STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	07/27/2018

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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 Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 07/23/18 to 07/27/18 Examination number: 2018-451 The survey was conducted by: Surveyor #3 Surveyor #6 Surveyors investigated complaint #2018-5145 and #2018-9713 during the survey. The Washington Fire Protection Bureau conducted the fire life safety inspection.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by August 27, 2018. 4. Return the ORIGINAL REPORT with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by:	L 315		

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L 315	Continued From page 1 Based on observation, interviews, record reviews and review of hospital policies and procedures, the hospital failed to implement a system that provided a safe environment for those identified as high risk for suicide. Failure to ensure a safe environment places patients at risk for serious injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Suicide Precautions," policy number 1000.24, last revised 05/18, showed that staff would observe patients on suicide precautions with an increased level of vigilance. Room searches are conducted daily or more often as indicated to remove harmful or contraband items. 2. On 07/24/18 at 10:30 AM, Surveyor #3 interviewed a registered nurse (Staff #304) working on the child and adolescent unit about levels of observational monitoring. Staff #304 stated the unit had three patients (Patient #307, #308, #312) at the beginning of shift on every 5-minute monitoring but currently only Patient #307 and #308 were on every 5-minute checks . Both patients had recently demonstrated suicide gestures that involved wrapping materials around their neck. 3. On 07/24/18 at 11:00 AM, Surveyor #3 inspected Patient #307's room (Room #406). The surveyor observed a towel and scrub bottom pant lying on a desk near Patient #307's bed. The surveyor also observed a pillowcase and blanket lying on top of the other unoccupied bed in the room.	L 315		

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L 315	Continued From page 2 4. On 07/24/18 at 11:10 AM, Surveyor #3 interviewed the registered nurse (Staff #304) about the surveyor's observations of the towel and other items being available in the room. Staff #304 stated she was unaware of this and the items should not be in the room. 5. On 07/24/18 at 11:30 AM, Surveyor #3 reviewed the medical record of Patient #307 who was admitted on 07/17/18 from the partial hospitalization program for suicidal thoughts with a plan and psychosis. The review showed the following: - An admission psychiatric evaluation indicated that Patient #307 was having auditory hallucinations with an imaginary friend telling her to hurt herself. The provider's impression was that she is at high risk for suicidal behavior. - On 07/23/18 at 8:20 PM, a progress note showed a registered nurse entered Patient #307's room to check in on her condition because of other patients concerns for her increasing anxiety. The nurse observed Patient #307 talking to her roommate and then proceeded to tie a blanket with a knot around her neck loosely. The nurse was able to talk with the patient and remove the blanket from her possession. Patient #307 stated, "You're ruining my plan". Patient #307 was placed in a suicide gown with suicide linens. The patient received additional medications and was placed on every 5-minute observational monitoring. 6. On 07/24/18 at 1:15 PM, Surveyor #3 reviewed the medical record of Patient #312 who was admitted on 07/17/18 from the partial hospitalization program for increasing thoughts of	L 315		

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L 315	Continued From page 3 suicide ideation. The review showed the following: - The patient had previously been admitted on 07/01/18 for suicide attempt by drug overdose and was discharged on 07/13/18. The patient began the partial hospitalization program on 07/16/18. -Admission orders on 07/17/18 at 12:45 PM showed the patient was ordered for every 15-minute observational monitoring and suicide precautions. - On 07/18/18 at 2:23 PM, a daily nursing progress note showed Patient #312 gave a previously hidden shoelace to a program specialist (mental health technician) but denied any intent or plan to use it. The patient contracted for safety at the time of discovery. - Physician orders dated 07/19/18 at 10:18 AM showed unit restrictions and suicide precautions discontinued. - On 07/22/18 at 6:25 PM, a daily nursing progress note showed the patient was found making a noose out of shoe strings in his bathroom at the beginning of the shift. The patient was placed on room lockout and ordered for every 5-minute observational monitoring. Additionally, the patient was placed back on suicide precautions. -A daily progress note dated 07/23/18 at 12:22 AM (late entry) showed that on 07/22/18 at 3:45 PM, the patient was discovered in his room with a shoelace tied into a loop at one end and tied to a grate in the ceiling of his bathroom. The patient was standing on a chair and had told other	L 315		

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L 315	Continued From page 4 patients that he was going into his bathroom to "do something". The patient was placed on increased observations and locked out of room for the remainder of the shift. A skin and patient belongings search were performed with no additional contraband found. 7. On 07/24/18 at 1:15 PM, Surveyor #3 reviewed the medical record of Patient #308 who was admitted on 07/01/18 after attempting to jump off a bridge. The review showed the following: -The admission High Risk Notification Alert was marked for suicidal and self-harm indicators. - On 07/23/18, the patient's condition had improved and was taken off suicide precautions and was on 15-minute observational monitoring checks. - A progress note on 07/23/18 at 4:30 PM showed Patient #308 approach staff to discuss his anxiety. Patient was escorted to an area of reduced stimuli to discuss his feelings. After completing the discussion, the patient returned to his room. Shortly, afterwards, a registered nurse went back to check on the patient. The patient was found in the bathroom with a piece of torn towel and stated, "I can't do this anymore". Attempts to verbally de-escalate the situation were unsuccessful. The patient was observed holding the towel in his hands around his neck pulling it tightly without knotting it. The nurse responded by placing their hand between the towel and his neck to ensure an open airway before it could be removed. While holding the towel, the patient displayed facial discoloration. The patient was placed back on suicide precautions, unit restriction, and placed on every	L 315		

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L 315	Continued From page 5 5-minute observational monitoring. Enhanced vital signs, neuro checks, and pulse oximetry checks were ordered. A medical consultation to evaluate the patient was also ordered. - A case management progress note on 07/24/18 at 10:38 AM showed the case manager (CM) met with the patient one-on-one to check in on his suicide attempt from the previous night. The patient told the CM, he hallucinated about rats. He did not remember what happen but his roommate had told him he was on top of his desk stating "Kevin wins". The progress note showed the patient went into the bathroom and tied a towel around his neck. The nurse wrestled with the patient and the towel and was able to de-escalated the situation. The CM noted the patient had bruising on his neck and face. 8. On 07/24/18 at 1:50 PM, Surveyor #3 interviewed a program specialist (mental health technician) (Staff #305) about a behavioral "code" called on the unit earlier involving Patient #308. Staff #305 stated she had tried to get Patient #308 to turn in some pencils that he had used during the case management group. After refusing to return them, Patient #308 then attempted to barricade the door and Staff #305 had to get the assistance of other staff to open the door. After a brief period of de-escalating the situation, Patient #308 became agitated. The patient then grabbed a towel, tore it, and went into the bathroom wrapping it around his neck before staff could intervene. When asked how the patient could access a towel so easily, she stated it was difficult to control those items when other patients are sleeping in the same room. - At the time of the incident, the Child and Adolescent South Unit electronic intake census	L 315		

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L 315	Continued From page 6 board showed (under the notes section) that Patient #308 could have two pillows per physician order but no towels were allowed in the room. 9. On 07/25/18 at 2:25 PM, Surveyor #3 interviewed a registered nurse (Staff #304) about staffing and the suicide attempt of Patient #308. Staff #304 stated staffing could be better. The unit should have as much staff as possible. The nurse stated the child and adolescent unit deals with some very depressed and psychotic kids. Generally, she feels the unit is staffed safety but yesterday was unsafe. 10. On 07/25/18 at 3:45 PM, Surveyor #3 reviewed the medical record of Patient #308 surrounding the strangulation attempt on 07/25/18. The review showed the following: -A psychiatrist progress note dated 07/24/18 at 3:00 PM showed Patient #308 attempted to strangle self with towel. A code was called and the registered nurse had to cut off the towel. The patient was on every 5-minute monitoring at the time of the suicide attempt. The patient's monitoring status was changed to one-to-one direct monitoring after the event. -A seclusion/restraint note dated 07/24/18 showed that the patient went into the bathroom and staff followed. Hospital staff saw that Patient #308 had torn his flannel shirt and had placed part of the towel around his neck. Staff cut the towel off the patient, took the flannel pieces of the shirt away from the patient. The patient was placed in a physical hold restraint from 1:50 PM to 2:03 PM to prevent him from continuing to grab towel pieces to hurt himself.	L 315		

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L 780	Continued From page 7	L 780		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to provide a clean environment for patients, staff, and visitors. Failure to ensure a clean environment puts patients, staff, and visitors at risk of increased exposure to allergens and harmful microorganisms. Findings included: 1. On 07/23/18 at 1:30 PM, Surveyor #6 toured the South Unit with the Risk Management Coordinator (Staff #602). The observation showed un-cleanable surfaces; excessive amounts of dirt, dust, and debris; and signs of mold in the following areas: a. Patient room #401 - black mold on the shower curtain, mildew stains on the ceiling above the shower; b. Storeroom adjacent to the Day Room - dirt, debris, and dust accumulation on the floor; c. Linen closet - dust accumulations hanging from ceiling vent; d. Patient room #408 - black mold on the shower curtain, and in the shower;	L 780		

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L 780	Continued From page 8 e. Patient room #406 - black mold in the shower. 2. On 07/23/18 at 2:15 PM, Surveyor #6 toured the Central Unit with the Risk Management Coordinator (Staff #602). The observation showed black mold in the following areas: a. Patient room #103 - black mold in the shower; b. Patient room #102 - black mold on the shower curtain. 3. On 07/23/18 at 3:30 PM, Surveyor #6 toured the North Unit with the Risk Management Coordinator (Staff #602). The observation showed un-cleanable surfaces, excessive amounts of dirt, dust, and debris; and/or mold and mildew stains in the following areas: a. Un-numbered storage room for North Unit and Central Unit patients personal possessions - dust accumulation on the ceiling vent; b. Patient room #117 - peeling paint on bathroom cabinet; c. Shower room - black mold in the shower, dust accumulation on the ceiling vent. 4. On 07/24/18 at 8:20 AM, Surveyor #6 toured Unit W-1 with the Risk Management Coordinator (Staff #602). The observation showed un-cleanable surfaces and excessive amounts of dirt and debris in the following areas: a. Patient room #901 - peeling paint near the window; b. Storage closet - accumulation of dirt and debris on the floor.	L 780		

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L 780	Continued From page 9 5. On 07/26/18 at 9:00 AM, Surveyor #6 toured the Partial Hospitalization Unit with the Risk Management Coordinator (Staff #602). The observation showed an accumulation of dirt and dried food debris on the floor of a closet of the adult services side of the unit. 6. On 07/25/18 at 8:30 AM, Surveyor #6 toured the East Unit with the Risk Management Coordinator (Staff #602). The observation showed that the vinyl baseboard molding along the floor beside the toilet in Bathroom #4 had separated from the wall creating un-cleanable conditions. 7. On 07/24/18 at 10:00 AM, Surveyor #6 interviewed a housekeeper (Staff #603) about cleaning and replacing shower curtains in the patient care areas. Staff #603 stated that staff washed shower curtains as needed. 8. On 07/24/18 at 11:10 AM, Surveyor #6 interviewed the Facilities Director (Staff #604) about cleaning and replacing shower curtains. Staff #604 stated that staff clean or replace shower curtains as needed, and that the facilities staff is developing a cleaning schedule for shower curtains; and identifying conditions that require "as needed" cleaning or replacing.	L 780		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least	L 880		

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L 880	Continued From page 10 thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the facility failed to provide patients with an easily cleanable mattress. Failure to provide easily cleanable mattresses places patients at risk of exposure to harmful organisms. Findings included: 1. On 07/23/18 from 2:30 PM to 2:50 PM, Surveyor #6 observed the daily cleaning of patient room #102 on the Central Unit. The observation showed that one of the three beds had a mattress with cracks and tears in the vinyl covering. The tears exposed vinyl webbing and the foam of the mattress making it absorbent and not cleanable. 2. On 07/24/18 at 9:20 AM, Surveyor #6 inspected patient room #909 on the W-2 Unit. The observation showed that one of the two beds had a mattress with cracks and tears in the vinyl covering. The tears exposed vinyl webbing and the foam of the mattress making it absorbent and not cleanable. 3. On 08/24/18 at 11:10 AM, Surveyor #6 interviewed the Risk Management Coordinator (Staff #602) about the worn and damaged mattresses. Staff #602 stated that environmental services (EVS) has a new vendor for mattresses and that worn and damaged mattresses are	L 880		

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L 880	Continued From page 11 replaced as needed.	L 880		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policy and procedures, the hospital failed to ensure that staff developed, initiated, and updated care plans for 4 of 10 records reviewed (Patient #307, #309, #310, #311). Failure to develop care plans to address patient care problems risks patient safety and delays in treatment. Findings included:	L1065		

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L1065	Continued From page 12 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number 1000.81, last revised 05/18, showed that the individual patient's treatment team does treatment planning. A medical treatment plan will be initiated for any acute or chronic medical issue identified during the initial nursing assessment. The treatment plan may be revised at any time by the team when new information is obtained justifying a change. Document review of the risk/safety assessment section of the initial registered assessment form showed that "If any Fall Risk factors are present, complete Falls Risk Assessment & Treatment Plan for specific interventions." 2. On 07/24/18 at 08:20 AM, Surveyor #3 reviewed the medical record of Patient #309 who was admitted on 07/21/18 for bipolar disorder. The review showed the following: -The admission risk high notification alert showed the patient had an assaultive history and was a falls risk. -The Risk/Safety Assessment for falls risk screening showed Patient #309 was confused, disoriented, and sedated. -The Abnormal Involuntary Movement Scale (AIMS) assessment was not completed upon admission due to the patient being sedated. -On 07/22/18 at 10:45 PM, a progress note showed that Patient #309 had a witnessed ground level fall after walking by the medication room.	L1065		

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L1065	Continued From page 13 -The surveyor found no evidence that a falls risk problem was added to the treatment plan until after Patient #309 fell on 07/22/18. 3. On 07/24/18 at 09:05 AM, Surveyor #3 reviewed the medical record of Patient #310 who was admitted on 07/19/18 for schizophenia. The review showed the following: -The Risk/Safety Assessment for falls risk screening showed Patient #310 was marked for unsteady walking, balance problems, confusion, and urinary incontinence. -The Admission Data and Screening form for Skin and Body Check showed multiple bruises and abrasions on arms, back, shoulder, buttocks, elbow, and right foot. - On 07/21/18 at 06:10 AM, a progress note showed that Patient #310 at 06:05 AM was observed to be in bed with a blood spot on the floor. A program specialist observed that Patient #310 had a cut on the chin and more blood stains in the bed. The patient told the staff that she had fallen. Patient #310 was transported to an outside facility's emergency department (ED). -On 07/21/18 at 1:30 PM, a progress note showed that Patient #310 returned from the ED with no head or internal injuries but required sutures for the chin laceration. -Surveyor #3 found no evidence that the problem for falls risk had been added to the treatment plan at the time of the review. 4. On 07/24/18 at 11:30 AM, Surveyor #3 reviewed the medical record of Patient #307 who	L1065		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1065	Continued From page 14 was admitted on 07/17/18 for major depressive disorder and suicide ideation. The review showed the following: -The Admission Data and Screening form for nutritional screen showed the box marked for eating binges with periods of not eating. Staff documentation showed that the patient's body mass index was 17.8, which was below normal. -The Psychiatric Evaluation showed the patient stating they were intimidated by food, a desire to weigh 100 pounds and is afraid of being overweight. The admitting diagnosis included rule out anorexia nervosa. -Surveyor #3 found no evidence that the problem for an eating disorder had been added to the treatment plan at the time of the review. 5. On 07/25/18 at 11:10 AM, Surveyor #3 reviewed the medical record of Patient #311 who was admitted on 07/20/18 for schizoaffective disorder and suicide ideation with a plan to kill themselves. The review showed the following: -The Psychiatric Evaluation showed the patient presented to the ED stating he had attempted to overdose on heroin. He admitted to using 0.5 grams of heroin every couple of days and drank 10 bottles of alcohol daily. -Surveyor #3 found no evidence that a problem for substance abuse had been added to the treatment plan at the time of the review.	L1065		

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L1150	Continued From page 15	L1150		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider wrote an order for seclusion or restraint for 2 of 4 seclusion records reviewed (Patient #305, #306). Failure to ensure that a provider write an appropriate order for seclusion risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy and procedure titled, "Seclusion / Restraint / Physical Hold," policy number 1000.53, last revised 05/18, showed that the physician or registered nurse assesses the need for restrictive intervention. A written or telephone order is obtained from the physician for the seclusion or restraint episode. For adults, 18 years and older, the seclusion/restraint episode may be written up to four hours. For youth, ages 9 to 17, the seclusion/restraint episode may be written up to	L1150		

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L1150	Continued From page 16 two hours. 2. On 07/26/18 at 11:50 AM, Surveyor #3 reviewed the medical records of four patients who were placed in seclusion during their hospitalization. The review showed: a. Patient #305 was a 25 year old who was placed in seclusion after striking a hospital staff member. No physician order for seclusion was found in the medical record. b. Patient #306 was a 15 year old who was placed in seclusion after kicking a hospital staff member. A physician order for seclusion was written for a four-hour period instead of the maximum 2-hour time interval allowed in the hospital policy. 3. An interview at the time of the review with the Hospital Risk Manager (Staff #303) confirmed the finding.	L1150		
L1365	322-210.3A PROCEDURES-MED AUTH 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: (a) Assuring professional staff who prescribe are authorized to prescribe under chapter 69.41 RCW; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review	L1365		

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L1365	Continued From page 17 of hospital policies and procedures, the hospital failed to follow its policy for controlled substances management and accountability. Failure to maintain accountability for controlled substances risks potential diversion activity and patient safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Controlled Substances," policy number 1000.48, last revised 05/18, showed that two nurses (one from the off-going shift and one from the on-coming shift) must conduct an inventory of all patient owned medication controlled substances at each change of shift. Two signatures must be on each change of shift controlled substance record. 2. On 07/23/18 at 11:25 AM, Surveyor #3 inspected the North Unit medication room. At the time of the inspection, the surveyor reviewed the manual controlled drug record book. The review showed: a. Patient #301's controlled substance record for testosterone (steroid) 12.5mg/ 25 gram gel pump was missing inventory counts being completed for 07/10/18 day shift and 07/15/18 evening shift. Shift inventory counts were incomplete (missing one of two required signatures) for 07/22/18 evening shift. b. Patient #302's controlled substance record for alprazolam (a medication used for anxiety) 1 mg tablets was missing inventory counts for 07/15/18 for both day and evening shifts. At the time of the inspection, Surveyor #3 asked	L1365		

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L1365	Continued From page 18 the Assistant Chief Nursing Officer (Staff #301) about the manual controlled drug record sheet. Staff #301 confirmed that at shift change both the off-going and on-coming nursing staff perform an inventory count. 3. On 07/24/18 at 10:46 AM, Surveyor #3 inspected the South Unit medication room. At the time of the inspection, the surveyor reviewed the manual controlled drug record book. The review showed: a. Patient #303's controlled substance record for lorazepam (a medication used for anxiety) 0.5 mg tablets was missing inventory counts for 07/05/18 night shift, 07/11/18 evening shift, and 07/22/18 evening shift. Shift inventory counts were incomplete (missing one of two required signatures) for 07/06/18 night shift, 07/12/18 evening shift, and 07/22/18 day shift. 4. On 07/25/18 at 8:00 AM, Surveyor #3 interviewed the Director of Pharmacy (Staff #302) about controlled substance accountability. Staff #302 stated that all controlled substances issued by the hospital are located in the Pyxis machine with a perpetual inventory count. Patient's own medications that are controlled substances are recorded on the manual controlled drug sheet and should be inventoried at every shift change. 5. On 07/25/18 at 12:50 PM, Surveyor #3 inspected the Central Unit medication room. At the time of the inspection, the surveyor reviewed the manual controlled drug record book. The reviewed showed: a. Patient #304's controlled substance record for suboxone (a medication used to treat patients who are dependent on opioids) was missing	L1365		

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L1365	Continued From page 19 inventory counts for: - 07/10/18 both evening and night shifts, - 07/08/18 day, evening and night shift, - 07/09/18 night shift, - 07/101/8 night shift, - 07/12/18 evening shift - 07/15/18 night shift, - 07/16/18 night shift, - 07/18/18 evening shift, - 07/20/18 night shift Shift inventory counts were incomplete (missing one of two required signatures) for 07/15/18 evening shift and 07/24/18 evening shift.	L1365		
L1470	322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services. The licensee shall: (1) Provide access to laboratory services to meet emergency and routine needs of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation and review of manufacturer information, the hospital failed to ensure laboratory testing supplies did not exceed their designated expiration date. Failure to ensure testing supplies do not exceed their expiration date places patients at risk for inadequate medical treatment due to unreliable test results. Findings included: 1. The manufacturer test instructions for One	L1470		

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L1470	Continued From page 20 Step HCG Urine Pregnancy Tests include the precaution, "do not use test kit beyond expiration date." 2. On 07/26/18 at 9:20 AM, Surveyor #6 inspected the Hemingway Exam Room in the Partial Hospitalization building with the Risk Management Coordinator (Staff #602). The surveyor observed a box of One Step HCG Pregnancy Test (approximately 25 single use test strips) with an expiration date of 06/18. 3. Staff #602 confirmed the expiration date and discarded the box of test strips at the time of the observation.	L1470		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: . Based on observation and document review, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to follow food safety standards places patients and staff at risk of food borne illness. Findings included: 1. Document review of the hospital's policy titled, "Dietary Services," Policy #DS-001, revised 08/17, showed that hospital staff is to prepare and store food under sanitary conditions:	L1485		

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L1485	Continued From page 21 - Cold foods served at 41 degrees Fahrenheit. - Food storage areas, including equipment, maintained clean at all times. 2. On 07/23/18 between 11:00 AM and 12:20 PM, during a tour of the Dietary Department with the Dietary Manager (Staff #601) and the Risk Management Coordinator (Staff #602), Surveyor #6 used a thin-stemmed thermometer to assess the temperature of several potentially hazardous foods (PHF) at the service line salad bar. The observation showed: a. potato salad: 48.4 degrees Fahrenheit; b. pasta salad: 45.6 degrees Fahrenheit; c. cantaloupe melon pieces: 56.4 degrees Fahrenheit; d. honeydew melon pieces: 55.5 degrees Fahrenheit. All PHFs listed above had an internal temperature above the maximum allowable cold-holding temperature of 41 degrees Fahrenheit. 3. The Dietary Manager (Staff #601) confirmed the temperatures and discarded the items at the time of the observation. Reference: Washington State Retail Food Code WAC 246-215-03525(1)(b) 4. Document review of the hospital's policy titled, "Care of Refrigerators," Policy #1600.20, revised 06/18, showed that hospital staff should clean unit refrigerators:	L1485		

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L1485	Continued From page 22 - Nursing staff are to defrost and clean unit refrigerators weekly. - Facility operations staff are to clean refrigerators upon relocation, or as needed. 5. On 07/23/18 at 3:30 PM, Surveyor #6 observed liquid food waste and dried food debris in the refrigerator and freezer compartment of the refrigerator in the Day Room on the North Unit. 6. The Risk Management Coordinator confirmed the findings at the time of the observation. Reference: Washington State Retail Food Code WAC 246-215-04600	L1485		

Plan of Correction received 08/22/2018

Plan of Correction approved 08/29/18

Paula Westenskow, MN, MHA 8/29/18

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L 315	**322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures**	The following policies were reviewed by Clinical Leadership: PC 1000.26 Suicide Risk Assessment, PC 1000.24 Suicide Precautions, PC 1000.7 Search for Contraband, and PC.1000.5 Patient Observation Policy, and PC. 1000.21 Level of Observation Orders. All nursing staff (Program Specialists and Nurses) will be re-trained to the policies PC 1000.24 Suicide Precautions, PC.1000.5 Patient Observation, and PC. 1000.21 Level of Observation Orders (Q15, Q5, and 1:1) in-person via staff meetings and one-on-one trainings by members of Nursing Leadership by 9/15/18. All nursing staff will sign an attestation verifying their understanding and commitment to following each aforementioned policy and procedure. Additionally, effective 8/31/18, Charge Nurses will assess all patients on higher levels of observation at least twice per shift to ensure that levels of observation are carried out according to policy and will document that this review was completed. A new policy and procedure for linens	Interim Chief Medical Officer; ADON	9/15/18	At a minimum weekly, Nursing Leadership will audit to verify that Charge Nurses are assessing all patients on higher levels of observation at least twice per shift for the purpose of ensuring that levels of observation are carried out according to policy and documenting this assessment. Weekly Senior Leadership rounds also verify the correct level of observation on rounds sheets, that rounds are current, and that	< 90%

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		management will be approved by Quality Council, Medical Executive Committee, and the Governing Board by 9/10/18. Nursing Leadership will train all floor staff on the policy and procedure via staff meetings and one to one meetings by 9/15/18. The Director of Plant Operations will train housekeeping staff on the policy and procedure via staff meetings and one to one meetings by 9/15/18. The policy will specify the linen allocation amount for patients, and staff will ensure linens are not distributed in excess of these amounts. Patients assessed to be at high-risk for suicide and their roommates will have more restrictive access to linens. All floor staff and housekeeping staff will sign an attestation verifying their understanding and commitment to following the policy and procedure. Nursing staff will be re-trained to the policy PC 1000.7 Search for Contraband via staff meetings and one to one meetings effective 9/15/18. Included will be training specific to the hiding of shoelaces. Staff will			staff have specific rounds assignments for that shift. Compliance with the linens management and contraband policies will be monitored by the Charge Nurses on each unit via rounding at a minimum of twice per shift. Nursing Leadership will audit the documentation to ensure Charge Nurses are in compliance with these expectations. Further, Nursing Leadership and Risk Management will monitor contraband incident reports	

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		demonstrate competency through return demonstration. Re-training will also focus on the requirement, per policy, to conduct a room search and skin check after discovery of contraband. Beginning 9/17/18, all routine room checks for patients who are on Suicide Precautions will increase in frequency to every shift. Staff will immediately remove any prohibited items, such as excess or contraindicated linens and contraband, identified at the time of the room check.			and conduct chart audits to verify the room search and skin check were completed as required. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%	

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C 780	**322-120.1 SAFE ENVIRONMENT** **WAC 246-322-120 Physical Environment**	The Director of Plant Operations oversaw the following corrective action carried out by Facilities Staff Members: On the South Unit, dirt, dust, and debris; and signs of mold on surfaces were cleaned in the following areas: 1. Patient room 401 shower 2. Store room adjacent to the day room 3. Linen closet 4. Patient room 408 shower 5. Patient room 406 shower On the Central Unit, signs of mold on surfaces were cleaned in the following areas: 1. Patient room 103 shower 2. Patient room 102 shower On the North Unit, dirt, dust, and debris; and signs of mold on surfaces were cleaned in the following areas: 1. Patient belongings room 2. Patient room 117 (and peeling paint on bathroom cabinet) 3. Shower room	Director of Plant Operations	8/22/18	The DPO or designee audits EVS/housekeeping during weekly environmental rounds to verify compliance with cleaning expectations and reporting expectations for areas needing attention by engineering. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%.	< 90%

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		On the W1 Unit, dirt, and debris were cleaned in the following areas: 1. Patient room 901 (also: peeling paint near window) 2. Storage closet In the Partial Hospitalization Program, dirt and dried food were cleaned from the floor of the closet of the adult services side of unit. On the East Unit, the baseboard in bathroom 4, which was identified as damaged and un-cleanable, was replaced. Effective 8/22/18, facility-wide, the Director of Plant Operations is initiating a new routine process for EVS staff cleaning of shower curtains (where they hang). This includes a product addition and a process adjustment. The product addition is Ready-to-use Clorox Healthcare® Bleach Germicidal. This is an APIC and CDC Standards hospital approved product with a 3-minute dwell time to kill C dif spores, TB, and fungi. The				

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		process adjustment includes new steps in the existing routine room cleaning process. These steps are: a. At the beginning of the bathroom/shower room cleaning process, thoroughly clean shower curtain with standard surface cleaner on cart, then wipe away residue with damp cloth. b. Liberally apply Ready-to-use Clorox Healthcare® Bleach Germicidal to shower curtain. c. Allow to saturate and dwell for minimum of 3 minutes while cleaning the bathroom/shower room. d. Wipe away any residual product with dry cloth. e. On any shower curtain for which this method fails to achieve intended efficacy, report to maintenance department for curtain replacement.				

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L 880	**322-140.1i ROOM FURNISHINGS** **WAC 246-322-140 Patient living areas**	The Infection Preventionist will inspect all mattresses in the facility by 9/15/18 and report all compromised mattresses to the Director of Plant Operations for removal. On an on-going basis, the Infection Preventionist will audit all mattresses on at least a monthly basis for the purposes of identifying and reporting any compromised mattresses.	Director of Plant Operations; Infection Preventionist	9/15/18	Compliance will be monitored though monthly audits of all mattresses in the facility by the Infection Preventionist. Mattresses identified to be compromised will be reported to the Director of Plant Operations. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%.	< 90%
L1065	**322-170.2E TREATMENT PLAN-COMPREHENS** **WAC 246-322-170 Patient Care Services**	All licensed nursing staff will be re-trained in person through staff meetings and in-person training by the Nurse Educator on initiating,	ADON; Nurse Educator; Director of Clinical	9/15/18	Compliance will be monitored through weekly audits of medical	< 90%

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		developing and updating identified medical problems on the Treatment Plan by 9/15/18. All licensed nursing staff will sign an attestation verifying their understanding and commitment to following the policy and procedure.	Services		records by Nursing Leadership. Charts which are non-compliant will be immediately addressed and corrected. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%.	
L1150	**322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care.**	All RNs will be re-educated on obtaining physician orders for seclusions and restraints, per policy PC. 1000.53 Seclusion-Restraint-Physical Hold, in-person via staff meetings and one-on-one trainings by members of Nursing Leadership by 9/15/18. All RNs will sign an attestation verifying their understanding and commitment to	Interim Chief Medical Officer; ADON	9/15/18	Compliance will be monitored though audits of all seclusions and restraints, at the time of the seclusion or restraint, by Nursing Leadership or the	< 90%

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		following the policy and procedure.			House Supervisor, to ensure that a physician order was obtained and timed for the appropriate interval. Episodes that do not have the appropriate order will be immediately addressed and corrected. A separate, weekly audit, will be conducted by the Risk Management Coordinator. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%	

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L1365	**322-210.3A PROCEDURES-MED AUTH WAC 246-322-210 Pharmacy and Medication Services**	All licensed nursing staff will be retrained by Nursing Leadership in person via staff meetings and in-person trainings on counting patient narcotics per the policy PC. 1001.04 Patient's Own Medications by 9/15/18. All licensed nursing staff will sign an attestation verifying their understanding and commitment to following the policy and procedure.	Director of Pharmacy; ADON	9/15/18	Compliance will be monitored through daily audits of the Narcotic Log by Nursing Leadership. Non-compliant narcotic counts will be addressed and corrected immediately. Results of the audits will be reported monthly to the Pharmacy and Therapeutics Committee, Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 90%.	< 90%
L1470	**322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services.**	All expired items were removed and discarded at the time of the survey,	ADON; Director of	9/15/18	Compliance will be monitored	< 90%

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction (by 9/25/18)	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		effective 7/27/18. Nursing Leadership will audit all medication rooms and exam rooms on a weekly basis to ensure expired items are disposed of prior to expiration. A tracking sheet will assign responsibility for this task and ensure completion. On 7/27/18, the Director of Plant Operations re-educated the Supply Management Coordinator on the requirement to verify supplies are not expired prior to stocking. The Supply Management Coordinator audited Central Supply on 7/28/18, and all expired items were discarded. Effective 7/28/18, the Supply Management Coordinator now verifies supplies are not expired prior to stocking.	Plant Operations		through weekly audits of exam and medication rooms by Nursing Leadership. All expired items will be immediately removed and discarded, and this will be tracked on a spreadsheet. The ADON will audit the spreadsheets at least weekly to ensure compliance. The Director of Plant Operations will do a random weekly audit of Central Supply to verify expired items are not being stocked. Results of the audits will be reported monthly to Quality Council,	

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					Medical Executive Committee, and the Governing Board. The target for compliance is 90%.	
L1485	**322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services**	The Dietary Manager re-trained all Dietary Staff regarding the new daily temperature log sheet, and all Dietary Staff signed an attestation verifying their understanding and commitment to following the policy and procedure effective 8/20/17. Effective 8/20/17, the Dietary Staff will immediately stock all salad bar items 10 minutes before meals begin and adds ice to level of food in compartments. Dietary staff will take initial, during, and after meal service internal temperatures of items and record temperatures. Any items above 41 degrees F will be discarded at time of observation. These actions will be documented on the daily temperature log sheet. Effective 8/20/17, night shift unit staff will clean and sanitize dietary rooms	Dietary Manager	8/27/18	Compliance will be monitored through the Dietary Manager or designee auditing daily salad bar temperatures and cross checking daily temperature log sheet. The target for compliance is 100%. Spot checks will be performed during monthly rounding. Dietary Manager or designee will review the units breakfast/snack sheets daily to	90%

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		and refrigerators prior to stocking food items, at a minimum daily. Night shift will record cleaning and sanitizing on daily snack/breakfast sheets.			ensure completion of record by the unit. The target for compliance is 100%. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board.	

By submitting this Plan of Correction, the Fairfax Behavioral Health does not agree that the facts alleged are true or admit that it violated the rules. Fairfax Behavioral Health submits this Plan of Correction to document the actions it has taken to address the citations.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

August 29, 2018

Ms. Darcie Johnson, MSW, CPHQ
BHC Fairfax Psychiatric Hospital
10200 NE 132nd Street
Kirkland, WA 98034

Dear Ms. Johnson

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at BHC Fairfax Psychiatric Hospital on July 23 - 27, 2018. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on August 29, 2018.

A Progress Report is due on or before October 25, 2018 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please mail this progress report to me at the following address:

Mr. Paul Kondrat, MN, MHA, RN
Department of Health, Investigations and Inspections Office
P.O. Box 47874
Olympia, Washington 98504-7874

Please contact me if you have any questions. I may be reached at (360) 236 - 2911. I am also available by email at paul.kondrat@doh.wa.gov

Sincerely,

Paul M Kondrat

Paul Kondrat, MN, MHA, RN
Survey Team Leader