends will be reviewed monthly with senior leaders in the Quality Improvement Committee and with the	Medical Director **Hygiene:** Nathan Butts, Facilities Operations Manager	

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	8) During the survey, alcohol-based hand sanitizer bottles were placed on all housekeeping cleaning carts and have been maintained. 9) Alcohol based wall mounted hand sanitizer inserts were ordered through our Navos vendor in March 2020 and are on back-order. Once the order is fulfilled, Facilities will add the alcohol-based hand sanitizer into all wall mounted dispensers throughout Navos. 10) Facility Operations Manager and Housekeeping Staff Supervisor will provide education to housekeeping staff regarding Hand Hygiene expectations following the KVM Guidebook. In addition, the Supervisor will observe each staff member's knowledge of Hand Hygiene expectation and document that they are competent. All education will be completed by 6/5/20.	Infection Control Committee. • A quarterly report of the Infection Control MDRO Surveillance program is submitted to the Infection Control Committee, Quality Improvement Committee and the Board. **Hand Hygiene:** • Beginning 6/8/20, 10 housekeeping staff will be observed per week to assure room cleaning and hand hygiene are conducted accurately. Once compliance is sustained for 3 consecutive months at >=95% the rate of observation will be decreased to 5 staff per week • If a staff member is observed not following the procedure, they will receive real time feedback and re-education, as appropriate. • Hygiene compliance results will be monitored in the		

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		Quality Improvement Committee and the Infection Control Committee.		
L710 WAC 246-322-100	**Water Management Plan:** 1) The Water Management Plan Policy was updated to include Legionella disease protocols, water borne pathogen prevention system, mapping of the water system, on-going water testing, annual inspection of systems and periodic water system flushing. Additionally, a project plan has been developed as follows: a. Complete updated single line drawings with staff. b. Inventory all strainers, in-line filters and ice machines to verify preventive maintenance schedules. c. Drain and clean 3 "Y strainers". d. Inventory all water faucets and fixtures for validation and correction for any aerators identified. e. Flush water mains and perform water tests per policy on number and locations. f. Analyze test results and any corrective actions needed.	• An annual review of plan requirements will be conducted by the Facilities Operations Manager and staff via the established preventive maintenance (PM) process. • Criteria for review are based on following "Original Equipment Manufacture" (OEM) guideline recommendations and general industry standards/guidelines for similar systems. • The Water Management plan review and monitoring adherence to PM schedule will be conducted annually by the Environment of Care Safety Committee and Infection Control. • Reporting the results of this review will be annually to senior leaders at the Quality Improvement Committee.	Mary Ives, VP of Facilities	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
L1050 WAC 246-322-170	**Initial Treatment Plan:** 1) The Initial Treatment Plan (ITP) has been updated to include the documentation of Short and Long-Term goals and interventions pertaining to patient Precautions; including but not limited to, assault, fall, elopement, sexually inappropriate behavior (SIB) and Sexual Victimization precaution. 2) Nursing Care plans are completed within 24 hours of admission and updated by the RN upon assessment for and identification of changes in condition, including but not limited to medical conditions and other events. a. Nursing staff were educated by nursing management team. 3) RNs will be educated by Nurse Management to the expectations and form changes. 4) Nursing will be re-educated on the procedure of using the Nursing Admission check-list to verify the completion of the ITP in the EMR by 6/29/2020. 5) The Policy addressing the ITP has been reviewed by Nursing Administration and updates completed as necessary.	• Beginning 7/6/2020, this will be monitored by the Hospital Administrator via a weekly chart audit of 100% of all initial treatment plans. Once compliance is sustained at >=95% for 3 consecutive months, then the number of audits a week will be reduced to 10 charts per week. • Any records found to be missing an initial treatment plan or not addressing Precautions will be followed up with a one on one education session and documented discussion conducted by the Nurse Manager.	Angie Naylor, CNE/QO Cameron Livingston, Nrs Mgr Jay Sumalbag, Nrs Mgr	7/10/2020
L1055 WAC 246-322-170	**Exam and Medical History:** 1) In person re-education of LIP's to the policy "History & Physical Exam" and requirement for H&P's to be completed within 24 hrs. of admission, and a new H&P is required if patient is readmitted greater than 30 days since last hospitalization, per staff by-laws, will be provided by the Medical Director at the next medical staff meeting on 5/21/2020. In addition, a supplemental email will be sent to assure that each LIP receives the information.	• Beginning 7/6/2020, weekly chart audits will be conducted by the Primary Care Lead Physician or designee on 50% of all admitting H&P assessments. Once compliance is sustained for 3 consecutive months, audits will be reduced to 5 assessments per week.	Dr. Rebecca Richardson Physician & Infection Control Lead	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		• Any records found to be out of compliance will be followed up with a 1 on 1 education session and documented discussion conducted by the Primary Care Lead Physician. In addition, if a consistent trend of non-compliance is identified, a Focused Practice Evaluation (FPPE) may be implemented. • Report results of this review will be provided monthly to Medical Staff and to senior leaders at the Quality Improvement Committee.		
L1065 WAC 246-322-170	**Comprehensive Treatment plan:** a. Treatment Plans are reviewed at a minimum of every 7 days while a patient is admitted to the hospital. b. The Treatment Plan will be reviewed at the next scheduled treatment review meeting if the patient is involved in a reportable incident, such as and not limited to, a fall, assault, elopement, seclusion and/or restraint event. c. If the event occurs on a weekend or holiday, then the Charge RN will document the nursing assessment and reassessment information into the Nursing Care Plan. Treatment Teams will be notified of a reportable incident via the Nurse Managers. d. The Nursing Care Plan documentation will be scanned into the patient's EMR at the time of discharge.	• Beginning 7/6/2020 weekly chart audits will be conducted by the Hospital Nurse Managers on 50% of all treatment reviews. Once compliance is sustained for 3 consecutive months, audits will be reduced to 20 per week. • Any records found to be missing a treatment review within the designated timeframe and with	Angie Naylor, CNE/QO Cameron Livingston, Nrs Mgr Jay Sumalbag, Nrs Mgr	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	e. Staff involved with treatment planning will receive education to the timeliness of treatment plan completion and the Nursing Care Plan documentation, by Nursing Administration, beginning June 1, 2020; all staff will be educated by June 26, 2020 and Providers will be educated by the Medical Director on 5/21/2020. In addition, a supplemental required sign-off that they have read and understood the requirements will be completed. f. Nursing Care plans are completed within 24 hours of admission and updated by the RN upon assessment for and identification of changes in condition, including but not limited to medical conditions and other events. a. Nursing staff were educated by nursing management team.	documented discussion of significant events will be followed up with a one on one education session and documented discussion conducted by the Unit Manager with involved RN and Charge Nurse.		
L1220 WAC 246-322-200	**Medical Records Management:** 1) Rounding and Transfer forms: To address missing rounding and transfer forms in the EMR: a. A Rounding form has been created for individual patients. The form will be scanned into the identified patient's EMR, daily, by UC staff. b. All staff will receive education to the updated scanning protocols and Rounding policy, by Nursing Administration, beginning June 1, 2020; all staff will be educated by June 26, 2020. In addition, a supplemental required sign-off that they have read and understood the requirements will be completed. c. Orders pre-populated end dates, pre-printed patient label and inaccurate order times: d. Providers will enter discontinuation dates and times, including the designation of AM/PM, on all Orders. e. Hospital Administration staff will immediately notify Navos IT Department of any possible system errors in documentation. f. The Medical Director has educated the Providers on protocols for selecting the correct Order Types and documenting discontinuation dates/times (designation of AM/PM) on 5/7/2020. A follow-up	**Rounding & Transfer Forms:** • Beginning 7/6/2020 weekly chart audits will be conducted by the Nurse Managers on 100% of all patients transfer forms and 100% of Rounding sheets on one designated day per week. Once compliance is sustained for 3 consecutive months, audits will be reduced to 10 charts per week. • Any records found to be out of compliance will be followed up with a one on one education session and documented discussion	Angie Naylor, CNE/QO Dr. Monica Strope, Medical Director Lezlie Deuchrass, Medical Record Manager	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	educational email will be sent to reinforce the information and ensure that all Providers receive the education. g. Discharge summary completion data from the last 6 months will be reviewed with the Medical Executive Committee to evaluate whether the current delinquency threshold for FPPE initiation is appropriate. h. Nurse Management will educate Nursing staff on the importance of communication to the Providers if discontinuation dates/times (designation of AM/PM) on an Order is not complete by 6/26/2020. **Monitoring completed discharge summaries:** 2) Medical Records will conduct record reviews upon admit (95% of all new admits in a month), at discharge (95% of charts of all discharges in a month), as well as concurrently to assess for timely documentation compliance (80% of resident charts for a month). a. Results of the "audits" will be provided to the Hospital Administrator and Nursing Managers, the Quality Manager, and other disciplines (as pertinent to the documents reviewed) for review, collaboration, and assessment of change in intervention/process, as appropriate. b. Leaders will follow-up with those they supervise to provide feed-back and coaching, as appropriate.	conducted by the Nurse Manager. • Results will be reported at weekly Hospital Risk review meetings and to senior leaders at the Quality Improvement Committee. **Order Pre-populated, Pre-printed:** • 100% of completed discharge summaries will be monitored on a daily basis by the Medical staff services department. Once compliance is sustained for 3 consecutive months, audits will be reduced to 5 per week. • Monthly compliance reports are provided to the Medical Director. If non-compliance is noted, the Medical Director provides 1 on 1 education to the LIP involved. If a consistent trend of non-compliance is identified, a Focused Professional Practice Evaluation will be implemented.		

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		Monitoring Discharge Summaries: • Results of the audits will be presented and monitored at QIC on a quarterly basis. The presentation at QIC will be led by the Hospital Quality Manager, the Hospital Administrator (or designee), and other discipline leaders, as appropriate for the type of document compliance being discussed. • Reviews will be consistently performed at the sample size indicated the "Deficiency Corrected" column to the left. • Staff will be provided coaching, feedback and re-education as appropriate for areas of non-compliance.		
L1260 WAC 246-322-200	**Records - Signed Orders.** 1) In person re-education of LIP's to the requirement for signing order per Medical Staff By-laws, will be provided by the Medical Director at the next medical staff meeting 5/21/2020. In addition, a supplemental email will be sent to reinforce the message.	• Medical Director to review each Provider orders for signature daily, for 1 month. Performance trends and barriers will be identified and addressed. If	Dr. Monica Strope, Medical Director	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		compliance is maintained at 95% or higher for 1 month, then move to 1 weekly audit per month. • Any records found to be out of compliance will be followed up with a one on one education session and documented discussion conducted by the Medical Director or Primary Care Lead. • In addition, if a consistent trend of non-compliance is identified, a Focused Professional Practice Evaluation (FPPE) will be implemented.		
L1290 WAC 246-322-200	**Records – Nurse Services, documentation of 15 minute checks.** 1) Nurse Management has created a Rounding form to be used on each individual patient and scanned into their EMR daily. a. Rounding forms will include documentation on identified Special Precautions for each patient, including and not limited to Sexual Inappropriate Behaviors (SIB) and Sexual Victimization Precautions (SVP). b. In person re-education of staff requiring documentation of patients 15 minute and special precaution checks, will be provided by the Nursing Administration starting June 1, 2020 and ending June 26, 2020. c. Staff will be required sign-off that they have read and understood the updated rounding procedures/form and Special Precautions policy.	• Beginning 7/6/2020, this will be monitored by the Nurse Managers via a weekly chart audit, conducted on 50% of all Rounding forms. Once compliance is sustained for 3 consecutive months, audits will be reduced to 10 per week. • Any records found to be out of compliance will be followed up with a one on one education session and	Angie Naylor, CNE/QO	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		documented discussion conducted by the Nurse Manager. • Reporting the results of this review will be at weekly Hospital Risk review meetings and to senior leaders at the Quality Improvement Committee.		
L1295 WAC 246-322-200	**Records – Progress Notes:** 1) The Adjunctive Therapies Department has created and implemented a group grid, identifying core group categories and the subsequent groups within any one category. This will allow Adjunctive Therapy staff to document to group requirements and any staff member or patient to understand what group requirements is being met, when reviewing a patient's treatment plan or group progress notes. a. In person re-education of Adjunctive Therapy staff regarding appropriate documentation of patients' group categories and titles in treatment plans and group progress notes, will be provided by the Director of Adjunctive Therapy at the next all staff meeting on 6/1/2020. b. Patients will be assigned two Cluster Groups based on goals defined by the Treatment Team, and will be expected to attend three different groups a week within those Cluster groups. If a patient declines to attend a group activity, then alternative treatment will be offered by Adjunctive Therapy staff or designee and documented in the patient's EMR. c. The Adjunctive Therapy Department has developed a tracking tool to document what sub-group each patient attended within their assigned Cluster groups. This will allow the Adjunctive Therapy Department to quickly reference which patients need further	• Beginning 7/6/2020, this will be monitored by the Director of Adjunctive Therapy via a weekly audit, on 50% of all patient charts. Once compliance is sustained for 3 consecutive months, audits will be reduced to 5 per week. • Any records found to be out of compliance will be followed up with a one on one education session and documented discussion conducted by the Director of Adjunctive Therapy.	Cindy Spanton, Director of Hospital Extension Services & Adjunctive Therapy	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
	assigned group treatment or alternative therapy, and which have completed their treatment team defined goals in weekly Treatment Review meetings. d. Adjunctive Therapy has reviewed and updated policies to address this updated procedure.			
L1370 WAC 246-322-210	**Procedures – Med Orders:** 1) To ensure that staff follows Navos hazardous medication handling policy a required re-education of all Nursing staff by June 26, 2020, will be completed by the Hospital Administrator and Pharmacy Director. New staff will receive this education in Orientation. In addition, a supplemental required sign-off that they have read and understood the "Hazardous Pharmaceutical Management Handling and Waste" policy will be completed. 2) Pharmacy will require annual training via Navos' electronic training system for all nursing staff.	• This will be monitored by the Nurse Managers and/or Pharmacy via a weekly observation audit on 50% of all medication passes. Once compliance is sustained for 3 consecutive months, audits will be reduced to 5 per week. • Any staff conducting a hazardous medication pass found to be not utilizing appropriate PPE will be followed up with an immediate one on one education session and documented discussion conducted by the Unit Manager. • Reporting the results of this review will be at weekly Hospital Risk review meetings and to senior leaders at the Quality Improvement Committee.	Angie Naylor, CNE/QO	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
L1490 WAC 246-322-230	**Food Service 24 hr. manager:** 1) The Hospital Administrator will be responsible for managing patient nutritional services at the hospital; including contracted staff and food services. 2) A designated Nurse Manger will act as an alternate in the absence of the Administrator. 3) The Hospital Administrator and designated Nurse Manager will complete and maintain Certification in ServSafe® or program equivalent.	• This will be monitored by the Hospital Administrator via a quarterly audit of nutritional services completed by the Consulting Dietician. • Any fall-outs in nutritional services will trigger a Plan of Correction (POC) to be followed-up with and discussed in the Quality Improvement Committee meeting.	Angie Naylor, CNE/QO	7/10/2020
L1525 WAC 246-322-230	**Food Service Menu Planning:** 1) Hospital contracted food services program, FareStart, will supply a monthly lunch and dinner meal menu prior to the last business day of the month, for the following month, to the Nurse Managers who will post the menus in the kitchen window where they are visible to patients. 2) The Nurse Managers will post a monthly meal menu, including breakfast and snack options in the kitchen window where they are visible to patients.	• Beginning 7/6/2020, this will be monitored by the Hospital Nurse Managers via a weekly observation audit of 100% of patient menu services. Once compliance is sustained for 3 consecutive months, audits will be reduced to 5 per week. • Any fall-outs in patient menu services will be followed up with a one on one education session and documented discussion conducted by the Unit Manager with involved staff and Charge Nurse.	Angie Naylor, CNE/QO	7/10/2020

Tag Number & WAC	How the Deficiency Will Be Corrected	Monitors Put in Place to Assure Continuing Compliance	Responsible Individual(s)	Estimated Date of Correction
		• The Director of Nurses or their designee will compete a review of food quality and food service provider contractual compliance by end of 3rd quarter, 2020, and report findings and plan to QIC for monitoring of compliance or progress toward goals		

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

December 16, 2020

Angie Naylor, MSH, RN
Chief Nursing Executive and Quality Officer
Navos
PO Box 69080
Seattle, WA 98168

Dear Ms. Naylor:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau completed a state licensing survey at Navos on March 11, 2020. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on October 14, 2020.

Hospital staff members sent a Progress Report dated December 2, 2020, that indicates all deficiencies have been corrected. The Department of Health accepts Navos' attestation to be in compliance with Chapter 246-320 WAC.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Lisa Mahoney

Lisa Mahoney, MPH
Survey Team Leader