State of Washington (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: B. WNG 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE FAIRFAX BEHAVIORAL HEALTH MONROE **MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (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 000 INITIAL COMMENTS L 000 1. A written PLAN OF CORRECTION is STATE LICENSING SURVEY required for each deficiency listed on the Statement of Deficiencies. The Washington State Department of Health (DOH) in accordance with Washington 2. EACH plan of correction statement Administrative Code (WAC), Chapter 246-322 must include the following: Private Psychiatric and Alcoholism Hospitals conducted this health and safety survey. The regulation number and/or the tag number; Onsite dates: 01/22/20 to 01/23/20 HOW the deficiency will be corrected; Examination number: 2020-61 WHO is responsible for making the correction; The survey was conducted by: Surveyor #3 Surveyor #4 WHAT will be done to prevent Surveyor #10 reoccurrence and how you will monitor for continued compliance; and The Washington Fire Protection Bureau conducted the fire life safety inspection on WHEN the correction will be completed. 01/28/20. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be returned electronically by February 21, 2020. 4. Return the REPORT electronically with the required signatures. L 315 L 315 322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S

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(X6) DATE

STATE FORM

If continuation sheet 1 of 15

State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WNG 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE **FAIRFAX BEHAVIORAL HEALTH MONROE MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 315 L 315 Continued From page 1 or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to ensure staff provided a safe environment for those identified as high risk for suicide (Item #1) and failed to perform daily fall risk assessments according to policy for 2 of 3 records review (Patient #301, #302) (Item #2). Failure to ensure a safe environment and failure to identify patients who are at high risk for falls places patients at risk for serious injury or death. Findings included: Item #1 - Suicide Precautions 1. Document review of the hospital's policy and procedure titled, "Linens Management," Policy #1001.10, last revised 05/19, showed that to ensure a safe environment, staff will limit access to linens. For patients on Suicide Precautions (SP) and their roommates, towels are to be checked out for short-term use only and returned. Staff will check patient rooms housing SP patients and ensure towels are returned. Staff are to keep track of bed linens for patients and their roommates managed under SP. Document review of the hospital's policy and procedure titled, "Suicide Precautions," Policy #1000.24, last revised 05/19, showed that staff would provide close observation, provide intensive support, and conduct frequent re-assessments for patients on suicide precautions. The policy directs staff to use

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SUR COMPLET		
		012792	B. WING		01/28/	2020
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STAT	E, ZIP CODE		
FAIRFAX	BEHAVIORAL HEALTH M	ONROE 14701 1791 MONROE,		•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETE DATE
L 315	protective measures to physical welfare for the Room searches are conften as indicated to recontraband items.  2. On 01/22/20 at 8:45 observed care on the of the daily census should be contraband items.  Surveyor #10 and the #1001) toured eight probservation showed:  a. Patient room #826 #1001, #1002) in the and B). The surveyor near Bed A and one did b. Patient room #828 #1003, #1004) in the and B). The surveyor baskets containing a sa potential ligature rish and Interviewed the Direct who confirmed the exception of the policy number showed that a Register complete the Edmonstrate in the results of the policy number showed that a Register complete the Edmonstrate in the results of the physical interviewed that a Register complete the Edmonstrate in the results of the physical interviewed that a Register complete the Edmonstrate in the physical interviewed that a Register complete the Edmonstrate in the physical interviewed that a Register complete the Edmonstrate in the physical indicates a policy number showed that a Register complete the Edmonstrate in the physical indicates a policy number showed that a Register complete the Edmonstrates are proposed in the physical indicates a policy number showed that a Register complete the Edmonstrates are proposed in the physical indicates a policy number and physical indicates a	o ensure the emotional and ese patients at all times. onducted daily or more emove harmful or  5 AM, Surveyor #10 patient care unit. A review eet showed that staff were tients under suicide  Director of Nursing (Staff atient rooms. The  - Both patients (Patient room were on SP (Beds A observed three dirty towels inty towel near Bed B.  - Both patients (Patient room were on SP (Beds A observed two laundry scrub pants that presented c.  0 AM, Surveyor #10 or of Nursing (Staff #1001) cess linen.  sk Assessments  f the hospital's policy and Risk Assessment and 1000.19, last revised 01/19,	L 315	(		
State Form 25		patient scores greater than				

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	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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L 315	Continued From page	3	L 315			
<b>.</b> 510	or equal to 90, the RN and add "falls risk" to review also showed the patient's risk for falls of the patient is on falls patient is on 12/07/19 disorganized thinking showed:  a. Upon admission, st having low risk for falls b. On 12/12/19, the parisk score of 90, due to behavior.  c. The review showed failed to perform a dailed to perform a dailed.	I will initiate falls precautions the treatment plan. The nat nurses will re-assess the on a daily basis daily while precautions.  DAM, Surveyor #3 and the aff #301) reviewed the lient #301 who was for suicidal ideation and and behavior. The review aff assessed the patient as s.  atient received a high fall o undirectable, agitated  that on 12/13/19, staff ly fall risk assessment.		-		
	•	no evidence that staff risk assessment from				
		risk assessment from				
Cialo Form 255	g. The surveyor found performed a daily fall r 01/02/20 through 01/0	risk assessment from			. (	25a

STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE & COMPL	
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NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
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l. 315	h. On 01/19/20, the process indicating the palled to performed a between 01/19/20 three consecutive days.  3. 01/22/20 at 3:45 Pt Director of Quality (St medical record for Painvoluntarily admitted disability. The review  a. On 01/03/20, the pawas placed on fall risk b. The surveyor found performed a daily fall 11 days between 01/0 previous fall risk asset the patient was a high 4. On 01/22/20 at 2:10 interviewed the Direct about performing daily those patients identific stated that any patien would have an Edmor Assessment performes taff failed to performes taff failed to performes taff failed to performes.	pite previous assessment patient was a high fall risk.  atient suffered a fall. Staff daily fall risk assessment ough 01/21/20, a period of 3  M. Surveyor #3 and the aff #301) reviewed the tient #302 who was on 11/23/19 for grave showed:  atient suffered a fall and a precautions.  I no evidence that staff risk assessment for 5 out of 19/20 and 01/19/20 despite ssment scores indicating a fall risk.	L 315			
L 375	#301 and #302 322-035.1o POLICIES	S-HOUSEKEEPING	L 375			
	WAC 246-322-035 Po Procedures. (1) The li develop and implemen	censee shall				Rec

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE **FAIRFAX BEHAVIORAL HEALTH MONROE MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L 375 Continued From page 5 L 375 written policies and procedures consistent with this chapter and services provided: (o) Maintenance and housekeeping functions, including schedules; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the hospital staff failed to use an appropriate concentration of sanitizing solution in cleaning patient sleeping rooms. Failure to use appropriate levels of disinfectant for cleaning the patients' sleeping rooms puts patients and staff at risk of harm from infectious diseases. Findings included: 1. On 01/22/20 at 9:00 AM, Surveyor #4 observed a member of the Environmental Services Staff (Staff #401) as she cleaned a patient sleeping room. The surveyor used a chemical test strip to determine the level of quaternary ammonium disinfectant contained in the staff member's cleaning bucket. The observation showed the level of disinfectant was less than the minimum required amount for appropriate use. 2. On 01/22/20 at 9:20 AM, Surveyor #4 and Staff #401 returned to the housekeeping closet and used a chemical test strip to check the level of disinfectant being dispensed from the automated chemical dispensing unit. The observation

showed minimal levels of disinfectant present in

At the time of the observation, the contracted vendor for the hospital's environmental cleaning

the dispensed solution.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
		012792	B. WING		01/28/2020
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NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATE	E, ZIP CODE	
FAIRFAX	BEHAVIORAL HEALTH N	IONROF	TH AVE SE , WA 98272		
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L 375	Continued From page	6	L 375		
	supplies was onsite and corrected the malfunction in the dispensing unit.				
	about the staff knowle Staff #402 stated that	ies Manager (Staff #402) dge of disinfectants for use. environmental services d chemical test strips and			
L 765		CONTROL-MEETINGS	L 765		
	WAC 246-322-100 Inf The licensee shall: (3) Infection control comm of the individual or ind assigned to manage t multi-disciplinary repre from the professional staff and administrativ (d) Meet at regularly s intervals, at least quan This Washington Adm as evidenced by:	Designate an nittee, comprised lividuals he program and esentatives staff, nursing re staff, to: ocheduled			
	hospital failed to main control committee that presented written repo	nd document review, the tain an active infection to the tast quarterly and ports of findings to identify and reduce the incidence of acility.			
200	committee and implement hospital's current infect assessment puts paties of harm from exposure	ents, staff and visitors at risk			Kan

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING;	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		012792	B. WING		01/28/2020
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH N	14701 17	DDRESS, CITY, STAT 9TH AVE SE 5, WA 98272	E, ZIP CODE	
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L 765	diseases.  Findings included:  1. Document review of "Surveillance: Collecting Data", last the Infection Control Fanalysis monthly that Control Committee on Document review of the Control Committee meshowed the binder committees for the month.  2. On 01/23/20 beginn #4 and #10 reviewed control program with the Practitioner (Staff #40 staff member if there is the Infection Control Cavailable in the Infection Binder. Staff #404 staff	of the hospital policy titled, ing, Analyzing, and reviewed 12/19 showed that Practitioner prepares an is presented to the Infection a quarterly basis.  The hospital's 2019 Infection peting minutes binder intained only meeting s of April and December.  The hospital's infection he Infection Control (4). The surveyors asked the were any other meetings of Committee other than those on Control Committee ted there were not, since petings after the previous	L. 765		
<b>L.1065</b>	322-170.2E TREATMI WAC 246-322-170 P Services. (2) The licer provide medical super treatment, transfer, an planning for each patir retained, including but limited to: (e) A compr treatment plan develop seventy-two hours foll	nsee shall vision and discharge ent admitted or t not ehensive ped within	L1065		
	(i) Developed by a mu				Sez

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ B. WNG 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE FAIRFAX BEHAVIORAL HEALTH MONROE **MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY** L1065 L1065 Continued From page 8 treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: Based on record review and review of hospital policy and procedures, the hospital staff failed to develop, initiate, and update care plans for 2 of 4 records reviewed (Patient #301, #303). Failure to develop care plans to address patient care problems risks patient safety and delays in treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Fall Risk Assessment and Care," policy number 1000.19, last revised 01/19, showed that a Registered Nurse (RN) will complete a Edmonson Psychiatric Fall Risk Assessment on all patients upon admission. If the patient scores greater than or equal to 90, the RN will initiate Falls Precautions and a Fall Risk Treatment Plan. The plan will address interventions used to prevent falls while

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hospitalized. Should a patient fall during their hospitalization, the RN will initiate or update the Fall Risk Individual Treatment plan and associated interventions as appropriate.

2. On 01/22/20 at 9:30 AM, Surveyor #3 and the

FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE FAIRFAX BEHAVIORAL HEALTH MONROE **MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L1065 Continued From page 9 L1065 Director of Quality (Staff #301) reviewed the medical record for Patient #301 who was admitted on 12/07/19 for suicidal ideation and disorganized thinking and behavior. The review showed: a. Upon admission, staff assessed the patient as having low risk for falls. b. On 12/12/19, the patient received a high fall risk score of 90, due to undirectable, agitated behavior. c. On 12/14/19, the patient suffered a fall and was assessed as high risk (score of 125). The surveyor found no evidence that a Fall Risk Treatment plan was initiated. d. On 01/19/20, the patient suffered a fall and then received a high fall risk score of 125. The surveyor found no evidence that a Fall Risk Treatment plan was initiated. e. On 01/22/20, the patient suffered a fall. The surveyor found no evidence that a Fall Risk Treatment plan was initiated. 3. 01/22/20 at 3:25 PM, Surveyor #3 and the

Director of Quality (Staff #301) reviewed the medical record for Patient #303 who was admitted on 01/18/20 for suicide ideation and auditory hallucinations. The review showed:

a. The patient was assessed as a high risk for fall

b. Surveyor #3 found no evidence that the patient's risk for falls was added to the treatment

risk upon admission.

plan at the time of admission.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDING:		COMPLETED	
		012792	B. WING		01/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
		14701 17	9TH AVE SE	,	
FAIRFAX	BEHAVIORAL HEALTH M	IONROE	E, WA 98272		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
L1065	Continued From page	10	L1065		
	about documenting a treatment plan for tho high risk. Staff #301 s pre-printed fall risk tre be implemented for an greater on the Edmon Assessment or had su	for of Quality (Staff #301) fall risk problem on the se patients identified as stated that the hospital had a satment plan which should my patient scoring 90 or son Psychiatric Fall Risk uffered a fall. She s that staff failed to add a			
L1265	322-200.3F RECORD	S-OBSERVATIONS	L1265		
	WAC 246-322-200 Cli The licensee shall ens and filing of the follow the clinical record for a patient receives inpati outpatient services: (f, observations and ever patient's clinical treatn This Washington Adm as evidenced by:	sure prompt entry ing data into each period a ent or ) Significant nts in the			
	review of hospital poli- hospital staff failed to physician-ordered obs medical records review Failure to enter and for	servation levels for 2 of 7 wed (Patient #1004, #1005).			
9	through non-complian	to unsafe patient care ce with physician orders, or cols regarding levels of			
State Form 256	Findings included:			, 4,100 d. 4, 1, 100 d 1,	Ka

PRINTED: 02/21/2020 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: 012792 01/28/2020 STREET ADDRESS, CITY, STATE, ZIP GODE NAME OF PROVIDER OR SUPPLIER 14701 179TH AVE SE **FAIRFAX BEHAVIORAL HEALTH MONROE MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY L1265 Continued From page 11 L1265 1. Document review of the hospital's policy titled, "Level of Observation Orders," last revised 05/19, showed that all patients will be closely observed in compliance with provider orders and prescribed protocols. Upon admission, the physician will order one of three levels of observation or in a patient's change of condition: 1) every 15 minute checks; 2) 5 minute checks; or 3) 1:1 observation (one staff member dedicated to observe one...

2. On 01/22/20, Surveyor #10 reviewed seven inpatient medical records. The review showed:

patient). Staff will complete the patient observation record as rounds are being made, using the coding system described on the record for patient activities. Staff will be vigilant for potential risk factors identified for specific patients (safety level- unit restrictions, cafeteria privileges, etc., observation level- every 15 minutes, 1:1, or precautions - suicide, elopement, fall, sexual

aggression, etc.

a. Patient #1004 is a 58 year-old patient who was admitted following an attempted suicide by ingestion of prescription pills. The treatment plan for the patient's initial psychiatric evaluation included a medical evaluation, monitor for self-injury/violent behavior, participation in individual/group therapies and monitored medication therapy. The plan also included monitoring for the patient's safety. The physician ordered her potential risk factor to be managed under suicidal precautions, plus unit restrictions and observations to be done every fifteen minutes.

Review of the initial observation flowsheet dated 01/17/20, did not indicate or identify that the patient was under unit restrictions (safety level).

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		012792	B, WING		01/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	1
FAIRFAX	BEHAVIORAL HEALTH N	MONROF	79TH AVE SE E, WA 98272		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCEO TO THE APPROPI DEFICIENCY)	BE COMPLETE
L1265	The review also show the patient's flowshee through 5.  b. Patient #1005 is a admitted after display active suicidal ideatio on her prescriptions. I patient has a history of and thyroid disease. The patient's initial psychia medical evaluation, modical evaluation, modical evaluation, modical evaluation, modical evaluation, modicated her potential under suicidal precautionary. The monitoring for the pation ordered her potential under suicidal precaution and observations to be minutes. The review of screening showed that risk for suicide ideation risk for suicide ideation. Review of Patient's #1 showed that the sheet id in not indicate (not milevel (unit restrictions) 15 minutes), or precautions of flowsheets 2 showed that the safe entered for both days.  3. On 01/22/20 at 2:00 Chief Nursing Officer flowsheets and confirm documentation.	red the same indication on ats for inpatient days 2  64 year-old patient who was ing behavior consistent with n. She planned to overdose Records also showed the of diabetes, hypertension, The treatment plan for the atric evaluation included a conitoring for avior, participation in pies, and monitored the plan also included ient's safety. The physician risk factor to be managed tions, plus unit restrictions e done every fifteen of the patient's suicide at the patient was at high n.  1005 initial flowsheet tidd not include a date, plus marked or entered) a safety observation level (every utions identified (suicide), for inpatient day 1 and day ety level was not marked or	L1265		R
STATE FORM			6899 04	9211	If continuation sheet 13 of 15

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
:		012792	B. WNG		01	/28/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
FAIRFAX	BEHAVIORAL HEALTH N	IONROE	9TH AVE SE E, WA 98272			
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L1485	Continued From page	e 13	L1485			
L1485	322-230.1 FOOD SE	RVICE REGS	L1485			
	WAC 246-322-230 For Services. The license Comply with chapters 246-217 WAC, food so This Washington Admas evidenced by:  Based on document in the hospital dietary staff of potentially hazardous maintained compliant State Retail Food Cooker foods in a manner that bacterial growth puts food-borne illness.  Findings included:  1. On 01/22/20 betwee Surveyor #4 toured the	cood and Dietary see shall: (1) see 246-215 and service; ninistrative Code is not met review and interview, failed to cool cooked foods in a manner that see with the Washington de. de potentially hazardous at limits the potential for patients at risk of harm from				
	provides food service Document review of the "HACCP Cooling Log	to the hospital patients. he department's log titled, , Time/Temperature Log for s Food," showed incomplete			,	
	a. On 01/17/20, Strog	_			l	ć
	b. On 01/20/20, Carro temperatures for temp after 6 hours	ot Salad- No recorded peratures after 2 hours and				
State Form 25	temperatures for temp	et Potatoes- No recorded peratures after 2 hours and				Res

STATE FORM

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B. WING 012792 01/28/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE FAIRFAX BEHAVIORAL HEALTH MONROE **MONROE, WA 98272** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) L1485 Continued From page 14 L1485 after 6 hours d. On 01/21/20, Herbed Chicken- No recorded temperatures for temperatures after 2 hours and after 6 hours 2. At the time of the document review, Surveyor #4 interviewed the Dietary Manager (Staff #403) about the missing information. Staff #403 stated that staff should have documented the temperatures to complete the logs. Reference: WAC 246-215-03515

## Plan of Correction for State Licensing – Due 2/21/2020 Fairfax Behavioral Health Monroe (012792)

		Fairfax Behavioral Healtl Plan of Correction for State Licensing – Fairfax Behavioral Health Monroe	Due 2/21/2020	Plan	an of Correction of Correction of Manager of Correction of Correction of Correction of Manager of the Manager o	(2020 31021220 \$ 3
Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of	How Monitored to Prevent Recurrence &	Action Level
Number			iliuiviuuai(s)	Correction	Target for Compliance	Indicating on
						Need for
						Change of POC
L 315	322-035.1C POLICIES- TREATMENT	<u>Item #1 – Suicide Precautions</u>			<u>ltem #1:</u>	51,55
	WAC 246-322-035	The following policies were reviewed by	Chief	3/26/20	Compliance with the	< 90%
	Policies and	Clinical Leadership with no revisions required	Nursing		Suicide Precautions and	
	Procedures	at this time:	Officer and		Linens Management and	
		<ul> <li>Suicide Precautions: PC 1000.24</li> </ul>	Monroe		policies will be monitored	
		Linens Management: PC 1001.10	Program		by the Charge Nurses on	
		All Nursing staff, to include Program	Manager		each unit via rounding at a	
		Specialists, CNAs, LPNs and RNs, were			minimum of twice per	
	3	retrained, in person at staff meetings and			shift, ongoing. Nursing Leadership will audit the	
		individually for those unable to attend, to the Suicide Precautions and Linens Management			documentation weekly to	_
		policies. All staff signed an attestation			ensure Charge Nurses are	
		verifying their understanding and commitment		v	in compliance with these	
		to following each aforementioned policy and	2	22	expectations.	
		procedure.			expectations.	
		Focus of the training included:			The CNO and/or designee	
		The requirement that staff ensure that			will confirm compliance with	
		patients on Suicide Precautions and			this plan of correction by	
		their roommates do not have access		3.	daily reporting in the FLASH	
		to excess linens, such as towels,			meeting the status of linen	
		blankets or scrubs.	24.5		checks and compliance with the Linens Management	
		<ul> <li>Limiting distribution of linens to</li> </ul>			policy. All deficiencies are	
		patients on Suicide Precautions and		~-/	corrected immediately to	
		their roommates.			include staff retraining and	
		<ul> <li>Distribution will be no more than</li> </ul>			disciplinary action as	
		three towels, one top sheet, one			needed.	

Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action
Number			Individual(s)	Date of	Prevent Recurrence &	Level
				Correction	Target for Compliance	Indicating
					Target 10: Compilation	Need for
						Change
						of POC
		bottom sheet, one pillowcase and two			All aggregated data from	
	_	sets of scrubs.			monitoring compliance is	
		Re-training also included the requirement that	=		reported monthly to	
		during rounds, Nursing staff are to check for			Quality Council, Medical	
		any patients who are on Suicide Precautions			Executive Committee, and	
		and their rooms, to ensure that all linens are			the Governing Board.	
		accounted for and returned.				
		Towels and scrubs, not in use, found in rooms			The target for compliance	
	9	during rounds are immediately removed.			is 95%.	
		Sheets, blankets and pillowcases found in				11
		excess of distribution requirements of the		8		~
		Linens Management policy will be			*	
		immediately removed during rounds.				· ·
					N .	
		Monitoring excess linens was added to the				
		daily room checks. All unit staff was retrained, in				
		person at staff meetings, to the revised room checks log. Focus of the training included		0		
		confirming that patients on Suicide Precautions do		1		
		not have access to excess linens. Sheets,	*			
		blankets, pillowcases and scrubs found in		χ.		
		excess of distribution requirements of the	8			
		Linens Management policy are immediately		7		
	· ·	removed.			Y max	÷.
					) (1) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	
	17	All housekeeping staff were retrained, in	7			
		person at staff meetings, by the Director of				
		Plant Operations, and individually for those		¥	3	

## Plan of Correction for State Licensing – Due 2/21/2020

Fairfax Behavioral Health Monroe (012792)

Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action
Number			Individual(s)	Date of	Prevent Recurrence &	Level
				Correction	Target for Compliance	Indicating
						Need for
						Change
						of POC
		unable to attend, to the Linens Management			Item #2:	
		policy. Focus of the training will include the				
		requirement that housekeeping staff will not		3/26/20	All Nursing Admission	
		distribute linens in excess of the numbers			assessments will be	
		defined in the policy.	11		audited by the CNO	
	鱼			-	and/or designee to	
					confirm completion of the	
					Edmonson Psychiatric Fall	
	· ·	,	10		Risk Assessment.	
					100% of medical records	< 90%
			2.		for patients who have	
	Ţ.				scored $\geq$ 90 and/or are on	
					Fall Precautions will be	
					audited by the CNO	
		s ·			and/or designee to	
					confirm compliance with	
		,			the Fall Risk Assessment.	
		<u>Item #2 – Daily Fall Risk Assessments</u>			20	
			23		100% of fall incidents will	
		All Registered Nurses were retrained, in	Chief		be reviewed by the CNO	
		person at staff meetings by the CNO and/or	Nursing		and/or designee to	
	,	designee to the Fall Risk Assessment and Care	Officer and		confirm completion of the	
	3 4	policy (PC 1000.19). Focus of the training	Monroe		Edmonson Fall Risk	
1.0		included the requirement that the Edmonson	Program		Assessment.	
		Psychiatric Fall Risk Assessment is thoroughly	Manager	-		
	, I	completed:			The CNO and/or designee	
		On admission	/		will confirm compliance with	
					this plan of correction by	

	2 5	Fairfax Behavioral Health Monroe				
Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action
Number			Individual(s)	Date of	Prevent Recurrence &	Level
				Correction	Target for Compliance	Indicating
						Need for
						Change
						of POC
-		<ul> <li>Daily for three consecutive days, until</li> </ul>		2	daily reporting in the FLASH	
		score is <90, for patients who have			meeting the status of	
		scored ≥ 90 and/or are on Fall			patients identified as Fall risk and confirm completion of	
		Precautions	8		the Edmonson Fall risk	
		After every patient fall			assessment.	
			250			
	9 3				All deficiencies will be	
		c			corrected immediately to	
		•	2		include staff retraining and	
-	-				disciplinary action as	
					needed.	
		, a			All aggregated data from	
					monitoring compliance is	
		4)	70.		reported monthly to	
					Quality Council, Medical	
					Executive Committee, and	
					the Governing Board.	
	w					
	,				The target for compliance	
					is 95%	
L 375	322-035.1o POLICIES-	All Housekeeping Staff were retrained, in	Director of	2/17/20	Mookly monitoring of the	< 0.007
13/3	HOUSEKEEPING	person at staff meetings by the EVS Supervisor	Plant	2/1//20	Weekly monitoring of the documentation on the	< 90%
	WAC 246-322-035	on the correct method of testing disinfectants	Operations		daily log to confirm	
	Policies and	to ensure the cleaning solution has the	Operations			
Ц	Procedures	appropriate concentration of disinfectants.			compliance with this	
		appropriate concentration of disinfectants.	2		action plan will be	
					completed by Director of	

## Fairfax Behavioral Health Plan of Correction for State Licensing – Due 2/21/2020

Fairfax Behavioral Health Monroe (012792)

Tag	Deficiency	How the Deficiency Will Be Corrected		Catimated	Have Manitaged to	A -x:
Number	Deficiency	now the Deliciency will be corrected	Responsible	Estimated	How Monitored to	Action
Number			Individual(s)	Date of	Prevent Recurrence &	Level
				Correction	Target for Compliance	Indicating
						Need for
						Change
						of POC
		Housekeeping Staff will test cleaning solutions			Plan Operations and/or	
	r.	daily and maintain a log of results. If solution			designee. This monitoring	
	95	test outside of the proper pH range chemicals		_=	will ensure the	
5		will be remixed ad retested before use.	1		appropriate concentration	
	£				of disinfectants is being	
					used.	
				1	All deficiencies will be	(
		*	1		addressed and corrected	
_					immediately.	
	10				Aggregated monitoring	
					data will be reported	
	4				monthly to Quality	
		*		-	Council, Medical	
					Executive Committee, and	
3.					the Governing Board.	
					v.	
					The target for compliance	
					is 95%.	
L 765	322-100.3D INFECT	The Infection Control Committee is scheduled	Chief	3/11/20	The CNO will ensure that	< 95%
	CONTROL-MEETINGS	to meet 03/11/20 and the Chief Nursing	Nursing		Infection Control activities	
	WAC 246-322-100	Officer will ensure that the Infection Control	Officer		such as identifying,	
	Infection Control	Committee meets at least quarterly			reporting and evaluating	
		thereafter.			infections in patients and	
					personnel will continue to	
		Meetings are currently scheduled for 4/8/20		4/8/20	be conducted, ongoing.	7
		and 5/13/20, and then will move to quarterly			Infection Control	
		meetings.		5/13/20	Committee meetings will	

Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action
Number			Individual(s)	Date of	Prevent Recurrence &	Level
				Correction	Target for Compliance	Indicating
						Need for
						Change
						of POC
			-		be scheduled at least	
		During these meetings Infection Control			quarterly. The Infection	
		activities, such as identifying, reporting and			Control Committee	
		evaluating infections in patients and personnel			members will monitor	
		will be reviewed and evaluated by the			Infection Control	
		Infection Control Committee to ensure		11	activities, such as	
		adherence to the goals established in the			identifying, reporting and	
		Infection Control Risk Assessment and Plan.			evaluating infections in	
		The Infection Control plan includes the IC			patients and personnel,	
		Preventionist being aware of and intervening		5	which will ensure	
		with individual patients related to infectious			adherence to the	
		needs, to ensure proper staff			Infection Control Risk	
		interventions/use of precautions, making			Assessment and Plan,	
		monthly Infection Control Rounds, and			approved by the Infection	
	5	mitigating identified risks, performing staff			Control Committee.	
		Hand Hygiene Monitoring, both in person and				
		via camera monitoring, and tracking and			Aggregated data is	
		reporting Antibiotic Use for any usage			reported to monthly to	
2		patterns, and necessary interventions. The IC			Quality Council, Medical	
		Preventionist will also provide PPD and Flu		×	Executive Committee, and	
		Vaccinations for employees as part of		-	the Governing Board.	
		infection prevention.				
					The target for compliance	
		7			is 100%.	
		The Infection Control Committee consists of				
		the Director of Medical Services (as chair),				
		Chief Nursing Officer(currently as the Infection				
		Control Nurse), Director of Pharmacy Services,				

	Fairfax Benavioral Health (Vionroe (U12/92)						
Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action	
Number			Individual(s)	Date of	Prevent Recurrence &	Level	
				Correction	Target for Compliance	Indicating	
						Need for	
						Change	
						of POC	
		Director of Plant Operations, Facility Risk			5		
	p v	Manager, Food Services Manager, rotating					
		members of Nursing Leadership and others as			, a		
		deemed appropriate. Infection Control					
		activities such as identifying, reporting and					
		evaluating infections in patients and personnel					
		was be conducted by the Chief Nursing	•				
		Officer, or designee, until the Infection Control					
	8	Nurse position was hired and trained.					
		The second secon			iii		
N N		An Infection Control Preventionist was hired					
· ·		effective 2/24/2020 and is be responsible for					
.00		the implementation of the hospital wide					
		Infection Control Risk Assessment and Plan.			ă.		
		intection control Nisk Assessment and Flan.	.1	4.			
						5.	
			S	2/24/20			
		20		2/24/20			
14		i i		-			
		7					
L 1065	322-170.2E TREATMENT	All licensed nurses were retrained, in person	Chief	3/26/20	All patients who have	< 90%	
	PLAN-COMPREHENS	at staff meetings, to the Fall Risk Assessment	Nursing	3,20,20	scored $\geq$ 90 on the	30%	
1	WAC 246-322-170 Patient	and Care policy (PC 100.19). Focus of the	Officer		Edmonson Fall Risk		
	Care	training included initiating a Fall Risk	Officer	*	Assessment and/or all		
	Services	Treatment Plan for:			patients who have fallen		
					O • 4 THE STREET OF THE STREET		
		All patients who score ≥ 90 on the			will be audited by the		
		Edmonson Fall Risk Assessment			Program Manager to		

### Plan of Correction for State Licensing – Due 2/21/2020 Fairfax Behavioral Health Monroe (012792)

	Fairrax Benavioral Health Monroe (012/92)						
Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action	
Number			Individual(s)	Date of	Prevent Recurrence &	Level	
				Correction	Target for Compliance	Indicating	
						Need for	
						Change	
						of POC	
		After a patient fall			ensure the presence of a		
		•			Fall Risk Treatment Plan.		
					Deficiencies will be		
					addressed and corrected		
					immediately.	: *	
	272			12	ininiediately.		
	,	,			The CNO and/or designee		
				-	will confirm compliance with		
					this plan of correction by		
					reporting daily in the FLASH		
					meeting the status of		
	ı		1.		patients identified as Fall risk		
	× -	· ·			and confirm completion of a		
					Fall risk treatment plan.		
		9			Tan risk er edemente plani		
					Results will be reported		
		, , ,			monthly to Quality		
					Council, Medical		
		is.			Executive Committee, and		
					the Governing Board.		
		*	×		the doverning board.		
			7		The target for compliance		
			9		The target for compliance		
L 1265	322-200.3F RECORDS-	All licensed nurses were retrained in never at	Chief	2/26/20	is 95%.	4.0004	
L 1203	OBSERVATIONS	All licensed nurses were retrained in person at	2,3550,055,055,21	3/26/20	All Patient Observation	< 90%	
	WAC 246-322-200	staff meetings and individually for those	Nursing		Records (Rounds sheets)		
	Clinical Records	unable to attend, to the Level of Observation	Officer		will be audited nightly by		
	Cililical Necolus	Orders policy (PC 1000.21). Licensed nurses			unit staff to ensure they	49	
		were the audience for this training as only a			contain the ordered		
		licensed nurse can note a provider's order.					

	Fairtax Benavioral Health Monroe (012792)						
Tag	Deficiency	How the Deficiency Will Be Corrected	Responsible	Estimated	How Monitored to	Action	
Number			Individual(s)	Date of	Prevent Recurrence &	Level	
				Correction	Target for Compliance	Indicating	
						Need for	
						Change	
						of POC	
	Specifically, Rounds	Focus of the training included ensuring that all			safety level, observation		
	Sheets missing date,	provider orders for safety levels, observation			level and precautions.		
6	safety level, observation	levels and precautions are noted on the					
	level and precautions.	Patient Observation Record (Rounds sheet).		3/26/20	The Charge RN will audit		
		All staff signed an attestation verifying their			all Patient Observation		
		understanding and commitment to following			Records (Rounds sheets)	a i	
		each aforementioned policy and procedure.			to ensure that ordered		
					safety level, observation		
		Additionally, on 1/27/20, safety level,			level and precautions are		
		observation level and precaution orders were			correctly noted.		
		removed from HCS (electronic ordering			Deficiencies will be		
		system) due to lack of a notification system to			addressed and corrected		
		nursing staff. All safety levels, observation		al C	immediately.		
		levels and precautions are now written in the			The Program Manager will	10	
2:		patient's medical record and flagged by the			audit 100% of Patient		
		ordering provider to notify the nursing staff a			Observation Records to		
	(C)	new order is in place.			ensure that ordered		
					safety level, observation		
		97			level and precautions are		
11					correctly noted.		
					Results will be reported		
					monthly to Quality		
					Council, Medical	) ×	
		*			Executive Committee, and		
		, and the second			the Governing Board.		

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance  The target for compliance is 95%.	Action Level Indicating Need for Change of POC
L 1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services	All dietary staff were retrained, in person at staff meetings, on the "HACCP Cooling Log, Time/Temperature Log for Potentially Hazardous Food." Focus of the training included the requirement that temperatures of potentially hazardous foods be recorded, while cooling, after 2 hours and after 6 hours.  Dietary manager for Evergreen Health Monroe will ensure food temperatures are logged per code.  Fairfax DPO will review logs weekly to verify results and confirm compliance by reporting once a week at the FLASH meeting.	Director of Plant Operations	2/18/20	Fairfax Director of Plant Operations will audit cooling logs, weekly, to ensure that the temperatures of potentially hazardous foods are recorded after 2 hours and after 6 hours, while cooling.  Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board.  The target for compliance is 95%.	< 90%

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

tes: 1/22/20 - 1/23/20 Palm Kowl winnings

Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20 Fairfax Behavioral Health Monroe (012792)

	Tailtax behavioral freaten Monioc (012732)						
Tag Number	Deficiency	How Corrected	Date Completed	Results			
L 315	322-035.1C POLICIES-	<u>Item #1 – Suicide Precautions</u>	<u>ltem #1:</u>	<u>Item #1:</u>			
	TREATMENT	All Nursing staff, to include Program Specialists, CNAs, LPNs and RNs,					
	WAC 246-322-035 Policies	were retrained, in person at staff meetings and individually for those	3/26/20	95%			
	and Procedures	unable to attend, to the Suicide Precautions and Linens Management					
		policies. All staff signed an attestation verifying their understanding and					
		commitment to following each aforementioned policy and procedure.					
	*	Focus of the training included:					
		<ul> <li>The requirement that staff ensure that patients on Suicide</li> </ul>					
		Precautions and their roommates do not have access to excess					
		linens, such as towels, blankets or scrubs.					
		<ul> <li>Limiting distribution of linens to patients on Suicide Precautions</li> </ul>					
		and their roommates.					
		<ul> <li>Distribution will be no more than three towels, one top sheet, one</li> </ul>					
		bottom sheet, one pillowcase and two sets of scrubs.					
		Re-training also included the requirement that during rounds, Nursing					
		staff are to check for any patients who are on Suicide Precautions and					
		their rooms, to ensure that all linens are accounted for and returned.					
		Towels and scrubs, not in use, found in rooms during rounds are					
		immediately removed. Sheets, blankets and pillowcases found in excess					
		of distribution requirements of the Linens Management policy are to be					
		immediately removed during rounds.					
		Monitoring excess linens was added to the daily room checks. All unit					
		staff were retrained, in person at staff meetings, to the revised room					
		checks log. Focus of the training included confirming that patients on					
		Suicide Precautions do not have access to excess linens. Sheets, blankets,					
		pillowcases and scrubs found in excess of distribution requirements of the					
		Linens Management policy are immediately removed.					

## Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20

Fairfax Behavioral	Health Monroe	(012792)
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	Fairlax Beliavioral Health (Violine (012732)						
Tag Number	Deficiency	How Corrected	Date Completed	Results			
		All housekeeping staff were retrained, in person at staff meetings, by the Director of Plant Operations, and individually for those unable to attend, to the Linens Management policy. Focus of the training included the requirement that housekeeping staff do not distribute linens in excess of the numbers defined in the policy.					
		<u>Item #2 – Daily Fall Risk Assessments</u>	<u>ltem #2:</u>	<u>Item #2:</u>			
		All Registered Nurses were retrained, in person at staff meetings by the CNO and/or designee to the Fall Risk Assessment and Care policy (PC 1000.19). Focus of the training included the requirement that the Edmonson Psychiatric Fall Risk Assessment is thoroughly completed:  • On admission  • Daily for three consecutive days, until score is <90, for patients who have scored ≥ 90 and/or are on Fall Precautions  • After every patient fall	3/26/20	100%			
L 375	322-035.1o POLICIES- HOUSEKEEPING WAC 246-322-035 Policies and Procedures	All Housekeeping Staff were retrained, in person at staff meetings by the EVS Supervisor on the correct method of testing disinfectants to ensure the cleaning solution has the appropriate concentration of disinfectants. Housekeeping Staff test cleaning solutions daily and maintain a log of results. If solution test outside of the proper pH range chemicals will be remixed ad retested before use.	2/17/20	100%			
L 765	322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control	The Infection Control Committee met on 03/11/20 and 4/8/20. The Infection Control Committee is scheduled to meet on 5/13/20. The Chief Nursing Officer will ensure that the Infection Control Committee meets at least quarterly thereafter.	3/11/20	100%			

## Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20 Fairfax Behavioral Health Monroe (012792)

Too	Deficiency	Harrax Benavioral Health Ivionroe (U12/92)	D .	Dec II
Tag Number	Deficiency	How Corrected	Date Completed	Results
		During these meetings Infection Control activities, such as identifying, reporting and evaluating infections in patients and personnel were reviewed and evaluated by the Infection Control Committee to ensure adherence to the goals established in the Infection Control Risk Assessment and Plan. The Infection Control plan included the IC Preventionist being aware of and intervening with individual patients related to infectious needs, to ensure proper staff interventions/use of precautions, making monthly Infection Control Rounds, and mitigating identified risks, performing staff Hand Hygiene Monitoring, both in person and via camera monitoring, and tracking and reporting Antibiotic Use for any usage patterns, and necessary interventions. The IC Preventionist has also provided PPD and Flu Vaccinations for employees as part of infection prevention.		
	*	The Infection Control Preventionist was hired effective 2/24/2020 and is be responsible for the implementation of the hospital wide Infection Control Risk Assessment and Plan.	,	
L 1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services	All licensed nurses were retrained, in person at staff meetings, to the Fall Risk Assessment and Care policy (PC 100.19). Focus of the training included initiating a Fall Risk Treatment Plan for:  ■ All patients who score ≥ 90 on the Edmonson Fall Risk Assessment ■ After a patient fall	3/26/20	100%
L 1265	322-200.3F RECORDS- OBSERVATIONS WAC 246-322-200 Clinical Records	All licensed nurses were retrained in person at staff meetings and individually for those unable to attend, to the Level of Observation Orders policy (PC 1000.21). Licensed nurses were the audience for this training as only a licensed nurse can note a provider's order. Focus of the training included ensuring that all provider orders for safety levels, observation levels and precautions are noted on the Patient Observation Record	3/26/20	97%

## Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20 Fairfax Behavioral Health Monroe (012792)

Tag Number	Deficiency	How Corrected	Date Completed	Results
	Specifically, Rounds Sheets missing date, safety level, observation level and precautions.	(Rounds sheet). All staff signed an attestation verifying their understanding and commitment to following each aforementioned policy and procedure.  Additionally, on 1/27/20, safety level, observation level and precaution orders were removed from HCS (electronic ordering system) due to lack of a notification system to nursing staff. All safety levels, observation levels and precautions are now written in the patient's medical record and flagged by the ordering provider to notify the nursing staff a new order is in place.		
L 1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services	All dietary staff were retrained, in person at staff meetings, on the "HACCP Cooling Log, Time/Temperature Log for Potentially Hazardous Food." Focus of the training included the requirement that temperatures of potentially hazardous foods be recorded, while cooling, after 2 hours and after 6 hours.  Dietary manager for Evergreen Health Monroe ensures food temperatures are logged per code.  Fairfax DPO reviews logs weekly to verify results and confirms compliance.	2/18/20	100%

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



## STATE OF WASHINGTON DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

December 1, 2020

Mr. Ron Escarda, Group Director/CEO Fairfax Monroe Behavioral Hospital 14701 179<sup>th</sup> Ave SE Monroe, WA 98272

Dear Mr. Escarda,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Fairfax Monroe Behavioral Hospital on January 22-23, & 28<sup>th</sup>, 2020. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on March 4, 2020.

Hospital staff members sent a Progress Report dated April 27, 2020 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Monroe Behavioral Hospital's attestation to be in compliance with Chapter 246-32 WAC.

The Deputy Fire Marshal perform a revisit on November 18, 2020 and verifed the life safety corrections.

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

Sincerely,

Paul Kondrat, RN, MN, MHA

Survey Team Leader

Paul M Konot