STATE OF WASHINGTON
DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

Tuesday, August 15, 2023

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

Dear Mr. Wickel:

This letter contains information regarding the recent investigation at ***Inland Northwest Behavioral Hospital*** by the Washington State Department of Health. Your state licensing investigation was completed on Friday, June 30, 2023.

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

Each plan of correction statement must include the following:

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

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

You may receive notice of the Department's intent to take enforcement action against your license under RCW 71.24.037, 71.12, WAC 246-337-021 and WAC 246-341-0335 based on any deficiency listed on the enclosed report. Your submission of a Plan of Correction

or any other action you take in response to this Statement of Deficiency Report may be taken into consideration in an enforcement action but does not prevent the Department from proceeding with enforcement action.

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

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

Enclosures: Statement of Deficiency Report
Plan of Correction Instructions

Statement of Deficiency Report

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

Inland Northwest Behavioral Hospital, 104 W 5th Ave, Spokane, WA 99204-4880	Rylnn Wickel
Agency Name and Address	Administrator

Investigation	Tuesday, January 25, 2022	33894
Inspection Type	Investigation Start Date	Investigator Number
203-5196	BHA.FS.60894630	MH Evaluation & Treatment
Case Number	License Number	BHA/RTF Agency Services Type

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

Deficiency Number and Rule Reference	Findings	Plan of Correction
WAC 246-341-0640(1)(d)(ii, iv), Individual service record content. A behavioral health agency is responsible for the components and documentation in an individual's individual service record content unless specified otherwise in certification or individual service requirements. (1) The individual service record must include: (d) Individual service plan that: (ii) Addresses issues identified in the assessment and by the individual or, if applicable, the individual's parent(s) or legal representative; (iv) Must be mutually agreed upon and updated to address changes in identified needs and achievement of goals or at the request of the	Based on policy and procedure review, clinical record review, and interview, the agency failed to update a patient's individual service plan when needs were identified, for 1 of 1 patient reviewed (Patient #1). Failure to update a patient's individual service plan when needs are identified can result in missed treatment needs which can lead to poor treatment outcomes and potential patient victimization. Findings included: 1. Review of the agency's policy titled, "Treatment Planning," Policy# 10503953 revised 05/06/22, showed the following:	

individual or, if applicable, the individual's parent or legal representative;	a. The Master Treatment Plan (MTP) is to be completed within 72 hours of admission and updated at least once a week or sooner if warranted by clinical changes in condition or other factors. b. Each problem is linked to a specific individual treatment plan (ITP). c. A treatment plan update (TPU) is to be completed at least every seven days from completion of the MTP to include reviewing the MTP and each ITP and documenting progress toward short-term goals for each problem; any change in status of a problem; and any new active problems. d. MTPs or TPUs may be revised at any time when new information is obtained and can be documented by directly noting on the ITP and/or MTP along with the date, time, name, and signature of the person making the revision. e. If a scheduled TPU is not completed due to extenuating circumstances, it is to be completed the next working day with the reason for the delay documented. 2. Review of the agency's policy titled, "Sexual Aggression / Victimization Precautions," Policy# 10529879 revised 12/29/21, showed the following: a. The purpose of the policy is to provide a plan for the prevention of sexual behaviors including aggression and the potential for victimization by identifying early warning signs and implementing	

	intervention steps to minimize the risk of sexual behavior. b. The procedure includes nurses initiating a sexually inappropriate behavior treatment plan when a patient is identified as needing sexual victimization precautions (SVP) or sexual aggression precautions (SAP). 3. Review of the clinical record for Patient #1 showed that the patient was involuntary admitted to the facility on 09/05/22 and discharged on 09/22/22. The review showed that the patient was assessed to be at risk for sexual victimization on admit due to a recent sexual assault, and later during their stay for sexually aggressive behaviors. Review of the patient's treatment plan showed that the plan was never updated and did not address the patient's sexually aggressive behaviors based on the following: a. Review of the patient's document titled, "High Risk Notification Alert Form Inpatient," dated 09/05/22, showed that the patient had a history of sexual assault and was assessed to be at risk for sexual victimization. b. The review showed that the patient's sexual assault that occurred on 08/28/22 prior to admission was documented on 09/05/22 in the patient's "Standardized Intake Assessment" and their "Behavioral Health" document; on 09/06/22 in their "Nursing Admission Assessment" and "Psychiatric Evaluation"; on 09/08/22 in their "Adult Psychosocial Assessment"; and on 09/12/22 in their "Physician Daily Progress Note."	

	c. Review of the patient's document titled "Daily Nursing Flow Sheet," dated 09/11/22 at 6:00 AM, showed that it stated, "Patient is inappropriate with fellow patients on unit. Sexually suggestive with fellow patients, rolling around on furniture, touching fellow patients despite several attempts at redirection by staff…" d. Review of the patient's "Daily Nursing Flow Sheet," dated 09/12/22 at 6:30 AM, showed that it stated, "Patient is defiant, opposed unit rules, inappropriate touching and sexually suggesting with fellow patients...inappropriate touching and sexually suggesting with fellow patients… sexually suggestive dancing with fellow patients in the Noisy Activity room, despite attempts at redirection." e. Review of the patient's document titled, "Physician Daily Progress Note," dated 09/13/22 at 10:15 AM, showed that it stated that the patient "was observed being too close to male peers and making sexually suggestive statements…advised this behavior isn't OK for the hospital setting…" d. Review of the patient's document titled, "Initial Treatment Plan," dated 09/06/22 at 2:00 AM and signed by the patient on 09/05/22, showed that the box for "inappropriate sexual behavior" was checked for "none." The "risk of victimization" was checked for "sexual"; the interventions was "discuss with patient fears related to past trauma(s) and current triggers possible in hospital environment" upon admission and as needed; the target date was blank; and the staff responsible was "nursing." The plan showed it addressed suicidal/self-injurious behaviors; mood disturbance; risk of sexual victimization;	

	substance abuse; and medical problems. The treatment plan showed no updates from the initial date of 09/06/22 and discharge on 09/22/22 and did not address the patient's inappropriate sexual behaviors. e. The review showed no individual treatment plans linked to the master treatment plan. 4. During an interview on 05/24/23 at 9:30 AM with Staff B, Director of Risk, Staff B stated that review of Patient #1's record showed that it was documented that the patient had been sexually assaulted shortly before admitting to the facility but was not placed on sexual victimization precautions and was not placed on sexually aggressive behavior precautions after they were sexually provocative with other patients. 5. During an interview on 05/24/23 around 3:00 PM with Staff A, Director of Quality, when asked about Patient #1's clinical record showing no treatment plan updates for the 17 days Patient #1 was at the facility, Staff A stated that it had been brought to their attention.	

Plan of Correction Instructions

Introduction

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

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

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

An acceptable plan of correction must contain the following elements:

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

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

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

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

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

Checklist:

- Before submitting your plan of correction, please use the checklist below to prevent delays.
- Have you provided a plan of correction for each deficiency listed?
- Does each plan of correction show a completion date of when the deficiency will be corrected?

- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated what staff position will monitor the correction of each deficiency?
- If you included any attachments, have they been identified with the corresponding deficiency number or identified with the page number to which they are associated?

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

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

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

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

INLAND NORTHWEST BEHAVIORAL HEALTH HOSPITAL
Plan of Correction for state licensing investigation 2023-5196

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
WAC 246-341-0640(1)(d)(ii, iv)	**WAC 246-341-0640(1)(d)(ii, iv), Individual service record content**. A behavioral health agency is responsible for the components and documentation in an individual's individual service record content unless specified otherwise in certification or individual service requirements. (1) The individual service record must include: (d) Individual service plan that: (ii) Addresses issues identified in the assessment and by the individual or, if	**Item #1. #3, #5:** The Chief Executive Officer (CEO) reviewed the findings of this investigation and reviewed WAC 246-341-0640. The CEO reviewed the Treatment Planning Policy and Procedure. No changes were made to this policy at this time. The Chief Medical Officer, Chief Nursing Officer, and the Director of Clinical Services were retrained by the CEO to the Treatment Planning policy and procedure. The training focused on ensuring timely and thorough completion of treatment plan updates every 7 days or following a change in condition as well as ensuring individual medical or psychiatric individual plans were created for all identified active problems. Lastly, the training addressed the need for the treatment plan to include all identified problems. Attestations of understanding were completed and filed in employee files. The Chief Medical Officer facilitated a training for all medical staff. The Chief Nursing Officer facilitated a training for all nursing staff. The Director of Clinical Services facilitated a training for all clinical services staff. The training focused on a review of the Treatment Planning policy and procedure paying special attention to the following areas:	Chief Executive Officer Chief Medical Officer Chief Nursing Officer Director of Clinical Services	9/12/2023	The Director of Clinical Services will audit 30 records per month. Audit will include ensuing that all identified problems are addressed on the treatment plan, that treatment plan updates are completed timely every 7 days or following a change in condition and that all identified problems	Threshold for acceptable compliance : >90%

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	applicable, the individual's parent(s) or legal representative; (iv) Must be mutually agreed upon and updated to address changes in identified needs and achievement of goals or at the request of the individual or, if applicable, the individual's parent or legal representative;	• The Master Treatment Plan (MTP) is to be completed within 72 hours of admission and updated at least once a week or sooner if warranted by clinical changes in condition or other factors. • Each problem is linked to a specific individual treatment plan (ITP). • A treatment plan update (TPU) is to be completed at least every seven days from completion of the MTP to include reviewing the MTP and each ITP and documenting progress toward short-term goals for each problem; any change in status of a problem; and any new active problems. • MTPs or TPUs may be revised at any time when new information is obtained and can be documented by directly noting on the ITP and/or MTP along with the date, time, name, and signature of the person making the revision. • All identified active problems must be included in the treatment plan.			have a completed individual treatment plan. Monitoring will continue until 90% compliance has been achieved and sustained for 3 consecutive months. Thereafter, 30 records will be audited per quarter. Any instances of continued noncompliance will be	

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		Attestations of understanding were completed for all who attended the training, and they were placed in employee files.			addressed by the appropriate director to include re-education and corrective action when required. Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly	

Regulation Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
		Item #2, #4: The Chief Executive Officer (CEO) reviewed the findings of this investigation and reviewed WAC 246-341-0640. The CEO reviewed the Sexual Aggression/Victimization Precautions Policy and Procedure. No changes were made to this policy at this time. The CEO also reviewed the new policy Admission Order Process and revisions were made to include the Nurse accepting the patient will review the High-Risk Cue Form and sign it, they will review the Intake Assessment before doing their Nursing Assessment and will take the High-Risk Cue Form and assessments and order any Precautions that are needed from those assessments. The Chief Medical Officer, Chief Nursing Officer, Director of Intake and the Director of Clinical Services were retrained by the CEO to the Sexual Aggression/Victimization Precautions policy and procedure paying special attention to the need to provide a plan for the prevention of sexual behaviors including aggression and the potential for victimization by identifying early warning signs and implementing intervention steps to minimize the risk of sexual behavior. The procedure includes nurses initiating a sexually inappropriate behavior treatment plan when a patient is identified as needing sexual victimization precautions or sexual aggression precautions. The Chief Medical Officer,	Chief Medical Office Chief Nursing Officer Director of Intake Director of Clinical Services	9/12/2023	The Chief Nursing Officer will audit 30 patient records per month to ensure compliance with appropriate precautions implemented based off assessment findings and ensuring documentation on treatment plans when appropriate. Auditing will take place until 90%	Threshold for acceptable compliance: >90%

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		Chief Nursing Officer, and the Director of Clinical Services were directed to retrain all their clinical staff. All clinical staff were retrained by the Chief Medical Officer, Chief Nursing Officer, and the Director of Clinical Services to the Treatment Planning policy and procedure and the newly revised Admission Order Process policy and procedure paying special attention to the following areas: • The purpose of the policy is to provide a plan for the prevention of sexual behaviors including aggression and the potential for victimization by identifying early warning signs and implementing intervention steps to minimize the risk of sexual behavior. • The procedure includes nurses initiating a sexually inappropriate behavior treatment plan when a patient is identified as needing sexual victimization precautions (SVP) or sexual aggression precautions (SAP). • Intake staff will have the Nurse accepting the patient review the High-Risk Cue Form for Precautions needed and the Nurse will sign the form			compliance has been achieved and sustained for 3 consecutive months. Thereafter, 30 records will be audited per quarter. Any instances of continued noncompliance will be addressed by the Chief Nursing Officer with the identified staff to include re-	

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		• The Nurse, before doing the Nursing Assessment, will review the Intake Assessment and sign and document if needed on page 3 any precautions and/or observation changes needed. • The Nurse will take the High-Risk Cue Form and their Nursing Assessment and order any Precautions that are needed from their assessment. This newly revised policy and procedure was reviewed and approved by Governing Body on 8/18/23. Training was initiated and completed by 9/12/2023 Evidence of training is filed in staff's personnel file			education and corrective action when required.	

INLAND NORTHWEST BEHAVIORAL HEALTH HOSPITAL
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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

September 27, 2023

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

Re: Case Number: 2023-5196
License Number: BHA.FS.60894630
Acceptable Plan of Correction

Dear Mr. Wickel:

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

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

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

Investigator: 33894
Department of Health
HSQA/Office of Health Systems Oversight
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