STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

Friday, October 27, 2023

Fairfax Behavioral Health – Kirkland E&T
10200 NE 132nd Street
Kirkland WA 98034-2899

Dear Janet Huff:

This letter contains information regarding the recent investigation at Fairfax Behavioral Health - Kirkland E & T by the Washington State Department of Health. Your state licensing investigation was completed on Tuesday, September 26, 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: JAMC03
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

Fairfax Behavioral Health – Kirkland E&T
10200 NE 132nd Street
Kirkland WA 98034-2899
Agency Name and Address

Janet Huff
Administrator

Investigation
Inspection Type

07/26/23
Investigation Start Date

JAMC03
Investigator Number

2023-8800
Case Number

BHA.FS.60874579
License Number

Mental Health
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
246-341-0420(12)(a) Agency policies and procedures. Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following as applicable: (12) Reporting critical incidents. A description of how the agency directs staff to report to the department within 48 hours any critical incident that occurs involving an	Based on observation, interview, facility document review, individual service record review, and policy and procedure review, the administrator failed to implement policies and procedures that addressed the reporting of incidents of allegations of abuse or neglect to the Department of Health (DOH) within 48 hours and failed to implement policies and procedures that addressed determining patient’s mental capacity to consent to sexual activity. Failure to implement policies and procedures that address the reporting of incidents of abuse or neglect to DOH within 48 hours, and failure to implement policies and procedures that addressed determining patient’s	

individual, and actions taken as a result of the incident. A critical incident is a serious or undesirable outcome that occurs in the agency including: (a) Allegations of abuse, neglect, or exploitation.	mental capacity to consent to sexual activity, can result in a lack of agency oversight and poor patient care and patient harm. Findings included: 1. Review of the facility policy and procedure titled, "Suspected or confirmed cases of Patient Sexual Activity, 1000.30", dated 06/2023, showed that the facility had a list of steps staff were instructed to follow "in case of suspected or confirmed patient sexual activity." Review of the document showed that several terms were defined, including the term "mental incapacity" which was defined as "…the condition existing at the time of the offense which prevents a person from understanding the nature or consequences of the act of sexual intercourse whether that condition in produced by illness, defect, the influence of a substance or from some other cause." Review of the policy showed that "if the licensed nurse or provider has reasonable cause to believe that a patient who is unable to consent has suffered abuse or neglect, he or she shall report such incident…to the proper law enforcement agency." Review of the policy showed that the policy does not state how the facility determines or documents "mental incapacity." Review of the policy showed that the Director of Risk Management or designee will "as appropriate" report to "outside agency / authority". 2. Review of the facility policy and procedure titled, "Sentinel Event Review and Reporting, P1-003", dated 04/2023, showed that policy included a list of events that were reportable to DOH. The list included sexual assault and alleged abuse. Review of the policy	

	showed that it stated "Consent is defined by WAC 504-26-221 as clear, knowing, and voluntary at the time of the act, and throughout the sexual contact, all parties actively express words or conduct that a reasonable person would conclude demonstrates clear permission regarding willingness to engage in the activity. Consent is active; silence or passivity is not consent. Even if words or conduct alone seem to imply consent, sexual activity is nonconsensual when: …A reasonable person would or should know that the other person lacks the mental capacity* at the time of the sexual activity to be able to understand the nature or consequence of the act, whether that incapacity is produced by illness, defect, the influence of alcohol or another substance, or some other cause. When alcohol or drugs are involved, a person is considered incapacitated or unable to give valid consent if the individual cannot fully understand the details of the sexual interaction (i.e., who, what, when, where, why, and how) and / or the individual lacks the capacity to reasonably understand the situation and to make rational, reasonable decisions. *Mental Capacity is defined by RCW9A.44.010 as that condition existing at the time of the offense which prevents a person from understanding the nature or consequences of the act of sexual intercourse whether that condition is produced by illness, defect, the influence of a substance or from some other cause." 3. At approximately 1:15 PM on 08/24/23, Investigator #1, Investigator #2, and Staff F, Risk Manager, observed video footage of an alleged incident involving Patient #5 and Patient #7 that occurred starting on 07/23/23 at 11:58 PM. Review of the video footage showed that Patient #5 and # 7	

	engaged in oral and vaginal sex in the dayroom from approximately 11:58 PM to 12:03 AM. 4. Review of the facility document titled, “Suspected In House Abuse / Neglect / Sexual Activity Response Checklist”, dated 07/28/23, showed that “NA [Not Applicable]” was written next to the checklist items “Call police, as applicable” and “Notify the corporate Clinical Director to determine regulatory reporting (Child / Adult Protective Services, State Health Services, etc.) Make reports as directed.” 5. Review of Patient #7’s individual service record document titled, “Petition for Initial Detention,” dated 07/23/2023, showed that Patient #7 was found to be “in imminent danger due to grave disability” and “presents an imminent likelihood of serious harm to others.” Review of the document showed that Patient #7’s parent reported that Patient #7 “was getting sexual toward [their] father” and “…even when not psychotic [they] will misread social cues, and take things sexually.” 6. Review of Patient #7’s individual service record document titled, “Petition for 14 Day Involuntary Treatment”, dated 07/28/23, showed that a Medical Provider from the facility documented that Patient #7 “…has no insight or plan to care for essential needs of health and safety”. The document indicated that Patient #7 is “gravely disabled…as a result of a mental disorder is in danger of serious physical harm, resulting from a failure or inability to provide for his/her essential human needs of health or safety and / or manifests severe deterioration in routine functioning evidenced by repeated and escalating	

	loss of cognitive or volitional control over his / her actions…” 7. Review of Patient #5’s individual service record document titled, “Psychiatric Evaluation”, dated 06/09/23, showed they were “detained on an involuntary hold as gravely disabled.” Review of the document showed that the “admission diagnosis” included “Psychosis (not otherwise specified), Rule out schizophrenia (unspecified type), Rule out schizoaffective disorder (bipolar type versus depressed type).” 8. During an interview on 08/23/23 at 4:30 PM with Staff A, Director of Risk Management, Staff A stated that they did not report the incident to DOH that occurred between Patient #5 and #7 beginning at 11:58 PM on 07/23/23. Staff A stated that they did not report the incident because it was considered consensual sexual activity. 9. During an interview on 08/24/23 at approximately 3:30 PM with Staff A, the Investigators asked how the facility made the determination that the incident in the dayroom involving Patients #5 and #7 did not need to be reported to DOH. Staff A stated that the “RCA” (Root Cause Analysis) information was routed to their legal advisors and that “this one doesn’t need to go to DOH because no one said that they were assaulted.” Staff A stated that the event was an adverse event but wasn’t reportable to DOH. 10. During the interview on 08/24/23 at approximately 3:30 PM with Staff A, Staff A held a paper copy of “Suspected or Confirmed Cases of Patient Sexual Activity”, dated 06/2023, and stated	

	that they had followed the policy (during the investigation into the incident involving Patient # 5 and #7). Investigator #2 asked if a patient's mental status was included in the decision-making process to determine if a report to DOH was required. Staff A stated that facility's Medical Providers had input in the decision and that "the police, no one is saying they were assaulted. Consent is a funny thing…no one said this person isn't competent and they need a guardian…" 11. Review of the individual service records for Patient #7 showed a "Consultation" note, dated 07/25/23, that showed the reason for the consult by a Medical Provider with Patient #7 was "Sexual allegation, oral sex." Review of the note showed the provider documented, "Patient reportedly had oral sex with another patient" and the provider asked the "patient about what happened on 07/23/23, patient states 'I was under psychotic break out, was not understanding what was happening.'" 12. At approximately 2:25 PM on 08/23/23, Investigator #1, Investigator #2, and Staff A, Director of Risk Management, observed video footage of the alleged incident involving Patient #1 and Patient #2 that occurred on 07/08/23. Review of the video footage showed that Patient #1 was in the unit hallway at 11:10 AM along with several staff and several other patients. Review of the video showed that staff were working with other patients in the hallway and Patient #1 went into the bedroom of Patient #2 without being noticed by staff. Review of the video showed that a staff member entered Patient #2's bedroom at approximately 11:11 AM. Staff A stated that the staff that entered the room	

	was Staff G, Medical Provider. Staff A stated that Staff G reported that Patient #2 sat up in bed, then stood up. Staff G noticed there was someone else in the bed and discovered Patient #1 also in the bed. Staff A stated that Staff G reported that Patient #1 was "naked from the waist down" and that Patient #1 reported that they touched Patient #2's "boob" and was interrupted before anything else occurred. 13. During an interview on 08/23/23 at 9:00 AM, Staff A, Director of Risk Management, stated that they had reported to DOH the incident that occurred on 07/08/23 involving Patient #1 and Patient #2, and reported the incident later than the 48-hour required timeline. Investigator #1 asked if the facility reported all cases of alleged abuse, Staff A responded that the facility does not report all cases of alleged abuse to DOH. Staff A stated that they may not report allegations of abuse that are internally investigated and result in no evidence of abuse having occurred. 14. Review of a printout of an email provided to the Investigators by Staff A, dated 07/12/23, from DOH to the facility, showed that DOH did not receive the incident report from the facility within 48 hours. Review of the email showed that DOH received an incident report from the facility on 07/12/23 regarding the incident that occurred between Patient #1 and #2 on 07/08/23. 15. Review of the DOH database that tracks facility incident reports showed that the facility did not report the incident involving Patient #5 and Patient #7 that occurred on 07/23/23.	
WAC 246-341-0640(1)(d)(iv) Individual service record content. A behavioral health	Based on interview, individual service record review, and policy and procedure review, the agency failed to	

agency is responsible for the components and documentation in an 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: (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.	ensure that individual service records included a treatment plan that was updated to address changes in identified patient needs for 2 of 7 patient records reviewed (Patients #1 and #2). Failure to ensure individual service records include a treatment plan that is updated to address changes in identified patient needs can result in patient needs going unmet, poor patient care and poor patient outcomes. Findings included: 1. Review of the facility policy and procedure titled, "Interdisciplinary Patient Centered Care Planning 1000.81", dated 06/2023, showed that the facility provided services to patients based on an individualized treatment plan. Review of the policy showed that a Nurse would complete an initial treatment plan within 8 hours of admission, and a multidisciplinary treatment plan would be completed within 72 hours of admission. Review of the policy showed that treatment plan revisions would be conducted for multiple reasons, including when "A new impairment / problem or significant information about an existing impairment is identified" and "A major change occurs in the patient's clinical condition…" 2. During an interview on 08/23/23 at approximately 3:00 PM, Staff C, Director of Clinical Services, stated that they had recently started working at the facility. Staff C stated that they were working on "program evaluation" and reviewing incident reports to determine the facility processes around incidents. Staff C stated that Nurses and Medical Providers	

	would bring information about incidents to treatment team meetings. Staff C stated that there is a delay in incident information being relayed to the treatment team. Staff C stated that treatment plan updates aren't always occurring when significant events occur, and that increases or decreases in observation are not immediately added to the treatment plan. Staff C stated that the treatment plan format was difficult to use and there was not enough room to thoroughly document treatment planning. 3. Review of the individual service record for Patient #1, document titled, "Sexual Boundaries Individual Treatment Plan," with an initial date of 06/17/23, showed that Patient #1 had "Inappropriate or sexualized behaviors: masturbating / disrobing in public." Review of the patient's "Sexual Boundaries Individual Treatment Plan" was not updated with information about the event that occurred on 07/08/23 that involved Patient #1 entering another patient's room and allegedly having sexual contact with Patient #2. 4. Review of the individual service record for Patient #2, document titled, "Sexual Boundaries Individual Treatment Plan," with an initial date of 07/07/23, showed that staff documented that the treatment plan had been initiated due to "[Patient #2] Disrobing in the community / Milieu." Review of the "Sexual Boundaries Individual Treatment Plan" showed that it was not updated with information about the event that occurred on 07/08/23 that involved Patient #2 allegedly having sexual contact with Patient #1. The fields of "Inappropriate or sexualized behaviors, Poor boundaries" and "History of sexual victimization or / or exploitation" were all blank.	

WAC 246-341-1131(2)(b)(ii) Involuntary behavioral health residential and inpatient services – Certification standards. An agency providing involuntary behavioral health services must: (b) Ensure that services are provided in a secure environment. “Secure” means having: (ii) Visual monitoring, in a method appropriate to the individual. **WAC 246-341-0600(2)(d-e) Clinical—Individual rights.** (2) Each agency must protect and promote individual participant rights applicable to the services the agency is certified to provide in compliance with this chapter, and chapters 70.41, 71.05, 71.12, 71.24, and 71.34 RCW, as applicable…the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. “You have a right to:” (d) Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises…(e) Be free of any sexual harassment.	Based on observation, interview, individual service record review, and policy and procedure review, the agency failed to provide visual monitoring in a method appropriate to the individual, for 3 of 7 patients records reviewed (Patients #1, #5, and #7); and failed to protect and promote individual participant rights, including ensuring all patients were free from sexual harassment, in an environment that protected each patient’s right to be respected and treated with dignity for 4 of 7 patients reviewed (Patients #1, #2, #5, and #7). Failure to provide visual monitoring in a method appropriate to the individual; and failure to protect and promote individual participant rights, including ensuring all patients were free from sexual harassment, in an environment that protects each patient’s right to be respected and treated with dignity, can lead to poor patient care and patient harm. Findings included: 1. Review of the facility policy and procedure titled, “Sexual Aggression / Victimization Precautions, 1000.80”, dated 06/2023, showed that it was facility policy to “provide safety precautions for a safe, therapeutic environment of care which includes the prevention of patient-to-patient sexual incidents, as well as verbal/ physical threats of sexual incidents.” Review of the policy showed that patients would be assessed for sexual aggression or sexual victimization at intake and staff would document a “High Risk Notification” of “either Sexual Aggression and / or Sexual Victimization, as appropriate.” Review of the policy showed that staff would document the “signature / dates and time of hand off for both Intake staff and Unit RN at time of hand off” when a	

	patient with a high-risk notification was admitted to a treatment unit. Review of the policy showed that a "Nursing Order for the appropriate precaution will be initiated and documented next to the patient's name on the unit census board" and the heightened observation orders of "1:1" (a staff constantly observing a patient) or "Q 5 Minute Observation Rounds" (a staff documenting patient whereabouts and activity every 5 minutes) required an order from a Medical Provider or "designee". 2. Review of the facility policy and procedure titled, "Levels of Observation Orders, 1000.21", dated 07/2023, showed the levels of observation for patients at the facility included "15-minute checks; 5 minute checks; or 1:1 (dedicated staff assigned to a specific patient)." Review of the document showed that Nursing Staff could increase observation levels and "The physician will be notified as soon as possible of the change in condition." The policy listed reasons for an increase in the level of observation, which included "disorganization, self-harm ideation or activity; intrusive behavior with other patients or sexual assault; failure to maintain at the previous level of observation." Review of the policy showed that a Medical Provider could decrease patient observation levels, and no other staff could decrease the level. Review of the document showed instructions were listed for step-by-step procedures for documentation and implementation of each observation level. 3. Review of the facility policy and procedure titled, "Patient Rights and Responsibilities", dated 03/2023, showed that it was facility policy to inform patients of their rights. The list of patient rights included the	

	right to be free of any sexual exploitation or harassment. 4. Observation of the "North" facility treatment unit on 08/24/23 at approximately 2:45 PM showed that a dayroom was located across the hallway from the nursing station. The dayroom had a large entry way that did not have a door. In the dayroom there was a table with attached chairs, a television, and several large chairs and ottomans that were in front of the television. 5. At approximately 1:15 PM on 08/24/23, Investigator #1, Investigator #2, and Staff F, Risk Manager, observed video footage of the alleged incident involving Patient #5 and Patient #7 that occurred starting on 07/23/23 at 11:58 PM., in the North unit dayroom located across the hallway from the nursing station. Review of the video footage showed that staff left the dayroom (a room with chairs, a television, and a dining area) and turned off the lights in the dayroom at approximately 11:32 PM, and that Patients #5 and #7 were still in the dayroom when the lights were turned off. Review of the video footage showed that Patient #5 and # 7 engaged in oral and vaginal sex in the dayroom from approximately 11:58 PM to 12:03 AM. Review of the footage showed that at approximately 12:00 AM, a facility staff person conducting observation rounds looked into the dayroom and continued rounding without appearing to notice the patient sexual activity that was occurring in the dark room. Observation of the video footage showed that at 12:05 AM, facility staff entered the dayroom. Staff F, Risk Manager, stated that the staff that entered the dayroom at approximately 12:05 AM was a staff	

	member that had been assigned to supervise a patient on a 1:1 supervision level, and that the staff had left their 1:1 assignment to go to the dayroom to investigate where a noise they had heard was coming from. 6. Review of the individual service records for Patient #5 showed that they were admitted to the facility on 06/08/23. Review of the patient's "Psychiatric Evaluation" showed they were "detained on an involuntary hold as gravely disabled." Review of the document showed that the "admission diagnosis" included Psychosis (not otherwise specified), Rule out schizophrenia (unspecified type), Rule out schizoaffective disorder (bipolar type versus depressed type)." 7. Review of the individual service records for Patient #7 showed a document titled "Petition for Initial Detention," dated 07/23/2023, that showed Patient #7 was "gravely disabled…as a result of a mental disorder is in danger of serious physical harm, resulting from a failure or inability to provide for his/her essential human needs of health or safety and / or manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his / her actions…" Review of the document showed that Patient #7's parent reported that Patient #7 "was getting sexual toward [their] father" and "…even when not psychotic [they] will misread social cues, and take things sexually." 8. Review the individual service records for Patient #7 showed an "Addendum Progress Note", dated 07/24/23 at 1:30 AM, that showed a Nurse spoke	

	with Patient #7 (after the incident involving Patient #5 and #7) and documented that Patient #7 would be continued on SAP / SVP precautions and would be in sight of staff at all times. Review of the document showed that a medical consultation would be ordered, and the patient was to be evaluated (by a Medical Provider) "in the AM". 9. Review of the individual service records for Patient #7 showed the following: a. Patient #7 was admitted on 07/23/23. b. Patient #7 was assigned to 15-minute checks and sexual victimization and sexual aggression precautions throughout their treatment episode at the facility. c. Patient #7 had a history of multiple mental health diagnosis including schizoaffective disorder, bipolar disorder, major depressive disorder, borderline personality disorder, complex posttraumatic stress disorder. d. There was no documentation that that the observation level was changed from 15-minute checks or "...in line of sight at all times" as documented in the "Addendum Progress Note" dated 07/24/23. e. There was no documentation that Patient #7 was evaluated by a Medical Provider "in the AM" on 07/24/23 as documented in the "Addendum Progress Note" dated 07/24/23.	

	10. During an interview on 08/23/23 at approximately 2:40 PM, with Staff B, RN, Staff B stated that staff conducted rounds and always watched the hallways to maintain patient safety. 11. At approximately 2:25 PM on 08/23/23, Investigator #1, Investigator #2, and Staff A, Director of Risk Management, observed video footage of an alleged incident involving Patient #1 and Patient #2 that occurred on 07/08/23. Review of the video footage showed that Patient #1 was in the unit hallway at 11:10 AM along with several staff and several other patients. Review of the footage showed that hallway had multiple patient bedroom doors located on both sides of the hallway. Review of the video showed that staff were working with other patients in the hallway and Patient #1 went into the bedroom of Patient #2 without being noticed by staff. Review of the video showed that a staff entered Patient #2's bedroom at 11:11:27. Staff A stated that the staff that entered the room was Staff G, Medical Provider. Staff A stated that Staff G reported that Patient #2 sat up in bed, then stood up. Staff G noticed there was someone else in the bed and discovered Patient #1 also in the bed. Staff A stated that Staff G reported that Patient #1 was "naked from the waist down" and that Patient #1 reported that they touched Patient #2's "boob" and was interrupted before anything else occurred. 12. Review of the individual service records for Patient #1 showed that they were admitted to the facility on 06/16/23 and diagnosed with schizoaffective disorder and substance use disorder (no specific substance listed) and was involuntarily	

	admitted to the facility after being found “unaware of [their] surroundings.” 13. Review of the individual service records for Patient #2 showed a document titled, “Discharge Summary,” dated 08/08/23, that showed they were admitted to the facility on 07/07/23 involuntarily “for danger to self or others”. Review of the document showed that Patient #2’s diagnosis included “Rule out unspecified schizophrenia and related psychotic disorder, Rule out substance-induced psychosis”.	

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.

Fairfax Behavioral Health Hospital
Plan of Correction for
State Investigation
Case #2023-8800
Exit 09/26/23
Corrections Completed By: 11/13/23

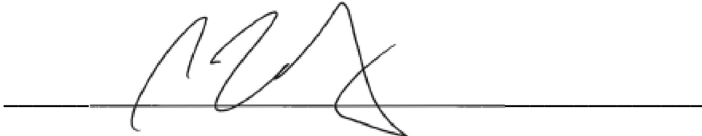
Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
WAC 246-341-0420(12)(a)	How: The CEO met with the Director of Risk Management on 10/30/23 to discuss the finding and requirements pertaining to the reporting of incidents of allegations of abuse or neglect to the Department of Health within 48 hours. This reporting is the responsibility of the Director of Risk Management. The policies "Suspected or confirmed cases of Patient Sexual Activity, 1000.30" and "Sentinel Event Review and Reporting, PI-003" were reviewed and found to meet requirements. The CEO and Director of Risk Management met with the Chief Medical Officer on 10/31/23 to discuss the finding and expectations of the Providers' documentation to include an assessment of the patients ability to consent, after an incident of sexual activity or sexual abuse has been reported to them. Providers were trained by the CMO and Director of Risk Management on the above as well as the requirement to notify Risk Management immediately if they are notified by a patient of any allegations of abuse or neglect and the requirements of	Director of Risk Management	11/13/23	The Director of Risk Management will review 100% of incidents where a patient has made allegations of abuse or neglect to ensure: 1. Allegations are reported to the Department of Health within 48 hours as evidenced by a saved copy of the Adverse Event Notification confirmation email with matching date of event. All deficiencies will be corrected immediately to include staff retraining as needed. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive committee monthly and Governing Board Quarterly until compliance goals have been met and sustained for a minimum of 3 consecutive months.

	the facility to notify the DOH within 48 hours of the incident.			
WAC 246-341-0640(1)(d)(iv)	How: The CEO met with the Director of Risk Management on 10/30/23 to discuss the finding and requirements pertaining to updating individual service plans to address changes in identified needs and achievement of goals or at the request of the individual. All policies noted in this finding were reviewed and did not require revision. The CEO met with the Chief Nursing Officer, Director of Clinical Services, and the Chief Medical Officer to discuss the finding on 10/30/23. All treatment team staff (Providers, RNs, and Case Managers) were re-educated by the Chief Medical Officer, Chief Nursing Officer, and Director of Clinical Services on the requirement to develop, initiate and update patient treatment plans to address changes in identified patient needs. Documentation on the treatment plan will include, but is not limited to, a description of the incident or behavior exhibited, interventions initiated, change in precautions or observations and the patient's response to the interventions. Staff are to review the patient's treatment plan on a weekly basis or sooner if a safety event occurs and revise the treatment plan if the current interventions are ineffective. All training and re-education is verified via staffs' signature on the training	Director of Risk Management Chief Nursing Officer Chief Medical Officer Director of Clinical Services	11/13/23	The Risk Management department will run a daily report of all patients with identified safety events that have occurred within the last 24 hours and will send this report out daily to the Chief Medical Officer, Chief Nursing Officer, and the Director of Clinical Services. These leaders will ensure the identified patients are discussed in treatment team and, if indicated, the treatment plan is updated and/or revised. Monitoring and Compliance Target: The Risk Management Department will audit 30 records a month of patients with safety events to ensure: 1. The patients' treatment plan updates include information on any safety incidents that have occurred since the last treatment team meeting. 2. The patients' treatment plan is reviewed/revised after significant safety events. 3. The patients' treatment plan includes interventions to address the identified safety concerns. 4. The patients' treatment plan interventions are amended/revised if current interventions are not effective. Target for compliance is 90% or greater on the above audits. Audit data found to be out of compliance will be reported to the respective department leader for follow up and corrective action with individual staff. Results of monitoring will be reported to Quality Council and Medical Executive committee monthly and Governing Board quarterly until compliance goals have been met and sustained for a minimum of 3 consecutive months.

	sign-in sheet at the completion of the training.			
WAC 246-341-1131(2)(b)(ii) WAC 246-341-0600(2)(d-e)	How: A motion sensor was installed in the day room on the North unit on 8/22/23 to prevent patients from being in a darkened room unobserved. The CEO met with the Director of Risk Management and the Chief Nursing Officer on 10/30/23 to discuss the finding. All policies noted in this finding were reviewed and did not require revision. During the Annual Skills Fair in September 2023, Nursing Leadership re-educated all staff responsible for regular patient supervision (nursing staff) on patient rounding and observation expectations per Fairfax Policies "Patient Observation Policy" policy #1000.5 and "Level of Observation Orders" policy #1000.21 to include appropriate visual monitoring of patients: monitoring patients through timely Patient Observation rounds, maintaining the ordered level of observation for each individual patient, maintaining hallway supervision in between rounds, and being actively aware of patient room doors and patient common areas. All staff responsible for creating, maintaining, and utilizing individual Patient Observation round sheets (nursing staff) were re-educated on the facility requirements according to the aforementioned policies to include the patient's current precaution(s) and level of observation at all times to ensure patient safety.	Chief Executive Officer Chief Operating Officer Director of Risk Management Chief Nursing Officer Assistant Administrator Director of Clinical Services Director of Quality/Performance Improvement	11/13/23	The Risk Management Department will identify and notify members of Leadership that are required to conduct Senior Leadership Audits. These leaders will collectively complete the required number of Senior Leadership Audits each month. These Senior Leaders were re-educated on expectations pertaining to performing these audits. Monitoring and Compliance Target: The monthly target number of Senior Leadership Audits will be calculated based on the facility requirement of one audit per shift per unit per week. Additionally, the Regional Risk Manager and Director of Risk Management together review five staff members a month for a full 60 minutes each for compliance with Patient Observation rounds and hallway supervision. The Director of Risk Management/designee will audit 30 in-person Senior Leadership Audits each month to ensure staff compliance with the following: 1. Each Observation Round sheet reflects current: monitoring level 2. Each Observation Round sheet reflects current precaution(s) 3. Staff are actively monitoring patients in the hallways 4. Patient room doors are closed/locked when not in use during Program hours The Director of Risk Management/designee will audit 30 camera review Senior Leadership Audits each month to ensure staff compliance with the following: 1. Timeliness of patient observation rounds 2. Staff carry Observation Round sheets during rounds 3. Doors are open at night when patient(s) are in the room Target for compliance is 90% or greater on the above audits.

	A Patient Observation training video and competency tool was introduced in September 2023 to be utilized for the purpose of training patient care staff at new hire and annually thereafter. The competency tool will be assessed prior to working with patients and will be maintained in each individual employee's HR file upon completion. Identified members of Leadership (Director of Risk Management, Chief Nursing Officer, Director of Quality/Performance Improvement, Director of Clinical Services, Assistant Administrator, Chief Operating Officer, Chief Executive Officer) were re-educated on how to conduct an audit, what to look for and how to correct findings in the moment. Members will conduct Senior Leadership Audits in-person and via camera review of Patient Observation activities, including but not limited to, properly maintaining patient-specific Patient Observation round sheets with current precautions and observation level, timeliness of rounds, and hallway supervision, by staff responsible for these activities across all patient care units at the facility. Any non-compliance observed during an in-person Senior Leadership Audit will be corrected in the moment. Any non-compliance observed during a camera review Senior Leadership Audit will be communicated to the appropriate supervisor for follow up and corrective or disciplinary action, if needed. The Risk Management Department will collect and review 100% of completed Senior			Audit data found to be out of compliance will be reported to the respective department leader for follow up and corrective action with individual staff. Results of monitoring will be reported to Quality Council and Medical Executive committee monthly and Governing Board quarterly until compliance goals have been met and sustained for a minimum of 3 consecutive months.

	Leadership Audits and the results will be communicated to Leadership in Patient Safety Council each month.			

Chief Executive Officer, Christopher West  Date: 11/13/23

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

November 22, 2023

Re: Case Number: 2023-8800
License Number: BHA.FS.60874579

Dear Janet Huff:

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: JAMC03
Department of Health
HSQA/Office of Health Systems Oversight
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Olympia, Washington 98504-7874