PRINTED: 06/24/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1''		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504002	B WING				C 29/2019
	ROVIDER OR SUPPLIER FAX HOSPITAL			102	EET ADDRESS, CITY, STATE, ZIP-CODE 90 NE 132ND 9T IKLAND, WA 98034		
(X4) ID PREFIX TAG	(EAGH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DÉFICIENCY)		(%5) COMPLETION DATE
A 000	INITIAL COMMENTS	AINT INVESTIGATION	A	000			
	The Washington State (DOH) in accordance Participation set forth Hospitals, conducted Onsite dates: 05/14/1 Intake number(s): #87770 #89607 #89871 #90190 #90327 #90191 #90209 #90163 #90363 The investigation was investigator(s) # 3 # 4 # 9 # 10	e Department of Health with Medicare Conditions of in 42 CFR 482 for this complaint investigation. 9 - 05/17/19; 05/29/19 a conducted by: was found to be NOT IN ne following Medicare of Participation below: ming Body			1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECT!ON must be returned within 10 calendar days from the date you receiv the Statement of Deficiencies, Your Pland of Correction must be postmarked by [specify the date]. 4. Return the ORIGINAL REPORT with the required signatures.	for	
A 043	GOVERNING BODY CFR(s): 482.12		A	043			
ABMBATMSVI	DECTOR OF PROMPER	IDDI ER BERDESENTATIVES SIGNATURE			TITLE 4		(X4) DATE

Any deficiency statement ending with an area as deficiency which the intiliution mentoe excused from correcting providing the determined that other safeguards provide sufficient protection to the petients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versiona Obsolete

Event ID: 18K611

Fecility ID: 000102

If continuation sheet Page 1 of 20

2-8-19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		SURVEY PLETED
			7 2025				C
		504002	B. WING			05/	/29/2019
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 18200 NE 132ND ST CIRKLAND, WA 88034		·
(X4) AD PREFIX TAG	EACH DEFICIENC	ATEMENT OF BEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EÁCH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIV DEFIGIENCY)		(XS) COMPLETION DATE
A 043	legally responsible for if a hospital does not governing body, the profession of the functions specified in governing body This CONDITION is represented in the conduct of the functions specified in governing body This CONDITION is represented in legal to meet the requirem to meet the requirem Condition of Participal Failure to protect the privacy resulted in legal to possible the privacy resulte	ective governing body that is in the conduct of the hospital. have an organized persons legally responsible to hospital must carry out the this part that pertain to the mot met as evidenced by: In, interview, and document alined that the hospital failed ents at 42 CFR 482.12 ation for Governing Body. In patient's right to personal as of personal dignity, and failure to ensure staff had a training, and equipment to a medical emergency and inappropriate es. If severity of deficiencies 2(f)(2) Emergency Services Condition of Participation for bodition of Participation for NOT MET.	A	043			
A 093	EMERGENCY SERV CFR(s): 482.12(f)(2)	/ICES	A	093	CORRECTIVE ACTION: The leadership team met to review the fill from this survey. The Code	ndings	Æ h

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	LE CONSTRUCTION	(X3) DATE:	LÉTEO
		504002	B WING_		05/2	: 29/2019
BHC FAIR	ROVIDER OR SUPPLIER FAX HOSPITAL SUMMARY ST	ATEMENT OF DEFICIENCIES	10	STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034 FROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	e Ate	(X5) COMPLETION DATE
A 093	hospital, the governing medical staff has write	s are not provided at the g body must assure that the ten policies and procedures	A 09	Blue policy, PC 1000.13 was reviewed a arevised to include the use of a back boar responses to a code blue in addition to to oxygen cylinder, the code blue bag and a The revised policy was reviewed and ap by the Medical Executive Committee, an Governing Board.	rd on all he AED. proved	7/3/19
	and referral when app	gencies, initial treatment, propriate. ot met as evidenced by:		A supply of backboards was ordered and received. Each unit and the House Supplesk were supplied with a backboard. A backboard is stored in the facilities departed for future replacement.	ervisor In extra	S/28/19
•	of policies and proced ensure direct care sta	ocument review, and review dures, the hospital failed to		All nursing staff were notified of the local each backboard on each unit, in addition one located at the House Supervisor des person staff meetings, email notification, in person notification.	to the	7/22/19
	resuscitation on a pate resuscitation on a pate . Failure to ensure hos knowledge, skills, trai respond to a patient's delays in activating attreatment. Reference: Basic Life Manual, American He Assess the patient to she is unresponsive shoulder and shout, "a ensure that you don't person. If the patient help and activate the system via mobile demake chest compress possible the victim mi surface. If a patient is mattress, sufficient for	ient (Patient #903). pital staff had the required ning and equipment to medical emergency risks and initiating urgent Support (BLS) Provider eart Association - 2016: determine whether he or Tap the patient on the Are you all right?" This helps begin CPR on a conscieus is unresponsive, shout for emergency response vice (If appropriate) to		All staff were retrained to the revised Copolicy in person, at mandatory staff meet and individually for staff that did not atter staff meeting. Focus of the training inclurequirements of: Immediately initiating CPR after verifying patient's unresponsive. Designating a Code Blue Leaded direct and coordinate all compositing the patient to a hard sure ensure effective chest compres. Utilizing the backboard in the extra patient cannot be moved to surface. Documenting assessment of all the Code Blue Leader. Documenting airway management and/or delivery of rescue breath the Code Blue Leader. Additionally, all nursing staff were retrain the location of supplies in the Code Blue specifically the location of the handheld.	tings and the lided the reness er to ments of reace to slons event that a hard rway by ent ent by ent ent by ent ent by ent ent co ent	//22/19 //22/19
		tne chest and heart to quipment: Backboard or		resuscitation bag (Ambu bag) in the Cod	e Blue	R.

	OT CHAILDICE WILL GI	MLDIGING OLIVIOLO	-,	_		01010 11C	r. 0200-000 r
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504002	B. WING			1	C
		304002	5. 11(145			05/	29 <u>/20</u> 19
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034		
	CUMMADVOT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
A 093	Continued From page	3	А	093	Bag. Understanding was verified by retu demonstration.	m	
'	other firm surface, au	lemaive haismoi	1		ľ		
		ptional: barrier mask with	ľ		†	1	1
	one-way valve, glove	s, and other personal			STAFF RESPONSIBLE; Director of Nurs	gnis	
	protective equipment	•			MONITORING:		
	Findings included:					1	
	1. Document review of	of the hospital's policy and	İ		Code Blue drills are scheduled once per		' i
	procedure titled, "Cod	le Blue," policy #1000.13			week to confirm compliance with appropri		ŀ
	reviewed 05/18, show	ved that staff members	\ 		response to actual Code Blue incidents for months followed by Code Blue drills once		
	trained in cardlopulm	onary resuscitation (CPR)			shift per month.	a hai	j
ĺ		veness and start CPR. The			enit permona.		
		ect the announcement of			The Director of Nursing and/or designee	are	
Ì		d by hospitals to activate			attending all Code Blue events to confirm		
ł	emergency response	•	ļ		immediate initiation of CPR, assignment		1
		on). Staff are to respond to			Blue Leader, placement of patient on a h		:
		en and code blue bag from	1		surface or utilization of a backboard, ass		i
		omated external defibrillator			of alrway, airway management and/or res	CVe	
		tinue until the AED arrives			preathing. All deficiencies are immediate	ely	
		patient to analyze cardias	ļ		corrected to include staff retraining and		. 1
	rhythms. The registe	red nurse (RN) with the	}		disciplinary action as needed.		
i		e patient is to act as the	1		180% of Code Blue events and Code Blu		·
		ecting other staff. The Code			documentation are being audited by the		
		til Emergency Medical			of Nursing or designee to ensure docum		1
·		es and relieves the staff to			of immediate initiation of CPR, assignme		
{	care for the patient.				Code Blue Leader, placement of patient hard surface or utilization of a backboard		
	2. Review of the med	ical record and resuscitation	l		assessment of airway, airway manageme		
	(Code Blue) notes fro	m 02/17/19 for Patient #903	ı		and/or rescue breathing. All deficiencies		,
ĺ	showed:				Immediately corrected to include staff ret and disciplinary action as needed.	raining	[
,	a. Patlent #903 was a				 Monitoring will be angoing for four month]
1		for schizophrenia and	1		compliance is achieved and sustained. A		ł
	alcohol usé disorder.				deficiencies are corrected immediately to		į
	showed many medica				staff retraining as needed. Aggregated d		ŀ
ļ		n, hyperlipidemia, coronary			be reported to the Quality Council, Media		j
ſ	artery disease, venou	s stasis of lower extremities,			Executive Committee and the Governing	Roard	}
	asthma and morbid o	besity.			monthly.		الما
		·		_			Q/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:	(XX) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504002	8 WING		C 05/29/2019	
NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 8200 NE 132ND ST KIRKLAND, WA 98034	animal and a	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
02/17/19 at 12:00 PM blood pressure 120/5 97,8 degrees and responsive patient #903 in his root breathing. d. Document review or showed that a staff must unresponsive in his beadditional staff were motes showed that no and that the patient we breathing), staff began 5:30 PM. The Code B documentation address if resource breathing was the form showed chess without addressing air breathing. At 5:34 PM the patient's chest. At compressions continue breathing was delivered a nonshocker not advise a shock. Carriving EMS crew at 1:40 arriving EMS crew at 1:40 arriving at 1:20 attempted to reach two (Staff #902 and #903)	hiatrist progress note dated , showed vital signs of 1, pulse 89, temperature pirations of 16. DPM, a staff memberfound om unresponsive and not of the Code Blue form ember found the patient ed at 5:30 PM, then tollfied at 5:32 PM. The detectable pulse was found as apneic (cessation of in chest compressions at lue form did not contain esting the patient's alreay or as provided. At 5:34 PM, st compressions continued way management or rescue it, staff applied the AED to 5:40 PM, chest lied without evidence rescue led. At that time the AED sible heart rhythm and did are was transferred to the 5:40 PM. resuscitation notes showed ontinued chest scue measures until 6:03 a patient deceased DPM, investigator #8 o staff nurses by telephone by present during Patient out both attempts were	A 093			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		504002	B. WING _			1	C 29/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 19200 NE 132ND 5T KIRKLAND, WA 98834	P CODE		2012419
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL L SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE AI CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
A 093	Interviewed the Nurse regarding her review resuscitation records present during the Coreviewed video footag #904 Identified the folia. The staff member of patient exited the roo initiating CPR. b. A Code Blue Leadeneeded to direct and of the resuscitation of the resuscitation of the resuscitation of the resuscitation was struggled to move the his large body size. Since was moved to the floor d. Backboards were resuscitation and were hospital's emergency e. Staff had difficulty resuscitation bag and bag-valve-mask unit, respiration) in the Coremergency equipmer. Item #2 - Emergency. Based on interview as hospital failed to ensu	e Educator (Staff #904) of Patient #903's and staff she interviewed, de Blue. Additionally, she ge of the resuscitation. Staff flowing issues: who found the unresponsive on to call for help prior to er (a designated leader coordinate all components was not identified or as performed on a non-firm are ineffective and staff a patient to the floor due to taff #904 noted the patient or using his bed mattress. not available during the e not included in the equipment. finding a handheld I mask (a self-refilling used for artificial the Blue bag containing at. Equipment and document review, the ure emergency equipment allable and accessible to	A	093			Rb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER,	1		E GONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504002	B WING				C /29/2019
	ROVIDER OR SUPPLIER	<u> </u>		١ ،	STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 093	Continued From page	a 6	A	093	·		
	and supplies places ;	dical emergency equipment patlents at risk of inadequate hat could lead to injury or					
	Findings included:						1
	procedure titled, "Cooreviewed 05/18, show	of the hospital's policy and de Blue," policy #1000.13 wed that staff are to respond kygen and code blue bag e autornated external					
ļ	The code blue bag in	ventory includes:					
•	- Bandages and dres	sings.					
	ambu bag (a seif-refi used for artificial resp	it supplies: a CPR mask, lling bag-valve-mask unit, siration), pleatic bite stick s), nasal cannula and mask an delivery).					
	eyewash solution, ice	swabs, alcohol prep pads, packs, antimicrobial hand e, antibiotic cintment, iodine					
	interviewed a Nurse is the Code Blue record board was not used of #903's resuscitation. initially chest compression patient was lying She noted the patient using the bed mattree.	5 PM, Investigator #9 Educator (Staff #904) about I. She stated that a back or available during Patient Staff #904 stated that ssions were conducted while on his bed, atop a mattress. t was moved to the floor, as and then the patient was the floor. A review of the					RC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES . CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1, ,	LE CONSTRUCTION	(X3)-DATH SURVEY COMPLETED
			A. BUILDING		c
		504002	B, WING		05/29/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034	
(%4) ID PREFIX YAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID FREFIX TAG	PROVIDER'S PLAN OF CORRECTII (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	DE COMPLETION
A 093	Continued From page	7	A 09	3	
		ode Blue record did not Include the time it took or staff to move the patient to the floor.			
A 115	PATIENT RIGHTS CFR(s): 482,13		A 11	5	
	A hospital must prote patient's rights.	ct and promote each			
	This CONDITION is n	ot met as evidenced by:			
	Based on observation, interview, record review, and review of hospital policies and procedures, the hospital falled to protect the patient's right to personal privacy.				
	for loss of personal di	privacy puts patlents at risk gnity and psychological g persenal hygiene and			
	Findings included:				
	Failure to provide for personal hygiene and	or privacy while performing dressing activities.			
	2. Fallure to provide p physical skin assessn	ersonal privacy during nents.			,
		of these systemic problems al's inability to provide for			
	under 42 CFR 482.13	severity of deficiencles i, the Condition of nt Rights was NOT MET.			
					Silve

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER-		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANU PLAN OF	- CORRECTION	IDENTIFICATION NUMBER	A. BUILDING]	
		504002	B WING		05	C /29/2019
NAME OF P	HOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			İ	10290 NE 132ND ST		
BHC FAIR	RFAX HOSPITAL			KIRKLAND, WA 98034		
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A 115	Continued From pag	ge 8	A 11	5		
i	Cross-reference: Ta		1	CORRECTIVE ACTION:		i
1	_		1		a findings	1 1
A 117	PATIENT RIGHTS: CFR(s): 482.13(a)(1	NOTICE OF RIGHTS)	The leadership team met to review the f A 117 from this survey and discuss an action p address findings. The Special Needs of Interpreter and Translator Services po 1001.11, was reviewed with no revisions		on plan to a of Patlents a policy PC	
		rm each patient, or when		required at this time.	ions	
		ent's representative (es		required at this time.		\
		law), of the patient's rights, in	1	All the InDemand Interpreter service	machines	6/26/19
		g or discontinuing patient	1	were checked and confirmed to be for		ļ
	care whenever poss	ibie.	Ì	by the COO. The COO was trained		
This STANDARD is not met as evidenced by:		ł	InDemand on how to confirm the fun		1 1	
			the interpreter service machines. The interpreter service machines are che		1 1	
	Gasad on istantour	and record review, the		weekly, by the COO, and replaced in		}
		vide a non-English speaking	ł	by contacting the service provider, w		! !
		preter to translate and explain	1	working properly. Documentation of		1
		and Responsibilities" upon		checks is maintained on the interpre	ter service	
	admission to the hos		ł	machine.		1 1
		, , , , , , , , , , , , , , , , , , ,				7/22/19
	Failure to provide ar	interpreter to a non-English		All admissions staff were retrained be Business Office Director, in person,		1122119
ļ		ranslate and explain their		mandatory staff meetings to the Spe		ļ <u></u>
		sponsibilities potentially		of Patients - Interpreter Services po		
	places patients at ris	k for abuse, neglect or	1	staff unable to attend this mandatory	meeling,	
!	unmet care needs.			Individually training was provided pri scheduled shift. Focus of the trainin		
	Findings Included:		1			
].		j	The use of the inDemand in		j l
İ		of the hospital's policy titled,	- [service for all patients with understanding of English or		ļ (
		atients - Interpreter and	l	English speaking. If the pa		j
		policy # 1001.11 reviewed		the inDemand Interpreter s		
	· ·	at patients that are not fluent	1	site interpreting services wi	ll be offered.	.j .
	in English are offere		l	Patient's refusal to use the		
		mitting staff at no cost . The		interpreter service or on site		4 1
		fered either through IN-	(services will be clearly doct their medical record. Staff		(1
		machine, telephone or an		to attempt completion of all) \
	on-ske service base	d on patient's preference.		paperwork, including the	C411133141	
	7 Dangel englass of l	Patient #902's medical record	1	acknowledgement of receip	t of patient	{
	E Udmin IsaisM DI	, and it wast a literical lection]	rights, every 24 hours until		16
				are thoroughly completed v	ath nationt's	<i>IL [15</i>

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		5 04002	B. WING _				C /29/2019
NAME DE D	ROVIDER OR SUPPLIER		<u> </u>		TREET ADDRESS, CITY, STATE, ZIP CODE	นอเ	28/20 (8
	TO TIPE IT OF GOT I CICIT		l l		9200 NE 132ND ST		
BHC FAIR	FAX HOSPITAL		Í				
		_			KIRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 117.	Continued From page showed:	9	A 1	117	cooperation. All Business Offic signed an attestation verifying t understanding and commitmen following the policy and proced	hair t to	
	involuntarily on 01/11 inability to care for he	anguage was Vietnamese .		!	All clinical staff, including Nursing, Social Services, and Licensed Independent Pro (LIP) were retrained in person, at mandar staff meetings to the Special Needs of Printerpreter Services policy. For staff una attend this mandatory meeting, individual training was completed prior to working the staff under the staff under the services policy.	viders lory atients – bie to I	7/22/19
	patient was unable to of patient rights.	ification étated that the sign to acknowledge receipt entailion in the medical			scheduled shift. Focus of the training included the require inDemand interpreter service for all paties are limited or non-English speaking to coall assessments. If the patient refuses the inDemand interpreter service, on-site	d use of ints who mplete	3
	record that showed the offered or used.	at interpreter services were			interpreting services will be offered. Pat refusal to use the inDemand interpreter s or on site interpreting services will be cla- documented in their medical record. Star	ervice erly	
	licensed independent complete the "Suicide 01/12/19. She wrote of Tool, "No records ave	nt review showed that the provider (LIP) did not seessment Tool" on the Suicide Assessment sitable and patient is unable interpreter machine not			continue to attempt completion of all assessments every 24 hours until assess are thoroughly completed with patient's cooperation. All staff signed an attestatic verifying their understanding and commit following the policy and procedure. STAFF RESPONSIBLE: Director of Nurs	iments on ment to	
	Interviewed the nurse the apparent lack of it	ncord review, Investigator #9 manager (Staff #901) about htterpreter services being			Director of Clinical Services, Business Of Director 100% of InDemand Interpreter carts are I	fice	
	services or document the Interpreter service	d have offered interpreter ed if the patient had refused es. She further stated that contacted an interpreter to			audited weekly by the COO, or designee ensure that the InDemand Interpreter ser functioning. Non-functioning InDemand interpreter service machines will be replate the properties of the properties of the properties are repaired.	, to vice Is ced and	
	interpreter machine w	as not working.	li li		The Business Office Director is auditing a admission paperwork for all patients adm who are limited or non-English speaking, including the notification of patient rights,	itted to	
A 143	PATIENT RIGHTS: P	ERSONAL PRIVACY	A 1	43	ensure the offer, use, and/or refusal of ar interpreting services, including the InDen	ıy	file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		ا ا	:
		504002	B WING			29/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
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BHC FAIR	FAX HOSPITAL			KIRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 143	Continued From page 10 CFR(s): 482,13(c)(1)		A 14	d to ction as		
	_	ght to personal privacy.		needed. 100% of LIP assessments, which include Psychiatric Evaluation, History and Physical Research Tool, for all pati	ical, and	
	This STANDARD is not met as evidenced by: item #1 - Privacy Curtains Based on observation, interview, and review of policies and procedures, the hospital falled to protect the patient's right to personal privacy.			who are limited or non-English speaking being monitored by the CMO or designe completion to ensure the offer, use, and	are e for for	
				refusal of any interpreting services, incluin InDemand interpreter service, is documed All deficiencies will be immediately corre	ented. cted to	
		privacy puts patients at risk		include staff retraining and disciplinary a needed.	ction as	
	for loss of personal dignity and psychological harm while performing personal hygiene and dressing activities.			100% of assessments and patient care documentation on patients with limited or English speaking is being monitored by the designed for compliance with the applications.	ne DON ropriate	
	Findings included:	•		use of InDemand Interpretative services an onsite translator. All deficiencies will immediately corrected to Include staff re-	be	
	procedure titled, "Pat			and disciplinary action as needed.	a zamag	
!	date 12/18, showed to personal privacy. Car	icy number1800.1, effective hat patients have a right to be less rendered in a way that and protects the personal it.		Monitoring will be ongoing for four month compliance is achieved and sustained. deficiencies will be corrected immediatel include staff retraining as needed. Aggreate will be reported to the Quality Counted	All y tø egated cli,	
 - 	the Director of Nursin Child and Adolescent observed that there we the patient bathrooms	0 AM, Investigator #3 and g (Staff #301) toured the l Unit. The investigator vere no privacy curtains for s in rooms #413 and #415. privacy curtain, any staff or		Board monthly.		
	patient could observe Room 415 was assig One of the 2 patients "sexual victimization the male patient (Pati	any activity inside the room. ned to 2 female patients. was identified as being on precautions". In room 413, ient #301) was identified as ault precautions", andwas		CORRECTIVE ACTION: The leadership team met to review the fifteen this survey and discuss an action paddress findings. The Patient Rights and Responsibilities policy, PI 1800.1, was muith no revisions required at this time	lan to	Rla

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED, 08/24/2019 FORM APPROVED OMB NO. 0938-0391

1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER)	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A. BUILUIN	NO _		1	С
		504002	B. WING_				29/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	81	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	18	200 NE 132ND ST		
BHC FAIR	FAX HOSPITAL			K	IRKLAND, WA 98034		
(X4) ID		ATEMENT OF DEFICIENCIES	[D		PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
A 143	Continued From page	a 11	A 1	142	Immediately, all patient rooms and bathrowere checked by the Director of Plant		6/26/19
	subject to monitoring	every 5 minutes because	<u> </u>		Operations and confirmed all patient rocu pathrooms had a privacy curtain in place		
		ntered another patient's	1	ľ	oathrooms had a phyacy curtain in place	•	
1		bathroom while the patient was tolleting.			A check for privacy curtains was added to	o the	7/22/19
			ļ		daily room check audit performed by unit		
		rvation, Investigator #3			All nursing unit staff were retrained by the		
		lor of Nursing (Staff #301) at			Director of Nursing and/or designee to th Patient Rights and Responsibilities policy		
		bsence of privacy curtains in			specific to the importance of providing pa		
	patients frequently pu	s. Staff #301 stated that the		þ	their privacy at all time. Focus of this trail	ining	
	patients nequently pu	iii down the cuitaina.			ncluded confirming on every shift that all		
	A Program Specialist	(Staff #302), stated during	}		rooms and bathrooms have privacy curta place. Nursing staff who observes a mis		
	an interview at 10:00				privacy curtain will immediately have this		•
i		re observed missing in the			replaced by contacting the Facilities man		'
	rooms.			•	and replacing them immediately.	- •	
i	Item #2- Skin Checks	;			The Skin Assessment policy, PC 1001.40 reviewed and revised to include a specific		7/22/19
					for all skin assessments to be completed		
		eview of recorded video		į	units. In all units, with the exception of S	outh	
	_	f policies and procedures, mplement and evaluate a			Unit, the skin assessment will be comple		
	•	kin check/search process			using the bathroom next to the seclusion The seclusion room will not be used for t		i
		t's right to personal privacy.]		assessment. On the South Unit, the unit		
					bathroom will be the place designated for		
	Failure to implement	and evaluate a standard			essessments for all patients admitted to	South	
		to inconsistent skin check	ļ		Unit. There are no cameras located in the		
		illents at risk for violating			bathrooms designated for completion of it assessment. The revised policy was rev		
	their right to personal				and approved by the Quality Council, Me		
	рзуспоюдіса: пагт а	nd loss of personal dignity.			Executive Committee, and the Governing		
	Findings included:				The Search for Contraband policy, PC 10 was reviewed. It was revised to include:		7/22/19
		ne hospital policy titled,			contraband checks will be completed as	-	
ĺ		esponsibilities," policy	ĺ	į	the skin assessment in the designated by	athroom	
		live 12/18, showed that			next to the seclusion room. On the South		
	, –	o personal privacy. Care is			the contraband checks will be completed designated unit bathroom. There are no o		
		at considers, respects, and	}		ocated in these bathrooms designated fo		
	protects the personal	dignity of each patient.			completion of the skin assessment. The	revised	
	a Review of the boom	oltal's policy titled, "Skin			policy was reviewed and approved by the	 Quality 	- د د ص
	e. Geriote Of Ale Hosp	nter a bálich mica! Othi	L		Council, Medical Executive Committee, a	ind the	Kh

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLÍA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF DEFICIENCES CORRECTION	(X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, -, ··· -				LETED
		504002	B. WING			1	C
NAME OF THE	ROVIDER OR SUPPLIER	304002	3. ******		TREET ADDRESS, CITY, STATE, ZIP CODE	US	29/2019
NAME OF P	KOVIDER DR BUFFLER				0200 NE 132ND ST		
BHC FAIR	FAX HOSPITAL			í	CIRKLAND, WA 98034		
(XA) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	Įp.	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
 -					Governing Board.		
A 143	Continued From page	e 12	A	143	 All nursing staff, including Program Spe	-taliets	
	Assessment," policy i	number 1001.40, revised			were retrained to the revised Skin Asset		7/22/19
		pon arrival on the unit, the	}		and revised Search for Contraband police		
	patient will go to a pri	ivate area, remove their	1		person, at mandatory staff meetings and	l in	
		d don a hospital gown. Once			person trainings for those who were una		
	they are gowned, pat	tients will go to a secondary			attend. Focus of the trainings stressed		
	•	ered Nurse (RN) will perform	1		importance of maintaining the privacy a		
		while another staff momber	[of patients during the skin assessment a search for contraband by:	na	
	•	nt's clothing for contraband.			Staff were trained to the Search	n for	
		staff will return all allowed			Contraband policy, which inclu		
		the patient. At all times the	Ì		requirement that no squatting		
	patient's privacy and	dignity will be respected.	ļ		coughing is to be used during	the	
	D 0-054440 b.b.	00:50 444 00 444			Search for Contraband.		
		een 09:50 and 11:20 AM,	1		Consistently use the designate		
	staff about the admis	iewed seven (7) direct care	İ		bathroom next to the seclusion for all skin assessments. On t		
		ree (3) staff interviews (Staff	Į		Unit, the unit bathroom will be		1
	#401, #402, #403) re		}		designated place for skin		ļ J
	#701, #702, #703/16	vesies the following.	l		assessments.		
	a The Investigator a	sked a Registered Nurse			 Ensuring that the skin assessm 	ent and	
	-	he South unit about the	}		search for contraband is done		
		ng initial skin checks and			area that is not video recorded		
		for patients once they are			the designated room per revise	90	
		The interview included			policy. • There should never be the nee	d to	
-	questions about the r	number and types of staff	1		complete any patient assessm		
	who perform the skin	checks, as well as where			room with a camera to ensure		
	•	. The RN stated that usually			privacy.	•	
		orm the initial check, but			 Ensuring that two staff member 		
	there have been time	s when only 1 staff person	\		present throughout the comple		
	was available to cond	duct the skin check and			the skin assessment per policy		
	search,				documentation of both staff on assessment document.	tue skin	
	 	-Lada Burasa Burasa			4		
		sked a Program Specialist			STAFF RESPONSIBLE: Director of Nu	sing and	
		st unit about the process for n checks and contraband			Director of Plant Operations		
		once they are admitted to	1		MONITORING:	1	i i
		w included questions about			MONITORING: All patient bedrooms with bathrooms are	heica	
		s of staff who perform the			audited dally during room checks by uni	t staff to	
		as where the exams take			ensure that privacy curtains are in place		
]		ber stated that staff perform			Facilities department will be notified and		116

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (PLE CONSTRUCTION (X3) DATE SURVEY				
	CORRECTION	IDENTIFICATION NUMBER:	, ,		COMPL	ETED
		504002	B WING.)	
NAME OF D	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	05/2	9/2018
NAME OF F	MOSIDER OR BUTTLER	₽		10200 NE 132ND ST		
BHÇ FAIR	FAX HOSPITAL					
-				KIRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	atement of deficiencies Y must be preceded by full Lec identifying information)	PREFIX TAĞ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(25) Completion Date
	A 143 Continued From page 13 skin checks in Room 505 (a seclusion room). The investigator observed that the seclusion room had a camera mounted on the wall near the celling. The staff member also stated that 2 people can do the skin checks, but 1 person can do it if it is a male staff member and a male patient. c. The Investigator asked a Registered Nurse (RN) (Staff #403) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that she performed them alone due to lack of staff, unless the patient showed agitation. She stated that she had patients change into a gown or cover themselves with a blanket in the seclusion room bathroom, and then she performed the skin check in the seclusion room. The investigator asked about the camera		A 14	curtains will be replaced immediately if a noted to be missing. The Director of Nursing and/or designee confirming compilance by completing we audits of the daily room checks. All deficient will be corrected immediately to include a retraining and disciplinary action as need. The Facilities department staff is auditing patient bedrooms with bathrooms, once passent. All deficiencies will be immediated corrected to include staff retraining and disciplinary action as needed. Nursing Leadership is observing a minimulation on each unit, daily to confirm compliance the revised Skin Assessment and Search Contraband policies. A variety of staff mand shifts are being audited to ensure full compliance. All deficiencies will be immediated to include staff retraining and disciplinary action as needed. Senior Leaders are interviewing staff on unit weekly to ensure that staff are able to verbalize the correct procedures regarding.	is ekly clencies staff led. g all per traband with a for embers lidistely each to	
	Following the intervieunit's Program Managstatus of the camera staff member stated ton, but no active mon 3. On 05/14/19 at 10: Interviewed a Program about the skin check done upon admission the skin check procespatient squat and the	55 AM, Investigator #3 in Specialist (Staff #302) and clothing search process . Staff #302 stated part of		revised Skin Assessment and revised Set Contraband policies. All deficiencies will immediately corrected to include staff ret and disciplinary action as needed. Monitoring will be ongoing for four month compliance is achieved and sustained. Adeficiencies will be corrected immediately include staff retraining as needed. Aggredata will be reported to the Quality Counted Medical Executive Committee and the George Monthly.	sarch for be raining is until All y to egated cil,	£/a

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OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		. ,	A, BUILDING	·	ļ	c	
		504002	B WING_			05/29/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP GODE 10200 NE 132ND ST KIRKLAND, WA 98034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 143	0 - Million - Carlo Parge	a 14 uat was that some patients	A 14	3			
	interviewed a nurse () East Unit of the Kirkla perform skin checks o stated that all patients assessment performe the admission proces that patients are esco- room and the initial si bathroom (no video o	ed by two nurses as part of s. Staff #1004 confirmed orted to the seclusion/quiet kin assessment begins in a amera) where patients are					
	nurse examines the e tattoos, wounds, etc., member searches the weapons. After a pati assessment and clot	(camera present), one entire skin for cuts, marks, and the second staff					
· .	Director of Nursing (S video camera in the s						
	the Risk Manager Co reviewed a video reco #1003) skin assessm A review of the footag	sign/quiet room that contains athroom. Inside the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE BURVEY COMPLETED	
		504002	B. WING				C /29/2018
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 0299 NE 132ND ST SRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	(D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 143	proceeded to undress door was wide open (handed him a gown to the patient and nurse room (camera present assessment. The sect observed opened, whe examining the patient back, throughly. Revisecond staff member door, while leaving the ajar, allowing other patiently nude patient, staff member walking room, only to return a The door remained of the patient removed from the patient removed from the patient was given bottoms, sacks, and staff #1006 confirmed room door was opened the patient's skin chembers who provide North Everett campus Staff #1002) interview a. A staff member (St patients undergo a ske by two nurses as part	to the antercom), then staff to the antercom), then staff to don. The video showed enter the seclusion/quiet at), the location for the skin lusion room door was sen the nurse began is hands, arms, chest and ew of the footage showed a looking through the open e main door (out to the unit) atients and staff to view the The footage showed a third in the room, then exit the not leave the roomagain. pened (out to the unit) while his underwear and shoes, tootage, the investigator the exam you can see a open door, allowing the room. After the exam, an orange scrub top, shoes, then escorted out of that the seclusion/quiet at to the main hallway during	A	143			A.S.

c	(XS) DATE SURVEY COMPLETED	
504002 B WING	19040	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/2015	
BHC FAIRFAX HOSPITAL 10200 NE 132ND ST KIRKLAND, WA 98034		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 143 Continued From page 16 begins in a bethnoom (no video camera) where patients are asked to remove all clothing and then taken to a secondary area, usually the seclusion/quiet room (video camera present). One nurse examines the patient's skin for cuts, marks, tattoos, wounds, etc., and the secondataff member searches the clothing for drugs or wespons. When staff have completed their examination of the patient's clothing and their skin assessment, patients can enter the unit. However if a patient refuses a skin check/assessment, they are placed on a 1:1 observation until they complete the assessment. Staff #1001 verbalized hie understanding that the quell/seclusion room is equipped with a video camera but is not sura if patients are informed of the camera's presence. b. A staff member (Staff #1002) stated that new patients are escorded to the seclusion/quiet room, lead inside the adjacent bathnoom (with the door ajar) where they fully undress and don a hospital gown. After they have donned a gown, staff ascort the patient inside the seclusion/quiet room where an RN performs the patient's skin check by having the patient remove parts of the gown to expose the patient's skin. Staff member #1002 stated that she will ask patients to squat to see if anything drops, but acknowledged that asking the patient to squat to see if anything drops, but acknowledged that asking the patient to squat to see if anything drops, but acknowledged that asking the patient to squat to see if anything drops, but acknowledged that sking the patient to squat to see if anything drops, but acknowledged that sex graphs and the staff member if video racordings are conducted for the skin check. Staff #1002 stated that she was unsure if the video camera in the Sochision/quiet room records the patients's sascenament.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.			(XZ) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		1	A BUILDING	·		C	
		504002	B WING_		_ n	5/29/2019	
NAME OF P	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>	
5110 CAIS	CAVILOGRITA:			10200 NE 132ND ST			
BHC FAIR	FAX HOSPITAL			KIRKLAND, WA 98034			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI. LSC IDENTIFYING INFORMATION)	(D PREFIX TAG	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE	
A 143	Continued From pag	e 17	A 14	43			
	the unit's Nurse Manavideo cameras in the a video camera is procomed and is constant. The recording function is movement in the mare not available to a recordings are available to a recordings are available to a recording of a patient assessment performs the footage showed the bathroom, adjact room (inside the anterproceeded to undressed door was wide open handed her a gown to patient and nurse en There the skin check examining the patient and then the patient was stand undressed with the dwhile another staff mather room. The video was closed to the undexam, the patient was stand to ack.	table for review by leadership only. Itaff #1003 provided a video of the control of the control of the control of the patient was escorted to the seclusion/quiet					
:	primary area (bathro	at skin checks begin in a om without camera) where s, then don a hospital gown				100	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 *****	E CONSTRUCTION	(X3) DATE COMPI	
		\$ 04002	B WING		05/2	C 29/2019
	ROVIDER OR BUPPLIER		1	BTREET ADDRESS, GITY, STATE, ZIP CODE 19200 NE 132ND ST KIRKLAND, WA 98034		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ε	COMPLETION DATE
A 143	and taken to a secon	ndary location (private area, ew) to perform the skin 1003 added that the process	A 143	CORRECTIVE ACTION: The leadership team met to review the fir from this survey and reviewed the Seclus Restraint-Physical Hold policy, PC 1000. revisions were required at this time.	sion-	
A 166	CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be— (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on record review, interview, and document review, the hospital failed to modify the patients in 2 of 5 (Patients # 901 and #902) patient records reviewed. Failure to modify care plans when patients are in restraints, placed patients at risk of harm by not meeting physical and emotional needs. Findings included: 1. Document review of the hospital's policy and procedure titled, "Seclusion/Restraint/Physical Hold," policy # 1000.53 reviewed 05/18, showed that updates to the Treatment Plan of Care must be completed within 24 hours to reflect seclusion/restraint intervention and chasters in restraint intervention and chasters in the requirement of updating freatment Plan of Care within 2 a hours to reflect seclusion/restraint intervention and chasters to the requirement of updating intervention and chasters to the patients are in reatment approach, if indicated. Treatment Plan of Care must be corrected immediately concerned individually with staff that did not attend training. STAFF RESPONSIBLE: Director of Nu MONITORING: 100% of seclusions and restraints (mee and physical) are reviewed concurrently Nursing Supervisors on duty to confirm completeness of documentation, incluid updating of the Treatment Plan within 2 of a seclusion, restraint, or physical hold deficiencies will be immediately corrected include staff retraining and disciplinary included. MONITORING: 100% of seclusions and restraints (mee and physical) are reviewed concurrently Nursing Supervisors on duty to confirm completeness of documentation, incluid updating of the Treatment Plan within 2 of a seclusion, restraint, or physical hold deficiencies will be immediately corrected include staff retraining and disciplinary included. MONITORING: 100% of seclusions and restraints (mee and physical) are reviewed concurrently Nursing Supervisors on duty to con		Seclusion-Restraint-Physical Hold policy, specifically to the requirement of updating Treatment Plan of Care within 24 hours to seclusion/restraint intervention and chang treatment approach, if indicated. Training completed during mandatory staff meetin individually with staff that did not attend to training. STAFF RESPONSIBLE: Director of Nurse.	g the lo reflect ges in gs were res and the staff sing sanical by Unit horough g hours . All d to ction as station is neger sees will will be	7/22/19	
		sligator #9 conducted a of five (5) patients placed in				Sil.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
1		504002	B. WING	B. WING		C 05/29/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
A 166	seclusion or restraints (Patients #901 and #8 the patients' care plan seclusion/restraint into 3. At the time of the reinterviewed the Nurse	a. In 2 of 5 records reviewed, 902) staff falled to update as to reflect erventions. scord review, Investigator #9 a Manager (Staff #901) atment plans. The staff	A 16				
						166	

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPFLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING. C R. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND 87 BHC FAIRFAX HOSPITAL KIRKLAND, WA 98034 SLIMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X8) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR USE IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY LOOF INITIAL COMMENTS L 000 STATE COMPLAINT INVESTIGATION 1. A written PLAN OF CORRECTION is The Washington State Department of Health required for each deficiency listed on the (DOH) in accordance with Washington Statement of Deficiencies. Administrative Code (WAC), Chapter 246-322 2. EACH plan of correction statement Private Psychiatric and Alcoholism Hospitals. conducted this complaint investigation. must include the following: Onsite dates: 05/15/19 - 05/17/19: 05/29/19 The regulation number and/or the tag Examination number(s): number: 2018-17976 HOW the deficiency will be corrected: 2019-3919 WHO is responsible for making the 2019-3716 correction: 2019-5267 WHAT will be done to prevent 2019-5934 reoccurrence and how you will monitor for 2019-6579 continued compliance; and Intake number(s): WHEN the correction will be completed. #87770 3. Your PLANS OF CORRECTION must #89607 #89871 be returned within 10 #90190 calendar days from the date you receive #90209 the Statement of Deficiencies, Your Plans #90363 of Correction must be postmarked by The investigation was conducted by: Investigator(s): 4. Return the ORIGINAL REPORT with #10 the required signatures #9 #4 #3 There were violations found pertinent to this complaint. L 320 322-035.1D POLICIES-PATIENT RIGHTS L 320 State Form 2567

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

Carp ()

Joesaty Officer 18KB11

(XB) DATE

If continuation shoot 1 of 13

State of Washington STATEMENT OF DEFICIENCIES (X3) DATE BURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: __ C 000102 B WING 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 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 DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSG IDENTIFYING INFORMATION; TAG DEFICIENCY L 320 L 320 Continued From page 1 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: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: Item #1 - Privacy Curtains Based on observation, interview, and review of policies and procedures, the hospital failed to protect the patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm while performing personal hygiene and dressing activities. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Rights and Responsibilities," policy number 1800.1, effective date 12/18, showed that patients have a right to personal privacy. Care is rendered in a way that considers, respects, and protects the personal dignity of each patient. 2. On 05/15/19 at 9:50 AM, Investigator #3 and the Director of Nursing (Staff #301) toured the Child and Adolescent Unit. The investigator observed that there were no privacy curtains for the patient bathrooms in rooms #413 and #415.

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Without the bathroom privacy curtain, any staff or

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L 320	Continued From page	⊋2	L 320			
		any activity inside the room.]		İ	
		ned to 2 female patients.	1 1		<u> </u>	
		was identified as being on				ı
		precautions ^a . In room 413,				ı
	• •	ient #301) was identified as				
		ault precautions", and was				
		every 5 minutes because				
	bathroom while the p	intered another patient's				
	i parillonili Mille ale bi	sticilit Mac Wilefith.				
	3. Following the obse	rvation, Investigator#3				
I.	_	tor of Nursing (Staff #301) at				
		bsence of privacy curtains in				
	the patient bathrooms	s, Staff #301 stated that the				
	patients frequently pu	all down the curtains.	1 1			
	4 Program Specialist	(Staff #302), stated, during				
	an interview at 10:00					
		re observed missing in the				
	rooms.					
	Item #2- Skin Checks	1				
	Boned on intentions -	nulmu of recorded vides	1			ŀ
		eview of recorded video of policies and procedures,				
		mplement and evaluate the	}			ł
		/assessment process that	[1
		ght to personal privacy, as	1			1
		ff interviews and review of 1]			1
	Patient's video record	led skin assessment				ı
	(Patient #1003),					
	Egilum to Implement	and evaluate a standard				
		and evaluate a standard to inconsistent skin check				
		itients at risk for violating				
	their right to personal					
		nd loss of personal dignity.				
	E January Grand Hamilli W	many.				
	Findings included:					
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	"Patient Rights and R number 1800.1, effect patients have a right in rendered in a way the protects the personal at Review of the hosp Assessment," policy in 05/18, showed that up patient will go to a pricothing in private and they are gowned, patient will inspect the patient will inspect the patient will inspect the patient After the check, the sarticles of clothing to patient's privacy and 2. On 05/14/19 betwee investigator #4 intervistaff about the admission Kirkland campus. The #401, Staff #402, Stafollowing: a. The investigator as (RN) (Staff #401) in the process for conducting contraband searches admitted to the unit. In questions about the right who perform the skin the exams take place 2 staff members perfethere have been time	ee (3) staff interviews (Staff				

State Form 2567

PRINTED: 06/25/2019 FORM APPROVED State of Washington (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY L 320 L 320 Continued From page 4 b. The Investigator asked a Program Specialist (Staff #402) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that staff perform skin checks in Room 505 (a seclusion room). The investigator observed that the seclusion room had a camera mounted on the wall near the ceiling. The staff member also stated that 2 people can do the skin checks, but 1 person can do it if it is a male staff member and a male patient. c. The Investigator asked a Registered Nurse (RN) (Staff #403) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that she performed them alone due to lack of staff, unless the patient showed agitation. She stated that she had patients change into a gown or cover themselves with a blanket in the seclusion room bathroom, and then she performed the skin check in the seclusion room. The investigator asked about the camera surveillance in the seclusion room. The staff member stated that the camera is turned off unless a patient is in the room for seclusion.

Following the interview, the Investigator asked the unit's Program Manager (Staff #404) about the status of the camera in the seclusion room. The staff member stated that the cameras are always

on, but no active monitoring occurs.

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State of Washington (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED. AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BLILDING: 000102 B. WNG 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 88034 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ĺĎ COMPLETE (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 DEFICIENCY L 320 Continued From page 5 L 320 3. On 05/14/19 at 10:55 AM. Investigator #3 interviewed a Program Specialist (Staff #302) about the skin check and clothing search process done upon admission. Staff #302 stated part of the skin check process includes having the patient squat and then checking for any visible contraband. Staff #302 indicated the reason for having the patient squat was that some patients hide contraband. 4, On 05/15/19 at 2:00 PM, Investigator #10 interviewed a nurse (Staff #1004) assigned to the East Unit of the Kirkland Campus about how staff perform skin checks on the unit. Staff #1004 stated that all patients undergo a skin assessment performed by two nurses as part of the admission process. Staff #1004 confirmed that patients are escorted to the quiet (seclusion) room and the initial skin assessment begins in a bathroom (no video camera) where patients are asked to remove all clothing. In the quiet room/seclusion room (camera present), one nurse examines the entire skin for cuts, marks. tattoos, wounds, etc., and the second staff member searches the clothing for drugs or weapons. When staff have completed their examination of the patient's clothing and their skin assessment, patients can enter the unit. During a subsequent interview at 3;00 PM, the Director of Nursing (Staff #1005), stated that the videe camera in the quiet room, lecated in the East unit, is fully functioning. However, conducting skin checks in the unit's quiet (seclusion) room is not their practice. 5. On 05/16/19 at 11:50 AM, Investigator #10 and the Risk Manager Coordinator (Staff #1006) reviewed a video recording of a patient's (Patient

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L 320	A review of the footage escorted to the seclus an anteroom and a bathroom (no camera proceeded to undress door was wide open (handed him a gown to the patient and nurse room (camera present assessment. The sect observed opened, which examining the patient back, throughly. Reviewed opened, while leaving the ajar, allowing other partially nude patient staff member walking room, only to return a Tha door remained op the patient removed in During review of the fobserved that during the patients walk past the individuals to see into the patient was given bottoms, socks, and a the room(s). Staff #1006 confirmed	ent performed on 05/09/19. le showed a patient sion/quiet room that contains athroom. Inside the present), the patient to the antercom), then staff to don. The video showed enter the seclusion/quiet t), the location for the skin lusion room door was en the nurse began is hands, arms, chest and ew of the footage showed a looking through the open e main door (out to the unit) attents and staff to view the The footage showed a third In the room, then exit the not leave the room again. bened (out to the unit) while vis underwear and shoes. cotage, the investigator the exam you can see e open door, allowing the room. After the exam, an erange scrub top, shoes, then escorted out of it that the seclusion/quiet ed to the main hallway during	L 320		
L 335	322-035.1G POLICIE	S-EMERGENCY CARE	L 335		
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State of Washington STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING . C R. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST BHC FAIRFAX HOSPITAL KIRKLAND, WA 98034 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRICCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG TAG DEFICIENCY) L 335 L 335 Continued From page 7 Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (g) Emergency medical care, including: (I) Physician orders; (ii) Staff actions in the absence of a physician; (ili) Storing and accessing emergency supplies and equipment: This Washington Administrative Code is not met as evidenced by: Based on Interview, document review, and review of hospital policies and procedures, the hospital failed to ensure hospital staff took appropriate immediate actions to address an emergency resuscitation on a patient (Patient #903). Failure to ensure hospital staff had the required knowledge, skills, training and equipment to respond to a patient's medical emergency risks delays in activating and initiating urgent treatment. Reference: Basic Life Support (BLS) Provider Manual, American Heart Association - 2016: Assess the patient to determine whether he or she is unresponsive. Tap the patient on the shoulder and shout, "Are you all right?" This helps ensure that you don't begin CPR on a conscious person. If the patient is unresponsive, shout for help and activate the emergency response system via mobile device (if appropriate) ... to make chest compressions as effective as possible the victim must be placed on a firm surface. If a patient is on a soft surface, such as a mattress, sufficient force cannot be achieved to allow compression of the chest and heart to create blood flow ... Equipment: Backboard or

State Form 2587

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 (X5) COMPLETE DATE **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) IAG TAG DEFICIENCY L 335 L 335 Continued From page 8 other firm surface, automated external defibrillator (AED), Optional: barrier mask with one-way valve, gloves, and other personal protective equipment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff members trained in cardiopulmonary resuscitation (CPR) will verify unresponsiveness and start CPR. The staff member is to direct the announcement of Code Blue (term used by hospitals to activate emergency response for patients requiring immediate resuscitation). Staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED), CPR is to continue until the AED arrives and is attached to the patient to analyze cardiac rhythms. The registered nurse (RN) with the most knowledge of the patient is to act as the Code Blue leader, directing other staff. The Code Blue is to continue until Emergency Medical Services (EMS) arrives and relieves the staff to care for the patient. 2. Review of the medical record and resuscitation (Code Blue) notes from 02/17/19 for Patient #903 showed: a. Patient #903 was a 58-year-old patient admitted on 01/30/19 for schizophrenia and

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alcohol use disorder. The patient's history showed many medical comorbidities that included: hypertension, hyperlipidemia, coronary artery disease, venous stasis of lower extremities,

b. Review of the psychiatrist progress note dated

asthma and morbid obesity.

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PRINTED: 06/25/2019 FORM APPROVED

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: C B. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) IO (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY L 335 Continued From page 9 L 335 02/17/19 at 12:00 PM, showed vital signs of blood pressure 120/51, pulse 89, temperature 97.9 degrees and respirations of 16. c. On 02/17/19 at 5:30 PM, a staff member found Patient #903 in his room unresponsive and not breathing. d. Document review of the Code Blue form showed that a staff member found the patient unresponsive in his bed at 5:30 PM, then additional staff were notified at 5.32 PM. The notes showed that no detectable pulse was found and that the patient was apnelo (cessation of breathing), staff began chest compressions at 5:30 PM. The Code Blue form did not contain documentation addressing the patient's airway or if rescue breathing was provided. At 5:34 PM, the form showed chest compressions continued without addressing airway management or rescue breathing. At 5:34 PM, staff applied the AED to the patient's chest. At 5:40 PM, chest compressions continued without evidence rescue breathing was delivered. At that time the AED detected a nonshockable heart rhythm and did not advise a shock. Care was transferred to the arriving EMS crew at 5:40 PM. e. A review of nursing resuscitation notes showed that EMS personnel continued chest compressions and rescue measures until 6:03 PM, then declared the patient deceased. 3. On 05/17/19 at 1:20 PM, Investigator #9 attempted to reach two staff nurses by telephone (Staff #902 and #903), present during Patient #903's resuscitation, but both attempts were unsuccessful. At 1:45 PM, Investigator #9 interviewed the Nurse Educator (Staff #904) regarding her review of Patlent #903's

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PRINTED: 06/25/2019 FORM APPROVED State of Washington (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 000102 05/29/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY L 335 L 335 Continued From page 10 resuscitation records and staff she interviewed, present during the Code Blue. Additionally, she reviewed video footage of the resuscitation. Staff #904 identified the following issues: a. The staff member who found the unresponsive patient exited the room to call for help prior to initiating CPR. b. A Code Blue Leader (a designated leader needed to direct and coordinate all components of the resuscitation) was not identified or designated. c. Chest compressions performed on a non-firm surface (bed) were ineffective and staff struggled to move the patient to the floor due to his large body size. Staff #904 noted the patient was moved to the floor using his bed mattress. d, Backboards were not available during the resuscitation and were not included in the hospital's emergency equipment. e. Staff had difficulty finding a handheld resuscitation bag and mask (a self-refilling bag-valve-mask unit, used for artificial respiration) in the Code Blue bag containing emergency equipment. L1165

State Form 2567

L1165 322-180,2 EMERGENCY SUPPLIES

WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators,

State of Washington (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A, BUILDING: _ B. WING. 05/29/2019 000102 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST **BHC FAIRFAX HOSPITAL** KIRKLAND, WA 98034 SLIMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE O(4) ID Ю (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY L1165 L1165 Continued From page 11 intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital falled to ensure emergency equipment and supplies were available and accessible to staff during a critical medical emergency. Failure to provide medical emergency equipment and supplies places patients at risk of inadequate resuscitation efforts that could lead to injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED). The code blue bag inventory includes: Bandages and dressings. Airway management supplies: a CPR mask, ambu bag (a self-refilling bag-valve-mask unit, used for artificial respiration), plastic bite stick (used during seizures), nasal cannula and mask with tubing (for oxygen delivery). EMS supplies (sting swabs, alcohol prep pads, eyewash solution, ice packs, antimicrobial hand wipes, instant glucose, antibiotic ointment, iodine

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	2 On 05/17/10 at 1:4	5 PM, Investigator #9			
		Educator (Staff #904) about	Į		
		I. She stated that a back			
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		t was moved to the floor,			
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	(DOH) in accordance	e Department of Health with Medicare Conditions of dials set forth in 42 CFR aurysy.						
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Any deficiency sintement ending with an asterisk (*) deficies a defictency which the institution may be excused from correcting providing it is determined that other sateguards provide sufficient protection to the gatigaits. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL			•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 18200 NE 132ND ST KIRKLAND, WA 98034		
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(A D43)	ROVIDER OR SUPPLIER RFAX HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(A)	043)			







STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(CZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL				STREET ADURESS, CITY, STATE, ZIP CODE 10200 NE 132ND 5T KIRKLAND, WA 98034			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(26) COMPLETION DATE
{A 043}	REQUIREMENTS OF PREVIOUSLY CITED.	FAILURE TO MEET THE THE CONDITION ON 05/29/19	(A Ó	•			
{A 093}	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Item #1- Code Blue Response Based on Interview and document review, the hospital failed to ensure all direct care staff took		{A 0	093)	The leadership team met to review the findings from this survey. The Code Blue policy, PC 1000.13 was reviewed by the CEO, DON and CMO with no revisions required at this time. Code Blue drills are conducted once per shift, weekly at Fairfax Everett and Monroe locations. Code Blue drills will continue at all locations for four months, then decrease to monthly per shift. Nursing Leadership at all locations will be held accountable through re-education and/or disciplinary action to ensure the drills are conducted as required.		8/30/19
	part in Code Blue Dril submitted Plan of Code Failure to ensure all in required knowledge, a equipment to respond	ls as outlined in their rection (POC). cospital staff had the			The Code Blue drill flow sheet was revise include backboards to enable staff the abdocument backboards being brought to C Blue events and drills. The debriefing shand emergency equipment delly inventor; checklists were revised to include all emerguipment including the backboard. The forms were approved by Forms Committe 9/30/19 All nursing staff including, RNs, LPNs and were retrained, in person at mandatory staff.	illity to code ests y sugernoy se se on directly	9/30/19 10/3/19
	Correction," dated 07: were retrained to the person, at staff meetic Training focused on it	of the hospital's, "Plan of /05/19, showed that all staff revised Code Blue policy in ngs, and individually. Immediate emergency requiring resuscitation and			meetings, to the revised Code Blue drill flowsheet. For staff unable to attend this mandatory meeting, individual training was completed. Focus of the training was on revised form and the requirement that the backboard be brought to all code blues a documented. The instructions for Emerg Medical Equipment (EME) Checklist documented.	the and ency	



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was also revised to include backboards and the expectation that backboards are audited daily to ensure they are in the designated location and they are in good repair. All nursing staff, including RNs, LPNs and PSs, algred an attestation verifying their understanding and commitment to completing the revised forms.

10/3/19

All Charge Nurses, House Supervisors and members of Nursing Leadership were retrained to the revised emergency medical equipment daily inventory checklist. Focus of the retraining was on the addition of the backboards to the emergency medical equipment daily inventory and the expectation that the backboards be checked daily to ensure they are in the designated location and are in good repair. All Charge Nurses, House Supervisors and members of Nursing Leadership, signed an attestation verifying their understanding and commitment to completing the revised form.

STAFF RESPONSIBLE: Director of Nursing

MONITORING:

Code Blue drills are scheduled, at all three boatlons, once per shift per week to confirm compliance with appropriate response to actual Code Blue incidents for four months followed by Code Blue drills once per shift per month. The Director of Nursing and/or designee are attending all Code Blue events to confirm backboards are present. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

Code Blue documentation from Fairfax Everett and Monroe will be forwarded to the Director of Nursing on a weekly basis to confirm compliance with Code Blue drills.

100% of Code Blue events and Code Blue drill documentation are being audited by the Director of Nursing or designee to ensure that the backboard is documented on the Code Blue flow sheet and debrief. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

The Emergency Medical Equipment Daily Checklist will be audited weekly by Nursing Leadership to ensure that backboards are included in the inventory and that staff are documenting the inventory.

Monitoring will be ongoing for four months until compliance is schleved and sustained. All

FORM CMS-2057(02-49) Previous Versions Obsciols

Event 10: 10K812

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If continuation sheet Page 4 of 6





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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			()(3) DATE SURVEY COMPLETED	
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BHC FAIR	FAX HOSPITAL				0200 NE 132ND 8T (IRKLAND, WA 98034		
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(A 093)	allowed staff to review policy/procedure(s). I confirm successful of Code Blue drills once months, then decrease Monitoring Code respondiance is achieved. 2. Review of a hospitudiance is achieved. 2. Review of a hospitudiance is achieved. 3. Review of a hospitudiance is achieved. I conducted by staff duratid not include other of Fairfax Hospital. Code records were not avail Hospitals. 3. On 08/20/19 at 2:2 interviewed the Direct and revealed that staff were retrained to the procedure and were conce a week per shift, POC. Staff at the Every were also trained on thowever, staff did not code drills. Both satell code drills once per sthe hospital's Plan of litem #2 - Emergency. Based on interview at hospital falled to ensue equipment, outlined in (POC) were included sheets, debriefing she equipment daily invented.	w the revised Code Blue The hospital planned to impliance by conducting i per shift, weekly for four ise to monthly drills per shift, ionses will continue until ed and sustained. al document titled, "Code iwed Code Blue drills ing 06/25/19 - 08/08/19 (log detes), at the Kirkland BHC is Blue Logs or other weekly liable for Everett or Monroe O PM, investigator #10 for of Quality (Staff #1001) If at the Kirkland hospital revised Code Blue conducting Code Blue drills is as outlined in the hospital's rett and Monroe campuses the revised code policy, participate in the weekly lite hospitals did not conduct hift, per week as cutlined in Correction. Equipment and document review, the lire all emergency their Plan of Correction in their Code Blue drill flow	(A 0	93)			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCOMENATION ALL MIDED.		TIPLE: ING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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(A 093)	Continued From page	. 4	€A:0	93)			
	and supplies places presuscitation efforts to death.	dical emergency equipment estients at risk of inadequate hat could lead to injury or					٠
	Findings included:	A					
	Correction (POC)," da all staff were retrained polloy in person, at st individually. The revision	ion to the policy included or all responses to a code			•		
	procedure titled, "Cod revised 06/19, shows						
	Blue Debriefing," should be conducted by state that included the drill focation, code leader's patient scenario, and the drill. The sheet into notes regarding areas his/her comments to a On the back page is a in the drill and an area additional training. The checklist of emergence bring to the scene, ho	s name, supply staff name, patient's condition during sluded the team leader's for improvement and staff to correct their practice. list of staff who participated a to list staff that may need					



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(E80 A)	Code Blue policy or F A review of a hospital "instructions for Emer Daily (EME) Checkis showed a list of emer staff check daily, plus note any missing or d showed that the Nura Educator will review to of each month. Howe included in the checking.	POC. I'clocument titled, rgency Medical Equipment it - Unit based," no date, rgency medical equipment i actions they take if they lamaged Items. It also is Manager or Nurse the EME checklist at the end wer, back boards were not list. I on 08/21/19 at 2:30 PM, or of Nursing (Staff #1002)	(A 0	93)	DEFICIENCY)			
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION SUBSTITICATION NUMBER:			(XX) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		, 804002	B. WING	B. WING		R-C 08/22/2019	
NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL				BTRŽET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034			
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{A 000}	INITIAL COMMENTS		(A)	000]		_	
	MEDICARE COMPL/ VISIT	AINT SURVEY FOLLOW-UP			-		
·	(DOH) in accordance	e Department of Health with Medicare Conditions of litals set forth in 42 CFR urvey.					
	Onsite dates; 08/20/1 Intake number (a); #87770 #89607	9-08/22/19					
	#89871 #90190 #90327						
	#90191 #90209 #90163 #90363						
	The survey was cond Surveyor #4 Surveyor #8 Surveyor #10	ucted by:			·		
•	of Health staff determ Hospital was found to	ow-up survey, Department ined that BHC Fairfax be NOT IN COMPLIANCE licare Hospital Conditions of			·	٠.	
	42 CFR 482.12 Gove	ming Body					
{A 043}	GOVERNING BODY CFR(s): 482.12			43}	Corrective Action: The Governing Board met on 10/7/19 to it the findings from this survey and directed CEO to immediately correct all deficiencies identified in this Statement of Deficiencies	the B	10/7/19
ABORATORYD	RECTOR'S OR PROPERTY	IPPLIER REPRESENTATIVE'S SIGNATURE			/ CP	, ,	(XS) DATE

Any deficiency statement ending withten existific (*) denotate a deticiency which the intellution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

AP141-614	O I OITMILDIONISL OF	AITDIGLAID OCITAIOTO				of Gana and I	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION IS		(XX) DATE SURVEY COMPLETED	
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{A 043}	There must be an efficiency responsible to if a hospital does not governing body, the proritions specified in governing body This CONDITION is not be represented in a condition of Participal to meet the requirement of the representation of Participal residual emergency medical	ective governing body that is r the conduct of the hospital. have an organized persons legally responsible hospital must carry out the this part that pertain to the not met as evidenced by: 1. Interview, and document ined that the hospital failed ents at 42 CFR 482.12 silon for Governing Body. 1. Interview and the hospital failed ents at 42 cfr 482.12 silon for Governing Body. 2. In had the knowledge, skills, and to respond to a patient's esuiting in treatment delay rescitation measures.	(A 04	to meet the requirements of 42 specific to the Condition of Pari Governing Body oversight. The actions included: • the revision of the Cox Sheet, • Code Blue Debrief, • Emergency Medical E inventory, and • Instructions for the Emergency Medical E inventory, and • Instructions for the Emergency Medical E inventory, and • Instructions for the Emergency Medical Emergency	icipation for corrective le Blue Flow quipment Daily lergency Medical le Blue drills at lett and Monroe. Ined to have all required to patient's and confirmed is. All licensed is corrective le Blue drills everett and Director of		
·	aquipment outlined in their Code Blue drill fi sheets and emergend cheklists Cross-reference: Tag	ensure all emergency their POC was included in low sheets, debriefing by equpment daily inventory A-093		The Governing Board will meet next three months until compile and austained. Aggregated dat blue drills completed at Fairfax and Monroe will be reported by Nursing. Monthly updates will the Governing Board specific to Co confirm compilence. This data documentation of the presence Medical Equipment, to Include the	nce is achieved a from all code Kirkland, Everett the Director of the reported to the de Blue drills to will include the of all Emergency		
	detailed under 482.12	seventy of deficiencies ?(f)(2) Emergency Services, sipation for Governing Body		All deficiencies will be corrected include disciplinary action as ne			



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(A 043)	Continued From page was NOT MET. THIS IS A REPEAT F REQUIREMENTS OF PREVIOUSLY CITED	AILURE TO MEET THE THE CONDITION	(A 0	943)			
(A 093)	hospital, the governing medical staff has writted appraisal of emergand referral when appraisal of emergand referral when appraisal of emergand referral when appraisal falled to ensure all in Code Blue Drill submitted Plan of Consultation of Consultation of the required knowledge, a equipment to respond emergency risks delaurgent treatment. Findings included: 1. Document review of Correction," dated 07.	as are not provided at the g body must assure that the ten policies and procedures gencies, initial treatment, propriate. of met as evidenced by: despense and document review, the are all direct care staff took is as outlined in their rection (POC). cospital staff had the skills, training and it to a patient's medical ye in activating and initiating of the hospital's, "Plan of 105/19, showed that all staff revised Code Blue policy in angs, and individually.	(A0)	CORRECTIVE ACTION: Item #1: Code Blue Response The leadership team met to review the from this survey. The Code Blue poll 1000.13 was reviewed by the CEO, D CMO with no revisions required at this Code Blue drills are conducted once pweekly at Fairfax Everett and Monroe Code Blue drills will continue at all locations will accountable through re-education and disciplinary action to ensure the drills conducted as required. STAFF RESPONSIBLE: Director of N MONITORING: Code Blue drills are scheduled, at all lengths.	ry, PC DN and time. er shift, ocations. etions for per shift. be held for ere	8/30/19	
	Training focused on la					ļ	



S04002 B. WING R-C 08/22/2019 NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 18200 NE 132ND ST KIRKLAND, WA 98034	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(02) MULTIPLE CONSTRUCTION A, BUILDING		(CG) DÀTE SURVEY COMPLETED	
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BHC FAIRFAX HOSPITAL 19200 NE 132ND ST KIRKLAND, WA 98034	25		304002	D. 4711465		U8/2	2/2019
BHC FAIRFAX HOSPITAL KIRKLAND, WA 98034	NAME OF P	PROVIDER OR SUPPLIER			••••••••••••••••••••••••••••••••••••••		
KIRKLAND, WA 98034	BHC FAIR	RFAX HORRITAL			10200 NE 132ND 8T		
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PREFIX (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (ACCIONATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION) DATE DATE		PRÉFIX (EACH DÉFICIENCY MUST BE PRÉGEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG (REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFÉRENCED TO THE APPROPRIATE				COMPLETION DATE	
Continued From page 3 allowed staff to review the revised Code Blue policyptrocedure(s). The hospital planned to continue successful compliance by conducting Code Blue drills once per shift, weakly for four morths, then decrease to monthly drifts per shift. Monitoring Code responses will continue until compliance is achieved and sustained. 2. Review of a hospital document titled, "Code Blue Log - 2019," showed Code Blue drills conducted by staff during 08/26/19 - 0.6/06/19 (log did not include other dates), at the Kridsand BHC Fairfax Hospital. Code Blue Loge or other weekly records were not available for Everett or Monroe Hospitals. 3. On 08/20/19 at 2:20 PM, Investigator #10 interviewed the Director of Qualify (Sieff #1001) and revealed that staff at the Kridsand hospital were retrained to the revised Code Blue drills once a week per shift, as outlined in the hospitals PCC, Staff at the Everett and Monroe Blue procedure and were conducting Code Blue drills once a week per shift, as outlined in the hospitals PCC, Staff at the Everett and Monroe campuses were also trained on the revised code policy, however, staff did not participate in the weakly code drills ence per shift, per weak as outlined in the hospitals Plan of Correction. Itim #2 - Emergency Equipment Based on interview and document review, the hospital failed to ensure all emergency equipment, cultiment, or the processing of the provision of the	(A 093)	allowed staff to review policy/procedure(s). I confirm successful or Code Blue drils once months, then decrease Monitoring Code responsive to a hospital compliance is achieved. Review of a hospital Blue Log - 2019," sho conducted by staff du did not include other of Fairfax Hospital. Code records were not avail Hospitals. 3. On 08/20/19 at 2:22 interviewed the Direct and revealed that staff were retrained to the procedure and were conce a week per shift, POC. Staff at the Eve were also trained on thowever, staff did not code drille. Both satel code drille noe per sithe hospital's Plan of Itam #2 - Emergency Based on interview at hospital falled to ensue equipment, outlined in (POC) were included sheets, debriefing she equipment daily invendempliance with the negations.	with revised Code Blue The hospital planned to compilance by conducting per shift, weekly for four se to monthly drils per shift, conses will continue until ad and sustained. al document titled, "Code owed Code Blue drils ring 06/26/19 - 08/06/18 (log dates), at the Kirkland BHC a Blue Logs or other weekly liable for Everett or Monroe O PM, Investigator #10 for of Quality (Staff #1001) If at the Kirkland hospital revised Code Blue conducting Code Blue drills as outlined in the hospital's crett and Monroe campuses the revised code policy, participate in the weekly lite hospitals did not conduct thift, per week as outlined in Correction. Equipment Ind document review, the are all emergency in their Plan of Correction In their Code Blue drill flow sets, and emergency intory checkliets, ensuring	(A 09:	compliance with appropriate response to Code Blue incidents for four months folio Code Blue drills once per shift per menth Director of Nursing and/or designee are attending all Code Blue events to confirm backboards are present. All deficiencies immediately corrected to include staff ret and disciplinary action as needed. Code documentation from Fairfax Everett and I will be forwarded to the Director of Nursin weekly basis to confirm compliance with Blue drills. Monitoring will be ongoing for four menth compliance is achieved and sustained. A deficiencies are corrected immediately to staff retraining as needed. Aggregated does reported to the Quality Council and Mc Executive Committee monthly and the Governing Board monthly. CORRECTIVE ACTION: Item #2: Emergency Equipment The leadership team met to review the fir from this survey. The Gode Blue policy, 1000,13 was reviewed by the CEO, DON CMO with no revisions required at this tin The Code Blue Flow Sheet was revised to include backboards to enable staff the abdocument backboards to enable staff the abdocumen	wed by a remaining Blue Monroe ag on a Code suntil all landude lata will edical	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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				KIRKLAND, WA 98034		
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(A 093)	Fallure to provide me and supplies places presuscitation efforts the death. Findings included: 1. Document review of Correction (POC)," da all staff were retrained policy in person, at standividually. The revisualing a back board for blue and each unit we Document review of the procedure titled, "Cod revised 06/19, shower medical emergency who code blue bag from eautomatic external death of the conducted by statistic included the drill focation, code leader's patient scenario, and the drill. The sheet inconducted present inconducted patient scenario, and the drill. The sheet inconducted comments to senario and the comments to senario an	dical emergency equipment patients at risk of inadequate hat could lead to injury or of the hospital's, "Plan of ated 07/05/19, showed that d to the revised Code Blue aff meetings, and sion to the policy included ar all responses to a code are supplied with one. The hospital's policy and le Blue," Policy #100.13 d that staff will respond to a sith a backboard, oxygen, ach unit and with the fibrillator (AED). The document titled, "Code wed a completed Code Blue of 07/09/19 at 4:32 PM, date, the shift, code a name, supply staff name, patient's condition during cluded the team leader's a for improvement and staff to correct their practice.		revised form and the requirement that the backboard be brought to all code blues a documented. The instructions for Emergined Medical Equipment (EME) Checklist documented in that backboards are audited ensure they are in the designated location that packboards are audited ensure they are in the designated location they are in good repair. All nursing staff, including RNs, LPNs and PSs, signed an attestation verifying their understanding a commitment to completing the revised for All Charge. Nurses, House Supervisors are members of Nursing Leadership were retaining was on the addition of the back to the emergency medical equipment dail inventory and the expectation that the backboards be checked daily to ensure the first the designated location and are in good All Charge Nurses, House Supervisors are members of Nursing Leadership, signed attestation verifying their understanding a commitment to completing the revised for STAFF RESPONSIBILE: Director of Nursing Code Blue events and Code Blue documentation are being audited by the Educumentation are being audited by the Ed	end leacy ument und the daily to n and mand rathed ment topards by hey are d repair. Id an ind m.	10/3/19
	in the drill and an area additional training. The checklist of emergence bring to the scene, ho	list of staff who participated a to list staff that may need e front page shows a sy equipment staff must swever, the list does not as cultined in the revised		compliance is achieved and sustained. A deficiencies are corrected immediately to staff retraining as needed. Aggregated do be reported to the Quality Council and Me Executive Committee monthly and the	include ata wili	





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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504002	B. WING			R-C /22/2019	
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(A 093)	Code Blue policy or P A review of a hospital "Instructions for Emer Daily (EME) Checkiss showed a list of emer staff check daily, plus note any missing or d showed that the Nurs Educator will review to of each month. Howe included in the checki 3. During an interview	document titled, gency Medical Equipment t - Unit based," no date, gency medical equipment actions they take if they amaged items. It also e Manager or Nurse he EME checklist at the end ver, back boards were not list. on 08/21/19 at 2:30 PM, of Nursing (Staff #1002)	{A	093)	Governing Board monthly.		

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STATE OF WASHINGTON DEPARTMENT OF HEALTH

20425 72rd Ave S, Ste. 310 - Kent, Washington 98032

October 22, 2019

Beckie Shauinger, Chief Executive Officer Fairfax Behavioral Health-Kirkland 10200 NE 132nd St. Kirkland, WA 98034

Re: Complaint(s) Case: #2018-17976. Intake #87770

Case: #2019-3919. Intake #89607 Case: #2019-3716. Intake #89871 Case: #2019-5267. Intake #90190 Case: #2019-5934. Intake #90209 Case: #2019-6579. Intake #90363

Dear Ms. Shauinger:

Surveyors from the Washington State Department of Health conducted a state complaint survey at Fairfax Behavioral Health-Kirkland on May 29, 2019. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on July 12, 2019.

Hospital staff members sent a Progress Report dated September 27, 2019 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Behavioral Health-Kirkland's attestation to be in compliance with Chapter 246-322 WAC.

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

Sincerely, Parie Tulstan RVMN

Rosie Tillotson, RN, MSN

Survey Team Leader