STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION O13260 NAME OF PROVIDER OR SUPPLIER SUMMAY STATEMENT OF DEFICENCES. IN A WAIG OFFICIAL PROVIDER OR SUPPLIER SUMMAY STATEMENT OF DEFICENCES. IN A WAIG OR STATE AND RESS. CITY, STATE, ZEP CODE 164 W STH AVE SPOKANE, WA 98204 SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH SOURCEST BEHAVIORAL HEALTH DEATH OF SOURCEST BEHAVIORAL HEALTH DEATH OF CORRECTION IS RESENTED TO THE BEHAVIORAL HEALTH THE PROPERTY BEHAVIORAL HEALTH THE PROPERTY OF LEGISLATION OF THE BEHAVIORAL HEALTH THE PROPERTY OF LOS OF THE BEHAVIORAL HEALTH THE PROPERTY OF L	State of V	State of Washington					
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INLAND NORTHWEST BEHAVIORAL HEALTH POKANE, WA 99204 Computer	NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	ATE, ZIP CODE		
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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. On site dates: 09/05/23 - 09/07/23 Examination number: 2023-602 The survey was conducted by: Surveyor #2 Surveyor #4 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell F7H911. WHEN the correction will be completed. 3, Your PLAN OF CORRECTION is required for each deficiency sisted on the Statement of Deficiencies. The Plan of Correction is due to orrected. WHO is responsible for making the correction. WHAT will be done to prevent reocurrence 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. The Plan of Correction is due on 09/28/23. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover latter.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
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WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures		The Washington State (DOH) in accordance Administrative Code (Private Psychiatric and conducted this health On site dates: 09/05/2 Examination number: The survey was cond Surveyor #2 Surveyor #4 Surveyor #9 The Washington Fire conducted the fire life	a Department of Health with Washington WAC), Chapter 246-322 d Alcoholism Hospitals, and safety survey. 23 - 09/07/23 2023-602 ucted by:		required for each deficiency listed on 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 monito continued compliance; and WHEN the correction will be complete 3. Your PLAN OF CORRECTION must returned within 10 calendar days from date you receive the Statement of Deficiencies. The Plan of Correction is due on 09/28/23. 4. Sign and return the Statement of Deficiencies and Plans of Correction is deficiencies and Plans of Correction in the statement of Deficiencies and Plans of Correction is deficiencies and Plans of Correction in the statement of Deficiencies and Plans of Correction is deficiencies and Plans of Correction in the statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is defined as a statement of Deficiencies and Plans of Correction is	or for ed. st be in the	
Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 315			L 315	•		
develop and implement the following written policies and procedures							
written policies and procedures							
consistent with this chapter and		written policies and pr	rocedures				
		consistent with this ch	napter and				

TITLE

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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State of Washington

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMPL	ETED
		013250	B. WING		09/0	7/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADE	DRESS, CITY, ST	NTE, ZIP CODE		
INI AND N	ORTHWEST BEHAVIOR	AL HEALTH 104 W 5TH	AVE			ĺ
711		SPOKANE	, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETE DATE
L315	Continued From page	1	L 315			
L 315	services provided: (c) or arranging for the catreatment of patients; This Washington Adm as evidenced by: . Item #1 Nutritional co. Based on interview, dof hospital policies an failed to ensure that putritional consult with nutritional deficiencies reviewed (Patient #90 Failure to properly sor consult may lead to proutcomes. Findings included: 1. Document review of procedure titled, "Nutritional reviews of procedure titled,"	Providing are and ininistrative Code is not met onsults comment review, and review deprocedures, the hospital natients at risk received an a dietician for evaluation of s for 3 of 4 patients of 1, #902 and #903). The and initiate a nutritional coor nutrition and poor health of the hospital's policy and ritional of 1, "PolicyStat ID 13428390,"	L 315			
		sment contains questions nts at risk for malnutrition or s.				
	b. Upon screening, if the patient's nutrition screening Registered Dietitian was					
	recommendations in t	ocument assessment and he nutrition consult form an of any recommendation				7
	Document review of the	ne nursing admission				
tate Form 25	÷7				1	

State of Washington					POR	MAPPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		09/	07/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	
INLAND N	ORTHWEST BEHAVIORA	AL HEALTH 104 W 57 SPOKAN	H AVE E, WA 99204			
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	assessment form short to be completed on actidentified risk factors. Which may be indicating such as binging or purpoor oral intake, unint >36 and BMI <19. If a present, the box is che consult should be obtained box to check when the process is completed. 2. On 09/05/23 between Surveyor #2, Surveyor #2, Surveyor (Staff #901) reviewed Patient #901 who was 08/30/23 with a diagnor. There was a provider of precautions. The nursi showed one risk factor habits/behaviors which eating disorder) was civitten by the RN that patient doesn't eat or sith they vomit. The State that a nutritional consultains patient. 3. At the time of the obverified that there was completed for this patient. 4. On 09/05/23 between Surveyor #2, Surveyor (Staff #901) reviewed the Patient #902 who was	wed a nutritional screen is dmission with 11 boxes with These include eating habits we of an eating disorder rging, decreased appetite or entional weight loss, BMI my of these risk factors are ecked, and a nutritional ained. There is an additional edictitian notification en 10:00 AM and 11:30 AM, r #9 and Director of Risk the medical records of a 14 year old admitted on one of Suicidal Ideation. Order for anorexicing admission assessment abox (eating a may be indicative of an another that sometimes the sometimes eats so much surveyor found no evidence with had been completed for the servation, Staff #901 no nutritional consult ent. entitional consult entities and Director of Risk the medical record of a 17 year old admitted on sis of Bipolar Disorder with nursing admission risk factor boxes	L 315			

State Form 2567

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __. B. WNG 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) L 315 Continued From page 3 L 315 change of 10 lbs, over the last 3 months) were checked. The Surveyor found no evidence that a nutritional consult had been completed for this patient. 5. At the time of the observation, Staff #901 verified that there was no nutritional consult completed for this patient. 6. On 09/05/23 between 2:25 PM and 3:40 PM. Surveyor #9 and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. The nursing admission assessment showed the patient had a BMI of 40 (an indicator for a nutritional consult). The Surveyor found no evidence that a nutritional consult had been completed for this patient. 7. At the time of the observation, Staff #901 verified that there was no nutritional consult completed for this patient. Item #2 Patient orientation Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were oriented to the unit during admission for 2 of 3 medical records reviewed (Patient #201 and #203). Failure to orient a patient to their environment places the patient at risk for a decreased level of understanding and safety and increased anxiety. Findings included: 1. Document review of the hospital's policy and State Form 2567

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		09/07/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, ST	TATE, ZIP CODE		
INLAND N	ORTHWEST BEHAVIOR	AL HEALTH 104 W 5T SPOKAN	H AVE E, WA 99204			
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L 315	Continued From page 4		L 315			
	Record," PolicyStat II. 07/23, showed nursing completed by the Reg hours of admission.	istered Nurse (RN) within 8				
	2. Interview of Chief of Compliance/Director of Risk (Staff #201) stated that the expectation is all areas of the nursing assessment form are to be completed when patients are admitted to the unit, including the patient orientation section. The patient orientation section addresses orientation to the unit/room, handbook, phone/visitation, identification photo taken, identification bracelet placed on the patient, unit					
	rules/routines/schedul	es, instruction to report s for self/others to staff, rmation provided, and		·		
	Surveyor #2, Surveyor Compliance Officer/Di	rector of Risk (Staff #201) records of Patient #201 and				
		ollowing a suicide attempt. section for Patient #201				
		or freatment of acute tive disorder, bipolar type, use. The patient orientation				
		view, Staff #201 verified entation.				

Slate Form 2567

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **104 W 5TH AVE** INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 315 Continued From page 5 L 315 L 390 322-035.1R POLICIES-PATIENT TRANSFER L 390 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 agencles; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff implemented its policies and procedures when patients experienced a change in condition that required a transfer to an acute care hospital for emergency medical treatment for 3 of 3 patients reviewed (Patient #207, #208, and #209). Failure of the hospital to ensure that staff followed the policies and procedures when transferring patients requiring emergency medical care places the patients at risk for serious physical and psychological harm or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Minor Emergency Treatment," PolicyStat ID #10529890, last approved 10/21, showed the following:

State Form 2567

a. The RN assesses the minor emergency including injuries/illnesses not severe enough to

STATE FORM

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		09/	07/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	FATE, ZIP CODE		
INLAND N	ORTHWEST BEHAVIOR	AL HEALTH 104 W 51				
	I	SPOKAN	E, WA 99204			
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L 390	Continued From page	6	L 390	,		
	warrant admission to evaluation or treatment at least within the next beyond the capabilities. The Lead Nurse not Physician on call, the (CNO) or designee Howard Manager, the House Stadministrator on Call or weekends, and parpatient is a minor. c. The physician will good disposition and method. The nurse calls the (ED), gives report to note. Staff is to send a convict with the staff that will at the ED: face-sheet, ac assessment, medical in medication administrative reports, certificate of pof medical necessity for progress notes, and in (ITA) detention docum.	a hospital but requiring int on an immediate basis or at few hours and that is as of this facility. Allifies: the Attending or Chief Nursing Officer buse Supervisor or Unit Supervisor notifies the (AOC) on evenings, nights ent or legal guardian if the vive the order for appropriate d of transportation. Emergency Department urse. The property of the following forms accompany the patient to laistory and physician, tion record, laboratory attent transfer, certification or ambulance transfer, voluntary treatment act entation (specifically IT-10). The turned to Inland Health, the MD and family	£ 390			
	are notified of the outc Hospital.	ome of the transfer to the				
	Surveyor #2, Surveyor Quality (Staff #202) rev for 3 patients who had	en 2:45 PM and 3:50 PM, #9, and the Director of viewed the medical records been transferred to an reatment for changes in showed the following:				

State Form 2567

State of Washington

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250 B. WNG			09/07/202	23
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
INLAND N	ORTHWEST BEHAVIOR	AL HEALTH SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	(X6) MPLETE DATE
L 390	90 Continued From page 7		F 380			
	an ED for treatment o was unable to find evi contacting the transfe	nt #207 was transferred to f chest pain. Surveyor #2 dence of the nurse rring facility to give report to e of staff accompanying the		·		AS THE PROPERTY OF THE PROPERT
	an ED for treatment o Surveyor #2 was unal	ole to find evidence of the ransferring facility to give dence of staff tient, and no family				A CONTRACTOR OF THE CONTRACTOR
To the state of th	an ED for treatment for				S. La I.	
	3. At the time of the re that the medical recor of the required elemen	eview, Staff #202 verified d did not contain evidence nts of patlent transfer.				
L 415	322-035.2 P&P-ANNU	JAL REVIEW	L 415			
overthe .	WAC 246-322-035 Po Procedures. (2) The li- review and update the procedures annually of needed. This Washington Adm as evidenced by:	censee shall policies and				
itale Form 256		w and interview, the re that required policies and				

State Form 256 STATE FORM

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L415 Continued From page 8 L415 procedures were reviewed and updated annually. Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Policy Development and Review Process," PolicyStat ID 11746188, last approved 06/22, showed that policies and procedures will be reviewed on an annual basis at a minimum. 2. Record review of the following policies showed that the hospital did not review all policies on an annual basis as required, including the following: a. Hand Hygiene, PolicyStat ID 11612029, last approved 06/22. b. Discharge Process, PolicyStat ID 10494850, last approved 06/22. c. Conducting a Root Cause Analysis, Policy Stat ID 11681060, last approved 06/22. d. Medication - Patient Consent, PolicyStat ID 10530113, last approved 12/21. e. Admission of Patients, PolicyStat ID 11681058, last approved 06/22. f. Patient's Rights and Responsibilities, PolicyStat ID 11612024, last approved 06/22. g. Abuse/Neglect Reporting, Policy Stat ID 10391605, last approved 05/22.

State Form 2567

State of Washington

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE			
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L 415	Continued From page	9	L 415		· M·!-		
	h. Emergency Medica 10529807, last appro	al Treatment, Policy Stat ID ved 12/21.					
	i. Departmental Resp Prevention and Contr last approved 12/21.	onsibility for Infection ol, PolicyStat ID 10893044,					
	j. Patient Elopement, PolicyStat ID 10529983, last approved 12/21. k. Patient Death Suicide, PolicyStat ID, 10529853, last approved 12/21. l. Patient Belongings, PolicyStat ID 12054438, last approved 07/22. m. Clinical Research, PolicyStat ID 11611965, last approved 06/22.						
		Patients on a Therapeutic 530107, last approved					
	o. Nursing Charting R 10687647, last approv	equirements, PolicyStat ID ved 12/21					
	p. Treatment Planning last approved 05/22.	g, PolicyStat ID 10503953,					
	q. Glucometer, PolicyStat ID 10530082, last approved 12/21.						
		nd Equipment Inspection, 16, last approved 12/21.					
- And the state of		of Care Scope of Services, 45, last approved 06/22.		·			
	t. Patient Observation 11899584, last approv						
ate Form 256 FATE FORM			6853 F7	H911	ll conlinuati	ion sheet 10 of 52	

State of Washington					(0, (,	MATHOVED	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	RÖVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
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L 415	Continued From page	10	L415				
77000		f Quality (Staff#902) by updates. Staff#902 at were not current and					
L 585	322-050.6i ORIENTAT	TION-APPROP TRAINING	L 585				
	WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (i) Appropriate training for expected duties This Washington Administrative Code is not met as evidenced by:						
	Based on record review and interview, the hospital failed to ensure that new staff were oriented with appropriate training for expected duties for 1 of 11 staff (Staff #407).				i		
	Failure to orient staff with appropriate training for expected duties places patients at risk for inadequate care.				:		
	Findings included:						
** ***********************************	"Staff Orientation and " ID 12524289, approve staff will be oriented to	e hospital's policy titled, Training Plan," PolicyStat d 10/13/22, showed that all the general standards, ess of the hospital within					
	2. On 09/07/23 at 9:30 personnel files with the	AM, Surveyor #4 reviewed HR Generalist (Staff					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE	, ZIP CODE			
ORTHWEST BEHAVIORA	AI HEAITH					
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Continued From page	11	L 585				
staff showed that a me (Staff #407) had no do records for orientation they worked in. 3. At the time of the rethat the employee file	ental health technician ocumented employee i to the hospital for the unit eview, Staff #406 confirmed for Staff #407 was missing					
322-050 9A TR-MANT	TOUX TEST	1 615				
shall: (9) In addition to WISHA requirements, from tuberculosis by r staff person to have u or starting service, anthereafter during the liassociation with the h tuberculin skin test by method, unless the structure procuments a previous skin test, which is ten millimeters of induration forty-eight to seventy-Documents meeting the date of (ili) Provides a written the department or autheafth department or autheafth department staskin test presents a hastaff person's health; This Washlington Admas evidenced by:	o following protect patients equiring each pon employment d each year individual's ospital: (a) A the Mantoux aff person: (i) is positive Mantoux or more on read at two hours; (ii) ne requirements of the six months employment; or waiver from horized local ting the Mantoux azard to the inistrative Code is not met					
	w and interview, the					
	SUMMARY STOPELER SUMMARY STOPE (EACH DEFICIENCY REGULATORY OR LEACH	OVIDER OR SUFPLIER STREET AT 104 W 5T SPOKAN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 #406). Record review of the personnel files for 11 staff showed that a mental health technician (Staff #407) had no documented employee records for orientation to the hospital for the unit they worked in. 3. At the time of the review, Staff #406 confirmed that the employee file for Staff #407 was missing documentation of orientation. 322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This Washington Administrative Code is not met as evidenced by: Based on record review and interview, the	OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 104 W 5TH AVE SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 #406). Record review of the personnel files for 11 staff showed that a mental health technician (Staff #407) had no documented employee records for orientation to the hospital for the unit they worked in. 3. At the time of the review, Staff #406 confirmed that the employee file for Staff #407 was missing documentation of orientation. 322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. 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Record review of the personnel files for 11 staff showed that a mental health technician (Staff #407) had no documented employee records for orientation to the hospital for the unit they worked in. 3. At the time of the review, Staff #406 confirmed that the employee file for Staff #407 was missing documentation of orientation. 322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. 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At the time of the review, Staff #406 confirmed that the employee file for Staff #407 was missing documentation of orientation. 322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. 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If continuation sheet 12 of 52

State of Washington					ron	WATROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I.	LE CONSTRUCTION	(X3) DATE	SURVEY
	<u> </u>	013250	B. WING		09	/07/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	· • • • • • • • • • • • • • • • • • • •	
INLAND	NORTHWEST BEHAVIORA	AL HEALTH 104 W 5T SPOKAN	H AVE E, WA 99204			
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L 615	hospital failed to ensure baseline screening and 3 of 11 personnel files #404, and #405). Failure to screen and of work risks patient a tuberculosis infection. Findings included: 1. Record review of the "Tuberculosis (TB) Screening Exposure Plasses of the "Tuberculosis (TB) Screening Plasses of the pathogen Exposure Plasses o	re that staff received and testing for tuberculosis for a reviewed (Staff #403, stest staff prior to their start and staff exposure to e hospital's policy titled, reening and Airborne lan, 300.04," PolicyStat ID red 05/09/23, showed that fied protein derivative st x-ray depending on test of TB vaccination or testing in the first two weeks of vention and control nurse sults. AM, Surveyor #4 reviewed at HR Generalist (Staff of the personnel files for 11 navironmental services at licensed social worker istered nurse (Staff #405) inployee health records for or testing prior to hire.	L 615	DEFICIENCY)		
L 720		ONTROL-PRECAUTION	L 720		THE TAXABLE PARTY OF TA	

PRINTED: 09/18/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WNG 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 720 Continued From page 13 L720 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: (q) Identifying specific precautions to prevent transmission of infections; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to implement an effective respiratory protection program that ensures appropriate staff are fit tested to use an N-95 respirator prior to working when respiratory precautions are required for 11 of 11 staff reviewed (Staff #403, #404, #405, #407, #408, #409, #410, #411, #412, #413 and #414). Failure to identify and fit test appropriate staff required to use N-95 respirators prior to use places staff at risk of improper use of PPE and places staff, patients, and visitors at risk of exposure to pathogens. Reference: CDC Morbidity and Mortality Weekly Report (MMWR) Respiratory-Protection Program showed that OSHA requires health-care settings in which HCWs use respiratory protection to develop, implement, and maintain a respiratory-protection program. All HCWs who use respiratory protection should be included in the program.

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a good fit.

Reference: CDC Morbidity and Mortality Weekly Report (MMWR) showed fit testing provides a means to determine which respirator model and size fits the wearer best and to confirm that the wearer can don the respirator properly to achieve

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
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L 720	Continued From pag	e 14	L 720			
	Findings included:					
	Fit Testing, 300.80," I approved 06/30/22, s define and implemen based on the hospital fit testing policy provispecifically needed fit testing should occur. 2. On 09/07/23 at 9:3 personnel files with the #406). Record review staff showed that an elechnician (Staff #403 #404), three registere and #411), two menta #407 and #412), a diedictician (Staff #409),	of the hospital's policy, "N-95 PolicyStat ID 11612111, last showed that the facility shall t an N-95 test fitting policy l's infection control plan. The ded did not identify who t testing and how often fit O AM, Surveyor #4 reviewed the HR Generalist (Staff of the personnel files for 11 environmental services b), a social worker (Staff d nurses (Staff #405, #410, I health technicians (Staff etary cook (Staff #408), a a licensed practical nurse reational therapist (Staff mentation of being fit				
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	tested, 3. At the time of the re that the employee files documentation of any then interviewed the Ir Control Nurse (Staff# fit testing. Staff #415 s	view, Staff #406 confirmed				
	322-120.6A WATER-B WAC 246-322-120 Phy		L 805			
	The licensee shall: (6)					

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PRINTED: 09/18/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 805 Continued From page 15 L 805 adequate supply of hot and cold running water under pressure meeting the standards in chapters 246-290 and 246-291 WAC, with: (a) Devices to prevent back-flow into the potable water supply system; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and review of manufacturer's instructions for use, the hospital failed to maintain the ice machine drain line according to manufacturer's instructions. Failure to maintain ice machine drain lines properly risks backflow contamination of the water and ice supply. Findings included: 1. Document review of the Follett Symphony Plus ice machine manufacturer's instructions for use showed drain lines at a minimum should be sloped 1/4 inch per foot. 2. On 09/05/23 at 10:00 AM, Surveyor #4 inspected the nourishment room on 3-East in the patient care unit with the Director of Plant Services (Staff #401). The Surveyor observed the countertop Follett Symphony Plus ice machine with a drain line that was not sloping downward as required in the section of drain line that routed through the lower cabinets.

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corrected.

3. The Surveyor interviewed Staff #401 regarding the ice machine drain line. Staff #401 confirmed the drain line should be sloping downward for the entire length of the line and had not been

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L 805 Continued From page 16 L 805 4. The Surveyor and Staff #401 then checked all the remaining nourishment rooms in the facility (3-West, 2-East and 2-West). The ice machines' drain lines were correctly sloped in all the other nourishment rooms. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 09/27/22. L1050 322-170.2B TREATMENT PLAN-INITIAL L1050 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: (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, document review, and review of policy and procedure, the hospital failed to ensure that staff members created an initial treatment plan that included psychiatric and medical problems for 4 of 5 patients reviewed (Patient #901, #902, #904, and #905). Failure to ensure the development of an initial treatment plan for behavioral and medical problems puts patients at risk for physical and mental harm, inconsistent, and delayed treatment. Findings included:

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09/07/2023

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State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WING 013250 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH** SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG L1050 Continued From page 17 L1050 1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care-Scope of Services," PolicyStat ID 10495145, last approved 06/22, showed the following: a. A nursing assessment will be completed by a

> registered nurse within 8 hours of admission and includes the patient's physical/mental health.

b. The nurse initiates the preliminary treatment plan based on the findings of the preadmission

c. Medical as well as mental health concerns are

2. On 09/05/23 between 10:00 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #901 who was a 14 year old admitted on 08/30/23 with a diagnosis of Suicidal Ideation. The patient had risk factors for Anorexia and was placed on anorexia precautions by the provider. The medical problem section of the treatment plan was blank. Surveyor #9 found no evidence of an initial treatment plan that included nutritional

3. At the time of the review, Staff #901 verified that there was no initial treatment plan for

 On 09/05/23 between 11:30 AM and 12:50 PM. Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #902 who was a 17 year old admitted on 08/29/23 with a diagnosis of Bipolar Disorder with a suicide attempt and a medical diagnosis of

and nursing assessments.

issues or Anorexia.

nutritional issues or anorexia.

addressed on the treatment plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MANUELOF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 W STH AVE SPOKANE, WA 9304 PRIERIX TAG LICONITIVE OF THE OFFICENCY OR STATEMENT OF DEFICIENCES LICACH DEFICIENCY AUST SEE PRECEDED BY FULL REGISLATIVE OR THE APPROPRIATE DATE OF THE APPROPRIATE	State of Washington						
NAME OF PROVIDER OR SUPPLIER NI LAND NORTHWEST BEHAVIORAL HEALTH OCA; ID PREFIX TAG SUMMARY STATEMENT OF DESIGNATES SIZE SECULATION SOLUTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG COntinued From page 18 problem section of the treatment plan was checked as none. Surveyor #9 found no evidence of an initial treatment plan for Endometriosis or Migraines. 5. At the time of the review, Staff #901 verified that there was no initial treatment plan for Endometriosis or Migraines. 6. On 09/00/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nursing (Staff #903) eviewed the medical record of Patient #904 who was admitted on 07/27/23 with a psychiatric diagnosis of Schizophrenia and a medical diagnosis of Diabets. The medical problem section of the treatment plan for Endometriosis on Migraines. 7. At the time of the review, Staff #903 verified that there was no initial treatment plan for expension of the treatment plan was signed by a registered nurse on 08/01/23 (a period of 5 days after admission). 7. At the time of the review, Staff #903 verified that there was no initial treatment plan for Diabets, and they would expect to see one. 8. On 09/08/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical record of Patient #905 who was admitted on 07/13/23 with a psychiatric diagnosis of Schizopficelive Disorder and Severe Alcohol Dependence. The initial treatment plan was completely blank with no nurse signature.				1 ' '			
CAJID PREFEX SUMMARY STATEMENT OF DEFICIENCIES ID PREFEX TAG COMPRETING ACTION CONTRICTION CONTR			013260	B. WING		09/0	7/2023
INLAND NORTHWEST BEHAVIORAL HEALTH IXA ID IX	NAME OF P	ROVIDER OR SUPPLIER	•		ATE, ZIP CODE		
PREFEX TAG Continued From page 18 problem section of the treatment plan was checked as none. Surveyor #9 found no evidence of an initial treatment plan for Endometriosis or Migraines. 5. At the time of the review, Staff #901 verified that there was no initial treatment plan for Endometriosis or Migraines. 6. On 09/08/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nating (Staff #903) reviewed the medical record of Patient #904 who was admitted on 07/27/23 with a psychiatric diagnosis of Diabetes. The medical problem section of the review, Staff #903 verified that there was no initial treatment plan for Diabetes, and they would expect to see one. 8. On 09/08/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of National Patient	INLAND N	ORTHWEST BEHAVIOR	AL HEALTH				
problem section of the treatment plan was checked as none. Surveyor #9 found no evidence of an initial treatment plan for Endometriosis or Migraines. 5. At the time of the review, Staff #901 verified that there was no initial treatment plan for Endometriosis or Migraines. 6. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nursing (Staff #903) reviewed the medical record of Patient #904 who was admitted on 07/27/23 with a psychiatric diagnosis of Diabetes. The medical problem section of the treatment plan was blank. The initial treatment plan was signed by a registered nurse on 08/01/23 (a period of 5 days after admission). 7. At the time of the review, Staff #903 verified that there was no initial treatment plan for Diabetes, and they would expect to see one. 8. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical record of Patient #905 who was admitted on 07/13/23 with a psychiatric diagnosis of Schizoaffective bisorder and Severe Alcohol Dependence. The initial treatment plan was completely blank with no nurse signature.	PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPROPR	BE	COMPLETE
that the initial treatment plan was completely blank.		problem section of the checked as none. Sur of an initial treatment Migraines. 5. At the time of the rethat there was no initial Endometriosis or Migraines. 6. On 09/06/23 betwee Surveyor #2, Surveyor (Staff #901) and Direct reviewed the medical was admitted on 07/2 diagnosis of Schizoph diagnosis of Diabetes section of the treatment plan volumes on 08/01/23 (a gradmission). 7. At the time of the rethat there was no initial Diabetes, and they work was admitted on 07/13 diagnosis of Schizoaff #901) and Direct reviewed the medical was admitted on 07/13 diagnosis of Schizoaff Alcohol Dependence, was completely blank 9. At the time of the rethat the initial treatment was no initial treatment.	e treatment plan was rveyor #9 found no evidence plan for Endometriosis or eview, Staff #901 verified al treatment plan for raines. en 9:40 AM and 11:30 AM, or #9, and Director of Risk ctor of Nursing (Staff #903) record of Patient #904 who 7/23 with a psychiatric urenia and a medical . The medical problem nt plan was blank. The evas signed by a registered period of 5 days after eview, Staff #903 verified al treatment plan for build expect to see one. en 9:40 AM and 11:30 AM, or #9, and Director of Risk ctor of Quality (Staff #902) record of Patient #905 who 3/23 with a psychiatric rective Disorder and Severe The initial treatment plan with no nurse signature.	L1050	DETOLINOTY		

PRINTED: 09/18/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION. (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L1065 Continued From page 19 L1065 L1065 322-170.2E TREATMENT PLAN-COMPREHENS L1065 WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition: (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to ensure that staff developed and implemented an interdisciplinary comprehensive treatment plan for all patients that included behavioral and medical problems, with individualized patient-specific interventions, as demonstrated by 4 of 4 records reviewed for patients with medical problems at the time of

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#204).

admission (Patient's #201, #202, #203, and

interdisciplinary treatment plan for behavioral and medical problems places the patients at risk for inappropriate, inconsistent, and delayed care,

Failure to develop and implement an

State of Washington						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		013250	9. WING		09/	07/2023
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	ATE, ZIP CODE		
INLAND N	NORTHWEST BEHAVIOR	AL HEALTH 104 W 51 SPOKAN	TH AVE IE, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETE DATE
L1065	Continued From page creating the potential outcomes, harm, or defindings included: 1. Document review on "Treatment Planning," last approved 05/22, so a. The Master Treatment ompleted within 72 hompletion of the indivinctuding the nursing apsychiatric assessment physical, and the psychological, and the psychological issues, alternated by condition or other factor medical issues, alternated in identifying assessments of provider in identifying included in the MTP. d. Each medical probleteter and link to a specific treatment Plan (ITP) e. Each problem will be chronic/stable, deferred.	for negative patient eath. If the hospital's policy titled, PolicyStat ID #10503953, showed the following: ent Plan (MTP) will be ours of admission following vidual assessments assessment, initial int, medical history and chosocial assessment. Id at least once a week or colinical changes in ors including new onset ative programing, etc. ysical as well as initial will guide the psychiatric medical problems to be em will be identified by a cific medical Individual e identified as active, d, or resolved.	L1065			
THE THE PARTY OF T	Surveyor #2, Surveyor Compliance Officer/Dir	#9, and the Chief rector of Risk (Staff #201) records of Patient #201,				

State Form 2567

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State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L1065 Continued From page 21 L1065 a. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. Patient #201 had a provider order placed for anorexic precautions on 08/30/23. The Master Treatment Plan completed on 09/01/23 that is used to identify initial medical diagnosis stated. "no acute conditions." The Master Treatment Plan subsection for chronic/stable medical problems was blank. The Master Treatment Plan did not include a medical problem of anorexia identified with a specific treatment plan. b. Patient #202 was a 17-year-old female admitted on 08/29/23 following a suicide attempt. Patient #202 had a Master Treatment Plan completed on 08/30/23 which included the medical diagnoses of endometriosis, migraines, and fainting due to unknown causes. The Master Treatment Plan subsection for chronic/stable medical problems was blank. The Master Treatment plan did not include a medical problem of endometriosis, migraines, or fainting due to unknown causes with a specific treatment plan. c. Patient #203 was a 34-year-old female with an involuntary admission on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 had a Master Treatment Plan completed on 08/03/23 which included medical diagnoses of type 2 diabetes mellitus, history of hepatitis A, and migraines. The subsection of chronic/stable medical problems was blank. The chronic stable individual treatment plan problem sheet included the medical diagnoses of asthma, gastroesophageal reflux disease (GERD), hypercholesterolemia, hypertension, seizures, hypothyroidism, diabetes, and acne, All boxes for a target date and specific intervention focus options were blank. The Master Treatment Plan

State Form 2567

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) L1065 Continued From page 22 L1065 update on 08/14/23 contained a blank nursing update and the nursing progress towards medical problems was blank. On 08/15/23, the patient was chemically restrained. There was no careplan for restraint initiated. The Master Treatment Plan update on 08/21/23 contained a blank nursing update, a blank psychiatrist update. and nursing progress towards medical problems was blank. The Master Treatment Plan update on 08/28/23 contained a blank nursing update, a blank psychiatrist update, and nursing progress towards medical problems was blank. 3. At the time of the review, Staff #201 stated the Master Treatment Plan should also contain any medical diagnoses on the patient's history and physical. Staff #201 also stated that all disciplines should be updating their section weekly on the Master Treatment Plan update. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was admitted on 07/27/23 for the treatment of Schizophrenia, paranola, and auditory visual hallucinations. The review showed the following: a. The Master Treatment Plan was completed on 07/27/23 and showed a diagnosis of Type 2 Diabetes Mellitus. b. The Master Treatment Plan subsection for chronic/stable medical problems on 07/27//23 was blank. c. The Master Treatment Plan did not include a medical problem of Type 2 Diabetes Mellitus identified with a specific treatment plan.

State Form 256

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROV	ODEDIENDO JEDIĆI IA		A-1191	l	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L1065 Continued From page 23		L1065			
d. The Master Treatment Plant 08/04/23 contained a blank psy no medical problems listed, and of progress towards medical a e. The Master Treatment Plant 08/11/23 contained a blank nur medical problems listed, and no progress towards a medical problems listed, and no nursing update problems listed, and no nursing towards a medical problem. g. The Master Treatment Plant 08/25/23 contained a blank nur medical problems listed, and no progress towards a medical problems listed, and no progress towards and no progress towards medical problems listed, and no progress towards a medical problems listed, and no progress towards and no progress towards and no progress towards and no	rchiatrist update, d no nursing note problem. Update on sing update, no o nursing note of oblem. Update on 08/18/23 ate, no medical g note of progress Update on rsing update, no o nursing note of oblem. Update on rsing update, no o nursing note of oblem. Update on rsing update, no o nursing note of oblem. aff #201 verified dates should have d including the date, social nning update, any ocial services oblems, and ical problems.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	1 ' '	SURVEY PLETED
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L1070	Continued From page	24	L1070			
L1070	322-170.2F PHYSICI/	AN ORDERS	L1070			
	as evidenced by: . Item #1 Withdrawal as Based on observation, the hospital policy and failed to ensure staff m	nsee shall vision and didischarge ent admitted or not limited s for drug treatments and inistrative Code is not met sessment interview, and review of procedures, the hospital tembers followed provider tion administration for 2 of				
	procedures puts patien wrong medications or u	nedication administration its at risk of receiving the unintended medication g in patient harm and/or				
	Findings included:					
	Surveyors #2, Surveyo Quality (Staff #202) rev of Patients #205 and #2 Clinical Institute Withdr protocol. The provider of instructs staff to assess	n 1:10 PM and 3:50 PM, r #9, and the Director of riewed the medical records 206 who had orders for awal Assessment (CIWA) order for CIWA protocol the patient for withdrawal urs, then every 4 hours for ne review showed the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	diagnosis of schizoaff alcohol dependence, order for CIWA protocolor of the provided assessed at 3 on 07/2 next documented CIWA approximately 6 hours documented CIWA sc AM (missing a period b. Patient # 206 was a diagnosis of bipolar, and dependence. Patient # 206 had 12 on 05/02/23 at 9:41 documented CIWA sc 05/03/23 at 8:02 AM (approximately 10 hour CIWA score assessed at 10 on 05/03 a period of approximately 10 hour CIWA score assessed at 10 on 05/03 a period of approximately 10 hour CIWA score assessed at 10 on 05/03 a period of approximately 10 hour cIWA score assessed at 10 on 05/03 a period of approximately 10 hour cIWA score assessed at 10 on 05/03 a period of approximately 10 hour cIWA score assessed at 10 on 05/03 a period of approxima 2. At the time of the rethe missing document assessments. Surveyor address the facility's Codependence. Staff #20 not have a specific point the elements of when symptoms of alcohol with provider's order.	idmitted on 07/13/23 with a fective disorder and severe Patient #205 had a provider to written on 07/14/23 at 5 had a CIWA score 14/23 at 7:53 PM, and the WA assessed score was 0 on missing a period of s). Patient #205's next ore assessed was 0 at 7:15 of approximately 5 hours). Admitted on 05/02/23 with a uicide attempt, and alcohol #206 had a provider order ten on 05/02/23 at 10:00 a CIWA score assessed at 7 PM, and the next ore assessed at 12 on missing a period of rs). Patient #206 had a at 1 on 05/03/23 at 8:53 umented CIWA score 104/23 at 8:18 AM (missing tely 11 hours). Eview, Staff #202 verified ed CIWA score or #2 requested a policy to DIWA protocol for alcohol 02 reported the facility does licy for CIWA protocol as	L1070			
	Item #2 Precautions			,		

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	tate of	<u>Washington</u>						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 013250				l l	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		the hospital policy and failed to ensure staff rorders for implementing or 1 of 2 adolescent rate and implemented puts inappropriate, inconsist treatment. Findings included: 1. Document review of procedure titled, "Patie PolicyStat ID #118995 showed the RN or MH the patient observation in individual patient procedure. 2. On 09/05/23 betwee Surveyor #2, Surveyor Compliance Officer/Dirreviewed the medical reviewed the medical reviewed the medical review showed Patient for anorexic precaution 7:56 PM. Patient #201 precautions written uncapatient observation reconstructions reconstructed the medical review showed Patient #201 precautions written uncapatient observation reconstructions reconstructed the medical review showed Patient #201 precautions written uncapatient observation reconstructed the medical reconstruction with the patient observation reconstructed the medical review showed Patient #201 precautions written uncapatient observation reconstructed the medical reconstruction with the patient observation reconstructed the medical reconstruction with the patient observation reconstructed the medical reconstruction with the patient observation reconstruction and the patient process of the patient with the patient process of the patient pro	interview, and review of diprocedures, the hospital numbers followed providering psychiatric precautions medical records reviewed. Cific psychiatric precautions patients at risk for stent, and delayed If the hospital's policy and ent Observation Policy," 84, last approved 06/22, T is to review and update in forms and reflect changes ecaution levels as they In 10:00 AM and 12:50 PM #9, and the Chief rector of Risk (Staff #201) records of Patient #201. -year-old female admitted a suicide attempt. The #201 had a provider order is written on 08/30/23 at did not have anorexic der the precautions on the ord until 09/02/23. Ariew, Staff #201 verified implemented until	L1070				
		Based on document rev	view of the hospital's					

PRINTED: 09/18/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A, BUILDING: B. WNG_ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1070 Continued From page 27 L1070 medical staff rules and regulations, the hospital failed to ensure that the healthcare providers authenticated orders for the care and treatment of patients according to the hospital's medical staff rules and regulations for 4 out of 4 medical records reviewed (Patient #201, #202, #203, and #204). Failure to write and authenticate orders for admission, medications, and treatment risks provision of incorrect and/or inadequate patient care,

Findings included;

- 1. Document review of the hospital policy titled, "Ordering and Prescribing General Requirements, 11" PolicyStat ID #12789868, last approved 01/23, showed the following:
- a. Only individuals authorized by state, federal and local authorities and as defined by hospital policy or Medical Staff Rules and Regulations may prescribe medications.
- b. All orders entered in the computerized order entry (COE) system must be electronically signed within 48 hours.
- c. Telephone orders are e-signed in COE and signed in chart within 48 hours by a provider practicing within their scope of practice.
- 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201 and #202. The review showed the following:

a. Patient #201 was a 14-year-old female with a

State Form 2567 STATE FORM

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **104 W 5TH AVE** INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1070 Continued From page 28 L1070 voluntary admission on 08/30/23 following a suicide attempt. Patient #201 had a telephone order for suicide precautions entered in the COE system on 08/30/23 at 7:55 PM. The order was authenticated by a provider on 09/05/23 at 7:55 AM (a period of approximately 132 hours). Patient #201 had a telephone order for anorexic precautions entered in the COE system on 08/30/23 at 7:56 PM. The order was authenticated by a provider on 09/04/23 at 8:36 AM (a period of approximately 108 hours). b. Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. Patient #202 had a telephone order for sexual aggression precautions entered in the COE system on 09/02/23 at 10:34 PM. The order had not been authenticated by a provider at the time of the review (a period of approximately 59 hours). c. Patient #203 was a 34-year-old female with an involuntary admission on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 had a telephone order for a vegetarian/diabetes mellitus diet entered in the COE system on 08/05/23 at 2:43 PM. The order was authenticated by a provider on 08/09/23 at 9:22 AM (a period of approximately 90 hours). Patient #203 had a telephone order for blood glucose monitoring entered in the COE system on 08/09/23 at 11:26 AM. The order was authenticated by a provider on 08/15/23 at 9:03 AM (a period of approximately 129 hours). Patient had a telephone order for a special diabetic 2000-calorie diet entered in the COE system on 08/22/23 at 5:42 PM. The order had not been authenticated by a provider at the time of the review (a period of approximately 328 hours). State Form 256

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE **INLAND NORTHWEST BEHAVIORAL HEALTH** SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) L1070 Continued From page 29 L1070 Patient #203 had a telephone order to stay in her room and not attend group therapy for 2 days due to medical reasons entered in the COE system on 08/29/23 at 10:39 AM. The order had not been authenticated by a provider at the time of the review (a period of approximately 167 hours). 3. At the time of the review, Staff #201 verified the required missing e-signature of orders by the provider within 48 hours. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranola, and auditory visual hallucinations. The review showed the following: a. Patient #204 had a telephone order miscellaneous Admit/Discharge/Transfer (ADT) for aggressive behavior entered in the COE system on 07/27/23 at 2:33 PM. The order was authenticated by a provider on 08/03/23 at 3:53 PM (a period of approximately 169 hours). b. Patient #204 had a telephone order for aggression/homicidal precautions entered in the COE system on 07/27/23 at 2:25 PM. The order was authenticated by a provider on 08/03/23 at 3:53 PM (a period of approximately 169 hours). 5. At the time of the review, Staff #201 verified the above orders placed by an RN had not been e-signed within 48 hours.

State Form 2567

STATE FORM

SAMPLAND CONTENTION (##) DATE SURVEY ONLY 19250 (##) DATE SURVEY ONLY 19	State c	f Washington				FOF	RM APPROVE	ΞD
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INLAND NORTHWEST BEHAVIORAL HEALTH SUMMARY STATEMENT OF DEFICIENCIES FROM EACH DEFICIENCY MUST BE PRECEDED BY FULL AREALATION OF LOS TORTHYMAG IN-ORMANDON L1105 WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (c) Apsychiatric nurse, employed full time, responsible for directing nursing services. Including: (i) Apsychiatric nurse, employed full time, responsible for directing nursing services two supervise nursing care; This Washington Administrative Code is not met as evidenced by: Item #1 Nursing seessments Based on interview, record review, and review of hospital's policies and procedures, the hospital failed to ensure staff completed nursing shift assessments on the delly progress notes for 2 of 4 patients (Patients #202 and #204). Failure to perform and document shift assessments can lead to evacerbalion of existing medical conditions or tack of recognition of emerging medical conditions. Findings included: 1. Review of the hospital's policy littled, "Format and Content of the Record," PolicyStat ID #1394/2273, last approved 07/23, showed that nursing progress notes are written by an RN at least once each shift and by a nursing staff emerger on second shift as the patients condition	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE			
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PREFIX TAG TAG RESULATORY OR ISE IDENTIFYED INFORMATION) L1105 Continued From page 30 L1105 L1105 L1105 L1105 L1105 L1105 L1105 L1106 L1106 L1106 L1106 L1107 AWA 246-322-170 Patient Care Services (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including; (c) Nursing services, including; (c) Nursing services, including; (c) Nursing services, including; (c) Nursing services, including; (a) psychiatric nurse, amployed full time, responsible for directing nursing services brenty-four hours per day; and (ii) One or more registered nurses on duly within the hospital at all times to supervise nursing care; This Washington Administrative Code is not met as evidenced by; Item #1 Nursing assessments Based on interview, record review, and review of hospital's policies and procedures, the hospital falled to ensure staff completed nursing shift assessments on the daily progress notes for 2 of 4 patients (Patients #202 and #204). Failure to perform and document shift assessments can lead to exacerbation of existing medical conditions or lack of recognition of emerging medical conditions. Firndings included: 1. Review of the hospital's policy titled, "Format and Content of the Record," PolicyStat ID #13942273, last approved 07/23, showed that nursing progress notes are written by an RN at least once each shift and by a nursing staff member on second shift and by a nursing staff member on second shift as the patients; condition	(X4) [D	SUMMARY STA						_
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State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING_ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1105 L1105 Continued From page 31 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical record of Patient #202, Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. The review showed the following: a. On 09/01/23 from 7:00 PM to 7:00 AM, the shift assessment was blank for patient assessment of affect, mood, speech, thought process, thought content, hallucinations, behaviors, social interaction, group attendance, insight, and judgement. The pain assessment was blank for both shifts on 09/01/23. b. On 09/03/23 from 7:00 AM to 7:00 PM, the shift assessment for patient assessment of affect, mood, speech, thought process, thought content, hallucination, behaviors, social interaction, group attendance, insight, and judgement had a line drawn from top to bottom. The pain assessment was blank for day shift on 09/03/23. 3. At the time of the review, Staff #201 verified the missing documentation and stated the expectation is assessments are completed each shift and every box/item should be addressed. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201). and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following:

State Form 2567

STATE FORM

State of Washington						
1	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
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		013250	B. WNG			
NAME OF	DOMANCE OF CHIRDHER				1 09/	07/2023
	PROVIDER OR SUPPLIER	404 184 22		STATE, ZIP CODE		
INLAND	NORTHWEST BEHAVIOR	AL HEALTH	IE, WA 99204			
(X4) ID		TEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
				DEFICIENCY)		
J.1105	Continued From page	32	L1105			
	a. On 07/28/23, the pa blank for night shift.	ain assessment boxes were				
	h On 07/31/23 the ne	eurological, pulmonary,	ł			
	cardiovascular, endoc	rine, genitourinary,				
	gastrointestinal, skin, c	detox, and medication nt boxes were blank for				
	both shifts.	ur boxes wate pigtik tot				
	c. On 08/01/23, the na	in assessment boxes were				
	blank for day shift.	ar additional portage from	ĺ			
	d. On 08/02/23, the pa blank for day shift.	in assessment boxes were				
		view, Staff #201 verified	1			
į	the missing documents	ation and stated the nents are completed each				
	shift and every box/iten	n should be addressed.				ĺ
	Item #2 Charge Nurse	Oversight				
İ	Based on observation,	interview, record review,			ļ	
	and review of hospital p	policies and procedures, povide care in a safe setting				
	by failing to implement	policies and procedures			1	l
ľ	that guide staff to ensur			·		
	rounds are occurring as demonstrated by 4 of 4	records reviewed (Patient			ĺ	
	#201, #202, #203, and	#204).				
	Failure to develop and i	mptement policies and				
	procedures that ensure	patient observation			ľ	
	rounds are occurring as potentially places patier					
	harm or violence.	a. morousus ngiy (o)				ľ
	Findings included:					
to Sam 15g	1. Document review of t	he hospital's policy and				

State of Washington (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ B. WNG 09/07/2023 013250 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L1105 L1105 Continued From page 33 procedure titled, "Patient Observation Policy," PolicyStat ID #11899584, last approved 06/22, showed the following: a. The Charge Nurse ensures that Patient Observations Rounds are conducted according to policy and are occurring as ordered, 24 hours a day, seven days a week. b. Three times per shift, the Charge Nurse reviews all patient observational rounds and initials the supervisor verification. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201 and #202. The review showed the following: a. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. Patient #201 was missing Charge Nurse oversight documentation on 4 of the 5 days reviewed. b. Patient #202 was a 17-year-old female admitted on 08/29/23 following a suicide attempt. Patient #202 was missing Charge Nurse oversight documentation on 5 of the 6 days reviewed. c. Patient #203 was a 34-year-old female admitted on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 was missing Charge Nurse oversight documentation on 30 of the 33 days reviewed. 3. At the time of the review, Staff #201 verified the missing Charge Nurse oversight

State Form 2567

STATE FORM

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L1105 Continued From page 34 L1105 documentation on the Patient Observation Records. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was admitted on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. Patient #204 was missing Charge Nurse oversight documentation on 18 of 20 days reviewed. 5. At the time of the reviews, Staff #201 verified the missing Charge Nurse oversight documentation on the Patient Observation Records. L1150 322-180.1D PHYSICIAN AUTHORIZATION L1150 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: Item #1 Authentication and timing of telephone orders for restraint

State Form 2567

PRINTED: 09/18/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) L1150 L1150 Continued From page 35 Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider authenticated telephone orders per hospital policy for seclusion or restraint for 3 of 4 restraint records reviewed (Patient #903, #906, and #907). Failure to ensure that a provider authenticates an appropriate order for restraints risks psychological harm, loss of dignity, and personal freedom.

State Form 2567 STATE FORM

Findings included:

showed the following:

minutes.

1. Document review of the hospital's policy and procedure titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," PolicyStat ID 13524979, last approved 07/23,

a. Telephone/verbal orders for restraint/seclusion may be received and recorded by an RN or LPN.

b. The physician/LIP must be contacted for the order during the emergency or within a few

1. On 09/05/23 between 2:25 PM and 3:40 PM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. The review showed on 08/15/23 at 6:24 PM, Patient #903 was chemically restrained. Telephone orders were entered by a nurse on 08/15/23 at

b. The physician shall authenticate the telephone/verbal order within 24 hours.

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1	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G:	(X3) DATE SU COMPLE	
		013250	B. WING _		09/07	/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
INLAND	NORTHWEST BEHAVIOR	AL HEALTH 104 W 5	ΓΗ AVE IE, WA 99204			
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	6:31 PM for Benadryl now and Haldol (an armilligrams intramuscul Lorazepam (a sedative Surveyor #9 found no medications had been at the time of the revie approximately 21 days 2. At the time of the revientat the orders were not 3. On 09/06/23 at 4:00 Director of Quality (Stamedical record of Paties on 07/12/23 with a diagonal transport of approximately review showed the a. On 07/14/23 at 3:10 placed in a physical holentered by a nurse on 0 period of approximately restraint). The order was provider on 07/21/23 at approximately 7 days). b. On 07/14/23 at 3:11 I Olanzapine (an antipsydmilligrams intramuscula entered by a nurse on 0 order was authenticated order was authenticated	and the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provider of the provid	L1150	DEFICIENCY)		
] :	authenticated by a proving AM (a period of approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately approximately a	der on 07/21/23 at 7:57				

State Form 2587 STATE FORM

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L1150 L1150 Continued From page 37 d. On 07/15/23 at 11:45 AM, Patient #906 was placed in a physical hold. A telephone order for restraint was entered by a nurse at 2:57 PM (a period of approximately 3 hours). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 6 days). e. On 07/15/23 at 11:50 AM, Patient #906 was chemically restrained. A telephone order for restraint was entered by a nurse at 3:00 PM (a period of approximately 3 hours). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 6 days). 4. At the time of the review, Staff #902 verified the times and dates of the telephone orders and authentications by provider. 5. On 09/07/23 at 8:55 AM, Surveyor #9 and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical chart of Patient #907 who was admitted on 04/18/23 for Manic Depressive Disorder, Generalized Anxiety Disorder and Post Traumatic Stress Disorder. The review showed the following: a. On 05/25/23 at 6:28 PM, Patient #907 was placed in a physical hold (restraint). A telephone order for restraint was entered by a nurse on 05/25/23 at 6:43 PM. The order was authenticated by a provider on 06/08/23 at 8:33 AM (a period of approximately 14 days). b. On 05/25/23 at 6:29 PM, Patient #907 was placed in seclusion. A telephone order for seclusion was entered by a nurse on 05/25/23 at 6:43 PM. The order was authenticated by a provider on 06/08/23 at 8:33 AM (a period of approximately 14 days).

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G:		E SURVEY IPLETED
·		013250	B. WING		09	9/07/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE		
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L1150	Continued From page	38	L1150			
	6. At the time of the rethe times and dated of authentications by properties and proceeding the second review hospital policies and procedure that a restraint or seclusion prestraint records review and #907). Failure to ensure that a appropriate order for repsychological harm, lost freedom. Findings included: 1. Document review of procedure titled, "Proper Physical/Chemical Res PolicyStat ID 13524979 showed that restraint or only in emergency situatorder from a physician.	eview, Staff #901 verified of the telephone orders and vider. It is a very interview, and review of rocedures, the hospital licensed provider ordered er hospital policy for 3 of 4 ved (Patient #903, #906, a provider authenticates an estraints risks as of dignity, and personal er Use and Monitoring of traints and Seclusion", a last approved 07/23, a seclusion shall be used ations and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and requires an extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and extension and				
; v v i i c	Surveyor #9 and Director reviewed the medical rewas a 34 year old femal with a diagnosis of Acut Disorder, and Polysubsi diagnosis of Diabetes. O	or of Risk (Staff #901) cord of Patient #903 who le admitted on 08/02/23 e Psychosis, Bipolar tance Use and a medical on 08/15/23 at 6:24 PM, lcally restrained. Surveyor				

State Form 2587

STATE FORM

State of Washington (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WNG____ 09/07/2023 013250 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 (X5) COVPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L1150 L1150 Continued From page 39 3. At the time of the review, Staff #901 verified that they were unable to find an order for restraint. 4. On 09/06/23 at 4:00 PM, Surveyor #9 and Director of Quality (Staff #902) reviewed the medical record of Patient #906 who was admitted on 07/12/23 with a diagnosis of Suicidal Ideation. The review showed that on 07/14/23 at 3:11 PM, Patient #906 was chemically restrained. Surveyor #9 was unable to find evidence of an order for restraint. 5. At the time of the review, Staff #902 verified that there was no order entered for this restraint. 6. On 09/07/23 at 8:55 AM, Surveyor #9 and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical chart of Patient #907 who was admitted on 04/18/23 for Manic Depressive Disorder, Generalized Anxiety Disorder and Post Traumatic Stress Disorder. The review showed the following: a. On 05/05/23 at 9:07 AM, Patient #907 was placed in seclusion. Surveyor #9 found no evidence of an order for seclusion. b. On 05/05/23 at 9:14 AM, Patient #907 was chemically restrained. Surveyor #9 found no evidence of an order for the chemical restraint. c. On 05/21/23 at 11:25 AM, Patient #907 was placed in a physical hold (restraint). Surveyor #9 found no evidence of an order for the physical hold (restraint). d, On 05/21/23 at 11:35 AM, Patient #907 was chemically restrained. Surveyor #9 found no evidence of an order for the chemical restraint.

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State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X6) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1150 Continued From page 40 L1150 7. At the time of the review, Staff #902 verified that there were no orders for the above restraint episodes. Staff #902 stated that the process is that all verbal/telephone orders should be entered into the computer system, THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 09/27/22. L1155 322-180.1E SECLUSION EXAM L1155 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: (e) A physician shall examine each restrained or secluded patient and renew the order for every twenty-four continuous hours of restraint and seclusion: This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital policy for restraints for 1 of 4 restraint records reviewed (Patient #903). Failure to follow approved policies and procedures for seclusion risks physical and psychological harm, loss of dignity, and violation of patient rights. Findings included:

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING;	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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L1155	Continued From page	41	L1155			٦
	procedure titled, "Propersional Propersion of the patient will be evaluation will be evaluation, an assimmediate situation, an assimmediate situation, an assimmediate situation, an assimmediate situation, an assimmediate and behaviors complete review of systof the need to continue of the need to continue of the evaluation, an assimmediate and behaviors complete review of systof the need to continue of the need	dependent provider, or be documented in the clude the date and time of essment of the patient's in evaluation of the patient's al condition to include a stems, and an assessment or terminate the restraint. an 2:25 PM and 3:40 PM, if #9 and Director of Risk the medical record of a 34 year old female with a diagnosis of Acute order, and Polysubstance gnosis of Diabetes. The 15/23 at 6:24 PM, Patient estrained. Surveyor #9 was a of a face to face view, Staff #901 confirmed cate face to face				
	322-210.3C PROCEDI MEDS	JRES-ADMINISTER	L1375			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S:	(X3) DATE	SURVEY
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INLAND	NORTHWEST BEHAVIOR	AL HEALTH 104 W 5	TH AVE NE, WA 99204			
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L1375	Continued From page	42	L1375			
	WAC 246-322-210 Ph Medication Services, shall: (3) Develop and procedures for prescriand administering medicacording to state and and rules, including: (Administering drugs; This Washington Administering drugs; This Washington Administering drugs; This Washington Administering drugs; This Washington Administration as evidenced by: Item #1 Insulin administration, the hospital policy and failed to ensure staff morders for safe medica 2 insulin administration reviewed (Patient #904) Failure to follow safe morocedures puts patien inadequate medication administration resulting death. Findings included: 1. Review of the hospit titled, "Medication Administration Administration Administration Procedures and The Critical Scheduladministered within 60 is scheduled dosing time as the When medications are stated and procedured dosing time as the When medications are stated and procedured dosing time as the When medications are stated and procedured and procedu	armacy and The Ilcensee implement bing, storing, dications federal laws c) inistrative Code is not met stration interview, and review of procedures, the hospital lembers followed provider tion administration for 1 of medication records l). inedication administration ts at risk of receiving s or unintended medication in patient harm and/or al's policy and procedure inistration," PolicyStat ID ad 05/23, showed the led Medications are minutes before or after the and include insulin. The not given within the	£1375			
	timeframe, nursing is to	document the reason the			ŀ	1

State Form 2567

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1375 Continued From page 43 L1375 dose was missed or delayed. c. Notify the physician for a time critical medication delay greater than 2 hours. 2. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nursing (Staff #903) reviewed the medication administration record of Patient #904. Patient #904 was admitted on 07/27/23 with a psychiatric diagnosis of Schizophrenia and a medical diagnosis of Diabetes. Medication orders were entered by a provider on 07/27/23 at 8:25 AM for insulin (a medication to treat elevated blood sugar) administration before meals using sliding scale coverage and showed the following: a. For blood glucose < 50, Call MD. b. For blood glucose 51-70 No insulin to administer c. For blood glucose 70-124 Regular Insulin Zero units d. For blood glucose 125-174 Regular Insulin 2 units SUB Q (subcutaneous) X 1 e. For blood glucose 175-225 Regular Insulin 4 units SUB Q X 1 f. For blood glucose 226-275 Regular Insulin 6 units SUB Q X 1 g. For blood glucose 276-325 Regular Insulin 8 units SUB Q X 1 h. For blood glucose 326-375 Regular Insulin 10

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units SUB Q X 1

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE C			E SURVEY PLETED
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L1375	Continued From page	e 44	L1375	,		
	i. For blood glucose 3 units SUB Q X 1	376-400 Regular Insulin 12				
	j. For blood glucose >	400 = call Provider.				
		1 AM, Patient #904 had a				
	blood glucose of 248 07/28/23 at 4:37 PM I	milligrams/deciliter and on Patient #904 had a blood				
	glucose of 312 milligra	ams/deciliter. Surveyor #9				
	was unable to find evi	dence of insulin notation as to why the dose				
	was missed, or annote	ation in the medication				
ŀ	administration record	that showed the provider				
	was notified of the mis	ssed dose.				
	4. At the time of the re	view, Staff #903 verified at				
	the above times, there	should have been insulin				
	medication administer was no documentation	ed to the patient, and there				
		ider for a missed dose.				
	Item #2 Medication rea	essessment				
	Based on record revie	w, interview, and review of				
[]	hospital policy and pro	cedures, the hospital failed				
	to ensure staff membe					
	documented reassessi	ments after each n for 1 of 2 medical records				
	reviewed (Patient #202				j	
	Failure to assess befor					
	administration and reas nedication administrati					
	nadequate, or delayed					
F	indings included:					
1	f. Document review of	the hospital's policy and				
p	procedure titled, "Pain /	Assessment,			į	

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FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING: _ COMPLETED B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE **INLAND NORTHWEST BEHAVIORAL HEALTH** SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L1375 Continued From page 45 L1375 Reassessment and Management", PolicyStat ID #10529976, last approved 12/21, showed the following: a. It is the responsibility of all clinical staff to screen all patients for the presence or absence of pain. b. All patients will undergo reassessment of pain at least once per shift while awake and after every pain control mechanism employed by patient care providers. Pain control mechanisms include but are not limited to medications administered for the control or relief of pain and medications administered for the control or relief of anxiety. c. As part of the reassessment, the Multidisciplinary team should assess and document the pain in terms of its duration, characteristics, and intensity as well as the time of the pain, the pain rating, and any use of analgesics. Also include other pain interventions, vital signs, the effectiveness of all interventions, and any side effects or adverse reactions. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical record of Patient #202. Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. The review showed the following: a. On 08/29/23 at 10:20 PM Patient #202 received Tylenol for a 5/10 pain rating. On 08/30/23 at 9:08 AM, a pain reassessment was completed (a period of approximately 11 hours)

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with a rating of "effective".

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NAME OF	PROVIDER OR SUPPLIER	STREET	DDRESS, CITY, S	STATE, ZIP CODE		
INLAND	NORTHWEST BEHAVIOR	AL HEALTH 104 W 5 SPOKAN	TH AVE NE, WA 99204			
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L137	Continued From page	46	1.1375	,	###	
	Vistaril for anxiety. On reassessment was con approximately 9 hours	as "effective".				-
	the delayed reassessn medication.	view, Staff #201 verified nents of as needed				
L1390	322-210.3F PROCEDI	JRES-AUTHENTICATE	L1390			
	as evidenced by: . Based on document revimedical staff rules and a failed to ensure that the authenticated orders for patients according to the rules and regulations for records reviewed (Patie	The licensee implement bing, storing, ications federal laws at the lephone at the light forty-eight histrative Code is not met wiew of the hospital's regulations, the hospital healthcare providers the care and treatment of a hospital's medical staff of 1 out of 4 medical int #204).				
	Failure to write and auth admission, medications, provision of incorrect an care.	and treatment risks				

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **104 W 5TH AVE** INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY L1390 Continued From page 47 L1390 Findings included: 1. Document review of the hospital policy titled, "Ordering and Prescribing - General Requirements, 11" PolicyStat ID #12789868, last approved 01/23, showed the following: a. Only individuals authorized by state, federal and local authorities and as defined by hospital policy or Medical Staff Rules and Regulations may prescribe medications. b. All orders entered in the computerized order entry (COE) system must be electronically signed within 48 hours. c. Telephone orders are e-signed in COE and signed in chart within 48 hours by a provider practicing within their scope of practice. 2. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following: a. Patient #204 had an order for Metformin (a medication used to treat diabetes) entered in the COE system on 07/27/23 at 8:21 AM. The order was authenticated by a provider on 07/31/23 at 8:18 AM (a period of approximately 95 hours). b. Patient #204 had an order for Metformin entered in the COE system on 08/01/23 at 3:12 PM. The order was authenticated by a provider

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on 08/12/23 at 12:49 PM (a period of

approximately 260 hours).

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FORM APPROVED State of Washington (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING. _ B. WNG 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE DATE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY L1390 Continued From page 48 L1390 3. At the time of the review, Staff #201 verified there were 5 medication orders placed by an RN that had not been e-signed within 48 hours. L1410 L1410 322-210.3J PROCEDURES-OUTDATED MEDS 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: (j) Prohibiting the administration of outdated or deteriorated drugs, as indicated by label: This Washington Administrative Code is not met as evidenced by: Based on interview, observation, and document review, the hospital failed to develop and implement procedures for ensuring that medications do not exceed the manufacturer's expiration date. Failure to monitor and establish a systematic process for ensuring medications do not exceed the manufacturer's expiration date risks deteriorated or potentially contaminated medication being available for patient care. Findings included: 1. Document review of the hospital's policy titled, "Multi-Dose Vials, Single-Dose Containers and

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Multi-Dose Bulk Medication Containers, 19", PolicyStat ID #12789922, last approved 01/23,

State of Washington (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: __ B. WNG 09/07/2023 013250 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) (D PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG L1410 Continued From page 49 L1410 showed the following: Labeling Open Multi-Dose vials a. Opened multi-dose vials are labeled with a beyond-use date or discard date, not the date the vial is opened. b. Attach an auxiliary label stating: "Discard unused portion after expiration date of ____ " or "INSULIN DISCARD AFTER 28 DAYS ____ ". "INSULIN DISCARD AFTER 28 DAYS ___ c. Label the container with the beyond-use date based on 28 days from the date the vial is opened; the manufacturer's expiration date; or the beyond-use date determined after reconstitution, whichever is shorter. 2. On 09/05/23 between 9:00 AM and 9:25 AM, Surveyor #2, Surveyor #9, and a Registered Nurse (Staff #204) inspected the 2 East Medication Room refrigerator. The observation showed the following: a. Two open vials of Regular Insulin (Novolin R) 10 milliliters with no date labeled of when opened or when to discard after 28 days. b. One open vial of Humalog Insulin (fast acting insulin) 10 milliliters with no date labeled of when opened or when to discard after 28 days. 3. At the time of the observation Staff #204 verified there was no date labeled on the vials of when opened or when to discard and removed them from use.

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State of Washington (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WNG 013250 09/07/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1485 Continued From page 50 L1485 322-230.1 FOOD SERVICE REGS L1485 L1485 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 interview, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to implement the food safety requirements puts patients, staff, and visitors at risk for development of food borne illness. Findings included: 1. On 09/05/23 at 12:30 PM, Surveyor #4 inspected the hospital's dietary services kitchen with the Director of Plant Services (Staff #401) and the Kitchen Manager (Staff #402). During the inspection, the surveyor observed a bucket of disinfection solution near the dishwasher and asked to see the testing strips. Staff #402 showed the inspector Hydrion QT-40 quaternary test strips with an expiration of 06/30/23. Staff #401 confirmed the strips were expired and could not be used to accurately confirm disinfectant levels in the solution. Reference: Equipment-Manual and mechanical warewashing equipment, chemical sanitization-Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). Washington State Retail Food Code WAC 246-215-04565(1).

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State of Washington (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: 01 013250 B. WING 09/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **104 W 5TH AVE** INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 Initial Comments S 000 This report is the result of an unannounced Fire and Life Safety state survey conducted at the Inland Northwest Behavioral Health on September 6, 2023 by a team of representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) survey teams. The facility has a total of 100 beds and at the time of this survey the census was 77. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a II construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. S 225 NFPA 101 Stairways and Smokeproof Enclosures S 225 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 6, 2023 between approximately 0930 to 1345 hours the facility has failed to maintain

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

State of Washington

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
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	- DENTALOR	SPOKANE	WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 225	Continued From page	····	S 225			
	stairways. This could fire and smoke throug	lead to the rapid spread of hout the facility and expose aff, and visitors to the threats				
	The findings include:					
	The 3rd floor stairwell and latch.	door 3517 does not close				
	The above was discust the facility staff.	ssed and acknowledged by				
S 920	NFPA 101 Electrical E and Extens	quipment Power Cords	S 920		:	
	Electrical Equipment - Extension Cords	Power Cords and				
	Power strips in a patie used for	ent care vicinity are only				
	electrical	ele patient-care-related				
	assembled by	ssembles that have been				
	10.2.3.6.	d meet the conditions of				
*	be used for	sonal electronics), except				
	in long-term	nat do not use PCREE.				
	Power strips for PCREE meet UL 1363	BA or UL 60601-1. Power				
	vicinity)	ient care rooms (outside of				
	strips meet	-patient care rooms, power				
	omer of standards. F	All power strips are used				

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PRINTED: 09/11/2023 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 01 013250 B. WING_ 09/06/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE **INLAND NORTHWEST BEHAVIORAL HEALTH** SPOKANE, WA 99204 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE ю PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) S 920 Continued From page 2 S 920 with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 6, 2023 between approximately 0930 to 1345 hours the facility failed to restrict the use of extension cords and non-approved power strips in their facility. This could endanger patients, staff, and visitors in the facility due to the increased fire risk. The findings include: In the FACP IT Room there is a surge protector hanging not secured to wall or floor. The above was discussed and acknowledged by the facility staff.

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Rec'd 10.4.23 Approved 10.5.23

Plan of Correction for State Licensing Hospital Survey 09/7/2023

Tag I Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
ITEM #1: The CEO, the PI met to rev and Procedur All licensed of Screening/As compliance of admission and consult as new as a complete. ITEM #2: The CEO, The Format and Commade at this The nursing so the Record Prof the nursing admission to thorough reversing in the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversion of the reversio	initiated by the CNO and Registered Dietitian and ed by 10/31/2023. CNO and the Director of PI met to review the content of the Record Policy. No changes were	Chief Nursing Officer Registered Dietitian	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of Nursing Admission Assessments to confirm compliance with completing the nutritional screening located within the admission nursing assessment and appropriate follow through with ordering a nutritional consult as deemed appropriate. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% The Chief Nursing Officer will monitor 50% of our census of Nursing Admission Assessments to confirm compliance with thorough completion of the nursing admission assessment within 8 hours of admission to include the patient orientation section. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality

				Target for compliance >/= 90%
L390	322035.1R POLICIES-PATIENT TRANSFER The CEO, the Director of PI and the CNO met to review the current Minor Emergency Treatment Policy. No changes were made at this time. All licensed Nursing staff were retrained to the Minor Emergency Treatment Policy specific to the requirement that a staff member from the sending facility is required to accompany every patient to the Emergency Department. Training focused on the requirement that the Registered Nurse must give a report to an RN, documentation of report provided and notification of the patient's family. The RN is responsible for notifying the patient's family of the outcome of the transfer to another facility and confirm there is an order entered into the HCS system for transfer. Training was initiated by the Chief Nursing Officer and completed on 10/31/2023.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of patient's sent out for change in condition to confirm patients are accompanied by a staff member. Monitoring will include confirmation that the RN will give report to the ER Registered Nurse and documented this, the RN will notify family of transfer and outcome of transfer and the RN will put an order in HCS for transfer. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L415	322035.2 P&P-ANNUAL REVIEW The CEO and the Leadership Team met to review the Policy Development and Review Process Policy. No changes were made at this time. The CEO retrained the Leadership Team to the Policy Development and Review Process Policy specific to the requirement that all policies and procedures must be reviewed on an annual basis at a minimum. The PI Director will implement a process to review policies on a quarterly basis until 100% are thoroughly reviewed and/or revised.	CEO Leadership Team	11/6/2023	The Director of PI will monitor 100% of policies and procedures for being reviewed annually. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance is 100%

The CEO, the CNO, the Manager of HR and the Clinical Educator met to review the Staff Orientation and Training Plan Policy. No changes were made at this time. The Manager of HR reeducated the Clinical Educator to the Staff Orientation and Training Policy specific to the requirements that every mental health technician has completed orientation to the hospital for the unit they work on. Training was initiated by the Manager of HR and completed on 10/31/2023. The Manager of HR reeducated the Clinical Educator to the Staff Orientation and Training Policy specific to the requirements that every mental health technician has completed on 10/31/2023. Human Resources Clinical Educator Educator Human Resources Clinical Educator All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% Training Was initiated by the Manager of HR and completed on 10/31/2023. Chief 11/6/2023 The Infection Control Nurse will monitor 100%	·	Training was initiated by the CEO and completed on 10/31/2023.		A1646	
The CEO, the CNO, the Clinical Educator and the Infection Control Nurse met to review the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. No changes were made at this time. The CNO retrained the Clinical Educator and the Infection Control Nurse on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of training was specific to the need for compliance with tuberculosis screening process. The Clinical Educator was instructed to give each new hire the tuberculosis screening and perform tuberculosis testing within the first two weeks of hire. TB forms will then be given to the Infection Control Nurse to monitor for compliance. Nursing Officer Nursing Officer Clinical Educator Lordinal Educator Nursing Officer Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%	L585	The CEO, the CNO, the Manager of HR and the Clinical Educator met to review the Staff Orientation and Training Plan Policy. No changes were made at this time. The Manager of HR reeducated the Clinical Educator to the Staff Orientation and Training Policy specific to the requirements that every mental health technician has completed orientation to the hospital for the unit they work on. Training was initiated by the Manager of HR and completed on	Human Resources Clinical	11/6/2023	compliance with completion of orientation to the hospital for the unit they work on. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly.
	L615	The CEO, the CNO, the Clinical Educator and the Infection Control Nurse met to review the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. No changes were made at this time. The CNO retrained the Clinical Educator and the Infection Control Nurse on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of training was specific to the need for compliance with tuberculosis screening process. The Clinical Educator was instructed to give each new hire the tuberculosis screening and perform tuberculosis testing within the first two weeks of hire. TB forms will then be given to the Infection Control Nurse to monitor for compliance.	Nursing Officer Clinical Educator Infection Control	11/6/2023	of the employee health files for compliance with tuberculosis screening and testing. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly.

L720	322-100.1G INFECT CONTROL- PRECAUTION The CEO, the CNO, the Clinical Educator and the Infection Control Nurse met to review the N-95 Fit Testing Policy. Revisions were made to the policy to include that all staff that interacted with patients will be fit tested annually. The newly revised N-95 Fit Testing Policy and Procedure was reviewed and approved by Governing Body on 10/3/2023. The CEO retrained the CNO, Clinical Education and the Infection Control Nurse to this newly revised policy focusing on the staff that need to be fit tested annually. The Clinical Educator will fit test all staff at new hire that interact with patients and the Infection Control Nurse will monitor the data for compliance. Training was initiated by the CEO and completed on 10/31/2023.	Chief Nursing Officer Clinical Educator Infection Control Nurse	11/6/2023	The Infection Control Nurse will monitor 100% of employee health files for compliance with fit testing on all staff that interact with patients to have annual fit testing done. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is >/= 90%
L805	322-120.6A WATER-BACKFLOW The CEO, Regional Director of Plant Operations, the Director of Plant Ops and the Director of Plant to review the citation. The Apollo Company came in and replaced all ice machine drain lines to make sure that they all follow manufacturer's instructions and slope ¼ inch per foot. This was completed on 9/22/2023. The Director of Plant Operations was retrained on following manufacturer's instructions and sloping the ice machine drain lines by ¼ inch per foot. Training was initiated by the Regional Director of Plant Operations and was completed on 9/20/2023.	Director of Plant Operations	11/6/2023	The Director of Plant Operations will monitor 100% of EOC rounds monthly for compliance of the ice machine drain lines sloping ¼ inch per foot. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%
L1050	322-170.2B TREATMENT PLAN-INITIAL The CEO, the CNO, the Director of PI met to review the Plan for Provision of Care-Scope of Services Policy. No changes were made at this time.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of the Initial Nursing Treatment Plans to confirm compliance for completion within 8 hours and addressing medical issues per the nursing assessment.

(The Nursing staff were retrained to the Plan for Provision of Care-Scope of Services Policy to confirm compliance with having an initial nursing treatment plan completed within 8 hours of admission that includes a specific medical treatment plan per the nursing assessment. Training was initiated by the CNO and completed on 10/31/2023. The Day and Noc House Supervisors are responsible for reviewing all new admissions to confirm completion of the initial nursing treatment plan. Findings will be reported to the CNO daily. Training was initiated by the Chief Nursing Officer and competed on 10/31/2023.			Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. The Day and Noc House Supervisors will audit daily the new admissions and report daily to the CNO the results of initial nursing treatment plans being completed, and medical issues being addressed. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
	322-170.2E TREATMENT PLAN-COMPREHENSION The CEO, Medical Director, CNO and the Director of PI met to review the Treatment Planning Policy. No changes were made at this time. The Providers were all retrained by the CMO to the Treatment Planning Policy to confirm compliance with required documentation pertinent to patient's status on the Master Treatment Plan Update Form. Training was initiated by the Medical Director and completed on 10/31/2023. All licensed Nursing staff were retrained to the Treatment Planning Policy to confirm compliance with identifying medical problems on the Master Treatment Plan, completing the Chronic/Stable Treatment Plan on each patient with target dates and specific interventions if needed, completing the Master Treatment Plan Update forms weekly addressing the patient's medical problems and documenting progress towards goals of the medical problems.	Medical Director Chief Nursing Officer	11/6/2023	The Medical Director will monitor 50% of our census of Master Treatment Plan Updates to confirm compliance with Providers updating their portion of the treatment plan. The Chief Nursing Officer will monitor 50% of our census of the Master Treatment Plans and Master Treatment Plan Updates to confirm compliance with identifying medical problems on the Master Treatment Plan, completing the Chronic/Stable Treatment Plan on each patient with target dates and specific interventions if needed, completing the Master Treatment Plan Update forms weekly addressing the patient's medical problems and documenting progress towards goals of the medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

	Training was initiated by the CNO and completed on	T		
	10/31/2023.			
L1070	322-170.2F PHYSICIAN ORDERS	Chief	11/6/2023	The Chief Nursing Officer will monitor 100% of
	ITEM #1	Nursing		patients on CIWA Protocol to confirm
-	The CEO, Medical Director, CNO and the Director of PI met to review the citation. A CIWA Protocol Policy and Procedure was	Officer		compliance with following provider orders.
	made.	Medical		The Chief Nursing Officer will monitor 50% of
		Director		our census of the Patient Observation forms to
	All licensed Nursing staff were retrained to the new CIWA			confirm compliance with updating the patient
	Protocol Policy and Procedure to confirm compliance with			observation form with precautions orders in a
	implementation of the CIWA protocol and assessing the score per the Providers orders.			timely manner.
	·			The Medical Director will monitor 100% of
	CIWA Protocol Policy and Procedure was reviewed and			physician orders to confirm compliance with
	approved by Governing Body on 10/3/2023.	·		electronically signing within 48 hours.
				Noncompliance data will be added to the
	Training was initiated by the CNO and completed on 10/31/2023.			provider's OPPE profile and reviewed quarterly.
				Monitoring will be ongoing for 4 months until
	ITEM #2			compliance of 90% or greater is achieved and
	The CEO, CNO and the Director of PI met to review the Patient			sustained.
	Observation Policy. No changes were made at this time.			
	The Nursing staff were all vetweined to the Detient Observation			Aggregated data will be reported to the Quality
	The Nursing staff were all retrained to the Patient Observation Policy to confirm compliance with updating the patient			Committee, and the MEC monthly and to the
	observation form timely when precaution orders are added	***************************************		Governing Board quarterly. Target for compliance is >/= 90%
	and/or discontinued.			raiset for compliance is 71 - 30/0
	Training was initiated by the CNO and completed on 10/31/2023.			
:				
	ITEM #3			
	The CEO, Medical Director and the Director of PI met to review			
	the Ordering and Prescribing-General Requirements Policy. No			
	changes were made at this time.			

	All Providers were retrained by the CMO to the Ordering and Prescribing-General Requirements Policy to confirm compliance with electronically signing orders within 48 hours. Noncompliance with policy will be dealt with individually with the provider by the CMO. Training was initiated by the Medical Director and completed on 10/31/2023.			
L1105	322-170.3C NURSING SERVICES ITEM #1 The CEO, CNO and the Director of PI met to review the Format and Content of the Record Policy. The Policy was updated to reflect that reassessments of patients occur every shift. All licensed Nursing staff were retrained to the newly revised Format and Content of the Record Policy to confirm compliance with assessments of patients occurring every shift. Focus of this training included completion of the pain assessment. The Format and Content of the Record Policy was reviewed and approved by Governing Body on 10/3/2023. Training was initiated by the CNO and completed on 10/31/2023. ITEM #2 The CEO, CNO and the Director of PI met to the Patient Observation Policy. No changes were made at this time.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of the nursing daily assessment for compliance with occurring every shift including pain assessment. The Chief Nursing Officer will monitor 50% of our census of the Patient Observation forms to confirm compliance with Charge Nurse oversight three times a shift and the Charge Nurse signing the form. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
	All licensed Nursing staff were retrained to the Patient Observation Policy to confirm compliance with the Charge Nurse reviewing all patient observation rounds three times per shift and signing the Observation form. Training was initiated by the CNO and completed on 10/31/2023.			
L1150	322-180.1D PHYSICIAN AUTHORIZATION ITEM #1	Medical Director	11/6/2023	The Medical Director will monitor 100% of restraint and seclusion orders to confirm

The CEO, Medical Director, CNO and the Director of PI met to	Chief	compliance with authenticating orders within 24
review the Proper Use and Monitoring of Physical/Chemical	Nursing officer	hours.
Restraints and Seclusion Policy. No changes were made at this time.	officer	The Medical Director will monitor 100% of
unie.		patients that were in restraint and/or seclusion
The Providers were all retrained to the Proper Use and		for a restraint and/or seclusion order in HCS to
Monitoring of Physical/Chemical Restraints and Seclusion		confirm compliance with orders entered for any
Policy by the CMO to confirm compliance with authenticating		restraint and/or seclusion.
telephone/verbal seclusion and restraint orders within 24		
hours.		The Chief Nursing Officer will monitor 100% of
		patients that were in restraint and/or seclusion
Training was initiated by the Medical Director and completed		for a restraint and/or seclusion order in HCS to
on 10/31/2023.		confirm compliance with orders entered for any
		restraint and/or seclusion by the Registered
ITEM #2		Nurse.
The CEO, Medical Director, CNO, Director of Risk and Director		
of PI met to review the Proper Use and Monitoring of		Monitoring will be ongoing for 4 months until
Physical/Chemical Restraints and Seclusion Policy. No changes		compliance of 90% or greater is achieved and
were made at this time.		sustained.
The Providers were all retrained to the Proper Use and		Aggregated data will be reported to the Quality
Monitoring of Physical/Chemical Restraints and Seclusion		Committee, and the MEC monthly and to the
Policy by the CMO to confirm compliance with orders entered		Governing Board quarterly.
into the HCS system for the restraint and/or seclusion.		
		Target for compliance is >/= 90%
Training was initiated by the Medical Director and completed		
on 10/31/2023.		
The Nursing staff were all retrained to the Proper Use and		
Monitoring of Physical/Chemical Restraints and Seclusion		*
Policy to confirm compliance with entering the telephone/verbal order into HCS for the restraint and/or		
seclusion.		
,		
Training was initiated by the CNO and completed on		
10/31/2023.		

L1155	The CEO, CNO, Director of Risk and the Director of PI met to review the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy. No changes were made at this time. All licensed Nursing staff were all retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy to confirm compliance with a face-to-face evaluation of the patient to be completed within one hour of the initiation of the restraint. This evaluation will be documented in the medical record and include the date and time of evaluation, an assessment of the patient's immediate situation, an evaluation of the patient's medical and behavioral condition to include a complete review of systems, and an assessment of the need to continue or terminate the restraint. Training to the seclusion/restraint packet that includes all required documentation was the focus of this training. Training was initiated by the CNO and completed on 10/31/2023.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 100% of patients that were in restraint and/or seclusion to confirm compliance with a face-to-face evaluation completed within one hour and documented and on the seclusion/restraint packet and kept in the medical record. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS ITEM #1 The CEO, CNO and the Director of PI met to review the Medication Administration Policy. No changes were made at this time. All licensed Nursing staff were retrained to the Medication Administration Policy to confirm compliance with scheduled dosing times of certain medications within 60 minutes before or after the scheduled dosing time. Training focused on the requirement to document the reason the dose was missed or delayed and notification of the physician for a delay greater than 2 hours and document this. Training was initiated by the CNO and completed on 10/31/2023. ITEM #2	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 100% of timed medications to confirm compliance with administering within 60 minutes and documentation if dose was missed and notification of physician if delay was greater than 2 hours. The Chief Nursing Officer will monitor 100% of pain interventions for a reassessment of pain to be completed in a timely manner and documented in HCS. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

	The CEO, CNO and the Director of PI met to review the Pain Assessment, Reassessment and Management Policy. No changes were made at this time. All licensed Nursing staff were all retrained to the Pain Assessment, Reassessment and Management Policy to confirm compliance with reassessing the patient's pain level before and after administering any pain interventions and to document this reassessment in HCS. Training was initiated by the CNO and completed on 10/31/2023.			
L1390	322-210.3F PROCEDURES-AUTHENTICATE The CEO, Medical Director, CNO and the Director of PI met to review the Ordering and Prescribing-General Requirements Policy. No changes were made at this time. The Providers were all retrained to the Ordering and Prescribing-General Requirements Policy by the CMO to confirm compliance with all orders entered into the computerized order entry system are electronically signed within 48 hours. Training was initiated by the Medical Director and completed on 10/31/2023.	Medical Director	11/6/2023	The Medical Director will monitor 100% of orders entered into HCS for compliance with being electronically signed within 48 hours. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
L1410	322-210.3J PROCEDURES-OUTDATED MEDS The CEO, CNO and the Director of PI met to review the Multi-Dose Vials, Single-Dose Containers and Multi-Dose Bulk Medication Containers Policy. No changes were made at this time. All licensed Nursing staff were all retrained to the Multi-Dose Vials, Single-Dose Containers and Multi-Dose Bulk Medication Containers Policy to confirm compliance with labeling opened multi-dose vials with a discard date not an opened date. This date will be 28 days from the date the vial is opened, the manufacturer's expiration date; or the beyond use date, whichever is shorter.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 100% of multi-use vials to confirm compliance with dating the open vials with discard date and not open date. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

	Training was initiated by the CNO and completed on 10/31/2023.		****	
L1485	322-230.1 FOOD SERVICE REGS	Director of	11/6/2023	The Director of Plant Operations will monitor
	The CEO, Director of Plant Operations, Dietary Manager and	Plant		100% of Hydrion QT-40 test strips for expiration
	the Director of PI met to review the citation.	Operations		date.
				Monitoring will be ongoing for 4 months until
	The Director of Plant Operations retrained the Dietary Manager	Dietary		compliance of 90% or greater is achieved and
	to the Washington State Retail Food Code WAC 246-215-	Manager		sustained.
	04565(1) to confirm compliance with monitoring the Hydrion			Aggregated data will be reported to the Quality
	QT-40 test strips for their expiration date.			Committee, and the MEC monthly and to the
	Training was initiated by the Director of Plant Operations and			Governing Board quarterly. Target for compliance is >/= 90%
	completed on 10/31/2023.			ranger for compliance is $7/=30\%$
	The Dietary Manager then trained all kitchen staff to the			
	Washington State Retail Food Code WAC 246-215-04565(1) to			
	confirm compliance with monitoring the Hydrion QT-40 test			
	strips for their expiration date.			
	Training was initiated by the Dietary Manager and completed on 10/31/2023.			

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PO Box 47874 • Olympia, Washington 98504-7874

December 6, 2023

Brenda Arlt, RN Inland Northwest Behavioral Health 104 W. 5th Ave Spokane, WA 99204

Dear Ms. Arlt,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Inland Northwest Behavioral Hospital on September 7-9, 2023. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on October 5, 2023.

Hospital staff members sent a Progress Report dated December 4, 2023, that indicates all deficiencies have been corrected. The Department of Health accepts Inland Northwest Behavioral Hospital's attestation to be in compliance with Chapter 246-320 WAC.

If there were fire life safety deficiencies identified in your report, the Deputy Fire Marshal will perform an on-site revisit after the correction date to verify those corrections.

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.

Samantha Roe

Samantha Roe, MSN, RNS-OB Survey Team Leader