State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	09/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

(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)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. On site dates: 09/05/23 - 09/07/23 Examination number: 2023-602 The survey was conducted by: Surveyor #2 Surveyor #4 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell F7H911.	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on 09/28/23. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and	L 315		

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L 315	Continued From page 1 services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Item #1 Nutritional consults Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients at risk received a nutritional consult with a dietician for evaluation of nutritional deficiencies for 3 of 4 patients reviewed (Patient #901, #902 and #903). Failure to properly screen and initiate a nutritional consult may lead to poor nutrition and poor health outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nutritional Screening/Assessment," PolicyStat ID 13428390, last approved 05/23, showed the following: a. The nursing assessment contains questions that will identify patients at risk for malnutrition or nutritional deficiencies. b. Upon screening, if the RN determines the patient's nutrition screen is positive, the Registered Dietitian will be notified. c. The dietician will document assessment and recommendations in the nutrition consult form and notify the physician of any recommendation in a timely manner. Document review of the nursing admission	L 315		

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L 315	Continued From page 2 assessment form showed a nutritional screen is to be completed on admission with 11 boxes with identified risk factors. These include eating habits which may be indicative of an eating disorder such as binging or purging, decreased appetite or poor oral intake, unintentional weight loss, BMI >36 and BMI <19. If any of these risk factors are present, the box is checked, and a nutritional consult should be obtained. There is an additional box to check when the dietitian notification process is completed. 2. On 09/05/23 between 10:00 AM and 11:30 AM, Surveyor #2, Surveyor #9 and Director of Risk (Staff #901) reviewed the medical records of Patient #901 who was a 14 year old admitted on 08/30/23 with a diagnosis of Suicidal Ideation. There was a provider order for anorexic precautions. The nursing admission assessment showed one risk factor box (eating habits/behaviors which may be indicative of an eating disorder) was checked. There was a note written by the RN that stated that sometimes the patient doesn't eat or sometimes eats so much that they vomit. The Surveyor found no evidence that a nutritional consult had been completed for this patient. 3. At the time of the observation, Staff #901 verified that there was no nutritional consult completed for this patient. 4. On 09/05/23 between 11:30 AM and 12:50 PM, Surveyor #2, Surveyor #9 and Director of Risk (Staff #901) reviewed the medical record of Patient #902 who was a 17 year old admitted on 08/29/23 with a diagnosis of Bipolar Disorder with a suicide attempt. The nursing admission assessment showed 2 risk factor boxes (decreased appetite and unintentional weight	L 315		

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L 315	Continued From page 3 change of 10 lbs. over the last 3 months) were checked. The Surveyor found no evidence that a nutritional consult had been completed for this patient. 5. At the time of the observation, Staff #901 verified that there was no nutritional consult completed for this patient. 6. On 09/05/23 between 2:25 PM and 3:40 PM, Surveyor #9 and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. The nursing admission assessment showed the patient had a BMI of 40 (an indicator for a nutritional consult). The Surveyor found no evidence that a nutritional consult had been completed for this patient. 7. At the time of the observation, Staff #901 verified that there was no nutritional consult completed for this patient. Item #2 Patient orientation Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were oriented to the unit during admission for 2 of 3 medical records reviewed (Patient #201 and #203). Failure to orient a patient to their environment places the patient at risk for a decreased level of understanding and safety and increased anxiety. Findings included: 1. Document review of the hospital's policy and	L 315		

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L 315	Continued From page 4 procedure titled, "Format and Content of the Record," PolicyStat ID #13942273, last approved 07/23, showed nursing assessment will be completed by the Registered Nurse (RN) within 8 hours of admission. 2. Interview of Chief of Compliance/Director of Risk (Staff #201) stated that the expectation is all areas of the nursing assessment form are to be completed when patients are admitted to the unit, including the patient orientation section. The patient orientation section addresses orientation to the unit/room, handbook, phone/visitation, identification photo taken, identification bracelet placed on the patient, unit rules/routines/schedules, instruction to report safety concerns/issues for self/others to staff, patient rights, and information provided, and policy on personal belonging. 3. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201 and #203. The review showed the following: a. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. The patient orientation section for Patient #201 was blank/not addressed. b. Patient #203 was a 34-year-old female admitted on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. The patient orientation section for Patient #203 was blank/not addressed. 4. At the time of the review, Staff #201 verified the missing patient orientation documentation.	L 315		

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L 315	Continued From page 5	L 315		
L 390	322-035.1R POLICIES-PATIENT TRANSFER WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (r) Transferring patients to other health care facilities or agencies; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff implemented its policies and procedures when patients experienced a change in condition that required a transfer to an acute care hospital for emergency medical treatment for 3 of 3 patients reviewed (Patient #207, #208, and #209). Failure of the hospital to ensure that staff followed the policies and procedures when transferring patients requiring emergency medical care places the patients at risk for serious physical and psychological harm or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Minor Emergency Treatment," PolicyStat ID #10529890, last approved 10/21, showed the following: a. The RN assesses the minor emergency including injuries/illnesses not severe enough to	L 390		

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L 390	Continued From page 6 warrant admission to a hospital but requiring evaluation or treatment on an immediate basis or at least within the next few hours and that is beyond the capabilities of this facility. b. The Lead Nurse notifies: the Attending or Physician on call, the Chief Nursing Officer (CNO) or designee House Supervisor or Unit Manager, the House Supervisor notifies the Administrator on Call (AOC) on evenings, nights or weekends, and parent or legal guardian if the patient is a minor. c. The physician will give the order for appropriate disposition and method of transportation. d. The nurse calls the Emergency Department (ED), gives report to nurse. e. Staff is to send a copy of the following forms with the staff that will accompany the patient to the ED: face-sheet, admission psychiatric assessment, medical history and physician, medication administration record, laboratory reports, certificate of patient transfer, certification of medical necessity for ambulance transfer, progress notes, and involuntary treatment act (ITA) detention documentation (specifically IT-10). f. When the patient is returned to Inland Northwest Behavioral Health, the MD and family are notified of the outcome of the transfer to the Hospital. 2. On 09/06/23 between 2:45 PM and 3:50 PM, Surveyor #2, Surveyor #9, and the Director of Quality (Staff #202) reviewed the medical records for 3 patients who had been transferred to an Emergency Room for treatment for changes in condition. The review showed the following:	L 390		

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L 390	Continued From page 7 a. On 08/08/23, Patient #207 was transferred to an ED for treatment of chest pain. Surveyor #2 was unable to find evidence of the nurse contacting the transferring facility to give report to a RN and no evidence of staff accompanying the patient to the ED. b. On 08/07/23, Patient #208 was transferred to an ED for treatment of seizure-like activity. Surveyor #2 was unable to find evidence of the nurse contacting the transferring facility to give report to a RN, no evidence of staff accompanying the patient, and no family notification of the outcome of the transfer. c. On 08/26/23, Patient #209 was transferred to an ED for treatment for a laceration. Surveyor #2 was unable to find evidence of a physician order for transfer and no family notification of the outcome of the transfer. 3. At the time of the review, Staff #202 verified that the medical record did not contain evidence of the required elements of patient transfer.	L 390		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed. This Washington Administrative Code is not met as evidenced by: Based on record review and interview, the hospital failed to ensure that required policies and	L 415		

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L 415	Continued From page 8 procedures were reviewed and updated annually. Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Policy Development and Review Process," PolicyStat ID 11746188, last approved 06/22, showed that policies and procedures will be reviewed on an annual basis at a minimum. 2. Record review of the following policies showed that the hospital did not review all policies on an annual basis as required, including the following: a. Hand Hygiene, PolicyStat ID 11612029, last approved 06/22. b. Discharge Process, PolicyStat ID 10494850, last approved 06/22. c. Conducting a Root Cause Analysis, Policy Stat ID 11681060, last approved 06/22. d. Medication - Patient Consent, PolicyStat ID 10530113, last approved 12/21. e. Admission of Patients, PolicyStat ID 11681058, last approved 06/22. f. Patient's Rights and Responsibilities, PolicyStat ID 11612024, last approved 06/22. g. Abuse/Neglect Reporting, Policy Stat ID 10391605, last approved 05/22.	L 415		

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L 415	Continued From page 9 h. Emergency Medical Treatment, Policy Stat ID 10529807, last approved 12/21. i. Departmental Responsibility for Infection Prevention and Control, PolicyStat ID 10893044, last approved 12/21. j. Patient Elopement, PolicyStat ID 10529983, last approved 12/21. k. Patient Death Suicide, PolicyStat ID, 10529853, last approved 12/21. l. Patient Belongings, PolicyStat ID 12054438, last approved 07/22. m. Clinical Research, PolicyStat ID 11611965, last approved 06/22. n. Food Services for Patients on a Therapeutic Diet, PolicyStat ID 10530107, last approved 12/21. o. Nursing Charting Requirements, PolicyStat ID 10687647, last approved 12/21. p. Treatment Planning, PolicyStat ID 10503953, last approved 05/22. q. Glucometer, PolicyStat ID 10530082, last approved 12/21. r. Nursing Supplies and Equipment Inspection, PolicyStat ID 10529816, last approved 12/21. s. Plan for Provision of Care Scope of Services, PolicyStat ID 10495145, last approved 06/22. t. Patient Observation Policy, PolicyStat ID 11899584, last approved 06/22.	L 415		

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L 415	Continued From page 10 3. On 09/06/23 at 8:30 AM, Surveyor #9 interviewed Director of Quality (Staff #902) regarding annual policy updates. Staff #902 verified the policies that were not current and stated that they are working on them.	L 415		
L 585	322-050.6i ORIENTATION-APPROP TRAINING WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (i) Appropriate training for expected duties This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that new staff were oriented with appropriate training for expected duties for 1 of 11 staff (Staff #407). Failure to orient staff with appropriate training for expected duties places patients at risk for inadequate care. Findings included: 1. Record review of the hospital's policy titled, "Staff Orientation and Training Plan," PolicyStat ID 12524289, approved 10/13/22, showed that all staff will be oriented to the general standards, organization, and process of the hospital within the first 30 days of hire. 2. On 09/07/23 at 9:30 AM, Surveyor #4 reviewed personnel files with the HR Generalist (Staff	L 585		

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L 585	Continued From page 11 #406). Record review of the personnel files for 11 staff showed that a mental health technician (Staff #407) had no documented employee records for orientation to the hospital for the unit they worked in. 3. At the time of the review, Staff #406 confirmed that the employee file for Staff #407 was missing documentation of orientation. .	L 585		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the	L 615		

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L 615	Continued From page 12 hospital failed to ensure that staff received baseline screening and testing for tuberculosis for 3 of 11 personnel files reviewed (Staff #403, #404, and #405). Failure to screen and test staff prior to their start of work risks patient and staff exposure to tuberculosis infection. Findings included: 1. Record review of the hospital's policy titled, "Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan, 300.04," PolicyStat ID 13469569, last approved 05/09/23, showed that staff will receive a purified protein derivative (PPD) test for TB, chest x-ray depending on test results or prior history of TB vaccination or testing and questionnaire within the first two weeks of hire. The infection prevention and control nurse will document these results. 2. On 09/07/23 at 9:30 AM, Surveyor #4 reviewed personnel files with the HR Generalist (Staff #406). Record review of the personnel files for 11 staff showed that an environmental services technician (Staff #403), a licensed social worker (Staff #404), and a registered nurse (Staff #405) had no documented employee health records for tuberculosis screening or testing prior to hire. 3. At the time of the review, Staff #406 confirmed that the employee files for these staff were missing documentation of TB testing or screening.	L 615		
L 720	322-100.1G INFECT CONTROL-PRECAUTION	L 720		

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L 720	Continued From page 13 WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (g) Identifying specific precautions to prevent transmission of infections; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to implement an effective respiratory protection program that ensures appropriate staff are fit tested to use an N-95 respirator prior to working when respiratory precautions are required for 11 of 11 staff reviewed (Staff #403, #404, #405, #407, #408, #409, #410, #411, #412, #413 and #414). Failure to identify and fit test appropriate staff required to use N-95 respirators prior to use places staff at risk of improper use of PPE and places staff, patients, and visitors at risk of exposure to pathogens. Reference: CDC Morbidity and Mortality Weekly Report (MMWR) Respiratory-Protection Program showed that OSHA requires health-care settings in which HCWs use respiratory protection to develop, implement, and maintain a respiratory-protection program. All HCWs who use respiratory protection should be included in the program. Reference: CDC Morbidity and Mortality Weekly Report (MMWR) showed fit testing provides a means to determine which respirator model and size fits the wearer best and to confirm that the wearer can don the respirator properly to achieve a good fit.	L 720		

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L 720	Continued From page 14 Findings included: 1. Document review of the hospital's policy, "N-95 Fit Testing, 300.80," PolicyStat ID 11612111, last approved 06/30/22, showed that the facility shall define and implement an N-95 test fitting policy based on the hospital's infection control plan. The fit testing policy provided did not identify who specifically needed fit testing and how often fit testing should occur. 2. On 09/07/23 at 9:30 AM, Surveyor #4 reviewed personnel files with the HR Generalist (Staff #406). Record review of the personnel files for 11 staff showed that an environmental services technician (Staff #403), a social worker (Staff #404), three registered nurses (Staff #405, #410, and #411), two mental health technicians (Staff #407 and #412), a dietary cook (Staff #408), a dietician (Staff #409), a licensed practical nurse (Staff #413) and a recreational therapist (Staff #414) all had no documentation of being fit tested. 3. At the time of the review, Staff #406 confirmed that the employee files were missing documentation of any fit testing. The surveyor then interviewed the Infection Prevention and Control Nurse (Staff #415) regarding the facility's fit testing. Staff #415 stated that the hospital was behind on fit testing due to testing staff being out on leave.	L 720		
L 805	322-120.6A WATER-BACKFLOW WAC 246-322-120 Physical Environment. The licensee shall: (6) Provide an	L 805		

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L 805	Continued From page 15 adequate supply of hot and cold running water under pressure meeting the standards in chapters 246-290 and 246-291 WAC, with: (a) Devices to prevent back-flow into the potable water supply system; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of manufacturer's instructions for use, the hospital failed to maintain the ice machine drain line according to manufacturer's instructions. Failure to maintain ice machine drain lines properly risks backflow contamination of the water and ice supply. Findings included: 1. Document review of the Follett Symphony Plus ice machine manufacturer's instructions for use showed drain lines at a minimum should be sloped ¼ inch per foot. 2. On 09/05/23 at 10:00 AM, Surveyor #4 inspected the nourishment room on 3-East in the patient care unit with the Director of Plant Services (Staff #401). The Surveyor observed the countertop Follett Symphony Plus ice machine with a drain line that was not sloping downward as required in the section of drain line that routed through the lower cabinets. 3. The Surveyor interviewed Staff #401 regarding the ice machine drain line. Staff #401 confirmed the drain line should be sloping downward for the entire length of the line and had not been corrected.	L 805		

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L 805	Continued From page 16 4. The Surveyor and Staff #401 then checked all the remaining nourishment rooms in the facility (3-West, 2-East and 2-West). The ice machines' drain lines were correctly sloped in all the other nourishment rooms. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 09/27/22.	L 805		
L1050	322-170.2B TREATMENT PLAN-INITIAL WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (b) An initial treatment plan upon admission incorporating any advanced directives of the patient; This Washington Administrative Code is not met as evidenced by: Based on interview, document review, and review of policy and procedure, the hospital failed to ensure that staff members created an initial treatment plan that included psychiatric and medical problems for 4 of 5 patients reviewed (Patient #901, #902, #904, and #905). Failure to ensure the development of an initial treatment plan for behavioral and medical problems puts patients at risk for physical and mental harm, inconsistent, and delayed treatment. Findings included:	L1050		

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	013260	A. BUILDING: _____ B. WING _____	09/07/2023

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L1050	Continued From page 17 1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care-Scope of Services," PolicyStat ID 10495145, last approved 06/22, showed the following: a. A nursing assessment will be completed by a registered nurse within 8 hours of admission and includes the patient's physical/mental health. b. The nurse initiates the preliminary treatment plan based on the findings of the preadmission and nursing assessments. c. Medical as well as mental health concerns are addressed on the treatment plan. 2. On 09/05/23 between 10:00 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #901 who was a 14 year old admitted on 08/30/23 with a diagnosis of Suicidal Ideation. The patient had risk factors for Anorexia and was placed on anorexia precautions by the provider. The medical problem section of the treatment plan was blank. Surveyor #9 found no evidence of an initial treatment plan that included nutritional issues or Anorexia. 3. At the time of the review, Staff #901 verified that there was no initial treatment plan for nutritional issues or anorexia. 4. On 09/05/23 between 11:30 AM and 12:50 PM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #902 who was a 17 year old admitted on 08/29/23 with a diagnosis of Bipolar Disorder with a suicide attempt and a medical diagnosis of Endometriosis and Migraines. The medical	L1050		

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L1050	Continued From page 18 problem section of the treatment plan was checked as none. Surveyor #9 found no evidence of an initial treatment plan for Endometriosis or Migraines. 5. At the time of the review, Staff #901 verified that there was no initial treatment plan for Endometriosis or Migraines. 6. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nursing (Staff #903) reviewed the medical record of Patient #904 who was admitted on 07/27/23 with a psychiatric diagnosis of Schizophrenia and a medical diagnosis of Diabetes. The medical problem section of the treatment plan was blank. The initial treatment plan was signed by a registered nurse on 08/01/23 (a period of 5 days after admission). 7. At the time of the review, Staff #903 verified that there was no initial treatment plan for Diabetes, and they would expect to see one. 8. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical record of Patient #905 who was admitted on 07/13/23 with a psychiatric diagnosis of Schizoaffective Disorder and Severe Alcohol Dependence. The initial treatment plan was completely blank with no nurse signature. 9. At the time of the review, Staff #902 verified that the initial treatment plan was completely blank.	L1050		

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L1065	Continued From page 19	L1065		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to ensure that staff developed and implemented an interdisciplinary comprehensive treatment plan for all patients that included behavioral and medical problems, with individualized patient-specific interventions, as demonstrated by 4 of 4 records reviewed for patients with medical problems at the time of admission (Patient's #201, #202, #203, and #204). Failure to develop and implement an interdisciplinary treatment plan for behavioral and medical problems places the patients at risk for inappropriate, inconsistent, and delayed care,	L1065		

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L1065	Continued From page 20 creating the potential for negative patient outcomes, harm, or death. Findings included: 1. Document review of the hospital's policy titled, "Treatment Planning," PolicyStat ID #10503953, last approved 05/22, showed the following: a. The Master Treatment Plan (MTP) will be completed within 72 hours of admission following completion of the individual assessments including the nursing assessment, initial psychiatric assessment, medical history and physical, and the psychosocial assessment. b. The MTP is updated at least once a week or sooner if warranted by clinical changes in condition or other factors including new onset medical issues, alternative programing, etc. c. The History and Physical as well as initial nursing assessments will guide the psychiatric provider in identifying medical problems to be included in the MTP. d. Each medical problem will be identified by a letter and link to a specific medical Individual Treatment Plan (ITP) e. Each problem will be identified as active, chronic/stable, deferred, or resolved. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201, #202, and #203. The review showed the following:	L1065		

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L1065	Continued From page 21 a. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. Patient #201 had a provider order placed for anorexic precautions on 08/30/23. The Master Treatment Plan completed on 09/01/23 that is used to identify initial medical diagnosis stated, "no acute conditions." The Master Treatment Plan subsection for chronic/stable medical problems was blank. The Master Treatment Plan did not include a medical problem of anorexia identified with a specific treatment plan. b. Patient #202 was a 17-year-old female admitted on 08/29/23 following a suicide attempt. Patient #202 had a Master Treatment Plan completed on 08/30/23 which included the medical diagnoses of endometriosis, migraines, and fainting due to unknown causes. The Master Treatment Plan subsection for chronic/stable medical problems was blank. The Master Treatment plan did not include a medical problem of endometriosis, migraines, or fainting due to unknown causes with a specific treatment plan. c. Patient #203 was a 34-year-old female with an involuntary admission on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 had a Master Treatment Plan completed on 08/03/23 which included medical diagnoses of type 2 diabetes mellitus, history of hepatitis A, and migraines. The subsection of chronic/stable medical problems was blank. The chronic stable individual treatment plan problem sheet included the medical diagnoses of asthma, gastroesophageal reflux disease (GERD), hypercholesterolemia, hypertension, seizures, hypothyroidism, diabetes, and acne. All boxes for a target date and specific intervention focus options were blank. The Master Treatment Plan	L1065		

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L1065	Continued From page 22 update on 08/14/23 contained a blank nursing update and the nursing progress towards medical problems was blank. On 08/15/23, the patient was chemically restrained. There was no careplan for restraint initiated. The Master Treatment Plan update on 08/21/23 contained a blank nursing update, a blank psychiatrist update, and nursing progress towards medical problems was blank. The Master Treatment Plan update on 08/28/23 contained a blank nursing update, a blank psychiatrist update, and nursing progress towards medical problems was blank. 3. At the time of the review, Staff #201 stated the Master Treatment Plan should also contain any medical diagnoses on the patient's history and physical. Staff #201 also stated that all disciplines should be updating their section weekly on the Master Treatment Plan update. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was admitted on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following: a. The Master Treatment Plan was completed on 07/27/23 and showed a diagnosis of Type 2 Diabetes Mellitus. b. The Master Treatment Plan subsection for chronic/stable medical problems on 07/27//23 was blank. c. The Master Treatment Plan did not include a medical problem of Type 2 Diabetes Mellitus identified with a specific treatment plan.	L1065		

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L1065	Continued From page 23 d. The Master Treatment Plan Update on 08/04/23 contained a blank psychiatrist update, no medical problems listed, and no nursing note of progress towards medical a problem. e. The Master Treatment Plan Update on 08/11/23 contained a blank nursing update, no medical problems listed, and no nursing note of progress towards a medical problem. f. The Master Treatment Plan Update on 08/18/23 contained a blank nursing update, no medical problems listed, and no nursing note of progress towards a medical problem. g. The Master Treatment Plan Update on 08/25/23 contained a blank nursing update, no medical problems listed, and no nursing note of progress towards a medical problem. h. The Master Treatment Plan Update on 09/01/23 contained a blank nursing update, no medical problems listed, and no nursing note of progress towards a medical problem. 5. At the time of the review, Staff #201 verified the Master Treatment Plan Updates should have all elements of the plan updated including the nursing update, psychiatrist update, social services update, discharge planning update, any incidents/behavior changes, social services progress toward psychiatric problems, and nursing progress towards medical problems. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 09/27/22.	L1065		

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L1070	Continued From page 24	L1070		
L1070	322-170.2F PHYSICIAN ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (f) Physician orders for drug prescriptions, medical treatments and discharge; This Washington Administrative Code is not met as evidenced by: . Item #1 Withdrawal assessment Based on observation, interview, and review of the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for safe medication administration for 2 of 2 patient records reviewed (Patient #205 and #206). Failure to follow safe medication administration procedures puts patients at risk of receiving the wrong medications or unintended medication administration resulting in patient harm and/or death. Findings included: 1. On 09/06/23 between 1:10 PM and 3:50 PM, Surveyors #2, Surveyor #9, and the Director of Quality (Staff #202) reviewed the medical records of Patients #205 and #206 who had orders for Clinical Institute Withdrawal Assessment (CIWA) protocol. The provider order for CIWA protocol instructs staff to assess the patient for withdrawal every 2 hours for 24 hours, then every 4 hours for 48 hours, then daily. The review showed the	L1070		

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L1070	Continued From page 25 following: a. Patient #205 was admitted on 07/13/23 with a diagnosis of schizoaffective disorder and severe alcohol dependence. Patient #205 had a provider order for CIWA protocol written on 07/14/23 at 1:00 PM. Patient #205 had a CIWA score assessed at 3 on 07/14/23 at 7:53 PM, and the next documented CIWA assessed score was 0 on 07/15/23 at 1:58 AM (missing a period of approximately 6 hours). Patient #205's next documented CIWA score assessed was 0 at 7:15 AM (missing a period of approximately 5 hours). b. Patient # 206 was admitted on 05/02/23 with a diagnosis of bipolar, suicide attempt, and alcohol dependence. Patient #206 had a provider order for CIWA protocol written on 05/02/23 at 10:00 PM. Patient #206 had a CIWA score assessed at 12 on 05/02/23 at 9:47 PM, and the next documented CIWA score assessed at 12 on 05/03/23 at 8:02 AM (missing a period of approximately 10 hours). Patient #206 had a CIWA score assessed at 1 on 05/03/23 at 8:53 PM, and the next documented CIWA score assessed at 10 on 05/04/23 at 8:18 AM (missing a period of approximately 11 hours). 2. At the time of the review, Staff #202 verified the missing documented CIWA score assessments. Surveyor #2 requested a policy to address the facility's CIWA protocol for alcohol dependence. Staff #202 reported the facility does not have a specific policy for CIWA protocol as the elements of when to assess a patient for symptoms of alcohol withdrawal are included in the provider's order. Item #2 Precautions	L1070		

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L1070	Continued From page 26 Based on observation, interview, and review of the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for implementing psychiatric precautions for 1 of 2 adolescent medical records reviewed. Failure to ensure specific psychiatric precautions are implemented puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Observation Policy," PolicyStat ID #11899584, last approved 06/22, showed the RN or MHT is to review and update the patient observation forms and reflect changes in individual patient precaution levels as they occur. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. The review showed Patient #201 had a provider order for anorexic precautions written on 08/30/23 at 7:56 PM. Patient #201 did not have anorexic precautions written under the precautions on the patient observation record until 09/02/23. 3. At the time of the review, Staff #201 verified the precaution was not implemented until 09/02/23. Item #3 Order authentication Based on document review of the hospital's	L1070		

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L1070	Continued From page 27 medical staff rules and regulations, the hospital failed to ensure that the healthcare providers authenticated orders for the care and treatment of patients according to the hospital's medical staff rules and regulations for 4 out of 4 medical records reviewed (Patient #201, #202, #203, and #204). Failure to write and authenticate orders for admission, medications, and treatment risks provision of incorrect and/or inadequate patient care. Findings included: 1. Document review of the hospital policy titled, "Ordering and Prescribing - General Requirements, 11" PolicyStat ID #12789868, last approved 01/23, showed the following: a. Only individuals authorized by state, federal and local authorities and as defined by hospital policy or Medical Staff Rules and Regulations may prescribe medications. b. All orders entered in the computerized order entry (COE) system must be electronically signed within 48 hours. c. Telephone orders are e-signed in COE and signed in chart within 48 hours by a provider practicing within their scope of practice. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201 and #202. The review showed the following: a. Patient #201 was a 14-year-old female with a	L1070		

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L1070	Continued From page 28 voluntary admission on 08/30/23 following a suicide attempt. Patient #201 had a telephone order for suicide precautions entered in the COE system on 08/30/23 at 7:55 PM. The order was authenticated by a provider on 09/05/23 at 7:55 AM (a period of approximately 132 hours). Patient #201 had a telephone order for anorexic precautions entered in the COE system on 08/30/23 at 7:56 PM. The order was authenticated by a provider on 09/04/23 at 8:36 AM (a period of approximately 108 hours). b. Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. Patient #202 had a telephone order for sexual aggression precautions entered in the COE system on 09/02/23 at 10:34 PM. The order had not been authenticated by a provider at the time of the review (a period of approximately 59 hours). c. Patient #203 was a 34-year-old female with an involuntary admission on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 had a telephone order for a vegetarian/diabetes mellitus diet entered in the COE system on 08/05/23 at 2:43 PM. The order was authenticated by a provider on 08/09/23 at 9:22 AM (a period of approximately 90 hours). Patient #203 had a telephone order for blood glucose monitoring entered in the COE system on 08/09/23 at 11:26 AM. The order was authenticated by a provider on 08/15/23 at 9:03 AM (a period of approximately 129 hours). Patient had a telephone order for a special diabetic 2000-calorie diet entered in the COE system on 08/22/23 at 5:42 PM. The order had not been authenticated by a provider at the time of the review (a period of approximately 328 hours).	L1070		

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L1070	Continued From page 29 Patient #203 had a telephone order to stay in her room and not attend group therapy for 2 days due to medical reasons entered in the COE system on 08/29/23 at 10:39 AM. The order had not been authenticated by a provider at the time of the review (a period of approximately 167 hours). 3. At the time of the review, Staff #201 verified the required missing e-signature of orders by the provider within 48 hours. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following: a. Patient #204 had a telephone order miscellaneous Admit/Discharge/Transfer (ADT) for aggressive behavior entered in the COE system on 07/27/23 at 2:33 PM. The order was authenticated by a provider on 08/03/23 at 3:53 PM (a period of approximately 169 hours). b. Patient #204 had a telephone order for aggression/homicidal precautions entered in the COE system on 07/27/23 at 2:25 PM. The order was authenticated by a provider on 08/03/23 at 3:53 PM (a period of approximately 169 hours). 5. At the time of the review, Staff #201 verified the above orders placed by an RN had not been e-signed within 48 hours.	L1070		

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L1105	Continued From page 30	L1105		
L1105	322-170.3C NURSING SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (c) Nursing services, including: (i) A psychiatric nurse, employed full time, responsible for directing nursing services twenty-four hours per day; and (ii) One or more registered nurses on duty within the hospital at all times to supervise nursing care; This Washington Administrative Code is not met as evidenced by: . Item #1 Nursing assessments Based on interview, record review, and review of hospital's policies and procedures, the hospital failed to ensure staff completed nursing shift assessments on the daily progress notes for 2 of 4 patients (Patients #202 and #204). Failure to perform and document shift assessments can lead to exacerbation of existing medical conditions or lack of recognition of emerging medical conditions. Findings included: 1. Review of the hospital's policy titled, "Format and Content of the Record," PolicyStat ID #13942273, last approved 07/23, showed that nursing progress notes are written by an RN at least once each shift and by a nursing staff member on second shift as the patient's condition warrants it.	L1105		

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L1105	Continued From page 31 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical record of Patient #202. Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. The review showed the following: a. On 09/01/23 from 7:00 PM to 7:00 AM, the shift assessment was blank for patient assessment of affect, mood, speech, thought process, thought content, hallucinations, behaviors, social interaction, group attendance, insight, and judgement. The pain assessment was blank for both shifts on 09/01/23. b. On 09/03/23 from 7:00 AM to 7:00 PM, the shift assessment for patient assessment of affect, mood, speech, thought process, thought content, hallucination, behaviors, social interaction, group attendance, insight, and judgement had a line drawn from top to bottom. The pain assessment was blank for day shift on 09/03/23. 3. At the time of the review, Staff #201 verified the missing documentation and stated the expectation is assessments are completed each shift and every box/item should be addressed. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following:	L1105		

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L1105	Continued From page 32 a. On 07/28/23, the pain assessment boxes were blank for night shift. b. On 07/31/23, the neurological, pulmonary, cardiovascular, endocrine, genitourinary, gastrointestinal, skin, detox, and medication compliance assessment boxes were blank for both shifts. c. On 08/01/23, the pain assessment boxes were blank for day shift. d. On 08/02/23, the pain assessment boxes were blank for day shift. 5. At the time of the review, Staff #201 verified the missing documentation and stated the expectation is assessments are completed each shift and every box/item should be addressed. Item #2 Charge Nurse Oversight Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to provide care in a safe setting by failing to implement policies and procedures that guide staff to ensure patient observation rounds are occurring as ordered at all times as demonstrated by 4 of 4 records reviewed (Patient #201, #202, #203, and #204). Failure to develop and implement policies and procedures that ensure patient observation rounds are occurring as ordered at all times potentially places patients at increased risk for harm or violence. Findings included: 1. Document review of the hospital's policy and	L1105		

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L1105	Continued From page 33 procedure titled, "Patient Observation Policy," PolicyStat ID #11899584, last approved 06/22, showed the following: a. The Charge Nurse ensures that Patient Observations Rounds are conducted according to policy and are occurring as ordered, 24 hours a day, seven days a week. b. Three times per shift, the Charge Nurse reviews all patient observational rounds and initials the supervisor verification. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical records of Patient #201 and #202. The review showed the following: a. Patient #201 was a 14-year-old female admitted on 08/30/23 following a suicide attempt. Patient #201 was missing Charge Nurse oversight documentation on 4 of the 5 days reviewed. b. Patient #202 was a 17-year-old female admitted on 08/29/23 following a suicide attempt. Patient #202 was missing Charge Nurse oversight documentation on 5 of the 6 days reviewed. c. Patient #203 was a 34-year-old female admitted on 08/02/23 for treatment of acute psychosis, schizoaffective disorder, bipolar type, and polysubstance abuse. Patient #203 was missing Charge Nurse oversight documentation on 30 of the 33 days reviewed. 3. At the time of the review, Staff #201 verified the missing Charge Nurse oversight	L1105		

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L1105	Continued From page 34 documentation on the Patient Observation Records. 4. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was admitted on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. Patient #204 was missing Charge Nurse oversight documentation on 18 of 20 days reviewed. 5. At the time of the reviews, Staff #201 verified the missing Charge Nurse oversight documentation on the Patient Observation Records. .	L1105		
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: . Item #1 Authentication and timing of telephone orders for restraint	L1150		

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L1150	Continued From page 35 Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider authenticated telephone orders per hospital policy for seclusion or restraint for 3 of 4 restraint records reviewed (Patient #903, #906, and #907). Failure to ensure that a provider authenticates an appropriate order for restraints risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy and procedure titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," PolicyStat ID 13524979, last approved 07/23, showed the following: a. Telephone/verbal orders for restraint/seclusion may be received and recorded by an RN or LPN. b. The physician/LIP must be contacted for the order during the emergency or within a few minutes. b. The physician shall authenticate the telephone/verbal order within 24 hours. 1. On 09/05/23 between 2:25 PM and 3:40 PM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. The review showed on 08/15/23 at 6:24 PM, Patient #903 was chemically restrained. Telephone orders were entered by a nurse on 08/15/23 at	L1150		

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L1150	Continued From page 36 6:31 PM for Benadryl 50 milligrams intramuscular now and Haldol (an antipsychotic medication) 10 milligrams intramuscular now and at 6:32 PM for Lorazepam (a sedative) 2 milligrams now. Surveyor #9 found no evidence that the orders for medications had been authenticated by a provider at the time of the review (a period of approximately 21 days). 2. At the time of the review, Staff #901 verified that the orders were not authenticated. 3. On 09/06/23 at 4:00 PM, Surveyor #9 and Director of Quality (Staff #902) reviewed the medical record of Patient #906 who was admitted on 07/12/23 with a diagnosis of Suicidal Ideation. The review showed the following: a. On 07/14/23 at 3:10 PM, Patient #906 was placed in a physical hold. A telephone order was entered by a nurse on 07/14/23 at 10:02 PM (a period of approximately 7 hours after the restraint). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 7 days). b. On 07/14/23 at 3:11 PM, Patient #906 received Olanzapine (an antipsychotic medication) 10 milligrams intramuscular as a one time order entered by a nurse on 07/14/23 at 3:05 PM. The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 7 days). c. On 07/15/23 at 11:42 AM, Patient #906 was placed in seclusion. A telephone order for seclusion was entered by a nurse at 1:39 PM (a period of approximately 2 hours). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 6 days).	L1150		

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L1150	Continued From page 37 d. On 07/15/23 at 11:45 AM, Patient #906 was placed in a physical hold. A telephone order for restraint was entered by a nurse at 2:57 PM (a period of approximately 3 hours). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 6 days). e. On 07/15/23 at 11:50 AM, Patient #906 was chemically restrained. A telephone order for restraint was entered by a nurse at 3:00 PM (a period of approximately 3 hours). The order was authenticated by a provider on 07/21/23 at 7:57 AM (a period of approximately 6 days). 4. At the time of the review, Staff #902 verified the times and dates of the telephone orders and authentications by provider. 5. On 09/07/23 at 8:55 AM, Surveyor #9 and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical chart of Patient #907 who was admitted on 04/18/23 for Manic Depressive Disorder, Generalized Anxiety Disorder and Post Traumatic Stress Disorder. The review showed the following: a. On 05/25/23 at 6:28 PM, Patient #907 was placed in a physical hold (restraint). A telephone order for restraint was entered by a nurse on 05/25/23 at 6:43 PM. The order was authenticated by a provider on 06/08/23 at 8:33 AM (a period of approximately 14 days). b. On 05/25/23 at 6:29 PM, Patient #907 was placed in seclusion. A telephone order for seclusion was entered by a nurse on 05/25/23 at 6:43 PM. The order was authenticated by a provider on 06/08/23 at 8:33 AM (a period of approximately 14 days).	L1150		

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L1150	Continued From page 38 6. At the time of the review, Staff #901 verified the times and dated of the telephone orders and authentications by provider. Item #2 Restraint orders Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider ordered restraint or seclusion per hospital policy for 3 of 4 restraint records reviewed (Patient #903, #906, and #907). Failure to ensure that a provider authenticates an appropriate order for restraints risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy and procedure titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion", PolicyStat ID 13524979, last approved 07/23, showed that restraint or seclusion shall be used only in emergency situations and requires an order from a physician. 2. On 09/05/23 between 2:25 PM and 3:40 PM, Surveyor #9 and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. On 08/15/23 at 6:24 PM, Patient #903 was chemically restrained. Surveyor #9 was unable to find evidence of an order for restraint.	L1150		

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L1150	Continued From page 39 3. At the time of the review, Staff #901 verified that they were unable to find an order for restraint. 4. On 09/06/23 at 4:00 PM, Surveyor #9 and Director of Quality (Staff #902) reviewed the medical record of Patient #906 who was admitted on 07/12/23 with a diagnosis of Suicidal Ideation. The review showed that on 07/14/23 at 3:11 PM, Patient #906 was chemically restrained. Surveyor #9 was unable to find evidence of an order for restraint. 5. At the time of the review, Staff #902 verified that there was no order entered for this restraint. 6. On 09/07/23 at 8:55 AM, Surveyor #9 and Director of Risk (Staff #901) and Director of Quality (Staff #902) reviewed the medical chart of Patient #907 who was admitted on 04/18/23 for Manic Depressive Disorder, Generalized Anxiety Disorder and Post Traumatic Stress Disorder. The review showed the following: a. On 05/05/23 at 9:07 AM, Patient #907 was placed in seclusion. Surveyor #9 found no evidence of an order for seclusion. b. On 05/05/23 at 9:14 AM, Patient #907 was chemically restrained. Surveyor #9 found no evidence of an order for the chemical restraint. c. On 05/21/23 at 11:25 AM, Patient #907 was placed in a physical hold (restraint). Surveyor #9 found no evidence of an order for the physical hold (restraint). d. On 05/21/23 at 11:35 AM, Patient #907 was chemically restrained. Surveyor #9 found no evidence of an order for the chemical restraint.	L1150		

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L1150	Continued From page 40 7. At the time of the review, Staff #902 verified that there were no orders for the above restraint episodes. Staff #902 stated that the process is that all verbal/telephone orders should be entered into the computer system. THIS IS A REPEAT CITATION, PREVIOUSLY CITED ON 09/27/22.	L1150		
L1155	322-180.1E SECLUSION EXAM WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (e) A physician shall examine each restrained or secluded patient and renew the order for every twenty-four continuous hours of restraint and seclusion; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital policy for restraints for 1 of 4 restraint records reviewed (Patient #903). Failure to follow approved policies and procedures for seclusion risks physical and psychological harm, loss of dignity, and violation of patient rights. Findings included:	L1155		

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L1155	Continued From page 41 1. Document review of the hospital's policy and procedure titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion", PolicyStat ID 13524979, last approved 07/23, showed the following: a. Within one hour of the initiation of the restraint, the patient will be evaluated in person by a physician, licensed independent provider, or trained RN. b. The evaluation will be documented in the medical record and include the date and time of the evaluation, an assessment of the patient's immediate situation, an evaluation of the patient's medical and behavioral condition to include a complete review of systems, and an assessment of the need to continue or terminate the restraint. 2. On 09/05/23 between 2:25 PM and 3:40 PM, Surveyor #2, Surveyor #9 and Director of Risk (Staff #901) reviewed the medical record of Patient #903 who was a 34 year old female admitted on 08/02/23 with a diagnosis of Acute Psychosis, Bipolar Disorder, and Polysubstance Use and a medical diagnosis of Diabetes. The review showed on 08/15/23 at 6:24 PM, Patient #903 was chemically restrained. Surveyor #9 was unable to find evidence of a face to face evaluation. 3. At the time of the review, Staff #901 confirmed they were unable to locate face to face documentation in the medical record.	L1155		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS	L1375		

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	013260	A. BUILDING: _____ B. WING _____	09/07/2023

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L1375	Continued From page 42 WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Item #1 Insulin administration Based on observation, interview, and review of the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for safe medication administration for 1 of 2 insulin administration medication records reviewed (Patient #904). Failure to follow safe medication administration procedures puts patients at risk of receiving inadequate medications or unintended medication administration resulting in patient harm and/or death. Findings included: 1. Review of the hospital's policy and procedure titled, "Medication Administration," PolicyStat ID 13339868, last approved 05/23, showed the following: a. Time Critical Scheduled Medications are administered within 60 minutes before or after the scheduled dosing time and include insulin. b. When medications are not given within the timeframe, nursing is to document the reason the	L1375		

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L1375	Continued From page 43 dose was missed or delayed. c. Notify the physician for a time critical medication delay greater than 2 hours. 2. On 09/06/23 between 9:40 AM and 11:30 AM, Surveyor #2, Surveyor #9, and Director of Risk (Staff #901) and Director of Nursing (Staff #903) reviewed the medication administration record of Patient #904. Patient #904 was admitted on 07/27/23 with a psychiatric diagnosis of Schizophrenia and a medical diagnosis of Diabetes. Medication orders were entered by a provider on 07/27/23 at 8:25 AM for insulin (a medication to treat elevated blood sugar) administration before meals using sliding scale coverage and showed the following: a. For blood glucose < 50, Call MD. b. For blood glucose 51-70 No insulin to administer c. For blood glucose 70-124 Regular Insulin Zero units d. For blood glucose 125-174 Regular Insulin 2 units SUB Q (subcutaneous) X 1 e. For blood glucose 175-225 Regular Insulin 4 units SUB Q X 1 f. For blood glucose 226-275 Regular Insulin 6 units SUB Q X 1 g. For blood glucose 276-325 Regular Insulin 8 units SUB Q X 1 h. For blood glucose 326-375 Regular Insulin 10 units SUB Q X 1	L1375		

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L1375	Continued From page 44 i. For blood glucose 376-400 Regular Insulin 12 units SUB Q X 1 j. For blood glucose >400 = call Provider. 3. On 07/28/23 at 7:41 AM, Patient #904 had a blood glucose of 248 milligrams/deciliter and on 07/28/23 at 4:37 PM Patient #904 had a blood glucose of 312 milligrams/decliliter. Surveyor #9 was unable to find evidence of insulin administration, an annotation as to why the dose was missed, or annotation in the medication administration record that showed the provider was notified of the missed dose. 4. At the time of the review, Staff #903 verified at the above times, there should have been insulin medication administered to the patient, and there was no documentation of administration, or notification of the provider for a missed dose. Item #2 Medication reassessment Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff members completed and documented reassessments after each medication intervention for 1 of 2 medical records reviewed (Patient #202). Failure to assess before medication administration and reassess patients after medication administration risks inconsistent, inadequate, or delayed relief of symptoms. Findings included: 1. Document review of the hospital's policy and procedure titled, "Pain Assessment,	L1375		

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L1375	Continued From page 45 Reassessment and Management", PolicyStat ID #10529976, last approved 12/21, showed the following: a. It is the responsibility of all clinical staff to screen all patients for the presence or absence of pain. b. All patients will undergo reassessment of pain at least once per shift while awake and after every pain control mechanism employed by patient care providers. Pain control mechanisms include but are not limited to medications administered for the control or relief of pain and medications administered for the control or relief of anxiety. c. As part of the reassessment, the Multidisciplinary team should assess and document the pain in terms of its duration, characteristics, and intensity as well as the time of the pain, the pain rating, and any use of analgesics. Also include other pain interventions, vital signs, the effectiveness of all interventions, and any side effects or adverse reactions. 2. On 09/05/23 between 10:00 AM and 12:50 PM Surveyor #2, Surveyor #9, and the Chief Compliance Officer/Director of Risk (Staff #201) reviewed the medical record of Patient #202. Patient #202 was a 17-year-old female with a voluntary admission on 08/29/23 following a suicide attempt. The review showed the following: a. On 08/29/23 at 10:20 PM Patient #202 received Tylenol for a 5/10 pain rating. On 08/30/23 at 9:08 AM, a pain reassessment was completed (a period of approximately 11 hours) with a rating of "effective".	L1375		

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L1375	Continued From page 46 b. On 09/04/23 at 5:37 AM, Patient #202 received Vistaril for anxiety. On 09/04/23 at 2:21 PM, a reassessment was completed (a period of approximately 9 hours) as "effective". 3. At the time of the review, Staff #201 verified the delayed reassessments of as needed medication. .	L1375		
L1390	322-210.3F PROCEDURES-AUTHENTICATE WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (f) Authenticating verbal and telephone orders by prescriber in a timely manner, not to exceed forty-eight hours for inpatients; This Washington Administrative Code is not met as evidenced by: . Based on document review of the hospital's medical staff rules and regulations, the hospital failed to ensure that the healthcare providers authenticated orders for the care and treatment of patients according to the hospital's medical staff rules and regulations for 1 out of 4 medical records reviewed (Patient #204). Failure to write and authenticate orders for admission, medications, and treatment risks provision of incorrect and/or inadequate patient care.	L1390		

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L1390	Continued From page 47 Findings included: 1. Document review of the hospital policy titled, "Ordering and Prescribing - General Requirements, 11" PolicyStat ID #12789868, last approved 01/23, showed the following: a. Only individuals authorized by state, federal and local authorities and as defined by hospital policy or Medical Staff Rules and Regulations may prescribe medications. b. All orders entered in the computerized order entry (COE) system must be electronically signed within 48 hours. c. Telephone orders are e-signed in COE and signed in chart within 48 hours by a provider practicing within their scope of practice. 2. On 09/06/23 between 9:40 AM and 11:50 AM, Surveyor #2, Surveyor #9, the Chief Compliance Officer/Director of Risk (Staff #201), and the Chief Nursing Officer (Staff #203) reviewed the medical record for Patient #204 who was an involuntary admit on 07/27/23 for the treatment of Schizophrenia, paranoia, and auditory visual hallucinations. The review showed the following: a. Patient #204 had an order for Metformin (a medication used to treat diabetes) entered in the COE system on 07/27/23 at 8:21 AM. The order was authenticated by a provider on 07/31/23 at 8:18 AM (a period of approximately 95 hours). b. Patient #204 had an order for Metformin entered in the COE system on 08/01/23 at 3:12 PM. The order was authenticated by a provider on 08/12/23 at 12:49 PM (a period of approximately 260 hours).	L1390		

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L1390	Continued From page 48 3. At the time of the review, Staff #201 verified there were 5 medication orders placed by an RN that had not been e-signed within 48 hours. .	L1390		
L1410	322-210.3J PROCEDURES-OUTDATED MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (j) Prohibiting the administration of outdated or deteriorated drugs, as indicated by label; This Washington Administrative Code is not met as evidenced by: . Based on interview, observation, and document review, the hospital failed to develop and implement procedures for ensuring that medications do not exceed the manufacturer's expiration date. Failure to monitor and establish a systematic process for ensuring medications do not exceed the manufacturer's expiration date risks deteriorated or potentially contaminated medication being available for patient care. Findings included: 1. Document review of the hospital's policy titled, "Multi-Dose Vials, Single-Dose Containers and Multi-Dose Bulk Medication Containers, 19", PolicyStat ID #12789922, last approved 01/23,	L1410		

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L1410	Continued From page 49 showed the following: Labeling Open Multi-Dose vials a. Opened multi-dose vials are labeled with a beyond-use date or discard date, not the date the vial is opened. b. Attach an auxiliary label stating: "Discard unused portion after expiration date of_____" or "INSULIN DISCARD AFTER 28 DAYS _____". c. Label the container with the beyond-use date based on 28 days from the date the vial is opened; the manufacturer's expiration date; or the beyond-use date determined after reconstitution, whichever is shorter. 2. On 09/05/23 between 9:00 AM and 9:25 AM, Surveyor #2 , Surveyor #9, and a Registered Nurse (Staff #204) inspected the 2 East Medication Room refrigerator. The observation showed the following: a. Two open vials of Regular Insulin (Novolin R) 10 milliliters with no date labeled of when opened or when to discard after 28 days. b. One open vial of Humalog Insulin (fast acting insulin) 10 milliliters with no date labeled of when opened or when to discard after 28 days. 3. At the time of the observation Staff #204 verified there was no date labeled on the vials of when opened or when to discard and removed them from use.	L1410		

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L1485	Continued From page 50	L1485		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to implement the food safety requirements puts patients, staff, and visitors at risk for development of food borne illness. Findings included: 1. On 09/05/23 at 12:30 PM, Surveyor #4 inspected the hospital's dietary services kitchen with the Director of Plant Services (Staff #401) and the Kitchen Manager (Staff #402). During the inspection, the surveyor observed a bucket of disinfection solution near the dishwasher and asked to see the testing strips. Staff #402 showed the inspector Hydrion QT-40 quaternary test strips with an expiration of 06/30/23. Staff #401 confirmed the strips were expired and could not be used to accurately confirm disinfectant levels in the solution. Reference: Equipment-Manual and mechanical warewashing equipment, chemical sanitization-Temperature, pH, concentration, and hardness (FDA Food Code 4-501.114). Washington State Retail Food Code WAC 246-215-04565(1). .	L1485		

State of Washington

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S 000	Initial Comments This report is the result of an unannounced Fire and Life Safety state survey conducted at the Inland Northwest Behavioral Health on September 6, 2023 by a team of representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) survey teams. The facility has a total of 100 beds and at the time of this survey the census was 77. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a II construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services.	S 000		
S 225	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 6, 2023 between approximately 0930 to 1345 hours the facility has failed to maintain	S 225		

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S 225	Continued From page 1 stairways. This could lead to the rapid spread of fire and smoke throughout the facility and expose residents/patients, staff, and visitors to the threats of fire. The findings include: The 3rd floor stairwell door 3517 does not close and latch. The above was discussed and acknowledged by the facility staff.	S 225		
S 920	NFPA 101 Electrical Equipment Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used	S 920		

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S 920	Continued From page 2 with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 6, 2023 between approximately 0930 to 1345 hours the facility failed to restrict the use of extension cords and non-approved power strips in their facility. This could endanger patients, staff, and visitors in the facility due to the increased fire risk. The findings include: In the FACP IT Room there is a surge protector hanging not secured to wall or floor. The above was discussed and acknowledged by the facility staff.	S 920		

Rec'd 10.4.23
Approved 10.5.23
SLM

Inland Northwest Behavioral Health

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

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L315	**323-035. 1C POLICIES-TREATMENT** **ITEM #1:** The CEO, the CNO, the Registered Dietitian and the Director of PI met to review the Nutritional Screening/Assessment Policy and Procedure. No changes were made at this time. All licensed nursing staff was retrained to the Nutritional Screening/Assessment Policy and Procedure to confirm compliance with completing full nutritional screening on admission and identifying risk factors and ordering a nutritional consult as needed. Training was initiated by the CNO and Registered Dietitian and was completed by 10/31/2023. **ITEM #2:** The CEO, The CNO and the Director of PI met to review the Format and Content of the Record Policy. No changes were made at this time. The nursing staff was retrained to the Format and Content of the Record Policy to confirm compliance with 100% completion of the nursing admission assessment within 8 hours of admission to include the patient orientation section. A thorough review of the orientation section was included in the training. Training was initiated by the CNO and was completed by 10/31/2023.	Chief Nursing Officer Registered Dietitian	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of Nursing Admission Assessments to confirm compliance with completing the nutritional screening located within the admission nursing assessment and appropriate follow through with ordering a nutritional consult as deemed appropriate. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% The Chief Nursing Officer will monitor 50% of our census of Nursing Admission Assessments to confirm compliance with thorough completion of the nursing admission assessment within 8 hours of admission to include the patient orientation section. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly.

				Target for compliance >/= 90%
L390	**322.-035.1R POLICIES-PATIENT TRANSFER** The CEO, the Director of PI and the CNO met to review the current Minor Emergency Treatment Policy. No changes were made at this time. All licensed Nursing staff were retrained to the Minor Emergency Treatment Policy specific to the requirement that a staff member from the sending facility is required to accompany every patient to the Emergency Department. Training focused on the requirement that the Registered Nurse must give a report to an RN, documentation of report provided and notification of the patient's family. The RN is responsible for notifying the patient's family of the outcome of the transfer to another facility and confirm there is an order entered into the HCS system for transfer. Training was initiated by the Chief Nursing Officer and completed on 10/31/2023.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 50% of our census of patient's sent out for change in condition to confirm patients are accompanied by a staff member. Monitoring will include confirmation that the RN will give report to the ER Registered Nurse and documented this, the RN will notify family of transfer and outcome of transfer and the RN will put an order in HCS for transfer. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L415	**322.-035.2 P&P-ANNUAL REVIEW** The CEO and the Leadership Team met to review the Policy Development and Review Process Policy. No changes were made at this time. The CEO retrained the Leadership Team to the Policy Development and Review Process Policy specific to the requirement that all policies and procedures must be reviewed on an annual basis at a minimum. The PI Director will implement a process to review policies on a quarterly basis until 100% are thoroughly reviewed and/or revised.	CEO Leadership Team	11/6/2023	The Director of PI will monitor 100% of policies and procedures for being reviewed annually. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance is 100%

	Training was initiated by the CEO and completed on 10/31/2023.			
L585	**322-050.6i ORIENTATION-APPROP TRAINING** The CEO, the CNO, the Manager of HR and the Clinical Educator met to review the Staff Orientation and Training Plan Policy. No changes were made at this time. The Manager of HR reeducated the Clinical Educator to the Staff Orientation and Training Policy specific to the requirements that every mental health technician has completed orientation to the hospital for the unit they work on. Training was initiated by the Manager of HR and completed on 10/31/2023.	Manager of Human Resources Clinical Educator	11/6/2023	The Manager of HR and the Clinical Educator will monitor 100% of new hire HR files to confirm compliance with completion of orientation to the hospital for the unit they work on. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%
L615	**322-050.9A TB-MANTOUX TEST** The CEO, the CNO, the Clinical Educator and the Infection Control Nurse met to review the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. No changes were made at this time. The CNO retrained the Clinical Educator and the Infection Control Nurse on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of training was specific to the need for compliance with tuberculosis screening process. The Clinical Educator was instructed to give each new hire the tuberculosis screening and perform tuberculosis testing within the first two weeks of hire. TB forms will then be given to the Infection Control Nurse to monitor for compliance. Training was initiated by CNO and completed on 10/31/2023.	Chief Nursing Officer Clinical Educator Infection Control Nurse	11/6/2023	The Infection Control Nurse will monitor 100% of the employee health files for compliance with tuberculosis screening and testing. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%

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

	The Nursing staff were retrained to the Plan for Provision of Care-Scope of Services Policy to confirm compliance with having an initial nursing treatment plan completed within 8 hours of admission that includes a specific medical treatment plan per the nursing assessment. Training was initiated by the CNO and completed on 10/31/2023. The Day and Noc House Supervisors are responsible for reviewing all new admissions to confirm completion of the initial nursing treatment plan. Findings will be reported to the CNO daily. Training was initiated by the Chief Nursing Officer and competed on 10/31/2023.			Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. The Day and Noc House Supervisors will audit daily the new admissions and report daily to the CNO the results of initial nursing treatment plans being completed, and medical issues being addressed. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
L1065	**322-170.2E TREATMENT PLAN-COMPREHENSION** The CEO, Medical Director, CNO and the Director of PI met to review the Treatment Planning Policy. No changes were made at this time. The Providers were all retrained by the CMO to the Treatment Planning Policy to confirm compliance with required documentation pertinent to patient's status on the Master Treatment Plan Update Form. Training was initiated by the Medical Director and completed on 10/31/2023. All licensed Nursing staff were retrained to the Treatment Planning Policy to confirm compliance with identifying medical problems on the Master Treatment Plan, completing the Chronic/Stable Treatment Plan on each patient with target dates and specific interventions if needed, completing the Master Treatment Plan Update forms weekly addressing the patient's medical problems and documenting progress towards goals of the medical problems.	Medical Director Chief Nursing Officer	11/6/2023	The Medical Director will monitor 50% of our census of Master Treatment Plan Updates to confirm compliance with Providers updating their portion of the treatment plan. The Chief Nursing Officer will monitor 50% of our census of the Master Treatment Plans and Master Treatment Plan Updates to confirm compliance with identifying medical problems on the Master Treatment Plan, completing the Chronic/Stable Treatment Plan on each patient with target dates and specific interventions if needed, completing the Master Treatment Plan Update forms weekly addressing the patient's medical problems and documenting progress towards goals of the medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

	Training was initiated by the CNO and completed on 10/31/2023.			
L1070	**322-170.2F PHYSICIAN ORDERS** **ITEM #1** The CEO, Medical Director, CNO and the Director of PI met to review the citation. A CIWA Protocol Policy and Procedure was made. All licensed Nursing staff were retrained to the new CIWA Protocol Policy and Procedure to confirm compliance with implementation of the CIWA protocol and assessing the score per the Providers orders. CIWA Protocol Policy and Procedure was reviewed and approved by Governing Body on 10/3/2023. Training was initiated by the CNO and completed on 10/31/2023. **ITEM #2** The CEO, CNO and the Director of PI met to review the Patient Observation Policy. No changes were made at this time. The Nursing staff were all retrained to the Patient Observation Policy to confirm compliance with updating the patient observation form timely when precaution orders are added and/or discontinued. Training was initiated by the CNO and completed on 10/31/2023. **ITEM #3** The CEO, Medical Director and the Director of PI met to review the Ordering and Prescribing-General Requirements Policy. No changes were made at this time.	Chief Nursing Officer Medical Director	11/6/2023	The Chief Nursing Officer will monitor 100% of patients on CIWA Protocol to confirm compliance with following provider orders. The Chief Nursing Officer will monitor 50% of our census of the Patient Observation forms to confirm compliance with updating the patient observation form with precautions orders in a timely manner. The Medical Director will monitor 100% of physician orders to confirm compliance with electronically signing within 48 hours. Noncompliance data will be added to the provider's OPPE profile and reviewed quarterly. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

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

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

L1155	**322-180.1E SECLUSION EXAM** The CEO, CNO, Director of Risk and the Director of PI met to review the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy. No changes were made at this time. All licensed Nursing staff were all retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy to confirm compliance with a face-to-face evaluation of the patient to be completed within one hour of the initiation of the restraint. This evaluation will be documented in the medical record and include the date and time of evaluation, an assessment of the patient's immediate situation, an evaluation of the patient's medical and behavioral condition to include a complete review of systems, and an assessment of the need to continue or terminate the restraint. Training to the seclusion/restraint packet that includes all required documentation was the focus of this training. Training was initiated by the CNO and completed on 10/31/2023.	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 100% of patients that were in restraint and/or seclusion to confirm compliance with a face-to-face evaluation completed within one hour and documented and on the seclusion/restraint packet and kept in the medical record. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
L1375	**322-210.3C PROCEDURES-ADMINISTER MEDS** **ITEM #1** The CEO, CNO and the Director of PI met to review the Medication Administration Policy. No changes were made at this time. All licensed Nursing staff were retrained to the Medication Administration Policy to confirm compliance with scheduled dosing times of certain medications within 60 minutes before or after the scheduled dosing time. Training focused on the requirement to document the reason the dose was missed or delayed and notification of the physician for a delay greater than 2 hours and document this. Training was initiated by the CNO and completed on 10/31/2023. **ITEM #2**	Chief Nursing Officer	11/6/2023	The Chief Nursing Officer will monitor 100% of timed medications to confirm compliance with administering within 60 minutes and documentation if dose was missed and notification of physician if delay was greater than 2 hours. The Chief Nursing Officer will monitor 100% of pain interventions for a reassessment of pain to be completed in a timely manner and documented in HCS. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

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

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

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

December 6, 2023

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

Dear Ms. Arlt,

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

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

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

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

Sincerely,

Samantha Roe

Samantha Roe, MSN, RNS-OB
Survey Team Leader