State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING: ______ B. WING ______	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
L 000	INITIAL COMMENTS The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-324 Private Alcohol and Chemical Dependency Hospitals, conducted this health and safety survey. On site dates: 04/08/22 - 04/09/22 [handwritten correction: 3 over 4 in each date] Examination number: 2022-158 The survey was conducted by: Surveyor #7 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection (See Shell # LOTH21).	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your 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 received electronically by March 21, 2022. 4. Return the REPORT electronically with the required signatures.	
L 435	322-040.4 ADMIN-ADMINISTRATOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (4) Appoint an administrator responsible for implementing the policies adopted by the governing body;	L 435		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Chris West [handwritten signature] 3/28/22

[handwritten signature] 4/4/22
Rcvd 3/28/22 State Approved ~~[date]~~
~~FM Approved [date]~~

State of Washington

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L 435	Continued From page 1 This Washington Administrative Code is not met as evidenced by: Based on interview and review of hospital documents, the hospital's Governing Body failed to appoint an administrator to be responsible for implementing the policies adopted by the Governing Body and be accountable for all aspects of patient care. Failure to have an administrator to direct and oversee all aspects of hospital treatment and policy implementation, puts patients at risk of harm from substandard care. Findings included: 1. On 03/09/22 between 12:10 PM and 12:45 PM, Surveyor #9 and Surveyor #7 interviewed representatives of the hospital's Governing Body, Director of Risk Management and Compliance (Staff # 902) and Assistant Director of Nursing (Staff #901). The surveyors reviewed the Governing Body meeting minutes from 05/10/21, 08/04/21, 11/12/21, and 02/11/22. Review of the Governing Body meeting minutes showed no evidence the Governing Body had appointed the current administrator. 2. On 03/09/22 at 12:30 PM, the surveyors interviewed Staff #902 and asked if there were meeting minutes to document the appointment of the current Chief Executive Officer (CEO) as administrator for the hospital. 3. Staff #902 verified that there was no documentation of appointment of the current CEO as administrator for the hospital reflected in the Governing Body minutes.	L 435		

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L 440	322-040.5 ADMIN-MEDICAL DIRECTOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day; This Washington Administrative Code is not met as evidenced by: Based on interview and record review, the hospital's Governing Body failed to appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day. Failure to provide a medical director who directs and supervises medical treatment and patient care twenty-four hours per day puts patients at risk for inadequate or unsafe care. Findings included: 1. On 03/09/22 between 12:10 PM and 12:45 PM, Surveyor #9 and Surveyor #7 interviewed representatives of the hospital's Governing Body, Director of Risk Management and Compliance (Staff # 902) and Assistant Director of Nursing (Staff #901). The surveyors reviewed the Governing Body meeting minutes from 05/10/21, 08/04/21, 11/12/21, and 02/11/22. Review of the Governing Body meeting minutes showed no evidence the Governing Body had appointed the current medical director. 2. On 03/09/22 at 12:35 PM, the surveyors interviewed Staff #902 and asked if there were meeting minutes to document the appointment of	L 440		

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L 440	Continued From page 3 the current medical director for the hospital. 3. Staff #902 verified that there was no documentation of appointment of the current medical director for the hospital reflected in the Governing Body minutes. .	L 440		
L 460	322-040.8B ADMIN RULES-PRIVILEGES WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (b) Delineation of privileges; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview the hospital failed to maintain provider appointments and privileges in compliance with the psychiatric hospital's Medical Staff bylaws. Failure to assure that all staff have current appointments and privileges for the hospital where they are seeing patients puts patients at risk from substandard care and poor outcomes. Findings included: 1. Document review of the "Medical Staff Bylaws," dated 06/17, showed that the hospital grants provider privileges for a maximum of two years (24 months) between appointments. 2.On 03/08/22, Surveyor #9 reviewed credentialing files for 3 providers currently seeing patients at the psychiatric hospital. The review	L 460		

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L 460	Continued From page 4 showed 2 of 3 providers had expired appointments. a.One Advanced Practice Registered Nurse (Staff #903) had an appointment letter in their credentialing file that indicated their appointment period from 04/18 to 04/20. Staff # 903 had been granted a temporary extension for 90 days. b.One Physician (Staff # 904) had an appointment letter in their credentialing file that indicated their appointment period from 10/18 to 10/20. 3. At the time of the review, the surveyor interviewed the Director of Risk Management and Compliance (Staff #902) who confirmed the two staff members had lapsed appointments.	L 460		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider	L1150		

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L1150	Continued From page 5 authenticate telephone orders per hospital policy for seclusion or restraint for 1 of 2 seclusion or restraint records reviewed (Patient #703). Failure to ensure that a provider authenticate an appropriate order for seclusion risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy titled "Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion" policy # 1000.53, last reviewed 06/21, showed: a. telephone/verbal orders shall be authenticated by the Physician within 24 hours. b. a face-to-face evaluation of the patient shall be performed by the Physician or Qualified Registered Nurse (QRN) within one hour. c. Patients in restraints or seclusion will be assessed every 15 min, assessment to include: signs of injury, circulation and skin integrity, mental status, level of distress and agitation, readiness for discontinuation of restraint/seclusion. 2. On 03/08/22 at 3:50 PM Surveyor #7 reviewed the chart for Patient #703. The review showed that the patient had been place in a physical restraint on 07/02/21. Staff had obtained a telephone order on 07/02/21 at 7:00PM. At the time of the review the order had not been authenticated. 3. At the time of the finding Staff #701 verified there was no Psychiatrist signature on the	L1150		

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L1150	Continued From page 6 telephone order for restraint/seclusion. 4. On 03/08/22 at 4:27 PM, Surveyor #7 reviewed the chart of Patient #704, review found a telephone order for restraint dated 09/24/21 at 3:25 PM, the patient was placed in physical restraint at 3:34PM. When the provider authenticated/signed the order, they failed to document the date and time of the authentication. 5. At the time of the finding Staff #701 verified the date and time were missing from the practitioners' section of the telephone restraint order. .	L1150		
L1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders; This Washington Administrative Code is not met as evidenced by: . Based on document review of the hospital's policy, the hospital failed to ensure that the healthcare providers authenticated orders for the care and treatment of patients according to the hospital's policy.	L1260		

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L1260	Continued From page 7 Failure to write and authenticate orders for admission, medications, and treatment risks provision of incorrect and/or inadequate patient care. Findings included: 1. Document review of the hospital policy titled "Ordering and Prescribing- General Requirements," policy number 11, dated 03/21, showed that all orders entered into computerized order entry system must be electronically signed within 48 hours. 2. On 03/08/22 at 01:50 PM, Surveyor #9 and Assistant Director of Nursing (Staff# 901) reviewed the medical records of a patient. The review showed that the orders for admission, vital signs, and mediations were not authenticated within 48 hours for Patients #901. 3. Staff #901 confirmed the finding of the orders not being authenticated within 48 hours.	L1260		

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S 000	Initial Comments This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Fairfax Behavioral Health Monroe, in Monroe Washington on 03/09/2022 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health health survey teams. During the physical tour of the facility I was accompanied by the Facilities Director who witnessed any deficiency noted during this survey. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a two story structure, without a basement, of Type II construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. The facility has a total of 34 beds and at the time of this survey the census was 0. The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The following citations were documented during the survey: The surveyor was: Brendan Magee Deputy State Fire Marshal 38402 The surveyor was from: Washington State Patrol	S 000		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Chris West 3/28/22

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S 000	Continued From page 1 Office of the State Fire Marshal Fire Protection Bureau 2803 156th Ave SE Bellevue, WA 98007 Telephone: (360) 481-3933	S 000		
S 346	NFPA 101 Fire Alarm System ' Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on observation and staff interview on 03/09/2022 during document review between approximately 1100 and 1130 hours the facility has failed to have a written procedure for instituting an approved fire watch in the event of a failure of the fire alarm system. This could result in an inadequate fire watch which may result in a delay of fire detection and suppression, potentially endangering patients, staff, and/or visitors within the facility. The findings include: - The facility was unable to provide documentation for instituting an approved fire watch in the event of a failure of the fire alarm	S 346		

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S 346	Continued From page 2 system. NFPA 101 (2012 ed) 19.1.1.1.1, 19.3.4.1, 9.6.1.6 The above was discussed and acknowledged by the Facilities Director who stated that the Evergreen Health Monroe Hospital manages the Fire Alarm system, and was under the impression that they would institute a fire watch if needed. Fairfax Monroe shall have their own policy in place for Fire Watch.	S 346		
S 354	NFPA 101 Sprinkler System Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	S 354		

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S 354	Continued From page 3	S 354		

This STANDARD is not met as evidenced by:
Based on observation and staff interview on 03/09/2022 during document review between approximately 1100 and 1130 hours the facility has failed to have a written procedure for instituting an approved fire watch in the event of a failure of the fire sprinkler system. This could result in an inadequate fire watch which may result in a delay of fire detection and suppression, endangering patients, staff, and/or visitors within the facility.
The findings include:

- The facility was unable to provide documentation for instituting an approved fire watch in the event of a failure of the fire sprinkler system.

NFPA 101 (2012 ed) 19.1.1.1.1, 19.3.5.1, 9.7.5, 2.1, NFPA 25 (2011 ed) 1.1, 15.5.2(4)(b)

The above was discussed and acknowledged by the Facilities Director who stated that the Evergreen Health Monroe Hospital manages the Fire sprinkler system, and was under the impression that they would institute a fire watch if needed. Fairfax Monroe shall have their own policy in place for Fire Watch.

Fairfax Behavioral Health Monroe
Plan of Correction for
State survey
Case # 2022-158
Date on site- 3/8/2022-3/9/2022

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance	Action Level indicating need for change of POC
L 435	322-040.4 ADMIN-ADMINISTRATOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (4) Appoint an administrator responsible for implementing the policies adopted by the governing body.	The CEO, CMO, COO, and the Director of Risk Management and Performance Improvement met to review all survey findings on 3/21/22. The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Executive Officer in compliance with the policies adopted by the governing body. On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Christopher West as the Chief Executive Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board.	Chief Executive Officer	3/10/2022	The Chief Executive Officer and/or designee will confirm compliance with all governing bylaws by ensuring appropriate and timely appointment of the Chief Executive Officer as required. In the event of a change in the Chief Executive Officer, an ad hoc committee meeting of the Governing Board will reconvene to appoint a hospital administrator as required by the Governing Bylaws. All actions are documented in the Governing Board minutes. Target for compliance is 100%. This monitoring has no end date.	< 100%

Mari Dale
RCVd. ~~7/1/22~~ 3/28/22
Approval ~~7/5/22~~ 4/4/22.

		Appointment of the Chief Executive Officer was confirmed and documented in the Governing Board minutes.				
L 440	322-040.5 ADMIN-MEDICAL DIRECTOR WAC 246-322-040 Governing Body and Administration The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day	The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical Officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Medical Officer in compliance with the policies adopted by the governing body. On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Dr. Aaron Andersen as the Chief Medical Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board.	Chief Executive Officer	3/10/2022	The Chief Executive Officer and/or designee will confirm compliance with all governing bylaws and Medical Staff bylaws by ensuring appropriate and timely appointment of the Chief Medical Officer as required. In the event of a change in the Chief Medical Officer an ad hoc committee meeting of the Governing Board will reconvene to appoint a qualified Chief Medical Officer as required by the Governing Bylaws and Medical Staff bylaws. All actions are documented in the Governing Board minutes. Target for compliance is 100%. This monitoring has no end date.	< 100%
L 460	322-040.8B ADMIN RULES-PRIVILEGES WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve	The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Medical Staff bylaws, Rules, and Regulations were reviewed by the CEO, Chief Medical Officer and COO on 3/21/22. No revisions required at this time. 100% of credential files for all providers was completed by the Medical Staff	CEO, CMO COO	5/9/2022	The Medical Staff Coordinator will review 100% of provider credential files to confirm compliance with Medical Staff bylaws. On an ongoing basis, the medical staff coordinator will complete monthly audits of files to confirm ongoing compliance. . Additionally, the Medical Staff Coordinator will ensure each providers credentialing file is updated after each Medical Executive	< 90%

	professional staff bylaws and rules concerning, at a minimum: (b) Delineation of privileges	coordinator to confirm compliance with the Medical Staff bylaws. Providers with lapsed privileges were temporarily suspended from providing further services until the completion of the credentialing and privileging process was completed. Providers with lapsed privileges were credentialed and approved for requested privileges at an ad-hoc Medical Executive Committee meeting. The Medical Executive Committee chair and the Medical Staff Coordinator were re-educated by the CEO and the Director of Risk Management on the requirement of provider privileging and credentialing all providers for a period of two years per Medical Staff Bylaws. The Medical Staff Coordinator implemented a tracking spreadsheet to alert her three months in advance of upcoming provider re-appointments and confirm timely completion of the credentialing and privileging process per the Medical Staff bylaws.			Committee meeting to reflect current appointment dates. All appointments are documented in the Medical Executive Committee monthly and reported to the Governing Board quarterly. Target for compliance is 100%. This audit has no end date.	
L 1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care	The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Seclusion and Restraint policy was reviewed with no revision required at this time. All Providers were reeducated to policy # 1000.53 *Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion* by 5/1/22. Training focused on the requirement to authenticate verbal orders by signing, dating and	Chief Medical Officer	5/9/22	100% of all seclusion or restraint orders will be monitored by the Director of Performance Improvement and/or designee to confirm compliance with Provider authentication of all verbal orders, including seclusion and restraint orders within 24 hours. Authentication of verbal orders required provider signature, date and time. Aggregated data will be reported in Quality Council, Medical Executive	< 90%

		timing the orders within 24 hours. Additionally, all providers are required to sign date and time all orders written by them at the time of the order. All Fairfax Providers signed an attestation indicating understanding expectation to comply with hospital policy.			Committee monthly and to the Governing Board quarterly. Noncompliance with this requirement by any provider will participate in 1:1 remediation with the Chief Medical Officer. Continued non-compliance will include disciplinary action up to and including termination of employment. Target for compliance is > or = 90% for 4 consecutive months.	
L 1260	322-200.3E RECORDS-SIGNED ORDERS WAC 246-322-200 Clinical Records	The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Ordering and Prescribing – general requirements policy was reviewed with no revision required at this time. All Providers were reeducated to the policy titled, "*Ordering and Prescribing – General Requirements*" by 5/1/22 Provider training focused on computerized entry of orders must be authenticated within 48 hours. All Fairfax Providers signed an attestation to comply with hospital policy.	Chief Medical Officer	5/9/22	Monitoring of 10 charts per month per unit will be completed by the Performance Improvement Director and/or designee to confirm compliance with policy. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported in Quality Council, Medical Executive Committee monthly and to the Governing Board quarterly. Providers not compliant with hospital policy will participate in 1:1 remediation with the Chief Medical Officer. Continued non-compliance may be met with disciplinary action up to and including termination of employment. Target for compliance is > or = 90% for 4 consecutive months.	< 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.

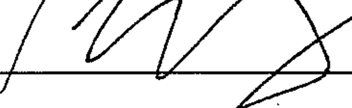
APPROVED
By Kimberly Bloor at 1:24 pm, Apr 01, 2022

Fairfax Behavioral Health
Plan of Correction for State
Fire & Life Safety survey Monroe campus
Date on site 3/9/2022

Tag Number	Deficiency	How the Deficiency Will be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance	Action level indicating need for change of POC
S 346	NFPA 101 Fire Alarm System Out of Service. Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6	The CEO, CMO, COO, Facilities Director and the Director of Risk Management and Performance Improvement met to review all survey findings on 3/9/2022 The Fire Watch policy was not reviewed by the fire marshal during this life safety survey, however, the policy was in place. The *"Interim Life Safety Measures"* policy was reviewed by the CEO and DPO. No revisions required at this time. The CEO retrained the Director of Facilities to the location of all facilities policies and content of policies. Training focused on accessing all required policies for training purposes and use during regulatory surveys. Documentation of training located in personnel file. The Director of Facilities retrained all facilities staff to the policy *"Interim Life Safety Measures"* for EvergreenHealth Monroe, which would apply to Fairfax as the Hospital Fire Life Safety System covers the Fairfax space, which is leased from EvergreenHealth. Additionally, the Director of Facilities retrained all facilities staff on how to access facilities policies, location of policies and content of policies by 4/26/22.	Director of Facilities	4/13/2022	The Director of Facilities and/or designee will review 100% personnel files of all facilities staff to confirm training completion of all facilities related policies specific to fire and safety, including procedure to access policies. All deficiencies will be corrected immediately to include retraining as needed or disciplinary action if required. New facilities staff hired will be trained to all facilities policies during new employee orientation and annually thereafter including process to access facilities related policies. The Director of Facilities will keep a spreadsheet with the names of all staff in his department and the date of their signed attestation. Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly for the next 4 months until compliance is achieved and sustained. Target for compliance is 100%	< 100%

		All facilities staff signed an attestation of comprehension of all training provided and understanding of policy compliance.				
S 354	NFPA 101 Sprinkler System Out of Service. Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)	The CEO, CMO, COO, Facilities Director and the Director of Risk Management and Performance Improvement met to review all survey findings on 3/9/2022 The sprinkler system policy *"Interim Life Safety Measures"* that covers the sprinkler system was not reviewed by the fire marshal however, the policy was in place. The CEO retrained the Director of Facilities to the location of all facilities policies and content of policies. Training focused on accessing all required policies for training purposes and use during regulatory surveys. Documentation of training located in personnel file. The Director of Facilities retrained all facilities staff to the policy *"Interim Life Safety Measures"* for EvergreenHealth Monroe, which would apply to Fairfax as the Hospital Fire Life Safety System covers the Fairfax space, which is leased from EvergreenHealth. Additionally, the Director of Facilities retrained all facilities staff on how to access facilities policies, location of policies and content of policies by 4/26/22. All facilities staff signed an attestation of comprehension of all training provided and understanding of policy compliance.	Director of Facilities		The Director of Facilities will ensure he and his staff know the content of policies pertaining to their department and how to access the policies from all Fairfax satellite locations. Additionally, that all facilities staff have an attestation in their employee file pertaining to the same. Any new facilities staff hired will be educated on how to access policies at all Fairfax locations. The Director of Facilities will keep a spreadsheet with the names of all staff in his department and the date of their signed attestation. He will report his data to Quality Council monthly for the next 4 months and continue to educate and track this data indefinitely. Target for compliance is 100% 4/13/2022	< 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.

Christopher West, CEO:  Date: 3/29/22

Fairfax Behavioral Health, Monroe
Progress Report for
State Licensing Survey Case #2022-158
(3/8/22-3/10/22)

Tag Number	How Corrected	Date Completed	Results of Monitoring
L435	The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Executive Officer in compliance with the policies adopted by the governing body. On 3/10/22 an ad-hoc Governing Board meeting was convened to formally appoint Christopher West as the Chief Executive Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board. Appointment of the Chief Executive Officer was confirmed and documented in the Governing Board meeting minutes.	3/10/22	**Compliance** March 100% April 100% May 100% June 100% There has been no change in the Chief Executive Officer since the survey exit. The Governing Board meeting minutes reflect the appointment of the current Chief Executive Officer, Christopher West. The Governing Board will reconvene to hold an ad-hoc meeting in the event a new hospital administrator is appointed.
L440	The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Medical Officer in compliance with	3/10/22	**Compliance** March 100% April 100% May 100% June 100% There has been no change in the Chief Medical Officer since the survey exit. The Governing Board meeting minutes reflect the appointment of the current Chief Medical Officer, Aaron Andersen.

Rcvd 7/1/22
Approved 7/1/22

	the policies adopted by the governing body. On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Dr. Aaron Andersen as the Chief Medical Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board and documented in the Governing Board meeting minutes.		The Governing Board will reconvene to hold an ad-hoc meeting in the event a new Chief Medical Officer is appointed.
L460	The Medical Staff Bylaws, Rules, and Regulations were reviewed by the CEO, Chief Medical Officer, and COO on 3/21/22. No revisions required at this time. A review of all the credentialling files for current providers at Fairfax was completed by the Medical Staff coordinator to confirm compliance with the Medical Staff Bylaws. Any Providers with lapsed privileges were temporarily suspended from providing further services until the completion of the credentialing and privileging process was completed. Providers with lapsed privileges were credentialed and approved for requested privileges at an ad-hoc Medical Executive Committee meeting. The Medical Executive Committee chair and the Medical Staff Coordinator were re-educated by the CEO and the Director of Risk Management on the requirement of provider privileging and credentialing of all providers for a period of two years per Medical Staff Bylaws. The Medical Staff Coordinator		**Timely Credentialling Audit** March 100% April 100% May 100% June 100% Medical Executive Meeting minutes reflect credentialling requests and approvals. March: no meeting held April: no meeting held May: Yes Quarterly Governing Board Meeting minutes reflect credentialling appointments. 2022 Q1: Yes 2022 Q2: To be held in July 2022

	implemented a tracking spreadsheet to alert her three months in advance of upcoming provider re-appointments and confirm timely completion of the credentialing and privileging process per the Medical Staff bylaws.		
L1150	All Providers were reeducated to policy #1000.53 *Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion* by 5/1/22. Training focused on the requirement to authenticate verbal orders by signing, dating and timing the orders within 24 hours. Additionally, all providers are required to sign date and time all orders written by them at the time of the order. All Fairfax Providers signed an attestation indicating understanding expectation to comply with hospital policy.		**<u>Compliance</u>** **Seclusion/Restraint verbal orders authenticated within 24 hours to include: Provider signature, date and time.** March 94% April 94% May 93% June 89% 6/30/22 Chief Medical Officer addressed Providers in the Medical Executive committee meeting reiterating the importance and requirement to sign, date and time seclusion/restraint packets within 24 hours.
L1260	The Ordering and Prescribing - general requirements policy was reviewed with no revision required at this time. All Providers were reeducated to the policy titled, *"Ordering and Prescribing-General Requirements"* by 5/1/22 Provider training focused on computerized entry of orders must be authenticated within 48 hours. All Fairfax Providers signed an attestation to comply with hospital policy.	5/9/22	**<u>Compliance</u>** **Computerized orders entered by Providers are authenticated within 48 hours.** March 80% April 90% May 100% June 90%
S346	The "Fire Watch" policy was not reviewed by the fire marshal during this life safety survey; however, the policy was in place. The sprinkler system policy *"Interim Life*	4/26/22	**<u>Compliance</u>** All facilities staff have signed an attestation of understanding regarding the location and accessibility of hospital policies and an understanding of the content of the EvergreenHealth "Interim Life Safety Measures" policy and the Fairfax "Fire Watch"

	Safety Measures" that covers the sprinkler system was not reviewed by the fire marshal however, the policy was in place. The CEO retrained the Director of Facilities to the location of all facilities policies and content of policies. Training focused on accessing all required policies for training purposes and use during regulatory surveys. Documentation of training located in his personnel file. The Director of Facilities trained all facilities staff to Fairfax policy LS.01.02.01-1 "Fire Watch" as well as EvergreenHealth Monroe's policy "Interim Life Safety Measures" which would apply to Fairfax as the Hospital Fire Life Safety System covers the Fairfax space, which is leased from EvergreenHealth. The Director of Facilities retrained all facilities staff on how to access facilities policies, location of policies and content of policies by 4/26/22.		policy. | | # employees | # attestations | | March | 4 | 4 | | April | 4 | 4 | | May | 4 | 4 | | June | 4 | 4 | Compliance maintained at 100%

Signature: Christopher West , CEO

Date: 7/1/22