STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

February 13, 2019

Fairfax, Kirkland E & T
10200 NE 132nd St
Kirkland, WA 98034-2899

Dear Mr. Carpenter:

This letter contains information regarding the recent investigation at Fairfax E & T by the Washington State Department of Health. Your state licensing investigation was completed on date January 17, 2019.

During the investigation, deficient practice was found in the areas listed on the attached Statement of Deficiencies. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies 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 Deficiencies form.

B Ramos CEO 3/1/19

Please sign and return the original reports and Plans of Correction to me at the following address:

Jennifer Ross
Department of Health, Office of Health Systems Oversight
P.O. Box 47874
Olympia, WA 98504-7874

Please contact me if there are questions regarding the investigation process, deficiencies cited, or completion of the Plans of Correction. I may be reached at 360-688-6779. I am also available by email at Jennifer.Ross@Doh.wa.gov

I want to extend another "thank you" to you and to everyone that assisted me during the investigation.

Sincerely,

Jennifer Ross
Behavior Health Reviewer

Enclosures: DOH Statement of Deficiencies
Plan of Correction Brochure

Behavioral Health Agency Investigation Report

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

February 7, 2019

Fairfax, Kirkland E &T, 10200 NE 132nd St
Kirkland, WA 98034-2899
Agency Name and Address

Michael Carpenter
Administrator

Complaint
Inspection Type

1/17/19
Investigation Onsite Dates

Jennifer Ross
Investigator

2018-14313
Case Number

BHA.FS.60874579
License Number

BHA 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 on-site investigation.

Deficiency Number and Rule Reference	Observation Findings	Plan of Correction
WAC 246-341-0410 (2)(b): Agency Administrator-Key Responsibilities: The administrator must: (b) Ensure administrative, personnel, and clinical policies and procedures are adhered to and kept current to be in compliance with the rules in this chapter, as applicable;	Washington Administrative Code WAS NOT met as evidence by: Failure to ensure compliance with agency policies and procedures may result in staff not following proper procedures that ensure the safe welfare of their patients and staff. Findings include: 1. In review of the Suicide Precaution Policy 1000.24, Section 7.5 it states "when conducting Q15 min checks, the staff shall observe patients directly". Section 7.10 states "the room doors of Patients on Suicide Precautions shall remain open at all times. Both of these sections WERE NOT followed by staff per report of Staff #1 and also Incident timeline created by Staff #1 off of video from agency.	

B Haney CEO 3/1/19

	2. In review of Level of Observation policy 1000.21 Section G, and review of "round sheets", RN's on duty ARE NOT signing off on the "round sheets" during their shift as required by this policy. 3. In review of Level of Observation policy 1000.21 Section I: the provider did not evaluate the patient for a 1:1 twice a shift nor document their findings as required by this policy.	
WAC 246-341-0600(1)(e): Clinical-Individual Rights: Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:" Be free of any sexual harassment	Washington Administrative Code WAS NOT met as evidence by: Findings include: 1. In interview with staff #1 it was documented that patient called her mother and reported that a staff member had sexually touched her. Staff were unable to determine if this was true but did document that staff were in the patients room unsupervised with door closed and had even requested to do the monitoring on this patient. Staff #1 reports that her mother wanted her immediately discharged due to this and mother contacted to police to file a report of abuse. 2. In review of policy 1000.29 Abuse Assessment and Report, a staff member that receives the reportable information, or his/her designee, will comply with the state reporting requirements by informing the appropriate agency, e.g., APS, CPS, DOH or law enforcement. In interview with Staff #1, agency did not report to DOH nor law enforcement of the suspected sexual abuse.	
WAC 246-341-1126 (1)(B): Mental Health Inpatient-Policy and Procedures-Adults: Policies to ensure that services are provided in a secure environment. "Secure" means having: (b) Visual monitoring, either by line of sight or camera as appropriate to the individual;	Washington Administrative Code WAS NOT met as evidence by: Findings include: 1. In review of policy 1000.21 Level of Observation Orders, it was determined that the staff member assigned to do the Q15 minute checks, did not visually observe the client on the 1:1. 2. In review of policy 1000.21 Section III (C): staff	

	assigned to 1:1 will document client behavior and location on the patient observation record or "round sheet", per interview with Staff #1 and incident timeline, the staff preforming the 1:1 was not documenting on the round sheet or in the record.	

Behavioral Health Agency
Telephone Contact Numbers

Management and Other Resources

Trent Kelly, Executive Director	360-236-4852
Shannon Walker, Operations Manager	360-236-2933
Judy Holman, Survey and Investigation Manager	360-236-2962

Introduction
We require that you submit a plan of correction for each deficiency listed on the inspection report 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 Inspection Report with Noted 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 in your inspection report 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 onsite investigation, or you may contact the supervisor.

Fairfax Behavioral Health
Plan of Correction for State Complaint Investigation 1/17/19 Case #2018-14313
Fairfax Kirkland (BHA.FS.60874579)

Deficiency Number and Rule Reference	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
WAC 246-341-0410 (2)(b): Agency Administrator-Key Responsibilities: The administrator must: (b) Ensure administrative, personnel, and clinical policies and procedures are adhered to and kept current to be in compliance with the rules in this chapter, as applicable;	The following policies were reviewed by Clinical Leadership: PC 1000.24 Suicide Precautions and PC 1000.21 Level of Observation. 1. All nursing staff were retrained, in person at staff meetings on 10/31/18 by the ADON regarding the expectation that during Q15 minute rounds, patients on Suicide Precautions are directly observed and that room doors of patients on Suicide Precautions are to remain open at all times. 2. Charge Nurses were retrained by the ADON, in person at staff meetings on 12/6/18 regarding the expectation that rounds are verified by the Charge Nurse as being completed and levels of observations are carried out per policy, twice per shift.	Director of Nursing (DON)	12/6/18	Compliance will be monitored through weekly Senior Leadership rounds that verify that patients on Suicide Precautions are directly observed, that room doors of patients on Suicide Precautions remain open at all times and that rounds are verified as completed by the Charge Nurse twice per shift. All deficiencies will be corrected immediately to include staff retraining and disciplinary action as needed. Results of the audits will be reported monthly to Quality Council, Medical Executive	< 90%

Fairfax Behavioral Health
Plan of Correction for State Complaint Investigation 1/17/19 Case #2018-14313
Fairfax Kirkland (BHA.FS.60874579)

Deficiency Number and Rule Reference	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
				Committee and the Governing Board. The target for compliance is 90%	
	3. The following policy was reviewed by Clinical Leadership: PC 1000.21 Level of Observation. The policy was revised to clarify the expectation that providers evaluate the need for continuation of 1:1 every 24 hours and document the evaluation in the medical record. The policy was approved by Quality Council on 2/26/19 and the Medical Executive Committee on 2/28/19. The policy will be approved by the Governing Board on 3/4/19. All medical staff will be retrained by the Interim CMO in person at the Medical Staff meeting on 3/7/19 regarding the revision to the Level of Observation	Interim Chief Medical Officer (CMO)	3/7/19	Compliance will be monitored through monthly random chart audits by the Interim CMO, or designee, to ensure that patients on 1:1 are evaluated every 24 hours and the results of the evaluation are documented in the medical record. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee and the Governing Board. The target for compliance is 90%	< 90%

Deficiency Number and Rule Reference	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
	policy. Focus of the training will include the expectation that providers evaluate the need for continuation of 1:1 every 24 hours and document the evaluation in the medical record.				
WAC 246-341-0600(1)(e): Clinical-Individual Rights: Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for, to ensure an individual's rights are protected in compliance with chapters 71.05, 71.12, and 71.34 RCW. In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:" Be free of any sexual harassment	The following policy was reviewed by Clinical Leadership: PC.1000.29 Abuse Assessment and Reporting. The policy was revised to clarify the requirements for reporting to the Department of Health (DOH) Adverse Events Program in cases of sexual abuse/assault on a patient while in hospital's care and death or serious injury of a patient resulting from a physical assault while in hospital's care. The revised policy and procedure was approved by Quality Council on 11/20/18 and by Medical Executive Committee and the Governing Board on 11/30/18. The Director of Quality and Risk Management was trained to the reporting requirements by the Risk Manager on 11/21/18.	Director of Quality and Risk Management; Risk Manager	11/30/18	All incidents related to potential or confirmed abuse and/or neglect will be reviewed for meeting requirements for reporting to the DOH Adverse Events Program. Compliance will be reported monthly to Quality Council. The target for compliance is 100%.	< 100%

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Deficiency Number and Rule Reference	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
WAC 246-341-1126 (1)(B): Mental Health Inpatient-Policy and Procedures-Adults: Policies to ensure that services are provided in a secure environment. "Secure" means having: (b) Visual monitoring, either by line of sight or camera as appropriate to the individual;	The following policy was reviewed by Clinical Leadership: PC 1000.21 Level of Observation. The policy was revised to clarify the requirement that the staff assigned to monitor the patient on 1:1 is responsible for documenting the observation on the patient observation record (rounds sheet). The policy was approved by Quality Council on 12/18/18, by the Medical Executive Committee on 12/27/18, and by the Governing Board on 1/23/19. Nursing staff will be retrained on 3/1/19, in person at staff meetings by Nursing Leadership regarding the revision to the Level of Observation policy, specifically that the staff who is assigned to monitor the patient on 1:1 is responsible to document the observations on the patient observation record (rounds sheet).	Director of Nursing (DON)	3/1/19	Compliance will be monitored through weekly Senior Leadership rounds that verify staff assigned to monitor the patient on 1:1 is documenting the observation on the patient observation record (rounds sheet). All deficiencies will be corrected immediately to include staff retraining and disciplinary action as needed. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee and the Governing Board. The target for compliance is 90%	< 90%

Fairfax Behavioral Health
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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.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

March 4, 2019

Fairfax Behavioral Health
Kirkland ARTS/Kirkland E & T
10200 Northeast 132nd Street
Kirkland, WA, 98034

Subject: Case Number: 2018-14313

Dear Mr. Carpenter:

The Washington State Department of Health conducted a Behavioral Health investigation at Fairfax. Your investigation review was conducted on 1/17/19. The Plan of Correction that was submitted was approved on 3/4/2019. No further action is required. I sincerely appreciate your cooperation and hard work during the investigation process and look forward to working with you again in the future.

Sincerely,

Jennifer Ross

Behavioral Health Reviewer
Investigations and Inspections Office
Washington State Department of Health