STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	11/16/2017

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FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

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L 000	INITIAL COMMENTS RECEIVED DEC 26 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection 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. Onsite dates: 11/14/17 to 11/16/17 Examination number: 2017-1688 The survey was conducted by: Robin Munroe, RS, PHA Cathy Strauss, BSN, RN The Washington Fire Protection Bureau conducted the fire life safety inspection on 11/15/17.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 12/22/17. 4. Return the ORIGINAL REPORT with the required signatures.	
L 440	322-040.5 ADMIN-MEDICAL DIRECTOR WAC 246-322-040 Governing Body and Administration. The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four	L 440		

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L 440	Continued From Page 1 hours per day; This RULE: is not met as evidenced by: . Based on interview and record review, the hospital's governing body failed to appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day. Failure to provide a medical director who directs and supervises medical treatment and patient care twenty-four hours per day puts patients at risk for inadequate or unsafe care. Findings included: On 11/15/17 at 3:30 PM, during an interview with the Facility Medical Staff Coordinator (Staff #2); the Facility Human Resources Manager (Staff #3); the Facility Human Resources Director (Staff #4); and the contracted Human Resources Business Partner (Staff #5), Surveyor #1 requested documentation of the Medical Director's appointment by the governing body. The surveyor was provided the Third Amendment to the Physician Employment Agreement for Medical Director for the Monroe Unit, signed 8/31/16. (The hospital is one of three individually state licensed psychiatric hospitals that is operated and managed by "the Facility.") Record review of the hospital's employment agreement with the medical director, showed that he serves as Medical Director for the Monroe Unit for "at least forty (40) hours per week." The employment agreement does not indicate that the medical director has responsibilty for directing and supervising medical treatment and patient care beyond a forty-hour week.	L 440		

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L 690	Continued From Page 2	L 690		
L 690	322-100.1A INFECT CONTROL-P&P 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: Based on interview and review of the hospital's Infection Control Plan, the hospital failed to establish an infection control plan specific to the hospital located in Monroe. Failure to have an infection control plan places patients, staff, and visitors at risk of infections. Findings included: 1. Review of the hospital's 2017 Infection Control Plan revealed that it did not address information related to the hospital situated in Monroe, Snohomish County, but rather only hospitals located in King County. 2. On 11/16/17 at 10:30 AM, during the Infection Control meeting, the Risk Manager (Staff #12) and the Infection Control Officer (Staff #15) acknowledged that the 2017 Infection Control Plan did not include assessments and or strategies specific to Monroe, Snohomish County. Cross-reference: Tag L-780	L 690		

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L 765	Continued From Page 3	L 765		
L 765	322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control. The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing staff and administrative staff, to: (d) Meet at regularly scheduled intervals, at least quarterly; This RULE: is not met as evidenced by: . Based on document review and interview, the hospital failed to hold regular infection control meetings. Failure to hold regular meetings prevents the dissemination of information to hospital employees regarding the prevention of infections. Findings included: 1. On 11/15/17 at 11:30 AM, Surveyor #2 reviewed Facility Infection Control Program meeting minutes for 2017. The surveyor noted there was a single instance of infection control surveillance attributed to the Monroe hospital, one of three individually state licensed psychiatric hospitals that is operated and managed by "the Facility." The surveyor requested minutes specific to the Monroe hospital. No additional meeting minutes were provided. 2. On 11/16/17 at 10:00 AM, during the Infection Control meeting, Surveyor #2 asked the Director of Nursing (Staff #7) and the Charge Nurse/Infection Control Nurse (Staff #14) about the frequency of Infection Control meetings at the Monroe hospital. Staff #7 and Staff #14 stated that	L 765		

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L 765	Continued From Page 4 the hospital does not hold regular infection control meetings. Staff #7 stated that the Facility holds quarterly Infection Control meetings that include information and concerns related to all three of the Facility's hospitals. Staff #7 attends the quarterly meetings and then shares any results or concerns that are specific to the Monroe hospital with the staff.	L 765		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: ITEM #1 - HANDWASHING SINKS Based on observation and interview, the hospital failed to provide a reliable source of running water for handwashing. Failure to ensure that on-demand access to running water at handwashing sinks places patients, staff, and visitors at increased risk of exposure to infectious microorganisms. Findings included: 1. On 11/14/17 at 10:40 AM, Surveyor #1 attempted to assess the water temperature at the handwashing sink in the patient dining room (room #725). The motion-activated water faucet did not provide water when the sensor was activated. The Facilities Director/Safety Officer (Staff #6) pointed out a red light flashing in the base of the faucet housing and suggested it indicated a problem with the battery for the motion sensor. Staff #6	L 780		

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L 780	Continued From Page 5 suggested the batteries for all the motion sensors throughout the hospital needed to be replaced and that he would place a work order to replace the batteries. 2. On 11/14/17 at 10:45 AM Surveyor #1 attempted to assess the water temperature at the handwashing sink in a patient rest room (room #709). The surveyor observed that the motion-activated water faucet did not provide water when the motion sensor was activated. 3. On 11/14/17 at 3:15 PM Surveyor #1 observed that the motion-activated water faucet in the rest room (room #833) for the Patient Seclusion Room did not provide water when the motion sensor was activated. On 11/15/17 at 8:00 AM, Surveyor #1 observed that the montion-activated water faucets for the dining room and patient rest room (rooms #725 & #709) were operating normally. Staff #6 stated that the batteries had been replaced in all motion-activated faucets in the hospital. ITEM #2 - UNSANITARY PAPER TOWEL STORAGE AT HANDWASHING SINKS Based on observation and interview, the hospital failed to ensure that clean, dry paper towels were readily available at patient handwashing sinks. Failure to ensure access to clean, dry paper towels at handwashing sinks places patients, staff, and visitors at increased risk of exposure to infectious microorganisms. Findings included: 1. On 11/14/17 at 2:15 PM, Surveyor #2 and the Director of Nursing (Staff #7) observed a	L 780		

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L 780	Continued From Page 6 handwashing sink with 4-5 folded paper towels resting on the faucet in the bathroom of patient room #830. The surveyor observed the towels to be damp. Staff #7 confirmed the finding and stated that the hospital was aware of the issue. 2. On 11/15/17 between 8:30 AM and 8:40 AM, Surveyor #1 and Staff #7 observed paper towels resting across the handwashing sink faucets (within the splash-zone) in the bathrooms of the following patient rooms: #810; #830; #816; #817; #822; and #829. 3. On 11/15/17 at 8:30 AM, Surveyor #1 interviewed Staff #7 about the lack of paper towel and soap dispensers in patient areas. Staff #7 stated that all wall-mounted dispensers in patient areas had been removed for patient safety. She stated that patients are provided paper towels and a 3-ounce bottle of liquid soap as needed, and upon request. ITEM #3 - UNSECURED E-CYLINDER OXYGEN TANKS Based on observation and interview, the hospital failed to secure and safely store oxygen tanks. Failure to safeguard pressurized gas tanks places patients, staff, and visitors at risk of injury from fire or explosion of a damaged tank. Findings included: 1. On 11/14/17 at 11:15 AM, Surveyor #1 and the Facilities Director/Safety Officer (Staff #6) observed 2 compressed oxygen e-cylinders lying unsecured and unsupported on the floor of the Consult Room (room #712). 2. On 11/14/17 at 2:00 PM, the surveyor and Staff	L 780		

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L 780	Continued From Page 7 #6 observed 2 of 3 compressed oxygen e-cylinders standing unsecured and unsupported in Central Supply (room #732). 3. On 11/14/17 at 2:00 PM, Surveyor #1 interviewed Staff #6 about storage of gas cylinders when not in use. Staff #6 acknowledged the oxygen cylinders had not been properly stored according to safety regulations; and stated that he would direct staff to secure all gas cylinders immediately.	L 780		
L1220	322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records. (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records; This RULE: is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure patient medical records had complete documentation in 4 of the 5 records reviewed (Patients # 2, #3, #4, #5). Failure to ensure medical records are complete places patients at risk for unmet care needs, and/or potential for patient harm. Findings included: 1. Hospital policy titled "Charting Requirements" policy #100.87, revised 1/2017, stated that each	L1220		

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L1220	Continued From Page 8 chart note needs to be signed, dated and timed to meet regulatory requirements. Writing needs to be legible and the writer's signature needs to be decipherable. 2. On 11/16/17 at 8:45 AM, Surveyor #2 reviewed the chart for Patient #2. During the review of documents regarding this patient's emergency room visit 10/25/17, the following omissions where noted: a. Psychosocial page dated 10/25/17 at 1338 (1:38 PM) was without the identity of the patient/patient label. b. Psychiatrist Progress Note was without date, time or patient identity. Physician signature without time/date (Staff #16). c. Psychiatrist Progress Note dated 10/25/17 at 1330 (1:30 PM) was without a patient label, and the history and physical questions were blank. d. Psychiatrist Progress Note was without date, time or patient identity. The Physician signature was without date or time. (Staff #16) e. The "Certification of Patient Transfer" record form was incomplete. The following items were not documented on the form: the full name and discipline of the patient escort; the time of patient transfer; the name of the hospital to which the patient was transferred; the time of the registered nurse's signature. 3. On 11/16/17 at 8:45 AM, Surveyor #2 reviewed the chart for Patient #3. Review of documents regarding the patient's emergency room visit of 11/7/17 at 11:00 AM showed the following: a. The "Certification of Patient Transfer" record	L1220		

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L1220	Continued From Page 9 dated 11/7/17 showed vital signs without pulse rate or temperature. b. The name and discipline of the staff member assigned to escort the patient to the emergency room was blank. c. There was no documented time of patient departure from the unit to Emergency Room. d. The name of the hospital to which the patient was to be transferred was blank. e. The name and discipline of the "ER Triage Nurse" who was contacted and informed of transfer was incomplete. f. The Physician's order to transfer the patient was not signed/dated/timed by a Registered Nurse as directed on the form. 4. On 11/16/17 at 8:45 AM, Surveyor #2 reviewed the chart for Patient #4. Review of documents regarding the patient's emergency room visit of 10/27/17 at 10:30 AM showed the following: a. On the "Certification of Patient Transfer" record, dated 10/27/17, the transfer staff failed to document any vital signs for the patient, as per policy. b. The name and title of the staff assigned to transfer the patient to the emergency room was incomplete; no last name or discipline was entered on on the form. c. The time of patient departure from the unit to emergency room was blank. d. The name of the hospital in which the patient was to be transferred remained blank.	L1220		

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L1220	Continued From Page 10 e. The spaces on the form for the date, time, and name and discipline of the "ER Triage Nurse" informed of transfer were blank. f. The signature of the Registered Nurse completing the transfer form was without date or time. 5. On 11/16/17 at 8:45 AM, Surveyor #2 reviewed the chart for Patient #5. Review of the emergency room transfer form, "Certification of Patient Transfer" for 11/9/17 at 10:00 AM showed the following: a. The name of the staff assigned to transfer the patient to the emergency room was incomplete. b. The time of patient departure to the emergency room was blank. c. The space on the form for the name and discipline of the ER Triage Nurse who was contacted and informed of transfer was blank. d. The signature of the Registered Nurse who completed the transfer form did not include the date or time as indicated on the form.	L1220		
L1255	322-200.3D RECORDS-TREATMENT PLAN WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (d) Comprehensive treatment plan; This RULE: is not met as evidenced by:	L1255		

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L1255	Continued From Page 11 Based on interview, review of patient records and review of hospital policies and procedures the hospital failed to ensure treatment plans were up to date for 1 of 4 records reviewed (Patients #2, #3, #4, #5). Failure to ensure care plans are kept current places patients at risk for delayed care, and potential for patient harm. Findings included: 1. Hospital policy titled "Treatment Planning," policy #1000.81 revised 1/2017, showed that care plans are to be updated at least once a week or sooner if warranted by clinical situations. 2. On 11/16/17 at 9:30 AM, Surveyor #2 reviewed the chart of a 77-year-old female patient admitted 10/24/17 for Depression Disorder. The patient complained of severe abdominal pain on 10/25/17 and then transferred to the Emergency Room where a urinary tract infection (UTI) was discovered. The patient returned on the same day with orders for an antibiotic. As of 11/2/17 there were no updates to the care plan to add the urinary tract infection and nursing interventions. 3. On 11/16/17 at 9:30 AM, the Director of Nursing (Staff #7) acknowledged the above finding.	L1255		
L1375	322-210.3C PROCEDURES-ADMINISTER 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	L1375		

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L1375	Continued From Page 12 and rules, including: (c) Administering drugs; This RULE: is not met as evidenced by: . Based on observation, interview and review of policies and procedures, the hospital failed to ensure staff members followed policies and procedures for safe medication administration. Failure to follow safe medication administration procedures puts patients at risk of receiving the wrong medications or wrong treatment resulting in patient harm and/or death. Findings included: 1. Hospital policy titled "Medication Administration," Policy #1000.37 revised 4/17, showed that the medication nurse will scan each medication package prior to administration; will utilize two patient identifiers to positively identify patient prior to administration, i.e. ask patient for name and date of birth, check the patient photograph or check the patient's identification band. Staff are to verify the patient's allergies prior to med administration. 2. On 11/15/17 between 8:00 AM and 8:25 AM, Surveyor #2 observed medication administration with the Traveling Nurse (Staff #11) and Staff Nurse (Staff #13). Surveyor #2 observed the following: a. Patient #2 arrived at the medication window for morning medications. Staff #13 greeted the patient by first name, verbally reviewed medications with patient, scanned medications, then opened meds and delivered to the patient with a glass of water. Staff #13 did not use two patient identifiers or validate patient allergies prior to medication administration, per hospital policy.	L1375		

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L1375	Continued From Page 13 b. Patient #3 was observed at the medication administration window. The nurse (Staff #11) asked the patient to spell their last name while the nurse reviewed the patient's medication administration record (MAR) in the Pyxis (an electronic medication record). There was no patient photograph in the computer record. The traveling nurse (Staff #11) administered the medications without using two patient identifiers or validating patient allergies as required by hospital policy. c. Patient #1 was observed at the medication administration window. Staff #11 administered medication without following the hospital policy to "utilize two patient identifiers to positively identify the patient prior to administration.	L1375		
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 RULE: is not met as evidenced by: ITEM #1 - HANDWASHING Based on observation, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to ensure that all staff who serve food follow appropriate handwashing procedures puts patients and staff at risk for foodborne illness. Findings included:	L1485		

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(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
L1485	Continued From Page 14 On 11/14/17 at 11:50 AM, Surveyor #1 and the Facilities Director/Safety Officer (Staff #6) observed as a Certified Nursing Assistant (CNA) (Staff #8) prepared the patient dining room for lunch service by clearing the tables from an earlier lunch shift. The observation showed that Staff #8 failed to perform handwashing before or after clearing the tables. On 11/14/17 at 12:15 PM, Surveyor #1 observed as a Program Specialist (Staff #9) collected a patient tray from the dining room for delivery to a patient's room. The observation showed that Staff #9 did not perform handwashing prior to collecting the patient tray. Reference: Washington State Retail Food Code, WAC 246-215-02310 ITEM #2 - FOOD WORKER CARDS Based on interview, the hospital failed to ensure that all staff who serve food to patients have received food safety training as required by the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to ensure that staff who serve food have appropriate knowledge and training puts patients at risk of foodborne illness. Findings included: On 11/15/17 at 3:30 PM, Surveyor #1 met with the Facility Medical Staff Coordinator (Staff #2), the Facility Human Resources Manager (Staff #3), the Facility Human Resources Director (Staff #4), and the dietary service contractor's Human Resources Business Partner (Staff #5). Surveyor #1 requested documentation that the staff who were	L1485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	11/16/2017

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L1485	Continued From Page 15 observed serving food to patients had obtained Food Worker Cards as required (a CNA [Staff #8] and a Program Specialist [Staff #9]). Staff #3 stated that neither Staff #8 nor Staff #9 had been asked to obtain Food Worker Cards; and that the Human Resources staff were not aware of the requirement. Reference: Washington State Retail Food Code, WAC 246-215-01115(47); WAC 246-215-02120(1)	L1485		
L1565	322-240.4A LAUNDRY-WATER TEMPERATURE WAC 246-322-240 Laundry. The licensee shall provide: (4) When laundry is washed on the premises: (a) An adequate water supply and a minimum water temperature of 140 F in washing machines; This RULE: is not met as evidenced by: Based on observation and interview, the hospital failed to ensure the water supply used for on-site patient laundry services reaches a minimum temperature of 140 degrees Fahrenheit. Failure to use adequate wash temperatures places patients at risk of illness due to insufficient reduction of microbial contamination in patient laundry. Findings included: 1. On 11/14/17 at 11:20 AM, Surveyor #1 observed the Patient Laundry (room # 713). The surveyor asked the Facilities Director/Safety Officer (Staff #6) about patient use of the laundry facility. Staff #6 stated that patients launder their own clothes under staff supervision. Surveyor #1 requested a copy of a Patient Laundry Policy but	L1565		

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	012792	A. BUILDING _____ B. WING _____	11/16/2017

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L1565	Continued From Page 16 one was not provided. 2. On 11/14/17 at 12:45 PM, Surveyor #1 asked the contracted Plant Operations Manager (Staff #10) about the hot water supply to the hospital and whether the hot water supplied to the Patient Laundry reached 140 degrees Fahrenheit as required. Staff #10 stated that two water heaters and a storage tank supplied water for the hospital, and that the hospital maintained the daily water temperature between 116 - 118 degrees Fahrenheit. 3. On 11/14/17 at 2:15 PM, Surveyor #1 observed a notice to nursing staff titled "Unit Update 1/27/16 LAUNDRY" on a bulletin board in the Soiled Utility (room #804). Under the heading, "PATIENTS BLANKETS, SHEETS, PILLOW CASES, TOWELS (hand/washcloths) PATIENT SCRUBS:" the notice said, "Please note; we are unable to wash these items in our wash machines due to the water not being hot enough."	L1565		

original submission revd 12-26-17
revised submission revd 01-17-18
approved 01-17-18
Robin Munroe

POC approved 1/19/18

RECEIVED
JAN 17 2018
DEPARTMENT OF HEALTH
Office of Investigations and Inspections

Plan of Correction for State Licensing
Fairfax Behavioral Health Monroe (012792) – L765 and L1485 revised 1/17/18

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
L 440	**322-040.5 ADMIN-MEDICAL DIRECTOR** **WAC 246-322-040 Governing body and administration.** (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day.	The Physician Employment Agreement for the Interim Chief Medical Officer was amended to include appointment as the medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day. The document will be finalized when signed and the approval process is complete.	Interim Chief Medical Officer	12/22/17	The Executive Assistant will review the contract at least annually and when any relevant personnel changes occur to ensure compliance.	100%
L690	**322-100.1A INFECT CONTROL – P & P** WAC 246-322-100 Infection control. (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (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.	The Infection Control Plan for Monroe was developed by the Infection Preventionist and Primary Care Lead to include Snohomish County effective 12/13/17. The plan was approved by the	Infection Control Practitioner; Primary Care Lead	12/22/17	Infection Control Practitioner will ensure that the plan is reviewed (and updated as needed) monthly, shared at the monthly infection control meeting, and documented	100%

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		Infection Control Committee Meeting on 12/14/17.			in the minutes. The Infection Control Practitioner and Primary Care Lead will audit the meeting minutes on a monthly basis. The Infection Control Plan will be presented at least annually to the Infection Control Committee and Quality Council.	
L765	**322-100.3D INFECT CONTROL – MEETINGS WAC 246-322-100 Infection Control.** (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multidisciplinary representatives from the professional staff, nursing staff and administrative staff, to: (d) Meet at regularly scheduled intervals, at least quarterly.	The Fairfax Monroe Infection Control meeting will be held monthly starting 12/18/17. The Infection Control Designee for Fairfax Monroe appointed by the Primary care lead will run the monthly meeting starting	Primary Care Lead; Infection Preventionist	12/23/17	The Fairfax Monroe Monthly Infection Control Meeting is now a standing agenda item on the monthly Fairfax Infection Control Committee (all sites). The Fairfax Monroe Infection Preventionist will	100%

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		12/18/17. The Monroe Infection Control Committee Members are as follows: 1. The Primary care Lead (Dr. Eric Roedel) 2. The Nurse Manager (Shelly Donnelly RN) 3. The Charge Nurse (Infection control Officer- Angie Nelson RN) 4. The Pharmacist (Mohammed Shawish) The Fairfax Monroe Infection Control concerns will be addressed separate			ensure the monthly meeting minutes are presented at the monthly Fairfax Monroe Infection Control Committee Meeting. The Primary Care Lead will audit the minutes on a quarterly basis.	

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		from other Fairfax hospitals through utilization of the Infection Control Committee that has been set up in Monroe to handle all infection control issues specific to Monroe. Any issue of concern will be addressed at the monthly Infection Control Committee Meeting by these committee members and this will be documented in the minutes.				
L780	**322-120.1 SAFE ENVIRONMENT** **WAC 246-322-120 Physical environment.** The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors. Item#1: Handwashing Sinks Item #2 Unsanitary Paper Towel Storage at Handwashing Sinks	The Director of Plant Operations oversaw the replacement of the faucet batteries on 11/15/17. The Director of Plant Operations or designee will install	Director of Plant Operations	1/4/18	Compliance to be monitored during on-going monthly EOC Rounding for a minimum of 3 months. Faucet batteries now on an annual	90%

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	Item #3: Unsecured E-Cylinder Oxygen Tank	recessed shelves for paper towels by 1/14/18. Extra oxygen carts for securing oxygen cylinders were delivered on 12/14/17. Staff were retrained by the Director of Plant Operations regarding the requirement to secure and safely store oxygen tanks effective 12/8/17.			Preventative Maintenance schedule to be replaced annually.	
L1220	**322-200.1A RECORDS MANAGEMENT** **WAC 246-322-200 Clinical records.** (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records;	The Nurse Manager will re-educate nursing staff, in-person, at staff meetings on the ED transport documentation and specifically, the Certification of Patient Transfer Form, by 12/18/17. All staff will sign an acknowledgement as	Director of Nursing; Interim Chief Medical Officer; Director of Clinical Services (DCS); HIM Manager	1/15/17	Nurse Manager or Charge RN will audit all ED transports to assess documentation compliance for a minimum of 3 months. DCS or Case Management Leads will	90%

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		attestation of the training. The ED Transfer policy will be updated to reflect current process and approved at Quality Council. The Director of Clinical Services will re-train the Case Managers on 12/21/17 in-person at a Case Management Team Meeting on the requirement for patient identifiers on ALL pages of psycho-social assessment and reinforce need to do so with stickers provided in charts. The Interim Chief Medical Officer will re-train provider to ensuring medical records are complete			monitor for real-time compliance for a minimum of 3 months by attending treatment team meetings where stickers can be observed to be placed on all pages in preparation of the CM meeting with newly admitted patients to complete the assessment. Provider documentation will be audited for completeness at monthly peer review meetings for a minimum of 3 months. It is also audited as part of the on-	

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		including signing, dating, and timing entries via e-mail by 12/15/17 and in-person at Medical Staff Meeting on 1/4/18.			going monthly CMS B-Tag audits.	
L1255	**322-200.3D RECORDS – TREATMENT PLAN** **WAC 246-322-200 Clinical records.** (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (d) Comprehensive treatment plan.	All RNs will be re-educated by the Nurse Manager in-person at a staff meeting on updating treatment plans, with a signed acknowledgement by 12/18/17.	Director of Nursing	12/18/17	Nurse Manager/Charge RN to audit at end of each shift for a minimum of 3 months with a goal of 90%.	90%
L1375	**322-210.3C PROCEDURES – ADMINISTER 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: (c) Administering drugs.	All RNs will be re-educated by the Nurse Manager, in-person, at staff meetings on the 5 rights of medication administration, with a signed acknowledgement and required return demonstration by 12/18/17. The Nurse	Director of Nursing	1/8/18	Medication administration will be spot checked by Nurse Manager weekly for a minimum of 3 months to ensure compliance.	90%

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		Manager will update the medication administration policy regarding allergy verification and re-educate staff on this change by 1/8/18. The policy will presented to Quality Council for approval.				
L1485	**322-230.1 FOOD SERVICE REGS** **WAC 246-322-230 Food and dietary services.** (1) Comply with chapters 246-215 and 246-217 WAC, food service; Item #1: Handwashing (CNA and PS) Item #2: Food Worker Cards	As part of an agreement with Evergreen Monroe, Evergreen Monroe food service workers provide food service to Fairfax Monroe patients. All food and beverage products, unwrapped cutlery (plastic or metal), and all dishes will be handled by the Evergreen Monroe Dietary Aides only, effective 12/22/17. The Dietary	Chief Operating Officer		This process change will be spot checked weekly for a minimum of 3 months by the Nurse Manager or Charge Nurse, and documented on a log to ensure compliance. Food service workers will be monitored for hand hygiene compliance by the Infection	95%

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		Coordinator at Evergreen Monroe will train staff, in-person by 12/22/17. Any patient requests for more food or beverages will be directed to the Dietary Aides. Fairfax Monroe staff will not handle uncovered food or beverage products, unwrapped cutlery (plastic or metal), or dishes.			Control Officer or designee on a random basis during meal times, at a minimum weekly. Any food service worker who is non-compliant with hand hygiene requirements will receive immediate re-training. Monitoring will be reported to the Infection Control Committee. The Fairfax Monroe Nurse Manager will verify that all food service workers designated to	

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					service the patients in Monroe have the current food worker card, at least annually. Monitoring will be reported to the Infection Control Committee.	
L1565	**322-240.4A LAUNDRY – WATER TEMPERATURE WAC 246-322-240 Laundry.** (4) When laundry is washed on the premises: (a) An adequate water supply and a minimum water temperature of 140°F in washing machines	The Director of Plant Operations will ensure the installation of a point of use electric water heater to boost the temperature up to 140°F.	Director of Plant Operations	1/15/18	Compliance to be monitored during monthly EOC Rounding for a minimum of 3 months.	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.