STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

Thursday, July 27, 2023

Inland Northwest Behavioral Hospital
104 W 5th Ave
Spokane, WA 99204-4880

Dear Mr. Wickel:

This letter contains information regarding the recent investigation at ***Inland Northwest Behavioral Hospital*** by the Washington State Department of Health. Your state licensing investigation was completed on Monday, June 26, 2023.

During the investigation, deficient practice was found in the areas listed on the attached Statement of Deficiency Report. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiency Report and will be due 14 days after you receive this letter.

Each plan of correction statement must include the following:

- The regulation number;
- How the deficiency will be corrected;
- Who is responsible for making the correction;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations.

You are not required to write the Plan of Correction on the Statement of Deficiency Report.

You may receive notice of the Department's intent to take enforcement action against your license under RCW 71.24.037, 71.12, WAC 246-337-021 and WAC 246-341-0335 based on any deficiency listed on the enclosed report. Your submission of a Plan of Correction or any other action you take in response to this Statement of Deficiency Report may be taken into consideration in an enforcement action but does not prevent the Department from proceeding with enforcement action.

Please email the report and Plans of Correction to the Investigator. You can also sign and send the original reports and Plans of Correction to the Investigator at following address:

Investigator: *33894*
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874

Enclosures: Statement of Deficiency Report
Plan of Correction Instructions

Statement of Deficiency Report

Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
TEL: 360-236-4732

Inland Northwest Behavioral Hospital, 104 W 5th Ave, Spokane, WA 99204-4880		Rlynn Wickel
Agency Name and Address		Administrator
Investigation	Tuesday, January 25, 2022	33894
Inspection Type	Investigation Start Date	Investigator Number
2021-12084	BHA.FS.60894630	MH Evaluation & Treatment
Case Number	License Number	BHA/RTF Agency Services Type

Please note that the deficiencies/violations/observations noted in this report are not all-inclusive, but rather were deficiencies/violations/observations that were observed or discovered during the investigation.

Deficiency Number and Rule Reference	Findings	Plan of Correction
WAC 246-341-0410, Agency administration-Administrator key responsibilities. (4) The administrator or their designee must ensure: (a) Administrative, personnel, and clinical policies and procedures are adhered to and compliant with the rules in this chapter and other applicable state and federal statues and regulations;	Based on policy and procedure review, agency document review, interviews, and email correspondence, the agency administrator or their designee failed to ensure that policies and procedures were adhered to and compliant with the rules, statutes, and regulations for 1 of 2 patients reviewed (Patient #1). Failure to ensure that policies and procedures are adhered to and compliant with the rules, statutes, and regulations can result in violation of patients right to have access to their treatment information and prevent individuals voluntarily seeking assessment for treatment	

	options from being able to leave the facility, causing trauma, harm, and aversion to seeking future treatment. Item #1 – Individual Service Records: Policy addressing intake assessment not in compliance with rules. References: WAC 246-341-0640 Individual service record content. A behavioral health agency is responsible for the components and documentation in an individual's individual service record content unless specified otherwise in certification or individual service requirements. (1) The individual service record must include: (c) An assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes: (i) Presenting issue(s); (ii) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm and, if the assessment indicates there is such a risk, a referral for provision of emergency/crisis services; (iii) Treatment recommendations or recommendations for additional program-specific assessment. Findings included: 1. Review of the agency's policy titled, "Intake Assessment," revised 01/2021, showed that the purpose of the intake assessment is to assess a patient's appropriateness for residential treatment or an	

	alternate level of care. The procedure showed that an assessment would be offered at no charge to anyone referred or making an inquiry, and that "the Integrated Assessment Form is a needs assessment only…that is only valid at the time of the assessment…It is used to determine level of care for the assessing hospital only." The procedure stated, "The Integrated Assessment will become a part of the medical record and will be placed in the chart upon admission…The Integrated Assessment tool is deemed to be information that is hospital use only and is deem[ed] outdated after 30 minutes or greater if not admitted." The policy did not address maintenance of the assessment when a patient is not admitted. 2. During an interview on 05/24/23 around 3:00 PM with Staff B, Director of Risk, when asked about patients requesting copies of their records, Staff B stated that the assessment conducted in Intake is a "needs only" assessment. Staff B stated that they called their corporate office to get clarification. Staff B stated that the assessment is invalid once the patient walks out the door and does not become part of the record until the patient is admitted, which may be upon return from the local hospital. Staff B stated that the assessment is considered for use by the facility only because once the patient leaves, the information becomes invalid because the information used in the assessment could change. 3. Review of email correspondence dated 06/21/23 at 9:39 PM from Individual #1, DOH Community Health Systems (Programs) Manager, in response to an email sent by Investigator #1 on 06/21/23 at 3:19 PM asking for clarification regarding patients access	

	to assessments conducted at the facility, showed that Individual #1 wrote, "If it contains any information that would be considered protected health information…it needs to be part of a clinical record." 4. Review of the clinical record for Patient #2, who was assessed at the facility on 06/13/23 and was referred to community resources and not admitted to the facility, showed that the assessment included protected health information including the patient's demographic information; vital signs; health and communicable disease screening; fall risk assessment; presenting problem; suicide risk assessment; sexual aggressive behavior and sexual victimization behavior screening; homicidal/violence risk assessment; elopement risk assessment; mental health screening; substance use disorder (SUD) screening; gambling screening; current mental status assessment; and a level of care determination section. Item #2 – Patient Belongings: Procedure not adhered to. Findings included: 1. Review of the agency's document titled, "Assessment and Referral," no date, included in the information packet given to patients upon admission, showed that patients who come to the facility for an assessment to determine what level of care is most appropriate for them will be asked to place their personal belongings into a plastic bin that will stay with the patient throughout the intake and admissions process, and that patients can keep their phone with them throughout the	

	process. The facility failed to adhere to this procedure based on the following. 2. During an interview on 01/25/22 at 10:00 AM with Patient #1, the patient stated that when they went to the facility to receive an assessment to determine what level of care was most appropriate for them, they were asked to give up their belt, wallet, and keys. 3. During an interview on 05/24/23 at 2:32 PM with Staff D, Manager of Intake, Staff D stated that patients' wallets and keys are taken before going back to intake "to remove all potential risks." Item #3 – Seclusion and Restraint: Policy not adhered to. Findings included: 1. Review of the agency's policy titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," Policy 13524979 dated 07/01/20 and revised 04/20/23, showed the following: a. Seclusion is defined as "The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. If a patient is restricted to a room alone and staff are physically intervening to prevent the patient from leaving the room or giving the perception that threatens the patient with physical intervention if the patient attempts to leave the room, the room is considered locked, whether or not the door is actually locked or not."	

	b. The policy of the agency is to support each patient's right to be free from restraint and seclusion and therefore limit the use to emergencies in which there is an imminent risk of a patient physically harming him/herself or others. c. Restraint and seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. c. Patients have a right to be free from restraint and seclusion imposed as a means of coercion; based on history of past use or dangerous behavior; or as a convenience for staff. d. The use of restraint and seclusion requires an order from a physician. e. When restraint or seclusion is used, the RN will immediately assign a staff member to continuous in-person observation/monitoring for the duration of the episode. f. The use of restraint and seclusion will be thoroughly documented in the patient's medical record to include: that the patient and/or family were informed of the hospital's policy on the use of restraint/seclusion and consent for notification; the initial assessment of the patient related to restraint/seclusion use; the circumstances that lead to the use; specific behaviors; consideration or failure of non-physical interventions; the rationale for use; written orders for use; behavioral criteria for discontinuation of use and informing the patient of those criteria; initial in-person and	

	subsequent evaluations of the patient; 15-minute assessments of the patient's status; continuous monitoring of patient and care provided; debriefing of the patient with staff; any injuries sustained and treatment received for injuries; time of initiation and termination; and treatment plan review/revision following each episode. 2. Interview with Patient #1 on 01/25/22 at 10:00 AM showed that the patient was secluded while they were in the intake room, then restrained on a gurney for transport, based on the following: a. The patient stated that when they went to the facility to receive an assessment to determine what level of outpatient mental health care was most appropriate for them, they were asked to give up their belt, wallet, and keys. b. The patient stated that the staff member conducting the assessment "got personal about suicidal ideations" and shared their own mental health history. The patient asked the staff member if there was anything they could say that would keep them there and was told "you are free to leave at any time." The patient shared that they had suicidal thoughts since about the age of 12 but never had a suicide attempt. The staff member asked the patient that if they were going to kill themselves, how would they do it. The patient told them they had a gun. The staff member asked the patient "do you feel suicidal now" to which the patient responded "no". c. The patient was left alone in the room for 30-45 minutes before the staff member came back, told them	

	they couldn't leave, then returned with another staff member. They told the patient that there were two doctors; one thought the patient didn't need to stay and the other one thought they did need to stay. d. The patient asked the staff members, "Am I being detained? You don't have a right," to which the staff responded, "yes we do." The patient stated that at that point they had been at the facility for approximately three and a half hours with no food, water, or bathroom break. The patient got up to leave and noticed there was no door handle on the door and told staff, "I'm going to leave. I will sign any waiver" to which staff kept reiterating, "you're detained, you can't leave." e. The patient stated that at that point there were four police officers with four guns and four tasers in the room with them and that "I got terrified at that point." The patient expressed they did not want to get on the gurney or to be strapped to the gurney and was told by the officers that they would be made to do it if they did not do it voluntarily. f. When asked if they received a copy of their rights or had their voluntary right to immediate discharge upon request explained to them, the patient stated, "absolutely not." 3. During an interview on 05/24/23 at 9:50 AM with Staff B, Director of Risk, Staff B stated that if patients meet criteria to be admitted and they refuse to voluntarily admit, the therapist presents the assessment information as a case to the provider,	

	and the provider makes the final decision. If the patient is not willing to sign in, they call the DCR. Staff B stated that DCRs are part of [another agency] and can take up to three days to come to the facility. For that reason, they will have American Medical Response (AMR) take the patient to a local hospital to receive a DCR evaluation. When patients refuse to go, AMR will call the police. Staff B stated, "It's a safety check for everybody involved to ensure the patient is safe." 4. During an interview on 05/24/23 at 2:11 PM with Staff C, Director of Intake and Assessments, Staff C stated that they staff all assessments with a provider and if a patient meets admission criteria, they will be taken to a local hospital by AMR for a DCR evaluation. If a patient refuses to go, AMR will wait for law enforcement. 5. An interview on 05/24/23 at 2:32 PM with Staff D, Manager of Intake, showed the following: a. Staff D stated that master's level clinicians or registered nurses (RN) conduct the 10-page assessment and call the psychiatric provider who will decide if the patient needs to stay or be referred elsewhere. b. When asked if patients are allowed to leave, Staff D stated that they can leave if they are in the lobby. When asked what happens if they ask to leave during the assessment, Staff D stated that they have the right to refuse services and leave. Staff D stated that if it's determined that the patient needs inpatient	

	care and needs to be in a secure setting, they explain involuntary detainment to the patient and contact the DCR or call the hospital and have the patient transferred "to reduce risk and ensure appropriate intervention." c. When asked if the facility is locked, Staff D stated that it is locked, "it's a secure unit." When asked if patient's stay a long time in Intake, Staff D stated that it "may be normal," that they will step out of the room to call the provider which they may have difficulty reaching. d. When asked if patients are informed of the process and the possibility of a DCR referral for potential involuntary detainment when they request an assessment, Staff D stated that they believe there are common misunderstandings. Staff D stated that they have heard that providers and facilities will refer patients to the facility and say, "Go to [facility name], they will give you a free assessment." Staff D stated that they have implemented a form that includes the patient's name, how they heard about the facility, and why do they need hospitalization. Staff D stated that they felt the last question explains that the evaluation may result in hospitalization of the patient. 6. During an onsite visit by Investigator #1 on 05/24/23 at 12:00 PM, Staff A, Director of Quality, came into the room to let the Investigator know that they were unable to locate Patient #1's intake assessment. Staff A stated that they believed it may have been misfiled in November or December of	

	2021 when they had a visit from Joint Commission to review the complaint. Staff A stated that they would continue to search for it and email a copy to Investigator #1 if they found it. 7. Review of email correspondence dated 06/14/23 at 10:37 AM from Staff A, Director of Quality, in response to an email sent by Investigator #1 on 06/14/23 at 10:02 AM asking if Patient #1's record had been found, showed that Staff A wrote, "I was not able to find the intake assessment." No documentation was provided by the agency to show documentation of the seclusion and restraint of the patient, including a physician's order authorizing the seclusion and restraint.	
246-341-0600(1)(2)(j) Individual rights. (1) Each behavioral health agency must protect and promote individual participant rights applicable to the services the agency is certified to provide in compliance with this chapter, and chapters 70.41, 71.05, 71.12, 71.24, and 71.34 RCW, as applicable. (2) Each agency must develop a statement of individual participant rights applicable to the services the agency is certified to provide, to ensure an individual's rights are protected in compliance with chapters 70.41, 71.05, 71.12, 71.24, and 71.34 RCW, as applicable. To the extent that the rights set out in those chapters do not specifically address the rights in this subsection or are not applicable to all of the agency's services, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following	Based on interviews and policy and procedure review, the agency failed to protect patient rights in compliance with RCW 71.05 and to review their individual service record for 1 of 2 patients reviewed (Patient #1). Failure to protect patient rights in compliance with RCW 71.05 and to review their individual service record can result in violation of patient civil liberties and rights causing trauma, harm, and aversion to seeking future treatment. Item #1 – Voluntary Patient Rights: Failure to protect patient rights in compliance with RCW 71.05. Findings included: 1.Review of the agency's policy titled, "Criteria and Evaluation for Detainment," Policy 10529967 revised 12/29/21, showed that voluntary patients requesting	

statements. "You have the right to: (j) Review your individual service record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections; **RCW 71.05.050(1-2) Voluntary application for treatment of a behavioral health disorder—Rights—Review of condition and status—Detention—Person refusing voluntary admission, temporary detention.** (1) Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a behavioral health disorder, either by direct application or by referral. Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request. Any person voluntarily admitted for inpatient treatment to any public or private agency shall orally be advised of the right to immediate discharge, and further advised of such rights in writing as are secured to them pursuant to this chapter and their rights of access to attorneys, courts, and other legal redress. Their condition and status shall be reviewed at least once each one hundred eighty days for evaluation as to the need for further treatment or possible discharge, at which time they shall again be advised of their right to discharge upon request. (2) If the professional staff of any public or private agency or hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a	to discharge who present as a danger to self, danger to others, or gravely disabled will be evaluated by a DCR. The process included notifying the provider about the patients request to discharge; assessing the patient for current level of risk, safety of discharge, and continued symptoms of mental disorder; negotiating with the patient about leaving; enlisting the help of a family/friend to help communicate and reason with the patient; contacting the DCR with required information and documentation available; and ensuring a copy of the DCR's crisis assessment is in the paper chart if the DCR does not detain the patient. The policy did not address people seeking voluntary admission who have not yet been admitted, sending patients to the local hospital for evaluations, nor the language used in RCW 71.02.050 that requires that a voluntary patient who requests discharge presents, as the result of a behavioral health disorder, as an imminent likelihood of serious harm, or as an imminent danger because of grave disability, as a prerequisite to being held for a DCR evaluation. 2. Review of the agency's document titled, "Assessment and Referral," no date, showed that an assessment is conducted to help determine what level of care is most appropriate for a patient. The document stated for patients to keep in mind that as a voluntary patient, they are under the care of a psychiatrist who is responsible for their health and well-being and even though a voluntary patient may request to be discharged against medical advice (AMA), the professional staff are still responsible for assessing if it is reasonably safe for them to do so and	

behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day.	will work with them on a discharge plan before agreeing to a discharge. If the medical provider continues to have concerns with the patient's health and safety should a discharge occur, a referral would be made for an evaluation by a DCR who would make the determination if the voluntary admission should be converted to an involuntary admission. 3. Review of the agency's policy titled, "Patient's Rights and Responsibilities, 100.11," Policy 11612024 approved 05/06/22, showed that voluntary patients have the right to object to hospitalization and request release from the hospital unless involuntary commitment proceedings are initiated. They also have the right to an explanation of the involuntary treatment process should they decide to leave the hospital against medical advice. The policy showed that all employees are responsible for ensuring that the rights of patients are safeguarded. 4. An interview on 01/25/22 at 10:00 AM, with Patient #1, showed the following: a. The patient had suffered from depression on and off for twenty years and went to the facility because their psychiatrist suggested they go there to receive an assessment to be evaluated for outpatient treatment. The patient spoke with their spouse who encouraged them to go to the facility and bring back information so they could make a decision together. b. When asked if they received a copy of their rights or had their voluntary right to immediate discharge upon request explained to them, the patient stated, "absolutely not."	

	c. The patient asked the staff member conducting the assessment if there was anything they could say that would keep them there and was told “you are free to leave at any time.” d. The patient shared that they had suicidal thoughts since about the age of 12 but never had a suicide attempt. The staff member asked the patient that if they were going to kill themselves, how would they do it. The patient told them they had a gun. The staff member asked the patient “do you feel suicidal now” to which the patient responded “no”. e. The staff member conducting the assessment left the room then came back and told the patient that there were two doctors; one thought the patient didn’t need to stay and the other one thought they did need to stay. The staff member asked the patient if they thought they needed to stay, to which the patient replied “no”. The patient stated that they did not meet either of the two doctors. f. The patient stated that they asked, “Am I being detained? You don’t have a right,” to which staff responded, “yes we do.” The patient stated that at that point they had been at the facility for approximately three and a half hours with no food, water, or bathroom break. The patient got up to leave and noticed there was no door handle on the door and told staff, “I’m going to leave. I will sign any waiver” to which staff kept reiterating, “you’re detained, you can’t leave.”	

	g. The patient stated that when they requested to see the psychiatrist, they were told that the psychiatrist wasn't coming down, that "that's not the way we do things." The patient stated that at that point there were four police officers with four guns and four tasers in the room with them and that "I got terrified at that point." The patient expressed they did not want to get on the gurney or to be strapped to the gurney and was told by the officers that they would be made to do it if they did not do it voluntarily. h. The patient was taken to a local hospital where they were evaluated by a DCR who told the patient "I just have to ask these questions and get you out of here." The patient was released to go home. i. The patient stated that they had "flash backs and panic attacks for weeks" as a result of their experience at the facility and stated, "I will never, ever seek any kind of mental health services. I will never. Do not ask me about SI [suicidal ideation] because I will not answer them. I felt destroyed. Because I was seeking help, you have to be brave because there's stigma associated with it. I have no other options. That's the way it has to be. I have a huge distrust in hospitals. It's probably been the most traumatic thing in my life." 5. During an interview on 05/24/23 at 9:50 AM with Staff B, Director of Risk, Staff B stated that intake staff are master's level therapists and that providers make the final decision about admission to the facility. If patients meet criteria to be admitted and they refuse to voluntarily admit, the therapist presents the assessment information as a case to the	

	provider, and the provider makes the final decision. If the patient is not willing to sign in, they call the DCR. Staff B stated that DCRs are part of Frontier Behavioral Health and can take up to three days to come to the facility. For that reason, they will have American Medical Response (AMR) take the patient to a local hospital to receive a DCR evaluation. When patients refuse to go, AMR will call the police. Staff B stated, "It's a safety check for everybody involved to ensure the patient is safe." 6. During an interview on 05/24/23 at 2:11 PM with Staff C, Director of Intake and Assessments, Staff C stated that they staff all assessments with a provider and if a patient meets criteria for admission, they will be taken to a local hospital by AMR for a DCR evaluation. If a patient refuses to go, AMR will wait for law enforcement. When asked what the criteria is for being referred for a DCR evaluation, Staff C stated harm to themselves or harm to others, or grave disability. Staff C stated that it's a judgement call and that providers make the call on a case-to-case basis, and that patient's wouldn't be admitted until they were seen by the DCR. 7. An interview on 05/24/23 at 2:32 PM with Staff D, Manager of Intake, showed the following: a. When asked what the process is when a voluntary patient walks in and requests an assessment, Staff D stated that reception will ask the patient why they are there and why they are seeking services. The patient is given the initial paperwork, then they will	

	do an evaluation to determine an appropriate level of care. b. Staff D stated that master's level clinicians or registered nurses (RN) conduct the 10-page assessment and call the psychiatric provider who will decide if the patient needs to stay or be referred elsewhere. c. Staff D stated that if it's determined that the patient needs inpatient care and needs to be in a secure setting, they explain involuntary detainment to the patient and contact the DCR or call the hospital and have the patient transferred "to reduce risk and ensure appropriate intervention." d. When asked if patients are informed of the process and the possibility of a DCR referral for potential involuntary detainment when they request an assessment, Staff D stated that they believe there are common misunderstandings. Staff D stated that they have heard that providers and facilities will refer patients to the facility and say, "Go to [facility name], they will give you a free assessment." Staff D stated that they have implemented a form that includes the patient's name, how they heard about the facility, and why do they need hospitalization. Staff D stated that they felt the last question explains that the evaluation may result in hospitalization of the patient. 8. During an onsite visit by Investigator #1 on 05/24/23 at 12:00 PM, Staff A, Director of Quality, came into the room to let the Investigator know that	

	they were unable to locate Patient #1's intake assessment. Staff A stated that they believed it may have been misfiled in November or December of 2021 when they had a visit from Joint Commission to review the complaint. Staff A stated that they would continue to search for it and email a copy to Investigator #1 if they found it. 9. Review of email correspondence dated 06/14/23 at 10:37 AM from Staff A, Director of Quality, in response to an email sent by Investigator #1 on 06/14/23 at 10:02 AM asking if Patient #1's record had been found, showed that Staff A wrote, "I was not able to find the intake assessment." No documentation was provided by the agency to show that Patient #1 met criteria for detainment for a DCR referral by presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or gravely disabled, when they requested to leave. Item #2 – Right to Review Individual Service Record Findings included: 1. Review of the agency's policy titled, "Patient Requests to Access PHI [Protected Health Information]," Policy 11611879 approved 05/06/22, showed that patients may request in writing access to their PHI in the medical and/or billing records and that the facility would respond within 30 days after receipt of the request. 2. Review of the agency's policy titled, "Patient's Rights and Responsibilities, 100.11," Policy 11612024 approved	

	05/06/22, showed that patients have the right to access information contained in their medical/clinical record within a reasonable timeframe and that the facility would actively seek to meet patient requests as quickly as health information management procedures permitted. 3. During an interview on 01/25/22 at 10:00 AM with Patient #1, the patient stated that they had not been able to get copies of their medical records from the facility despite calling them several times, and that the facility tells them they can't provide a copy because intake records are not medical records. 4. During an interview on 05/24/23 around 3:00 PM with Staff B, Director of Risk, when asked about patients requesting copies of their records, Staff B stated that the assessment conducted in Intake is a "needs only" assessment. Staff B stated that they called their corporate office to get clarification. Staff B stated that the assessment is invalid once the patient walks out the door and does not become part of the record until the patient is admitted, which may be upon return from the local hospital. Staff B stated that the assessment is considered for use by the facility only because once the patient leaves, the information becomes invalid because the information used in the assessment could change. 5. Review of email correspondence dated 06/21/23 at 9:39 PM from Individual #1, DOH Community Health Systems (Programs) Manager, in response to an email sent by Investigator #1 on 06/21/23 at 3:19 PM asking for clarification regarding patients access to assessments conducted at the facility, showed that	

	the individual wrote, “If it contains any information that would be considered protected health information…it needs to be part of a clinical record.”	

Plan of Correction Instructions

Introduction

We require that you submit a plan of correction for each deficiency listed on the statement of deficiency form. Your plan of correction must be Submitted to DOH within fourteen calendar days of receipt of the list of deficiencies.

You are required to respond to the statement of deficiencies by submitting a plan of correction (POC). Be sure to refer to the deficiency number. If you include exhibits, identify them and refer to them as such in your POC.

Descriptive Content

Your plan of correction must provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and provide information that ensures the intent of the regulation is met.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;

- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

Simply stating that a deficiency has been "corrected" is not acceptable. If a deficiency has already been corrected, the plan of correction must include the following:

- How the deficiency was corrected,
- The completion date (date the correction was accomplished),
- How the plan of correction will prevent possible recurrence of the deficiency.

Completion Dates

The POC must include a completion date that is realistic and coinciding with the amount of time your facility will need to correct the deficiency. Direct care issues must be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies that require bids, remodeling, replacement of equipment, etc., may need more time to accomplish correction; the target completion date, however, should be within a reasonable and mutually agreeable time-frame.

Continued Monitoring

Each plan of correction must indicate the appropriate person, either by position or title, who will be responsible for monitoring the correction of the deficiency to prevent recurrence.

Checklist:

- Before submitting your plan of correction, please use the checklist below to prevent delays.
- Have you provided a plan of correction for each deficiency listed?
- Does each plan of correction show a completion date of when the deficiency will be corrected?
- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated what staff position will monitor the correction of each deficiency?
- If you included any attachments, have they been identified with the corresponding deficiency number or identified with the page number to which they are associated?

Your plan of correction will be returned to you for proper completion if not filled out according to these guidelines.

Note: Failure to submit an acceptable plan of correction may result in enforcement action.

Approval of POC

Your submitted POC will be reviewed for adequacy by DOH. If your POC does not adequately address the deficiencies, you will be sent a letter detailing why your POC was not accepted.

Questions?

Please review the cited regulation first. If you need clarification or have questions about deficiencies, you must contact the investigator who conducted the investigation.

INLAND NORTHWEST BEHAVIORAL HEALTH HOSPITAL
Plan of Correction for Complaint # 2021-12084

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
WAC 246-341-0410	**WAC 246-341-0410 Agency Administration – Administrator key responsibilities.** Based on policy and procedure review, agency document review, interviews, and email correspondence, the agency administrator or their designee failed to ensure that policies and procedures were adhered to and compliant with the rules, statutes, and regulations for 1 of 2 patients reviewed (Patient #1). Failure to ensure that policies and procedures are adhered to and	**Item #1:** #1- The Chief Executive Officer (CEO) reviewed the findings of this investigation and reviewed WAC 246-341-0410. The CEO reviewed the Intake Assessment Policy and Procedure. This Policy was updated to reflect that the Intake Assessment form for any patient not admitted would be kept in Intake for one month, then the files would be moved to medical records where they will send them out for storage to iron mountain. These will stay in medical records for up to 30 days before being sent out to iron mountain. The Director of Intake, HIM Manager and Director of Quality were retrained by the CEO to the newly revised policy and procedure paying special attention to the process of maintenance of the written assessment when a patient is not admitted. The Director of Intake, HIM Manager and Director of Quality were directed to retrain all Intake Staff and HIM staff. All Intake staff and HIM staff were retrained by the Director of Quality to the revised Intake Assessment policy and procedure paying special attention to the following areas: • That if a patient does not get admitted, the Intake staff will file all available documents after final client disposition occurs and keep it in the Intake department. This file will consist of: ○ The Integrated Assessment	Director of Intake HIM Manager Director of Quality	8/25/2023	Monitoring of 100% of Intake Assessments of patients not admitted Monitoring will be ongoing for four months until compliance >/= 90% is achieved and sustained. Ongoing monitoring of 50% of Intake Assessment to occur quarterly along with all other Intake audits. All deficiencies	Threshold for acceptable compliance : >90%

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	compliant with the rules, statutes, and regulations can result in violation of patients right to have access to their treatment information and prevent individuals voluntarily seeking assessment for treatment options from being able to leave the facility, causing trauma, harm, and aversion to seeking future treatment.	○ Initial call sheets if applicable ○ Consent for Assessment ○ Voluntary Intake Assessment acknowledgement form ○ Patient Rights and Responsibilities acknowledgement form ○ Release of information ○ Observation form ○ Copy of the Safety Plan given to patient ○ Patient Disposition • That any individual who presents to Inland Northwest Behavioral Health for an assessment, but they are not admitted to our facility, this individual will still have access to copies of their record and PHI when a request is made. Training was initiated and completed by 8/25/2023 Evidence of training is filed in staff's personnel file. This newly revised policy was reviewed and approved by the Governing Body on 8/10/2023.			are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	

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		#2-The CEO then reviewed the policy: Assessment, Intake, and Referral Record Content. No changes were made to this policy. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were all retrained by the CEO to the Assessment, Intake, and Referral Record Content policy. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were directed to retrain all Intake staff and HIM staff. All Intake staff and HIM staff were retrained to Assessment, Intake, and Referral Record Content policy. Training focused on: • The Intake department will establish a file which will contain part or all of the file depending on the disposition of the client: ○ Initial call sheet ○ Intake Assessment ○ Consent for Assessment ○ Voluntary Intake Assessment acknowledgement form ○ Patient Rights and Responsibilities acknowledgement form ○ Release of Information if applicable ○ Observation form ○ Copies of medical or clinical information sent form the referring agency	Director of Intake HIM Manager Director of Quality Director of Risk	8/25/2023	Monitoring of 100% of Intake files on patient's not admitted Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of files of patients not admitted will occur quarterly. All deficiencies are corrected immediately to include	Threshold for acceptable compliance : >90%

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		• The Intake clinician will file all available documents after final client disposition occurs in the Intake department
		• The Intake department will give all patient files to Medical Records monthly.
		• The HIM Manager will forward patient files to off-site storage
		  ○ The Intake Assessment will be kept for 10 years
		  ○ Initial call sheets for patients who are not admitted will be kept for 5 years
		
		Training was initiated and completed by 8/25/2023
		Evidence of training is filed in staff's personnel file.
					staff retraining as needed.
					
					Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		#3, #4 -The CEO then reviewed the policy: Patient Requests to Access PHI. No changes were made to this policy. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were all retrained by the CEO to the Patient Requests to Access PHI policy. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were directed to retrain all Intake staff and HIM staff. All HIM staff and the Intake Department were retrained by the Director of Quality to the Patient Requests to Access PHI with key focus on: • It is the right of a patient to access their PHI contained in facility medical and billing records. • A patient may request in writing access to their PHI • A facility will respond to an individual's request for access to the PHI within thirty days after receipt of request. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.	Director of Intake HIM Manager Director of Quality Director of Risk	8/25/2023	Monitoring of 100% of requests for PHI access Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of requests for PHI will occur quarterly All deficiencies are corrected immediately to include staff	Threshold for acceptable compliance : >90%

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					retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		Item #2 #1, #2, #3 -The CEO reviewed the policy titled, Securing Patient Belongings. No changes were made to this policy at this time. The CEO then reviewed the document titled: "Assessment and Referral." Changes were made to this document to include that patient belongings would be kept secured in the Intake department and not with the patient. The form informs the patient that they will be asked to place their belongings into a plastic bin that will be secured. This bin will stay in the Intake Department locked up. Additionally, it states that patients will not be able to have their cell phone or any other items once they are brought back to the assessment room. The Director of Intake and the Director of Quality were all retrained by the CEO to the Securing Patient Belongings policy and the newly updated form titled: Voluntary Intake Assessment. The Director of Intake and the Director of Quality were directed to retrain all Intake staff and reception staff to this policy and the new Voluntary Intake Assessment form that includes patient's acknowledgement. All reception staff and the Intake Department were retrained by the Director of Quality to the Securing Patient Belongings policy and the new Voluntary Intake Assessment form with the key focus on: • Educating the patient on the admission process	Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of Voluntary Intake Assessment form with acknowledgement Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained Ongoing monitoring of 50% of Voluntary Intake Assessment forms will occur quarterly	Threshold for acceptable compliance: >90%

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		• That the patient will be asked to place their belongings into a plastic bin that will be secured. This will stay in the Intake Department locked up. • That the patient will need to write down any phone numbers on the form what we give them because we will be taking their cell phone from them. • No cell phones are allowed back in the assessment rooms. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file. This newly revised policy was reviewed and approved by the Governing Body on 8/10/2023.			All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		Item #3 #1-The CEO then reviewed the policy titled, Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion policy. No changes were made to this policy at this time. The Director of Intake, Director of Quality, and Director of Risk were all retrained by the CEO to the Proper Use and Monitoring of Physical/Chemical Restraint policy. After reviewing policy and findings, this patient was not secluded per our Policy and Procedure. Our hospital is a locked Hospital and once any client is taken into the Intake area, they are allowed to freely roam, walk the halls and use the bathroom. The Intake Assessment door is not kept locked, so they are not being prevented from leaving the room. Clients are not allowed to exit the Intake area on their own due to Inland NW being a locked facility with over 80% involuntary patients. A staff member must let the client out and escort them through each door. This occurs with all clients. The CEO, Director of Intake, Director of Quality, and the Director of Risk review the policy titled, Criteria and Evaluation for Detainment. No changes were made to this policy at this time. Per the patients Intake Assessment, per the Joint Commission response submitted on 11/30/2021, the patients suicide assessment showed the patients suicide risk to be higher than the patient's typical baseline. Per our Policy titled, Criteria and Evaluation of Detainment	Director of Intake Director of Quality Director of Risk	8/25/2023	Monitoring of 100% of seclusions Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing 100% monitoring of seclusions will be done monthly. All deficiencies are corrected immediately to include staff retraining as needed.	Threshold for acceptable compliance : >90%

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		any voluntary patient that is requesting to discharge/leave and is presenting to be a danger to self will need to be evaluated by a Designated Crisis Responder. DCR was notified per Providers orders and Intake staff were told to send patient to Sacred Heart Medical Center for DCR evaluation. Inland Northwest Behavioral Health followed their policy and procedures. A newly updated form was made titled, Voluntary Intake Assessment that reviews the following: • The patient will be asked to place their belongings into a plastic bin that will be secured. This bin will stay in the Intake department locked up. • That the patient will be unable to have their cell phone once they are brought back into the Intake department. • We are a locked facility, which means once you are brought back through the locked doors to the Intake area, you will have to remain there through your full assessment. The Intake Department and reception staff were retrained by the Director of Quality to the Criteria and Evaluation of Detainment policy and trained on the newly updated form titled, Voluntary Intake Assessment with the key focus being on:			Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		• The patient will be asked to place their belongings into a plastic bin that will be secured. This bin will stay in the Intake department locked up. • That the patient will be unable to have their cell phone once they are brought back into the Intake department. • We are a locked facility, which means once you are brought back through the locked doors to the Intake area, you will have to remain there through your full assessment. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.				

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		#2, #3 and #4- The CEO then reviewed the policy Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy. No changes were made to this policy at this time. The Director of Intake, Director of Quality, and Director of Risk were all retrained by the CEO to the Proper Use and Monitoring of Physical/Chemical Restraint policy. After reviewing policy and findings, this patient was not restrained by our staff. Per our policy titled, Intake Assessment the Intake staff completed the assessment to determine the appropriate level of care needed based upon our admission criteria. The Intake staff member had the Medical Director review the assessment and the Medical Director determined patient needed to be admitted to Inland Northwest Behavioral Health. The patient refused to be admitted. Per our policy titled, Criteria and Evaluation for Detainment, if a voluntary patient is requesting to discharge and is presenting as a danger to self, danger to others, or gravely disabled they will be evaluated by a Designated Crisis Responder (DCR). Per the policy, the Medical Director was notified of the patients request to discharge. The Medical Director gave the order for a DCR evaluation. The Intake staff member called the DCR and was told to send patient to Sacred Heart Medical center for evaluation. Per our policy AMR was called. AMR showed up with police escort. Patient was refusing to leave and get on the gurney to go to Sacred Heart Medical Center for the DCR evaluation. The police put the patient on the gurney	Director of Intake Director of Quality Director of Risk	8/25/2023	Monitoring of 100% of restraints Monitoring will be ongoing for four months until 90% compliance is achieved and sustained. Ongoing 100% monitoring of restraints to occur monthly. All deficiencies are corrected immediately to include staff retraining as needed.	Threshold for acceptable compliance : >90%

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		and restrained the patient. Inland Northwest Behavioral Health does not use mechanical restraints. We did not restrain this patient. A newly updated form was implemented titled, Voluntary Intake Assessment that reviews the following: • As a voluntary patient, you are under the care of a psychiatrist, who is responsible for your health and well-being. Even though a voluntary patient may request to be discharge AMA (Against Medical Advice), the professional staff are still responsible for assessing if it is reasonably safe to do so. If the Provider agrees for you to be discharge AMA, we will work with you on a discharge plan before agreeing to a discharge. • Should you request to leave AMA and the provider continues to have concerns about your health and safety and/or safety of others if you discharge, the provider will make a referral for an evaluation by a Designated Crisis Responder (DCR). The DCR will come and evaluate you and make the determination if you can discharge safely or if you should go from being a voluntary admission to an involuntary admission. • Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of			Aggregated data is reported to the Quality Council	

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		Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. The Intake Department and reception staff were retrained by the Director of Quality to the Criteria and Evaluation of Detainment policy, the Intake Assessment policy and trained on the newly updated form titled, Voluntary Intake Assessment with the key focus being on: • As a voluntary patient, you are under the care of a psychiatrist, who is responsible for your health and well-being. Even though a voluntary patient may request to be discharge AMA (Against Medical Advice), the professional staff are still responsible for assessing if it is reasonably safe to do so. If the Provider agrees for you to be discharge AMA, we will work with you on a discharge plan before agreeing to a discharge. • Should you request to leave AMA and the provider continues to have concerns about your health and safety and/or safety of others if you discharge, the provider will make a referral for an evaluation by a				

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		Designated Crisis Responder (DCR). The DCR will come and evaluate you and make the determination if you can discharge safely or if you should go from being a voluntary admission to an involuntary admission. • Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file. This newly revised form was reviewed and approved by the Governing Body on 8/10/2023.				

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		#5- The CEO reviewed the policy Criteria and Evaluation for Detainment and the Intake Assessment policy. No changes were made to these policies at this time. The Director of Intake and the Director of Quality were all retrained by the CEO to the Criteria and Evaluation for Detainment policy and the Intake Assessment policy. After reviewing policy and findings, this patient did not ask to leave during the assessment process. The patient asked to leave after being told he was going to be admitted. The Intake staff followed the policy titled, Criteria and Evaluation of Detainment by notifying the provider about the patients request to discharge. The provider then gave the order for the patient to have a DCR evaluation due to the patient's suicide risk was higher than the patient's baseline. A newly updated form was made titled, Voluntary Intake Assessment that reviews the following: • We are a locked facility, which means once you are brought back through the locked doors to the Intake area, you will have to remain there for your full assessment. • As a voluntary patient, you are under the care of a psychiatrist, who is responsible for your health and well-being. Even though a voluntary patient may	Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of Voluntary Intake Assessment form with acknowledgement Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained Ongoing monitoring of 50% of Voluntary Intake Assessment forms will occur quarterly	Threshold for acceptable compliance : >90%

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		request to be discharge AMA (Against Medical Advice), the professional staff are still responsible for assessing if it is reasonably safe to do so. If the Provider agrees for you to be discharge AMA, we will work with you on a discharge plan before agreeing to a discharge. • Should you request to leave AMA and the provider continues to have concerns about your health and safety and/or safety of others if you discharge, the provider will make a referral for an evaluation by a Designated Crisis Responder (DCR). The DCR will come and evaluate you and make the determination if you can discharge safely or if you should go from being a voluntary admission to an involuntary admission. • Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. The Intake Department and reception staff were retrained by the Director of Quality to the Criteria and Evaluation of			All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		Detainment policy, the Intake Assessment policy and trained on the newly updated form titled, Voluntary Intake Assessment with the key focus being on: • We are a locked facility, which means once you are brought back through the locked doors to the Intake area, you will have to remain there for your full assessment. • As a voluntary patient, you are under the care of a psychiatrist, who is responsible for your health and well-being. Even though a voluntary patient may request to be discharge AMA (Against Medical Advice), the professional staff are still responsible for assessing if it is reasonably safe to do so. If the Provider agrees for you to be discharge AMA, we will work with you on a discharge plan before agreeing to a discharge. • Should you request to leave AMA and the provider continues to have concerns about your health and safety and/or safety of others if you discharge, the provider will make a referral for an evaluation by a Designated Crisis Responder (DCR). The DCR will come and evaluate you and make the determination if you can discharge safely or if you should go from being a voluntary admission to an involuntary admission.				

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		• Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. • Staff were retrained on the Washington state involuntary commitment process. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.				

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		#6, #7- The CEO reviewed the policy titled, Assessment, Intake, and Referral Record Content policy. This Policy was updated to reflect that the Intake Assessment form for any patient not admitted would be kept in Intake for one month, then the files would be moved to medical records where they will send them out for storage to iron mountain. The Director of Intake, Director of Quality, HIM Manager were all retrained by the CEO to the Assessment, Intake, and Referral Record Content policy paying special attention to: • The Intake department will establish a file which will contain part or all of the file depending on the disposition of the client: ○ Initial call sheet ○ Intake Assessment ○ Consent for Assessment ○ Voluntary Intake Assessment acknowledgement form ○ Patient Rights and Responsibilities acknowledgement form ○ Release of Information if applicable ○ Observation form ○ Copies of medical or clinical information sent form the referring agency ○ Patient Disposition	Director of Intake Director of Quality HIM Manager	8/25/2023	Monitoring of 100% of patient's not admitted files Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of files of patients not admitted will occur quarterly. All deficiencies are corrected immediately to include	Threshold for acceptable compliance : >90%

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		• The Intake clinician will file all available documents after final client disposition occurs in the Intake department
		• The Intake department will give all patient files to Medical Records monthly.
		• The HIM Manager will forward patient files to off-site storage
		  ○ The Intake Assessment will be kept for 10 years
		  ○ Initial call sheets for patients who are not admitted will be kept for 5 years
		
		All Intake staff and HIM staff were retrained by the Director of Quality to the Assessment, Intake, and Referral Record Content paying special attention to the following areas:
		• The Intake department will establish a file which will contain part or all of the file depending on the disposition of the client:
		  ○ Initial call sheet
		  ○ Intake Assessment
		  ○ Consent for Assessment
		  ○ Release of Information if applicable
		  ○ Observation form
		  ○ Copies of medical or clinical information sent form the referring agency
		• The Intake clinician will file all available documents after final client disposition occurs in the Intake department
					staff retraining as needed.
					
					Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		• The Intake department will give all patient files to Medical Records monthly.
		• The HIM Manager will forward patient files to off-site storage
		  ○ The Intake Assessment will be kept for 10 years
		  ○ Initial call sheets for patients who are not admitted will be kept for 5 years
		
		Training was initiated and completed by 8/25/2023
		Evidence of training is filed in staff's personnel file.				

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WAC 246-341-0600(1)(2)(j) Individual Rights	**WAC 246-341-0600 (1)(2)(j) Individual Rights** Based on interviews and policy and procedure review, the agency failed to protect patient rights in compliance with RCW 71.05 and to review their individual service record for 1 of 2 patients reviewed (Patient #1). Failure to protect patient rights in compliance with RCW 71.05 and to review their individual service record can result in violation of patient civil liberties and	**Item #1:** #1- The Chief Executive Officer (CEO) reviewed the findings of this investigation and reviewed WAC 246-341-0600(1)(2)(j) and reviewed RCW 71.05. The CEO reviewed the policy titled, Criteria and Evaluation for Detainment. This policy was updated to reflect if the professional staff of Inland Northwest Behavioral Health hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day. This policy was also updated to reflect the process of how the assessment will be documented to show how patients meet or do not meet criteria to be detained for a DCR evaluation The Director of Intake and the Director of Quality were retrained by the CEO to the newly revised Criteria and Evaluation for Detainment policy. The Director of Intake	Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of voluntary patients made to involuntary patient's charts Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained Ongoing monitoring of 50% of voluntary patients made to involuntary patient's charts will occur quarterly	Threshold for acceptable compliance : >90%

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	rights causing trauma, harm, and aversion to seeking future treatment.	and Director of Quality were directed to retrain all Intake staff. All Intake staff were retrained by the Director of Quality to the newly revised Criteria and Evaluation for Detainment policy paying special attention to the following areas: • The professional staff of Inland Northwest Behavioral Health hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day. • If a patient is requesting to discharge, the Intake staff member will finish their Integrated Assessment which includes the Suicide Screening that formulates the patient's risk status/ risk state. The provider will be notified with the assessment results and the provider will be the one that orders			All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		a DCR evaluation if needed. DCR has 6-12 hours to respond to an evaluation request. This newly revised policy was reviewed and approved by the Governing Body on 8/10/2023.	Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of the Voluntary Intake Assessment acknowledgement forms Monitoring of 100% of Patient Rights and Responsibilities acknowledgement forms. Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of	Threshold for acceptable compliance: >90%

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		#2,#3- The CEO reviewed the policy titled, Patient's Rights and Responsibilities. No changed were made to this policy. The CEO reeducated the Director of Intake, and Director of Quality on the Patient's Rights and Responsibilities policy. After reviewing policy and findings, this patient did not ask to leave during the assessment process. The patient asked to leave after being told he was going to be admitted and after the involuntary commitment proceedings started. Per the Patient Rights and Responsibilities policy and per RCW 71.05 • The patient has a right to object to hospitalization and request release from the hospital unless involuntary commitment proceedings are initiated. The CEO then reviewed the Patient's Rights and Responsibilities regarding the right to an explanation of the involuntary treatment process should the patient decide to leave the hospital against medical advice. The CEO reeducated the Director of Intake and the Director of Quality paying special attention to the following: • The patient has the right to an explanation of the involuntary treatment process should they decide to leave the hospital against medical advice. The Director of Intake and Director of Quality were directed to retrain all Intake Staff. A newly updated form titled			50% of Voluntary Intake Assessment acknowledgement forms and Patient Rights and Responsibilities form will occur quarterly All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee	

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		Voluntary Intake Assessment was made with an acknowledgment form stating Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. All Intake staff were retrained by the Director of Quality to Patient's Rights and Responsibilities policy and to the newly updated form titled, Voluntary Intake Assessment paying special attention to the following areas: • The patient has a right to object to hospitalization and request release from the hospital unless involuntary commitment proceedings are initiated. • The patient has the right to an explanation of the involuntary treatment process should they decide to leave the hospital against medical advice. Training was initiated and completed by 8/25/2023 Evidence of training is filed in staff's personnel file.			and Medical Executive Committee monthly and to the Governing Board quarterly	

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
			Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of the Voluntary Intake Assessment acknowledgement forms and Patient Rights and Responsibilities acknowledgement forms. Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of the Voluntary Intake	Threshold for acceptable compliance : >90%

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		#4- The CEO reviewed the policy titled, Patient's Rights and Responsibilities. No changes were made to this policy. The Director of Intake and Director of Quality were retrained to this policy paying special attention to the following: • Prior to admission, each patient shall be given a copy of the Patient Bill of Rights as provided by the DSHS and shall sign a copy of the form which will be kept in the patient's medical record. • Prior to admission the patient shall be explained his rights in a manner that he/she can understand. • The explanation of the rights and responsibilities of the patient will be documented in the patient's medical record. The Director of Intake and Director of Quality were directed to retrain all Intake staff and reception staff. All Intake staff and reception staff were retrained by the Director of Quality to Patient's Rights and Responsibilities policy paying special attention to the following areas: • Prior to admission, each patient shall be given a copy of the Patient Bill of Rights as provided by the DSHS and shall sign a copy of the form which will be kept in the patient's medical record. • Prior to admission the patient shall be explained his rights in a manner that he/she can understand.			Assessment acknowledgement forms and the Patient Rights and Responsibilities forms will occur quarterly All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive	

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		• The explanation of the rights and responsibilities of the patient will be documented in the patient's medical record. The CEO reviewed the policy titled, Intake Assessment. No changes were made to this policy. The Director of Intake and the Director of Quality were retrained to his policy. After reviewing findings, per our Intake Assessment policy a mental health professional will complete the assessment and review clinical information with the physician for determining level of care. Following the above steps, an MD assignment is made, and the assigned attending will have the case reviewed with them by phone providing all pertinent information. Per the Conditions of Admission form given to patients it states that a physician is not staffed on the premises 24-hours a day, but a physician is on-call and may be reached 24-hours a day by hospital staff. Also, per the policy titled, Plan for Provision of Care- Scope of Services, A Psychiatric Evaluation is completed by the attending psychiatrist within 24 hours of admission. Per the Patient's Rights and Responsibilities, the patient has the right to a medical and psychosocial evaluation within 24 hours of admission to determine whether continued stay in the facility is appropriate.			Committee monthly and to the Governing Board quarterly	

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		A newly updated form was made titled, Voluntary Intake Assessment that reviews the following: • Our psychiatrist has 24 hours from admission to meet with the patient and perform their psychiatric evaluation. The Intake Department and reception staff were retrained by the Director of Quality to the newly updated form titled, Voluntary Intake Assessment with the key focus being on: • Our psychiatrist has 24 hours from admission to meet with the patient and perform their psychiatric evaluation. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.	Director of Intake Director of Quality	8/25/2023	Monitoring of 100% of the Voluntary Intake Assessment acknowledgement forms Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of the Voluntary Intake Assessment acknowledgement forms will occur quarterly	Threshold for acceptable compliance: >90%

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		#5,#6,#7- The CEO reviewed the Intake Assessment policy and the Criteria and Evaluation of Detainment policy. The Criteria and Evaluation of Detainment policy was updated to reflect if the professional staff of Inland Northwest Behavioral Health hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day. The Director of Intake and the Director of Quality were retrained by the CEO to the newly revised Criteria and Evaluation for Detainment policy. A newly updated form titled, Voluntary Intake Assessment was made to explain that the Intake Assessment is used to determine the appropriate level of care for the patient needs and it explains the DCR process. This form has an acknowledgment that the patient signs stating: Inland Northwest Behavioral Health Hospital shall recognize and			All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		follow the laws of the state of Washington related to involuntary commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. The undersigned acknowledges that per WAC 70.96B.080, Inland Northwest Behavioral Health will follow their policy and if a voluntary patient is requesting to discharge and is presenting as a danger to self, danger to others, or gravely disabled, they will be evaluated by a Designated Crisis Responder (DCR). The Director of Intake and Director of Quality were directed to retrain all Intake staff and reception staff. All Intake staff and reception staff were retrained by the Director of Quality to the newly revised Criteria and Evaluation for Detainment policy and newly updated form titled, Voluntary Intake Assessment paying special attention to the following areas: • The Intake Assessment is used to determine the appropriate level of care for the patient needs and it explains the DCR process. • This form has an acknowledgment that the patient signs stating: Inland Northwest Behavioral Health Hospital shall recognize and follow the laws of the state of Washington related to involuntary				

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		commitment. The hospital will follow the state designated involuntary commitment process for patients who were admitted voluntarily but for reasons determined by persons designated by the state to warrant a change to involuntary status. RCW 71.05 for Adults and RCW 71.34 for Minors. • The undersigned acknowledges that per WAC 70.96B.080, Inland Northwest Behavioral Health will follow their policy and if a voluntary patient is requesting to discharge and is presenting as a danger to self, danger to others, or gravely disabled, they will be evaluated by a Designated Crisis Responder (DCR). Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.	Director of Intake Director of Quality HIM Manager Director of Risk	8/25/2023	Monitoring of 100% of the Patient Rights and Responsibilities acknowledgement forms Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of the Patient Rights and Responsibilities acknowledgement forms	Threshold for acceptable compliance: >90%

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		#8, #9- The CEO reviewed the Patient's Rights and Responsibilities policy. No changes were made to this policy. The CEO reeducated the Director of Intake, Director of Quality, HIM Manager and the Director of Risk on the Patient's Rights and Responsibilities policy paying special attention to the following: • The patients have the right to access information contained in their medical/clinical record within a reasonable timeframe; Inland Northwest Behavioral Health will actively seek to meet your requests as quickly as health information management procedures permit. • The patients have the right to review their clinical record and be given any opportunity to make amendments or corrections. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were directed to retrain all Intake staff and HIM staff. All Intake staff and HIM staff were retrained by the Director of Quality to the Patient's Rights and Responsibilities paying special attention to: • The patients have the right to access information contained in their medical/clinical record within a reasonable timeframe; Inland Northwest Behavioral Health will actively seek to meet your			will occur quarterly All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

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		requests as quickly as health information management procedures permit. • The patients have the right to review their clinical record and be given any opportunity to make amendments or corrections. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.	Director of Intake Director of Quality HIM Manager Director of Risk	8/25/2023	Monitoring of 100% of patient requests for PHI Monitoring of 100% of the Patient Rights and Responsibilities acknowledgement forms Monitoring will be ongoing for four months until >/= 90% compliance is achieved and sustained. Ongoing monitoring of 50% of patient requests for	Threshold for acceptable compliance : >90%

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		Item #2 #1, #2, #3, #4, #5- The CEO reviewed the policies titled, Patient Requests to Access PHI and Patient's Rights and Responsibilities. No changes were made to these policies. The CEO reeducated the Director of Intake, Director of Quality, HIM Manager and the Director of Risk on the Patient Requests to Access PHI and the Patient's Rights and Responsibilities policy paying special attention to the following: • The patients may request in writing access to their PHI in the medical and/or billing records and that the facility would respond within 30 days after receipt of the request. • The patients have the right to access information contained in their medical/clinical record within a reasonable timeframe; Inland Northwest Behavioral Health will actively seek to meet your requests as quickly as health information management procedures permit. • The patients have the right to review their clinical record and be given any opportunity to make amendments or corrections. The Director of Intake, Director of Quality, HIM Manager and Director of Risk were directed to retrain all Intake staff and HIM staff.			PHI and the Patient Rights and Responsibilities acknowledgement forms will occur quarterly All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee	

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		All Intake staff and HIM staff were retrained by the Director of Quality to the policy titled, Patient Requests to Access PHI and the policy titled, Patient's Rights and Responsibilities paying special attention to: • The patients may request in writing access to their PHI in the medical and/or billing records and that the facility would respond within 30 days after receipt of the request. • The patients have the right to access information contained in their medical/clinical record within a reasonable timeframe; Inland Northwest Behavioral Health will actively seek to meet your requests as quickly as health information management procedures permit. • The patients have the right to review their clinical record and be given any opportunity to make amendments or corrections. Training was initiated and completed by 8/25/2023. Evidence of training is filed in staff's personnel file.			monthly and to the Governing Board quarterly	

INLAND NORTHWEST BEHAVIORAL HEALTH HOSPITAL
Plan of Correction for Complaint #2021-12084

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC

INLAND NORTHWEST BEHAVIORAL HEALTH HOSPITAL
Plan of Correction for Complaint #2021-12084

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

September 27, 2023

Inland Northwest Behavioral Hospital
104 W 5th Ave
Spokane, WA 99204-4880

Re: Case Number: 2021-12084
License Number: BHA.FS.60894630
Acceptable Plan of Correction

Dear Mr. Wickel:

This letter is to inform you that after careful review of the Plan of Correction (POC) you submitted for the investigation recently conducted at your agency, the Department has determined that the POC is acceptable. You stated in your plan that you will implement corrective actions by the specified timeline. By this, the Department is accepting your Plan of Correction as your confirmation of compliance.

Based on the scope and severity of the deficiencies listed in your statement of deficiency report, the Department will not conduct an unannounced follow-up compliance visit to verify that all deficiencies have been corrected.

The Department reserves the right to pursue enforcement action for any repeat and/or uncorrected deficiencies based on applicable statute and rules.

Investigator: 33894
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874