State of Washington

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety investigatio On site dates: 04/20/21 - 04/22/21 Case number: 2021-2399, 2021-2441 Intake number: 110601, 110602 The investigation was conducted by: Investigator #1 Investigator #3 Investigator #4, who was in orientation The investigators found violations pertinent to this complaint.	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. PLAN OF CORRECTION DUE: May 16, 2021. 4. The Administrator or Representative's signature is required on the first page of the original. 5. Return the original report with the required signatures.	
L 350	322-035.1J POLICIES-INFECTION CONTROL WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 350		

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

Progress Report Received 7/27/21, final progress report approved 8/6/21 MM

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L 350	Continued From page 2 3. Document review of the hospital's policy and procedure titled, "Transmission Based Precautions," policy #300.83, reviewed September 9, 2020, showed COVID-19 as an example under Droplet Precautions and Airborne Precautions. 4. Document review of the hospital's signage for N95 mask seal checks titled, "Filtering out Confusion: Frequently Asked Questions about Respiratory Protection, User Seal Check," undated, DHHS (NIOSH) Publication No. 2018-130, showed procedures for users to perform a seal check on successfully fit tested respirators and states the user seal check is not a substitute for fit testing. 5. On 04/20/21 at 9:53 AM, Investigators #1 and #4 interviewed the housekeeping manager (Staff #401). Staff #401 stated he was N95 fit tested but didn't know the brand. Staff #401 stated he wore an N95 respirator in the confirmed COVID positive patient rooms during cleaning. Documentation for fit testing did not show Staff #401 was fit tested as per policy. 6. On 04/20/21 at 10:15 AM, Investigators #1 and #4 interviewed the 3rd floor housekeeping staff (Staff #402). Staff #402 was assigned to clean the COVID positive patient area. Staff #402 stated she wore a N95 respirator and that the nursing staff helped fit her. Documentation for fit testing did not show Staff #402 was fit tested as per policy. 7. On 04/20/21 at 11:30 AM, Investigator #3 interviewed a provider (Staff #303) about the recent COVID-19 infection outbreak at the hospital. Staff #303 stated the hospital supplied N95 masks to the staff during the outbreak.	L 350		

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L 350	Continued From page 4 Director of Quality (Staff #405) stated this seal check guidance was used for just in time fit testing. The documentation that was given by the Director of Quality indicated that seal checks can not be subsituted for fit testing.	L 350		
L 405	322-035.1U POLICIES-CLINICAL RECORDS 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: (u) Clinical records consistent with WAC 246-322-200, the Uniform Medical Records Act, chapter 70.02 RCW and Title 42 CFR, chapter 1, Part 2, 10/1/89; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of hospital policy and procedures, the hospital failed to record and document the results of the rapid COVID-19 laboratory screening for 9 of 9 patients reviewed (Patients #301, 302, #303, #304, #305, #306, #307, #308, and #309). Failure to record and document the results of laboratory point of care testing risks the quality of the information the hospital can provide for ongoing treatment of the patient and risks inconsistent and unmet patient care needs resulting from an incomplete medical record. Findings included: 1. Document review of the hospital policy and	L 405		

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L 720	Continued From page 6	L 720		
L 720	322-100.1G INFECT CONTROL-PRECAUTION 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: (g) Identifying specific precautions to prevent transmission of infections; 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 staff ordered transmission-based precautions for patients diagnosed with infectious disease to prevent transmission of infections for 8 of 9 records reviewed (Patients #301, #302, #303, #304, #306, #307, #308, and #309). Failure to order transmission precautions for patients diagnosed with an infectious disease puts staff and patients at risk from communicable diseases. Findings included: 1. Document review of the hospital's policy and procedure titled, "COVID-19 Screening Policy and Procedure," policy # 300.74, reviewed 09/09/20, showed that patients with a positive screen will be removed from the population and placed in isolation. The physician will be notified for orders and standard and transmission-based precautions (contact, airborne, droplet) will be implemented. Document review of the hospital's policy and procedure titled, "Infectious Disease Outbreak/Pandemic," policy # 300.79, reviewed	L 720		

Plan of Correction 5/17/2021

Inland Northwest Behavioral Health approved 5/18/2021
Plan of Correction for
Department of Health Investigation
Complaint ID# 110601/2021-2399 & 110602/2021-2441; April 20-22nd

M. [illegible] 5/20/2021

Tag #	Corrective Action:	Responsible Individual:	Estimated Date of Completion:	Monitoring for procedure: Target for Compliance
Tag# A 749	**INFECTION CONTROL PROGRAM CFR: 482.42** **FIT TESTING** **CORRECTIVE ACTION:** The CEO and Director of Quality met to review the findings of this survey. The N-95 Fit Testing policy #300.80 was reviewed with no revisions required at this time. The Infection Control Preventionist initiated fit testing with Nursing Supervisors, Intake and Admissions staff and Housekeeping staff in March 2020. In March 2020, recommendations based on the Joint Commission PPE guidance, Inland NW hospital was mandated to ensure that staff were in surgical and KN95 masks on all patient care units except for isolation and quarantine. Fit testing was suspended in an effort to conserve the N95 masks with the understanding that the pandemic was in effect for an extended period than anticipated. Fit testing and retraining to policy 300.80 N-95 Fit testing was initiated immediately for all nursing staff, Intake/Admissions staff and housekeeping staff with a completion date by 6/21/2021. Evidence of training will be filed in each staff's personnel file. The CEO, Medical Director and Director of Quality reviewed the Infectious Diseases Outbreak/Pandemic policy #300.79 specifically related to ordering transmission based precautious. Policy required no revision at this time. Licensed nursing staff and nursing supervisors were retrained to the Infectious Disease Outbreak/Pandemic policy 300.79 to ensure staff ordered transmission-based precautions for patient diagnosed with COVID-19 to	The Director of Quality Clinical Nurse Educator	June 21,2021	Monitoring of 100% of fit tests completed will be audited for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Monitoring of 100% of records with transmission based precaution orders will be monitored for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff

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	Fit testing and retraining to policy 300.80 N-95 Fit testing was initiated for all nursing staff, Intake/Admissions staff and housekeeping staff with a completion date by 6/21/2021. Evidence of training will be filed in each staff's personnel file. The CEO, Medical Director and Director of Quality reviewed the Infectious Diseases Outbreak/Pandemic policy #300.79 specifically related to ordering transmission based precautious. Policy required no revision at this time. Licensed nursing staff and nursing supervisors were retrained to the Infectious Disease Outbreak/Pandemic policy 300.79 to ensure staff ordered transmission-based precautions for patient diagnosed with COVID-19 to prevent transmission of infections. Training focused on: • Patients with a positive screen will be removed from the population and placed in isolation • The physician is notified for orders including transmission based precautions (contact, airborne, droplet) to be implemented. • If the result is positive, the physician determines if the patient remains at the facility in isolation or sent out to another facility for medical treatment. • Documentation of the physician's orders and decision for patient transfer is documented in the medical record. Staff training to the Infectious Disease Outbreak/Pandemic policy 300.79 was initiated and completed by 6/21/2021. Evidence of staff training is filed in each personnel file.			Monitoring of 100% of records with transmission based precaution orders will be monitored for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality/Performance Improvement Committee and Medical Executive

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	Licensed nursing staff and nursing supervisors were retrained to the COVID - 19 Screening and Infectious Disease Outbreak/Pandemic policy 300.79 to ensure staff ordered transmission-based precautions for patient diagnosed with COVID-19 to prevent transmission of infections. Training focused on: • Patients with a positive screen will be removed from the population and placed in isolation • The physician is notified for orders including transmission based precautions (contact, airborne, droplet) to be implemented. • If the result is positive, the physician determines if the patient remains at the facility in isolation or sent out to another facility for medical treatment. • Documentation of the physician's orders and decision for patient transfer is documented in the medical record. Staff training to the Infectious Disease Outbreak/Pandemic policy 300.79 was initiated and completed by 6/21/2021. Evidence of staff training is filed in each personnel file.	Clinical Educator		Monitoring of 100% of fit tests will be completed for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality/Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.

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Tag #	Corrective Action:	Responsible Individual	Estimated Date of Completion	Monitoring for procedure; Target for Compliance
Tag # L 350	**POLICIES- CLINICAL RECORDS: WAC 246-322-035** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality met to review the findings of this survey. Documentation Standards policy was reviewed with no revisions required at this time. Registered Nurses and treatment providers were retrained to the Documentation Standards policy with focus on: • Documentation of all rapid point of care testing for COVID 19 including results/determination of test into the electronic medical record (EMR) • All radiology, diagnostic imaging and ancillary testing reports are required documentation in the medical record Threshold for acceptable compliance: >90% Training was initiated immediately to be completed by 6/21/2021. Evidence of training is filed in each staff's personnel file.	The Director of Quality Clinical Educator	6/2/2021	Monitoring of 100% of COVID 19 rapid tests and its documentation in the EMR will be completed for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Threshold for Acceptable Compliance: <90% Aggregated data will be reported to Quality/Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.
Tag # L 405	**INFECTION CONTROL-PRECAUTION: WAC 246-322-100** **CORRECTIVE ACTION:** The CEO, Medical Director and Director of Quality reviewed the Infectious Diseases Outbreak/Pandemic policy #300.79 specifically related to ordering transmission based	The Director of Quality	6/2/2021	Monitoring of 100% of fit tests will be completed for four months until compliance

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	Licensed nursing staff and nursing supervisors were retrained to the COVID -19 Screening and Infectious Disease Outbreak/Pandemic policy 300.79 to ensure staff ordered transmission-based precautions for patient diagnosed with COVID-19 to prevent transmission of infections. Training focused on: • Patients with a positive screen will be removed from the population and placed in isolation • The physician is notified for orders including transmission based precautions (contact, airborne, droplet) to be implemented. • If the result is positive, the physician determines if the patient remains at the facility in isolation or sent out to another facility for medical treatment. • Documentation of the physician's orders and decision for patient transfer is documented in the medical record. Threshold for acceptable compliance: >90% Staff training to the Infectious Disease Outbreak/Pandemic policy 300.79 was initiated and completed by 6/21/2021. Evidence of staff training is filed in each personnel file.	Clinical Educator		Aggregated data will be reported to Quality/Performance Improvement Committee and Medical Executive Committee monthly and to the Governing Board quarterly.