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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>012699</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>06/28/2017</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><b>BHC FAIRFAX HOSPITAL NORTH</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>916 PACIFIC AVE FI 7<br/>EVERETT, WA 98201</b> |
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| L 000 | <p><b>INITIAL COMMENTS</b></p> <p><b>STATE LICENSING SURVEY</b></p> <p>The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 WAC Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey.</p> <p>Onsite dates: 6/27/2017 to 6/28/2017</p> <p>Examination number: 2017-1063</p> <p>The survey was conducted by:</p> <p>Tyler Henning, ScM, MHS, PHA</p> <p>Kimberly Metz, MSN, BSN, RN, who was in orientation at the time of survey.</p> <p>The Washington Fire Protection Bureau conducted the fire life safety inspection on 6/27/2017</p> | L 000 | <p>1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.</p> <p>2. EACH plan of correction statement must include the following:</p> <p>The regulation number and/or the tag number;</p> <p>HOW the deficiency will be corrected;</p> <p>WHO is responsible for making the correction;</p> <p>WHAT will be done to prevent reoccurrence and you will monitor for continued compliance; and</p> <p>WHEN the correction will be completed.</p> <p>3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 7/30/2017.</p> <p>4. Return the ORIGINAL REPORTS with the required signatures.</p> |  |
| L 345 | <p>322-035.1i POLICIES-PHARMACY</p> <p>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: (i) Pharmacy</p>   | L 345 |  |  |

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **CEO** (X8) DATE **7/25/17**

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| L 345   | <p>Continued From Page 1</p> <p>and medication services consistent with WAC 246-322-210;<br/>This RULE: is not met as evidenced by:<br/>Item #1 Safe Medication Administration</p> <p>.Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff members followed policy and procedures for safe medication administration.</p> <p>Failure to follow safe medication administration procedures puts patients at risk of receiving the wrong medication or treatment resulting in patient harm and/or death.</p> <p>Reference:<br/>Institute for Safe Medication Practice (ISMP):<br/>Guidance on the Interdisciplinary Safe Use of Automated Dispensing Cabinets, 2008.</p> <p>ISMP Core Process #8 requires organizations develop procedures to ensure the accurate withdrawal of medications from the automatic dispensing cabinet (ADC) which include guidelines that:</p> <ol style="list-style-type: none"> <li>1. Require that practitioners remove medications from the ADC one patient at a time.</li> </ol> <p>Findings included:</p> <ol style="list-style-type: none"> <li>1. Review of the hospital's policy and procedure titled, "Medication Administration," Policy Number 28, Effective Date: 3/01/17, showed the medication administration procedure requires medications be prepared for one patient at a time.</li> <li>2. On 6/27/2017 from 9:50 AM-10:15 AM, Surveyor #2 inspected the hospitals medication room. The observation showed three drinking cups containing unit dosed medications on the counter near the Pyxis® (an automatic dispensing</li> </ol> | L 345  |   |   |

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| L 345   | <p>Continued From Page 2</p> <p>cabinet). Each cup was labelled with a patient's first name and last initial (Patient #1, #2, and #3).</p> <p>3. At the time of this observation, during an interview with the Registered Nurse (Staff Member C) and the Nurse Manger (Staff Member D), the Registered Nurse stated that it was the medication administration procedure to remove multiple patients' medications from the Pyxis® ahead of time and then scan the medications into the electronic medication record prior to individual patient medication administration. Staff Member C stated that the medications were pulled from the Pyxis® in advance because it took a long time to pull them individually and patients were lined up at the window waiting for their medications. The Nurse Manger (Staff Member D) verified this was the procedure.</p> <p>4. On 6/27/17, at 1:00 PM, Surveyor #2 interviewed the hospital's Director of Pharmacy (Staff Member E) and the hospital's Pharmacist (Staff member F). During this interview, Staff Member E, stated it was "the standard of practice in behavioral health" to remove multiple patient medications from the Pyxis® prior to medication administration. The Pharmacist (Staff Member F) agreed this was the hospital's practice.</p> <p>Item #2</p> <p>Medication Disposal</p> <p>Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff members followed policy and procedures for disposal of medication after patient refusal to take medications.</p> <p>Failure to follow medications disposal procedures put patient at risk for receiving the wrong</p> | L 345  |   |   |

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| L 345   | <p>Continued From Page 3</p> <p>mediation resulting in patient harm and/or death.</p> <p>Findings included:</p> <p>1. Review of the hospital's policy and procedure titled, "Medication Administration," Policy Number 28, Effective Date: 3/01/17, showed that medications are to be administered immediately after the medication is prepared without a break in process by the individual who prepares the dose and the expiration date and the dose of the medication must be verified prior to administration. The procedure for managing unused or unusable medication was to return intact (sealed) medications to the patients' supply or pharmacy per hospital policy and to destroy unusable medications per hospital policy.</p> <p>2. On 6/27/2017 at 9:50 AM to 10:15 AM, Surveyor #2 inspected the hospitals medication room. The observation showed a medication cup containing a white oval pill sitting on the top of the Pyxis® (an automatic dispensing cabinet). The cup was labelled with a first name, a date, and the medication name Benztropine (a psychiatric medication used to treat Bipolar Disorder). Surveyor #2 noted there was no medication dosage, no medication expiration date, or patient last name written on the medication cup.</p> <p>3. At the time of this observation, during an interview with the Registered Nurse (Staff Member C), the Registered Nurse stated Patient #4 had refused the medication and she was going to try to administer it to him later. The Registered Nurse stated she had already scanned the medication and removed it from its original packaging before the patient refused.</p> <p>4. On 6/27/2017 at 10:08 AM the Registered Nurse (Staff Member C) left the medication room</p> | L 345  |   |   |



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| L 345   | Continued From Page 4<br><br>to administer medication to a different patient leaving the medication cup containing the pill unattended on top of the Pyxis®. The Registered Nurse (Staff Member C) returned to the medication room 10:14 AM.<br><br>5. On 6/27/17 at 10:14 AM, Surveyor #2 interviewed the Nurse Manager (Staff Member D). During this interview the Nurse Manager verified the opened and improperly labelled medication should have been disposed of. The Registered Nurse (Staff Member C) disposed of the medication at the time of the interview.  | L 345  |   |   |
| L 690   | 322-100.1A INFECT CONTROL-P&P<br><br>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: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by:<br><br>Based on observations and policy and procedure review the hospital failed to ensure staff members followed the hospital policy for hand hygiene.<br><br>Failure to perform hand hygiene after contact with potentially contaminated surfaces places patients and staff at risk of infection<br><br>Reference: Centers for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the | L 690  |   |   |

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| L 690 | Continued From Page 5<br><br>Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No. RR-16):[pg. 33]. "Recommendations: 1. Indications for handwashing or hand antisepsis. J. Decontaminate hands after removing gloves."<br><br>Findings:<br><br>1. The hospital policy titled, "Hand Hygiene" (Policy #1600.4.4, Rev. 3/2017), states that staff should perform hand hygiene following exposure to potentially contaminated environmental surfaces.<br><br>2. On 6/27/2017 from 9:40 AM to 10:07 AM, Surveyor #1 observed a housekeeper (Staff Member A) cleaning the dining room of the facility. The staff member did not conduct hand hygiene following glove changes on five separate observations.<br><br>3. On 6/27/2017 from 10:17 AM to 10:35 AM, Surveyor #1 observed a housekeeper (Staff Member A) perform a patient room cleaning to ready it for a patient arrival. During the procedure, the housekeeper cleaned the mattress and removed her gloves before retrieving clean linens to make the bed. She did not perform hand hygiene prior to handling the clean linens and making the bed. | L 690 |  |  |
| L 715 | 322-100.1E INFECT CONTROL-PROVISIONS<br><br>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: (f) Provisions for: (i) Providing consultation   | L 715 |  |  |

*[Handwritten Signature]*

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| L 715   | <p>Continued From Page 6</p> <p>regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This RULE: is not met as evidenced by: .Based on observation and interview the hospital failed to provide a sanitary environment to avoid sources and transmission of infections and communicable diseases.</p> <p>Failure to maintain a sanitary environment put patients and staff at increased risk of exposure to infectious organisms.</p> <p>References:</p> <p>APIC Guidelines for Infection Control Practice 4th Edition 2014 state, "supplies must be stored at least 8 inched off the floor ...removed from outside shipping cartons or corrugated cardboard before storage to prevent contamination with soil/debris that may be on cartons ... must ensure all objects and surfaces are decontaminated as a common strategy to reducing infection."</p> <p>Findings included:</p> <p>1. On 6/27/2017 from 9:50 AM-10:15 AM,</p> | L 715  |   |   |

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| L 715 | <p>Continued From Page 7</p> <p>Surveyor #2 inspected the hospitals medication room. The observation showed a corrugated cardboard box containing a stock of drinking cups and a corrugated cardboard box containing 12 bottles of Gatorade drink sitting on the floor.</p> <p>2. During this observation, Surveyor #2 observed a corrugated cardboard box containing eight drinking cups filled with patients' topical medications sitting on the counter.</p> <p>3. At the time of this observation, the Nurse Manager (Staff Member D), confirmed these findings, removed the cardboard boxes off the floor, and replaced the cardboard box containing the patient medications with one that could be washed and sanitized.</p> | L 715 |  |  |
| L 880 | <p>322-140.1i ROOM FURNISHINGS</p> <p>WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow;</p> <p>This RULE: is not met as evidenced by:</p> <p>Based on observation and interview, the hospital failed to ensure that patients had an easily cleanable mattress.</p> <p>Failure to provide an easily cleanable mattress places patients at risk of infection.</p>                            | L 880 |  |  |



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| L 880   | Continued From Page 8<br><br>Findings:<br><br>1. On 6/27/2017 from 10:17 AM to 10:35 AM, Surveyor #1 observed a cleaning procedure in patient room 702. During the procedure, the surveyor observed a mattress with large tears measuring approximately 3 feet in length. The tears caused the foam in the mattress to be exposed, making the mattress uncleanable..<br><br>2. A registered nurse (Staff Member B) confirmed the finding at the time of the observation and stated that the facility had placed a work order for new mattresses. | L 880  |   |   |

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| S 000              | <p><b>Initial Comments</b></p> <p>This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at BHC Fairfax Hospital on 6/27/2017 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) health survey teams.</p> <p>The facility has a total of 30 beds and at the time of this survey the census was 28.</p> <p>The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 483.70.</p> <p>The facility is a nine story structure of Type 1-fr 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.</p> <p>The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare &amp; Medicaid Services.</p> <p>The surveyor was:</p> <p>Donald L West<br/>Deputy State Fire Marshal</p> | S 000         |   |                    |
| S 353              | NFPA 101 Sprinkler System Maintenance and Testing   | S 353         |   |                    |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*R. Miranda* CEO

TITLE

(X6) DATE

7/25/17

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| S 353  | <p>Continued From page 1</p> <p>Sprinkler System - Maintenance and Testing<br/>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br/>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is not met as evidenced by:<br/>Based upon observations and staff interviews on 6/27/2017 between approximately 0830 and 1115 hours the facility has failed to maintain the fire sprinkler system as required. This could result in the failure of the fire sprinkler system to operate properly in the event of a fire and allow the fire to increase in size and intensity which would endanger the residents, staff and/or visitors within the facility.</p> <p>The findings include, but are not limited to:</p> <ol style="list-style-type: none"> <li>1. The sprinkler head in the service elevator lobby has bent fins.</li> <li>2. In the storage closet by resident room #716</li> </ol> | S 353  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BHC FAIRFAX HOSPITAL NORTH</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>916 PACIFIC AVE FI 7<br/>EVERETT, WA 98201</b> |
|---|--|

| (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 |
|--------------------|---|---------------|---|--------------------|
| S 353              | <p>Continued From page 2</p> <p>has storage that is to high and obstructs sprinkler coverage.</p> <p>The above was discussed and acknowledged by the facilities director.</p> | S 353         |   |                    |

**Fairfax Behavioral Health  
Plan of Correction for State Licensing  
BHC Fairfax Hospital North (012699)**

| Tag 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 |
|------------|---|---|--|------------------------------|--|--|
| L345       | <b>322-035.1i POLICIES-PHARMACY<br/>WAC 246-322-035 Policies and Procedures</b>     | All licensed nursing staff will be re-trained on appropriate labeling, dispensing, disposal, and return of medications, at a staff meeting on 7/27/17 by the Pharmacist and Nursing Leadership. Ongoing 1:1 training will take place as needed. The Pharmacist will conduct random weekly observations of medication passes to ensure compliance to policy. | Director of Pharmacy;<br>Director of Nursing | 7/27/17                      | Compliance will be monitored through random weekly observation of licensed staff during medication administration. The target for compliance is 100% | 98%  |
| L690       | <b>322-100.1A INFECT CONTROL – P &amp; P<br/>WAC 246-322-100 Infection Control</b>  | The Infection Preventionist or designee will train Environmental Services (EVS) employees on proper hand hygiene protocols, to include a review of the policy on hand hygiene, at the 07/27/17 staff meeting.   | Infection Preventionist                      | 7/27/17                      | Compliance will be monitored through daily infection control rounding of EVS employees. The target for compliance is 100%                            | 90%  |
| L715       | <b>322-100.1E INFECT CONTROL – PROVISIONS<br/>WAC 246-322-100 Infection Control</b> | The cardboard box was removed on 6/28/17. The Infection Preventionist or designee will train direct care employees on proper procedures for cleaning, disinfecting, and sterilizing hospital products and patient care areas. The Infection Preventionist or designee will also review the  | Infection Preventionist                      | 7/27/17                      | Compliance will be monitored through weekly audits to ensure proper sanitary procedures are being followed by staff during                           | 90%  |

POC Received: 7/28/17

POC Approved: 8/4/17

 8/4/17

**Fairfax Behavioral Health  
Plan of Correction for State Licensing  
BHC Fairfax Hospital North (012699)**

| Tag 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 |
|------------|---|---|------------------------------|------------------------------|---|--|
|            |   | importance of proper handling of cardboard boxes with nursing staff at the 07/27/17 staff meeting                                 |                              |                              | medication administration. The Infection Preventionist or designee will monitor the medication room daily to ensure proper handling of cardboard boxes is maintained. The target for compliance is 100% |  |
| L880       | <b>322-140.1j ROOM FURNISHINGS</b><br><b>WAC 246-322-140 Patient living areas</b> | All damaged mattresses will be replaced by 7/31/17. Effective 7/24/17, EVS staff inspect mattresses daily to identify any damage. | Director of Plant Operations | 7/31/2017                    | EVS Staff to notify Nursing Manager anytime a damaged mattress is discovered. The Nurse Manager will do random weekly inspections. The target for compliance is   | 90%  |

**Fairfax Behavioral Health  
Plan of Correction for State Licensing  
BHC Fairfax Hospital North (012699)**

| Tag 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 |
|------------|------------|--------------------------------------|---------------------------|------------------------------|---|--|
|            |            |                                      |                           |                              | 100%  |  |

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

Fairfax Behavioral Health  
Plan of Correction for State Licensing  
BHC Fairfax Hospital North (012699)

| Tag 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 |
|------------|---|---|--|------------------------------|--|--|
| L345       | <b>322-035.1i POLICIES-PHARMACY</b><br><b>WAC 246-322-035 Policies and Procedures</b>     | All licensed nursing staff were trained on appropriate labeling, dispensing, disposal, and return of medications, at a staff meeting on 7/27/17 by the Pharmacist and Nursing Leadership. Ongoing 1:1 training will take place as needed. The Pharmacist will conduct a competency skills assessment with the staff by 8/25/17. The required minimum level of proficiency is 90%. The Pharmacist will conduct random weekly observations of medication passes to ensure compliance to policy. | Director of Pharmacy;<br>Director of Nursing | 8/25/17                      | Compliance will be monitored through random weekly observation of licensed staff during medication administration. The target for compliance is 100% | 90%  |
| L690       | <b>322-100.1A INFECT CONTROL – P &amp; P</b><br><b>WAC 246-322-100 Infection Control</b>  | The Infection Preventionist trained Environmental Services (EVS) employees on proper hand hygiene protocols, including a review of the policy on hand hygiene, at the 07/27/17 staff meeting. At the time of the staff meeting, each attendee demonstrated competency by return demonstration. All staff met or exceeded the 90% proficiency level required to pass.  | Infection Preventionist                      | 7/27/17                      | Compliance will be monitored through daily infection control rounding of EVS employees. The target for compliance is 100%                            | 90%  |
| L715       | <b>322-100.1E INFECT CONTROL – PROVISIONS</b><br><b>WAC 246-322-100 Infection Control</b> | The cardboard box was removed on 6/28/17. The Infection Preventionist trained direct care employees on  | Infection Preventionist                      | 7/27/17                      | Compliance will be monitored through weekly  | 90%  |

Updated POC Received - 8/3/17



Fairfax Behavioral Health  
 Plan of Correction for State Licensing  
 BHC Fairfax Hospital North (012699)

| Tag 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 |
|------------|--|--|-------------------------------------|------------------------------|---|--|
|            |  | <p>proper procedures for cleaning, disinfecting, and sterilizing hospital products and patient care areas. The Infection Preventionist also reviewed the importance of proper handling of cardboard boxes with nursing staff at the 07/27/17 staff meeting. At the time of the staff meeting, each attendee demonstrated competency by return demonstration. All staff met or exceeded the 90% proficiency level required to pass.</p> |                                     |                              | <p>audits to ensure proper sanitary procedures are being followed by staff during medication administration. The Infection Preventionist or designee will monitor the medication room daily to ensure proper handling of cardboard boxes is maintained. The target for compliance is 100%</p> |  |
| L880       | <p><b>322-140.1i ROOM FURNISHINGS</b><br/> <b>WAC 246-322-140 Patient living areas</b></p> | <p>All damaged mattresses will be replaced by 7/31/17. Effective 7/24/17, EVS staff inspect mattresses daily to identify any damage.</p>   | <p>Director of Plant Operations</p> | <p>7/31/2017</p>             | <p>EVS Staff to notify Nursing Manager anytime a damaged mattress is discovered. The Nurse Manager</p>  | <p>90%</p>                                     |

**Fairfax Behavioral Health  
Plan of Correction for State Licensing  
BHC Fairfax Hospital North (012699)**

| Tag 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 |
|------------|------------|--------------------------------------|---------------------------|------------------------------|--|--|
|            |            |                                      |                           |                              | will do random weekly inspections. The target for compliance is 100% |  |

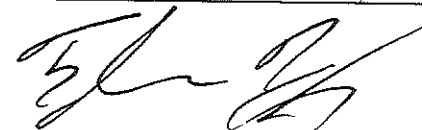
By submitting this Plan of Correction, the Fairfax Behavioral Health does not agree that the facts alleged are true or admit that it violated the rules. Fairfax Behavioral Health submits this Plan of Correction to document the actions it has taken to address the citations.

Fairfax Behavioral Health  
 Plan of Correction for State Licensing – Progress Report  
 BHC Fairfax Hospital North (012699)

| Tag Number | Deficiency  | How the Deficiency Was Corrected   | Responsible Individual(s)                    | Date of Completion | Results of Monitoring |
|------------|---|--|--|--------------------|-----------------------|
| L345       | <b>322-035.1i POLICIES-PHARMACY</b><br><b>WAC 246-322-035</b><br><b>Policies and Procedures</b>     | All licensed nursing staff were trained on appropriate labeling, dispensing, disposal, and return of medications, at a staff meeting on 7/27/17 by the Pharmacist and Nursing Leadership. Ongoing 1:1 training occurs as needed. The Pharmacist conducted a competency skills assessment with the staff effective 8/25/17. All trained staff met the required minimum level of proficiency of 90%. The Pharmacist conducts random weekly observations of medication passes to ensure compliance to policy.                                 | Director of Pharmacy;<br>Director of Nursing | 8/25/17            | 92%                   |
| L690       | <b>322-100.1A INFECT CONTROL – P &amp; P</b><br><b>WAC 246-322-100</b><br><b>Infection Control</b>  | The Infection Preventionist trained Environmental Services (EVS) employees on proper hand hygiene protocols, including reviewing the policy on hand hygiene, at the 07/27/17 staff meeting. At the time of the staff meeting, each attendee demonstrated competency by return demonstration. All staff met or exceeded the 90% proficiency level required to pass.   | Infection Preventionist                      | 7/27/17            | 90%                   |
| L715       | <b>322-100.1E INFECT CONTROL – PROVISIONS</b><br><b>WAC 246-322-100</b><br><b>Infection Control</b> | The cardboard box was removed on 6/28/17. The Infection Preventionist trained direct care employees on proper procedures for cleaning, disinfecting, and sterilizing hospital products and patient care areas. The Infection Preventionist also reviewed the importance of the proper handling of cardboard boxes with nursing staff at the 07/27/17 staff meeting. At the time of the staff meeting, each attendee demonstrated competency by return demonstration. All staff met or exceeded the 90% proficiency level required to pass. | Infection Preventionist                      | 7/27/17            | 100%                  |
| L880       | <b>322-140.1i ROOM FURNISHINGS</b><br><b>WAC 246-322-140</b><br><b>Patient living areas</b>         | All damaged mattresses were replaced effective 7/31/17. Effective 7/24/17, EVS staff now inspects mattresses daily to identify any damage.   | Director of Plant Operations                 | 7/31/2017          | 100%                  |

Progress Report Received: 9/26/17

PR Approved: 9/28/17

 9/28/17



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

August 4, 2017

Darcie Johnson  
Fairfax Behavioral Health  
10200 NE 132<sup>nd</sup> St  
Kirkland, WA 98034

Dear Ms. Johnson:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Fairfax Behavioral Hospital - North on 6/27/2017-6/28/2017. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 8/4/2017.

A Progress Report is due on or before 9/26/2017 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please mail this progress report to me at the following address:

Tyler Henning  
Department of Health, Investigations and Inspections Office  
P.O. Box 47874  
Olympia Washington, 98504-7874

Please contact me if you have any questions. I may be reached at (Team Leader's telephone number). I am also available by email at (Team Leader's email address)

Sincerely,

  
Tyler Henning  
Survey Team Leader