State of Washington

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 _____	01/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(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
L 000	INITIAL COMMENTS 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: 01/22/20 to 01/23/20 Examination number: 2020-61 The survey was conducted by: Surveyor #3 Surveyor #4 Surveyor #10 The Washington Fire Protection Bureau conducted the fire life safety inspection on 01/28/20.	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 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be returned electronically by February 21, 2020. 4. Return the REPORT electronically with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing	L 315		

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L 315	Continued From page 1 or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to ensure staff provided a safe environment for those identified as high risk for suicide (Item #1) and failed to perform daily fall risk assessments according to policy for 2 of 3 records review (Patient #301, #302) (Item #2). Failure to ensure a safe environment and failure to identify patients who are at high risk for falls places patients at risk for serious injury or death. Findings included: Item #1 - Suicide Precautions 1. Document review of the hospital's policy and procedure titled, "Linens Management," Policy #1001.10, last revised 05/19, showed that to ensure a safe environment, staff will limit access to linens. For patients on Suicide Precautions (SP) and their roommates, towels are to be checked out for short-term use only and returned. Staff will check patient rooms housing SP patients and ensure towels are returned. Staff are to keep track of bed linens for patients and their roommates managed under SP. Document review of the hospital's policy and procedure titled, "Suicide Precautions," Policy #1000.24, last revised 05/19, showed that staff would provide close observation, provide intensive support, and conduct frequent re-assessments for patients on suicide precautions. The policy directs staff to use	L 315		

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protective measures to ensure the emotional and physical welfare for these patients at all times. Room searches are conducted daily or more often as indicated to remove harmful or contraband items.

2. On 01/22/20 at 8:45 AM, Surveyor #10 observed care on the patient care unit. A review of the daily census sheet showed that staff were managing fourteen patients under suicide precautions.

Surveyor #10 and the Director of Nursing (Staff #1001) toured eight patient rooms. The observation showed:

a. Patient room #826 - Both patients (Patient #1001, #1002) in the room were on SP (Beds A and B). The surveyor observed three dirty towels near Bed A and one dirty towel near Bed B.

b. Patient room #828 - Both patients (Patient #1003, #1004) in the room were on SP (Beds A and B). The surveyor observed two laundry baskets containing a scrub pants that presented a potential ligature risk.

3. On 01/22/20 at 9:00 AM, Surveyor #10 interviewed the Director of Nursing (Staff #1001) who confirmed the excess linen.

Item #2 - Daily Fall Risk Assessments

1. Document review of the hospital's policy and procedure titled, "Fall Risk Assessment and Care," policy number 1000.19, last revised 01/19, showed that a Registered Nurse (RN) will complete the Edmonson Psychiatric Fall Risk Assessment on all patients upon admission. If upon assessment, the patient scores greater than

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or equal to 90, the RN will initiate falls precautions and add "falls risk" to the treatment plan. The review also showed that nurses will re-assess the patient's risk for falls on a daily basis daily while the patient is on falls precautions.

2. On 01/22/20 at 9:30 AM, Surveyor #3 and the Director of Quality (Staff #301) reviewed the medical record for Patient #301 who was admitted on 12/07/19 for suicidal ideation and disorganized thinking and behavior. The review showed:

a. Upon admission, staff assessed the patient as having low risk for falls.

b. On 12/12/19, the patient received a high fall risk score of 90, due to undirectable, agitated behavior.

c. The review showed that on 12/13/19, staff failed to perform a daily fall risk assessment.

d. On 12/14/19, the patient suffered a fall and then received a high fall risk score of 125.

e. The surveyor found no evidence that staff performed a daily fall risk assessment from 12/15/19 through 12/17/19, a period of 3 consecutive days.

f. The surveyor found no evidence that staff performed a daily fall risk assessment from 12/19/19 through 12/20/19, a period of 2 consecutive days despite previous assessment scores indicating the patient was a high fall risk.

g. The surveyor found no evidence that staff performed a daily fall risk assessment from 01/02/20 through 01/05/20, a period of 4

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L 315	Continued From page 4 consecutive days despite previous assessment scores indicating the patient was a high fall risk. h. On 01/19/20, the patient suffered a fall. Staff failed to performed a daily fall risk assessment between 01/19/20 through 01/21/20, a period of 3 consecutive days. 3. 01/22/20 at 3:45 PM, Surveyor #3 and the Director of Quality (Staff #301) reviewed the medical record for Patient #302 who was involuntarily admitted on 11/23/19 for grave disability. The review showed: a. On 01/03/20, the patient suffered a fall and was placed on fall risk precautions. b. The surveyor found no evidence that staff performed a daily fall risk assessment for 5 out of 11 days between 01/09/20 and 01/19/20 despite previous fall risk assessment scores indicating the patient was a high fall risk. 4. On 01/22/20 at 2:10 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) about performing daily fall risk assessments for those patients identified as high risk. Staff #301 stated that any patient scoring 90 or greater would have an Edmonson Psychiatric Fall Risk Assessment performed daily. She confirmed that staff failed to performed the required daily fall risk assessments as required by policy for Patients #301 and #302	L 315		
L 375	322-035.1o POLICIES-HOUSEKEEPING WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 375		

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L 375	Continued From page 5 written policies and procedures consistent with this chapter and services provided: (o) Maintenance and housekeeping functions, including schedules; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital staff failed to use an appropriate concentration of sanitizing solution in cleaning patient sleeping rooms. Failure to use appropriate levels of disinfectant for cleaning the patients' sleeping rooms puts patients and staff at risk of harm from infectious diseases. Findings included: 1. On 01/22/20 at 9:00 AM, Surveyor #4 observed a member of the Environmental Services Staff (Staff #401) as she cleaned a patient sleeping room. The surveyor used a chemical test strip to determine the level of quaternary ammonium disinfectant contained in the staff member's cleaning bucket. The observation showed the level of disinfectant was less than the minimum required amount for appropriate use. 2. On 01/22/20 at 9:20 AM, Surveyor #4 and Staff #401 returned to the housekeeping closet and used a chemical test strip to check the level of disinfectant being dispensed from the automated chemical dispensing unit. The observation showed minimal levels of disinfectant present in the dispensed solution. 3. At the time of the observation, the contracted vendor for the hospital's environmental cleaning	L 375		

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L 375	Continued From page 6 supplies was onsite and corrected the malfunction in the dispensing unit. 4. On 01/22/20 at 10:00 AM, Surveyor #4 interviewed the Facilities Manager (Staff #402) about the staff knowledge of disinfectants for use. Staff #402 stated that environmental services staff have the required chemical test strips and are supposed to check the concentration of disinfectants. .	L 375		
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 Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to maintain an active infection control committee that met at least quarterly and presented written reports of findings to identify infection control risks and reduce the incidence of infections within the facility. Failure to maintain an active infection control committee and implement activities related to the hospital's current infection control risk assessment puts patients, staff and visitors at risk of harm from exposure to communicable	L 765		

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L 765	Continued From page 7 diseases. Findings included: 1. Document review of the hospital policy titled, "Surveillance: Collecting, Analyzing, and Reporting Data", last reviewed 12/19 showed that the Infection Control Practitioner prepares an analysis monthly that is presented to the Infection Control Committee on a quarterly basis. Document review of the hospital's 2019 Infection Control Committee meeting minutes binder showed the binder contained only meeting minutes for the months of April and December. 2. On 01/23/20 beginning at 12:30 PM, Surveyors #4 and #10 reviewed the hospital's infection control program with the Infection Control Practitioner (Staff #404). The surveyors asked the staff member if there were any other meetings of the Infection Control Committee other than those available in the Infection Control Committee Binder. Staff #404 stated there were not, since there was a gap in meetings after the previous Infection Control Practitioner resigned.	L 765		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary	L1065		

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L1065	Continued From page 8 treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: Based on record review and review of hospital policy and procedures, the hospital staff failed to develop, initiate, and update care plans for 2 of 4 records reviewed (Patient #301, #303). Failure to develop care plans to address patient care problems risks patient safety and delays in treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Fall Risk Assessment and Care," policy number 1000.19, last revised 01/19, showed that a Registered Nurse (RN) will complete a Edmonson Psychiatric Fall Risk Assessment on all patients upon admission. If the patient scores greater than or equal to 90, the RN will initiate Falls Precautions and a Fall Risk Treatment Plan. The plan will address interventions used to prevent falls while hospitalized. Should a patient fall during their hospitalization, the RN will initiate or update the Fall Risk Individual Treatment plan and associated interventions as appropriate. 2. On 01/22/20 at 9:30 AM, Surveyor #3 and the	L1065		

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L1065	Continued From page 9 Director of Quality (Staff #301) reviewed the medical record for Patient #301 who was admitted on 12/07/19 for suicidal ideation and disorganized thinking and behavior. The review showed: a. Upon admission, staff assessed the patient as having low risk for falls. b. On 12/12/19, the patient received a high fall risk score of 90, due to undirectable, agitated behavior. c. On 12/14/19, the patient suffered a fall and was assessed as high risk (score of 125). The surveyor found no evidence that a Fall Risk Treatment plan was initiated. d. On 01/19/20, the patient suffered a fall and then received a high fall risk score of 125. The surveyor found no evidence that a Fall Risk Treatment plan was initiated. e. On 01/22/20, the patient suffered a fall. The surveyor found no evidence that a Fall Risk Treatment plan was initiated. 3. 01/22/20 at 3:25 PM, Surveyor #3 and the Director of Quality (Staff #301) reviewed the medical record for Patient #303 who was admitted on 01/18/20 for suicide ideation and auditory hallucinations. The review showed: a. The patient was assessed as a high risk for fall risk upon admission. b. Surveyor #3 found no evidence that the patient's risk for falls was added to the treatment plan at the time of admission.	L1065		

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L1065	Continued From page 10 4. On 01/22/20 at 3:45 PM, Surveyor #3 interviewed the Director of Quality (Staff #301) about documenting a fall risk problem on the treatment plan for those patients identified as high risk. Staff #301 stated that the hospital had a pre-printed fall risk treatment plan which should be implemented for any patient scoring 90 or greater on the Edmonson Psychiatric Fall Risk Assessment or had suffered a fall. She confirmed the findings that staff failed to add a "fall risk" problem to the treatment plan as required by policy.	L1065		
L1265	322-200.3F RECORDS-OBSERVATIONS 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: (f) Significant observations and events in the patient's clinical treatment; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of hospital policies and procedures, the hospital staff failed to enter significant physician-ordered observation levels for 2 of 7 medical records reviewed (Patient #1004, #1005). Failure to enter and follow ordered level of observations can lead to unsafe patient care through non-compliance with physician orders, or with prescribed protocols regarding levels of observation. Findings included:	L1265		

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L1265	Continued From page 11 1. Document review of the hospital's policy titled, "Level of Observation Orders," last revised 05/19, showed that all patients will be closely observed in compliance with provider orders and prescribed protocols. Upon admission, the physician will order one of three levels of observation or in a patient's change of condition: 1) every 15 minute checks; 2) 5 minute checks; or 3) 1:1 observation (one staff member dedicated to observe one patient). Staff will complete the patient observation record as rounds are being made, using the coding system described on the record for patient activities. Staff will be vigilant for potential risk factors identified for specific patients (safety level- unit restrictions, cafeteria privileges, etc., observation level- every 15 minutes, 1:1, or precautions - suicide, elopement, fall, sexual aggression, etc. 2. On 01/22/20, Surveyor #10 reviewed seven inpatient medical records. The review showed: a. Patient #1004 is a 58 year-old patient who was admitted following an attempted suicide by ingestion of prescription pills. The treatment plan for the patient's initial psychiatric evaluation included a medical evaluation, monitor for self-injury/violent behavior, participation in individual/group therapies and monitored medication therapy. The plan also included monitoring for the patient's safety. The physician ordered her potential risk factor to be managed under suicidal precautions, plus unit restrictions and observations to be done every fifteen minutes. Review of the initial observation flowsheet dated 01/17/20, did not indicate or identify that the patient was under unit restrictions (safety level).	L1265		

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L1265	Continued From page 12 The review also showed the same indication on the patient's flowsheets for inpatient days 2 through 5. b. Patient #1005 is a 64 year-old patient who was admitted after displaying behavior consistent with active suicidal ideation. She planned to overdose on her prescriptions. Records also showed the patient has a history of diabetes, hypertension, and thyroid disease. The treatment plan for the patient's initial psychiatric evaluation included a medical evaluation, monitoring for self-injury/violent behavior, participation in individual/group therapies, and monitored medication therapy. The plan also included monitoring for the patient's safety. The physician ordered her potential risk factor to be managed under suicidal precautions, plus unit restrictions and observations to be done every fifteen minutes. The review of the patient's suicide screening showed that the patient was at high risk for suicide ideation. Review of Patient's #1005 initial flowsheet showed that the sheet did not include a date, plus did not indicate (not marked or entered) a safety level (unit restrictions), observation level (every 15 minutes), or precautions identified (suicide). Review of flowsheets for inpatient day 1 and day 2 showed that the safety level was not marked or entered for both days. 3. On 01/22/20 at 2:00 PM, Surveyor #10 and the Chief Nursing Officer (Staff #1001) reviewed the flowsheets and confirmed the incomplete documentation.	L1265		

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L1485	Continued From page 13	L1485		
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 Washington Administrative Code is not met as evidenced by: Based on document review and interview, hospital dietary staff failed to cool cooked potentially hazardous foods in a manner that maintained compliance with the Washington State Retail Food Code. Failure to cool cooked potentially hazardous foods in a manner that limits the potential for bacterial growth puts patients at risk of harm from food-borne illness. Findings included: 1. On 01/22/20 between 10:05 and 11:15 AM, Surveyor #4 toured the dietary department that provides food service to the hospital patients. Document review of the department's log titled, "HACCP Cooling Log, Time/Temperature Log for Potentially Hazardous Food," showed incomplete information for the following items: a. On 01/17/20, Stroganoff- No recorded temperatures for temperatures after 2 hours and after 6 hours b. On 01/20/20, Carrot Salad- No recorded temperatures for temperatures after 2 hours and after 6 hours c. On 01/20/20, Sweet Potatoes- No recorded temperatures for temperatures after 2 hours and	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 after 6 hours d. On 01/21/20, Herbed Chicken- No recorded temperatures for temperatures after 2 hours and after 6 hours 2. At the time of the document review, Surveyor #4 interviewed the Dietary Manager (Staff #403) about the missing information. Staff #403 stated that staff should have documented the temperatures to complete the logs. Reference: WAC 246-215-03515	L1485		

Plan of Correction received 02/21/2020

Plan of Correction approved 03/02/2020

Copy Delivered 03/10/2020

Fairfax Behavioral Health
Plan of Correction for State Licensing – Due 2/21/2020
Fairfax Behavioral Health Monroe (012792)

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 315	**322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures**	Item #1 – Suicide Precautions The following policies were reviewed by Clinical Leadership with no revisions required at this time: • Suicide Precautions: PC 1000.24 • Linens Management: PC 1001.10 All Nursing staff, to include Program Specialists, CNAs, LPNs and RNs, were retrained, in person at staff meetings and individually for those unable to attend, to the Suicide Precautions and Linens Management policies. All staff signed an attestation verifying their understanding and commitment to following each aforementioned policy and procedure. Focus of the training included: • The requirement that staff ensure that patients on Suicide Precautions and their roommates do not have access to excess linens, such as towels, blankets or scrubs. • Limiting distribution of linens to patients on Suicide Precautions and their roommates. • Distribution will be no more than three towels, one top sheet, one	Chief Nursing Officer and Monroe Program Manager	3/26/20	Item #1: Compliance with the Suicide Precautions and Linens Management and policies will be monitored by the Charge Nurses on each unit via rounding at a minimum of twice per shift, ongoing. Nursing Leadership will audit the documentation weekly to ensure Charge Nurses are in compliance with these expectations. The CNO and/or designee will confirm compliance with this plan of correction by daily reporting in the FLASH meeting the status of linen checks and compliance with the Linens Management policy. All deficiencies are corrected immediately to include staff retraining and disciplinary action as needed.	< 90%

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		bottom sheet, one pillowcase and two sets of scrubs. Re-training also included the requirement that during rounds, Nursing staff are to check for any patients who are on Suicide Precautions and their rooms, to ensure that all linens are accounted for and returned. Towels and scrubs, not in use, found in rooms during rounds are immediately removed. Sheets, blankets and pillowcases found in excess of distribution requirements of the Linens Management policy will be immediately removed during rounds. Monitoring excess linens was added to the daily room checks. All unit staff was retrained, in person at staff meetings, to the revised room checks log. Focus of the training included confirming that patients on Suicide Precautions do not have access to excess linens. Sheets, blankets, pillowcases and scrubs found in excess of distribution requirements of the Linens Management policy are immediately removed. All housekeeping staff were retrained, in person at staff meetings, by the Director of Plant Operations, and individually for those			All aggregated data from monitoring compliance is reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 95%.	

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		unable to attend, to the Linens Management policy. Focus of the training will include the requirement that housekeeping staff will not distribute linens in excess of the numbers defined in the policy. <u>Item #2 – Daily Fall Risk Assessments</u> All Registered Nurses were retrained, in person at staff meetings by the CNO and/or designee to the Fall Risk Assessment and Care policy (PC 1000.19). Focus of the training included the requirement that the Edmonson Psychiatric Fall Risk Assessment is thoroughly completed: • On admission	Chief Nursing Officer and Monroe Program Manager	3/26/20	<u>Item #2:</u> All Nursing Admission assessments will be audited by the CNO and/or designee to confirm completion of the Edmonson Psychiatric Fall Risk Assessment. 100% of medical records for patients who have scored ≥ 90 and/or are on Fall Precautions will be audited by the CNO and/or designee to confirm compliance with the Fall Risk Assessment. 100% of fall incidents will be reviewed by the CNO and/or designee to confirm completion of the Edmonson Fall Risk Assessment. The CNO and/or designee will confirm compliance with this plan of correction by	< 90%

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		• Daily for three consecutive days, until score is <90, for patients who have scored ≥ 90 and/or are on Fall Precautions • After every patient fall			daily reporting in the FLASH meeting the status of patients identified as Fall risk and confirm completion of the Edmonson Fall risk assessment. All deficiencies will be corrected immediately to include staff retraining and disciplinary action as needed. All aggregated data from monitoring compliance is reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 95%	
L 375	**322-035.1o POLICIES-HOUSEKEEPING WAC 246-322-035 Policies and Procedures**	All Housekeeping Staff were retrained, in person at staff meetings by the EVS Supervisor on the correct method of testing disinfectants to ensure the cleaning solution has the appropriate concentration of disinfectants.	Director of Plant Operations	2/17/20	Weekly monitoring of the documentation on the daily log to confirm compliance with this action plan will be completed by Director of	< 90%

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		Housekeeping Staff will test cleaning solutions daily and maintain a log of results. If solution test outside of the proper pH range chemicals will be remixed ad retested before use.			Plan Operations and/or designee. This monitoring will ensure the appropriate concentration of disinfectants is being used. All deficiencies will be addressed and corrected immediately. Aggregated monitoring data will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 95%.	
L 765	**322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control**	The Infection Control Committee is scheduled to meet 03/11/20 and the Chief Nursing Officer will ensure that the Infection Control Committee meets at least quarterly thereafter. Meetings are currently scheduled for 4/8/20 and 5/13/20, and then will move to quarterly meetings.	Chief Nursing Officer	3/11/20 4/8/20 5/13/20	The CNO will ensure that Infection Control activities such as identifying, reporting and evaluating infections in patients and personnel will continue to be conducted, ongoing. Infection Control Committee meetings will	< 95%

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		During these meetings Infection Control activities, such as identifying, reporting and evaluating infections in patients and personnel will be reviewed and evaluated by the Infection Control Committee to ensure adherence to the goals established in the Infection Control Risk Assessment and Plan. The Infection Control plan includes the IC Preventionist being aware of and intervening with individual patients related to infectious needs, to ensure proper staff interventions/use of precautions, making monthly Infection Control Rounds, and mitigating identified risks, performing staff Hand Hygiene Monitoring, both in person and via camera monitoring, and tracking and reporting Antibiotic Use for any usage patterns, and necessary interventions. The IC Preventionist will also provide PPD and Flu Vaccinations for employees as part of infection prevention. The Infection Control Committee consists of the Director of Medical Services (as chair), Chief Nursing Officer(currently as the Infection Control Nurse), Director of Pharmacy Services,			be scheduled at least quarterly. The Infection Control Committee members will monitor Infection Control activities, such as identifying, reporting and evaluating infections in patients and personnel, which will ensure adherence to the Infection Control Risk Assessment and Plan, approved by the Infection Control Committee. Aggregated data is reported to monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 100%.	

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		Director of Plant Operations, Facility Risk Manager, Food Services Manager, rotating members of Nursing Leadership and others as deemed appropriate. Infection Control activities such as identifying, reporting and evaluating infections in patients and personnel was be conducted by the Chief Nursing Officer, or designee, until the Infection Control Nurse position was hired and trained. An Infection Control Preventionist was hired effective 2/24/2020 and is be responsible for the implementation of the hospital wide Infection Control Risk Assessment and Plan.		2/24/20		
L 1065	**322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services**	All licensed nurses were retrained, in person at staff meetings, to the Fall Risk Assessment and Care policy (PC 100.19). Focus of the training included initiating a Fall Risk Treatment Plan for: • All patients who score ≥ 90 on the Edmonson Fall Risk Assessment	Chief Nursing Officer	3/26/20	All patients who have scored ≥ 90 on the Edmonson Fall Risk Assessment and/or all patients who have fallen will be audited by the Program Manager to	< 90%

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
		• After a patient fall			ensure the presence of a Fall Risk Treatment Plan. Deficiencies will be addressed and corrected immediately. The CNO and/or designee will confirm compliance with this plan of correction by reporting daily in the FLASH meeting the status of patients identified as Fall risk and confirm completion of a Fall risk treatment plan. Results will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 95%.	
L 1265	**322-200.3F RECORDS-OBSERVATIONS WAC 246-322-200 Clinical Records**	All licensed nurses were retrained in person at staff meetings and individually for those unable to attend, to the Level of Observation Orders policy (PC 1000.21). Licensed nurses were the audience for this training as only a licensed nurse can note a provider's order.	Chief Nursing Officer	3/26/20	All Patient Observation Records (Rounds sheets) will be audited nightly by unit staff to ensure they contain the ordered	< 90%

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	Specifically, Rounds Sheets missing date, safety level, observation level and precautions.	Focus of the training included ensuring that all provider orders for safety levels, observation levels and precautions are noted on the Patient Observation Record (Rounds sheet). All staff signed an attestation verifying their understanding and commitment to following each aforementioned policy and procedure. Additionally, on 1/27/20, safety level, observation level and precaution orders were removed from HCS (electronic ordering system) due to lack of a notification system to nursing staff. All safety levels, observation levels and precautions are now written in the patient's medical record and flagged by the ordering provider to notify the nursing staff a new order is in place.		3/26/20	safety level, observation level and precautions. The Charge RN will audit all Patient Observation Records (Rounds sheets) to ensure that ordered safety level, observation level and precautions are correctly noted. Deficiencies will be addressed and corrected immediately. The Program Manager will audit 100% of Patient Observation Records to ensure that ordered safety level, observation level and precautions are correctly noted. Results will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board.	

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					The target for compliance is 95%.	
L 1485	**322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services**	All dietary staff were retrained, in person at staff meetings, on the "HACCP Cooling Log, Time/Temperature Log for Potentially Hazardous Food." Focus of the training included the requirement that temperatures of potentially hazardous foods be recorded, while cooling, after 2 hours and after 6 hours. Dietary manager for Evergreen Health Monroe will ensure food temperatures are logged per code. Fairfax DPO will review logs weekly to verify results and confirm compliance by reporting once a week at the FLASH meeting.	Director of Plant Operations	2/18/20	Fairfax Director of Plant Operations will audit cooling logs, weekly, to ensure that the temperatures of potentially hazardous foods are recorded after 2 hours and after 6 hours, while cooling. Results of the audits will be reported monthly to Quality Council, Medical Executive Committee, and the Governing Board. The target for compliance is 95%.	< 90%

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.

Progress Report received 04/27/20
Progress Report Approved 04/28/20
Pal M Kowalt RN, MN, CMSA
04/28/20

Fairfax Behavioral Health
Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20
Fairfax Behavioral Health Monroe (012792)

Tag Number	Deficiency	How Corrected	Date Completed	Results
L 315	**322-035.1C POLICIES-TREATMENT** **WAC 246-322-035 Policies and Procedures**	Item #1 – Suicide Precautions All Nursing staff, to include Program Specialists, CNAs, LPNs and RNs, were retrained, in person at staff meetings and individually for those unable to attend, to the Suicide Precautions and Linens Management policies. All staff signed an attestation verifying their understanding and commitment to following each aforementioned policy and procedure. Focus of the training included: • The requirement that staff ensure that patients on Suicide Precautions and their roommates do not have access to excess linens, such as towels, blankets or scrubs. • Limiting distribution of linens to patients on Suicide Precautions and their roommates. • Distribution will be no more than three towels, one top sheet, one bottom sheet, one pillowcase and two sets of scrubs. Re-training also included the requirement that during rounds, Nursing staff are to check for any patients who are on Suicide Precautions and their rooms, to ensure that all linens are accounted for and returned. Towels and scrubs, not in use, found in rooms during rounds are immediately removed. Sheets, blankets and pillowcases found in excess of distribution requirements of the Linens Management policy are to be immediately removed during rounds. Monitoring excess linens was added to the daily room checks. All unit staff were retrained, in person at staff meetings, to the revised room checks log. Focus of the training included confirming that patients on Suicide Precautions do not have access to excess linens. Sheets, blankets, pillowcases and scrubs found in excess of distribution requirements of the Linens Management policy are immediately removed.	Item #1: 3/26/20	Item #1: 95%

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		All housekeeping staff were retrained, in person at staff meetings, by the Director of Plant Operations, and individually for those unable to attend, to the Linens Management policy. Focus of the training included the requirement that housekeeping staff do not distribute linens in excess of the numbers defined in the policy. <u>Item #2 – Daily Fall Risk Assessments</u> All Registered Nurses were retrained, in person at staff meetings by the CNO and/or designee to the Fall Risk Assessment and Care policy (PC 1000.19). Focus of the training included the requirement that the Edmonson Psychiatric Fall Risk Assessment is thoroughly completed: • On admission • Daily for three consecutive days, until score is <90, for patients who have scored ≥ 90 and/or are on Fall Precautions • After every patient fall	<u>Item #2:</u> 3/26/20	<u>Item #2:</u> 100%
L 375	**322-035.1o POLICIES-HOUSEKEEPING WAC 246-322-035 Policies and Procedures**	All Housekeeping Staff were retrained, in person at staff meetings by the EVS Supervisor on the correct method of testing disinfectants to ensure the cleaning solution has the appropriate concentration of disinfectants. Housekeeping Staff test cleaning solutions daily and maintain a log of results. If solution test outside of the proper pH range chemicals will be remixed ad retested before use.	2/17/20	100%
L 765	**322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control**	The Infection Control Committee met on 03/11/20 and 4/8/20. The Infection Control Committee is scheduled to meet on 5/13/20. The Chief Nursing Officer will ensure that the Infection Control Committee meets at least quarterly thereafter.	3/11/20	100%

Tag Number	Deficiency	How Corrected	Date Completed	Results
		During these meetings Infection Control activities, such as identifying, reporting and evaluating infections in patients and personnel were reviewed and evaluated by the Infection Control Committee to ensure adherence to the goals established in the Infection Control Risk Assessment and Plan. The Infection Control plan included the IC Preventionist being aware of and intervening with individual patients related to infectious needs, to ensure proper staff interventions/use of precautions, making monthly Infection Control Rounds, and mitigating identified risks, performing staff Hand Hygiene Monitoring, both in person and via camera monitoring, and tracking and reporting Antibiotic Use for any usage patterns, and necessary interventions. The IC Preventionist has also provided PPD and Flu Vaccinations for employees as part of infection prevention. The Infection Control Preventionist was hired effective 2/24/2020 and is be responsible for the implementation of the hospital wide Infection Control Risk Assessment and Plan.		
L 1065	**322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services**	All licensed nurses were retrained, in person at staff meetings, to the Fall Risk Assessment and Care policy (PC 100.19). Focus of the training included initiating a Fall Risk Treatment Plan for: • All patients who score ≥ 90 on the Edmonson Fall Risk Assessment • After a patient fall	3/26/20	100%
L 1265	**322-200.3F RECORDS-OBSERVATIONS WAC 246-322-200 Clinical Records**	All licensed nurses were retrained in person at staff meetings and individually for those unable to attend, to the Level of Observation Orders policy (PC 1000.21). Licensed nurses were the audience for this training as only a licensed nurse can note a provider's order. Focus of the training included ensuring that all provider orders for safety levels, observation levels and precautions are noted on the Patient Observation Record	3/26/20	97%

Fairfax Behavioral Health
Plan of Correction for State Licensing Progress Report – Survey Dates: 1/22/20 – 1/23/20
Fairfax Behavioral Health Monroe (012792)

Tag Number	Deficiency	How Corrected	Date Completed	Results
	Specifically, Rounds Sheets missing date, safety level, observation level and precautions.	(Rounds sheet). All staff signed an attestation verifying their understanding and commitment to following each aforementioned policy and procedure. Additionally, on 1/27/20, safety level, observation level and precaution orders were removed from HCS (electronic ordering system) due to lack of a notification system to nursing staff. All safety levels, observation levels and precautions are now written in the patient's medical record and flagged by the ordering provider to notify the nursing staff a new order is in place.		
L 1485	**322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services**	All dietary staff were retrained, in person at staff meetings, on the "HACCP Cooling Log, Time/Temperature Log for Potentially Hazardous Food." Focus of the training included the requirement that temperatures of potentially hazardous foods be recorded, while cooling, after 2 hours and after 6 hours. Dietary manager for Evergreen Health Monroe ensures food temperatures are logged per code. Fairfax DPO reviews logs weekly to verify results and confirms compliance.	2/18/20	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.

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

December 1, 2020

Mr. Ron Escarda, Group Director/CEO
Fairfax Monroe Behavioral Hospital
14701 179th Ave SE
Monroe, WA 98272

Dear Mr. Escarda,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Fairfax Monroe Behavioral Hospital on January 22-23, & 28th, 2020. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on March 4, 2020.

Hospital staff members sent a Progress Report dated April 27, 2020 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Monroe Behavioral Hospital's attestation to be in compliance with Chapter 246-32 WAC.

The Deputy Fire Marshal perform a revisit on November 18, 2020 and verifed the life safety corrections.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Paul M Kondrat

Paul Kondrat, RN, MN, MHA
Survey Team Leader