DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504002	A. BUILDING ______ B. WING ______	C 05/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

(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) COMPLETION DATE
A 000	INITIAL COMMENTS MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482 for Hospitals, conducted this complaint investigation. Onsite dates: 05/14/19 - 05/17/19; 05/29/19 Intake number(s): #87770 #89607 #89871 #90190 #90327 #90191 #90209 #90163 #90363 The investigation was conducted by: Investigator(s) # 3 # 4 # 9 # 10 BHC Fairfax Hospital was found to be NOT IN COMPLIANCE with the following Medicare Hospital Conditions of Participation below: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient's Rights	A 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 postmarked by [specify the date]. 4. Return the ORIGINAL REPORT with the required signatures	
A 043	GOVERNING BODY CFR(s): 482.12	A 043		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Chief Operating Officer (X6) DATE: 7-8-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, and document review, it was determined that the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body. Failure to protect the patient's right to personal privacy resulted in loss of personal dignity, psychological harm and failure to ensure staff had the knowledge, skills, training, and equipment to respond to a patient's medical emergency resulting in treatment delay and inappropriate resuscitation measures. Findings included: Due to the scope and severity of deficiencies detailed under 482.12(f)(2) Emergency Services and 42 CFR 482.13 Condition of Participation for Patient Rights, the Condition of Participation for Governing Body was NOT MET. Cross-reference: Tag A-093 & Tag A-143.	A 043		
A 093	EMERGENCY SERVICES CFR(s): 482.12(f)(2)	A 093	**CORRECTIVE ACTION:** The leadership team met to review the findings from this survey. The Code	

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A 093	Continued From page 2 If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Item #1- Code Blue Response Based on interview, document review, and review of policies and procedures, the hospital failed to ensure direct care staff took appropriate immediate actions to address an emergency resuscitation on a patient (Patient #903). Failure to ensure hospital staff had the required knowledge, skills, training and equipment to respond to a patient's medical emergency risks delays in activating and initiating urgent treatment. Reference: Basic Life Support (BLS) Provider Manual, American Heart Association - 2016: Assess the patient to determine whether he or she is unresponsive Tap the patient on the shoulder and shout, "Are you all right?" This helps ensure that you don't begin CPR on a conscious person. If the patient is unresponsive, shout for help and activate the emergency response system via mobile device (if appropriate) ... to make chest compressions as effective as possible the victim must be placed on a firm surface. If a patient is on a soft surface, such as a mattress, sufficient force cannot be achieved to allow compression of the chest and heart to create blood flow ... Equipment: Backboard or	A 093	Blue policy, PC 1000.13 was reviewed and revised to include the use of a back board on all responses to a code blue in addition to the oxygen cylinder, the code blue bag and AED. The revised policy was reviewed and approved by the Medical Executive Committee, and the Governing Board.	7/3/19
			A supply of backboards was ordered and received. Each unit and the House Supervisor desk were supplied with a backboard. An extra backboard is stored in the facilities department for future replacement.	6/28/19
			All nursing staff were notified of the location of each backboard on each unit, in addition to the one located at the House Supervisor desk via in person staff meetings, email notification, and/or in person notification.	7/22/19
			All staff were retrained to the revised Code Blue policy in person, at mandatory staff meetings and individually for staff that did not attend the staff meeting. Focus of the training included the requirements of: • Immediately initiating CPR after verifying patient's unresponsiveness • Designating a Code Blue Leader to direct and coordinate all components of the resuscitation • Moving the patient to a hard surface to ensure effective chest compressions • Utilizing the backboard in the event that the patient cannot be moved to a hard surface • Documenting assessment of airway by the Code Blue Leader • Documenting airway management and/or delivery of rescue breathing by the Code Blue Leader	7/22/19
			Additionally, all nursing staff were retrained to the location of supplies in the Code Blue Bag, specifically the location of the handheld resuscitation bag (Ambu bag) in the Code Blue	7/22/19

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A 093 Continued From page 3

other firm surface, automated external defibrillator (AED). Optional: barrier mask with one-way valve, gloves, and other personal protective equipment.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff members trained in cardiopulmonary resuscitation (CPR) will verify unresponsiveness and start CPR. The staff member is to direct the announcement of Code Blue (term used by hospitals to activate emergency response for patients requiring immediate resuscitation). Staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED). CPR is to continue until the AED arrives and is attached to the patient to analyze cardiac rhythms. The registered nurse (RN) with the most knowledge of the patient is to act as the Code Blue leader, directing other staff. The Code Blue is to continue until Emergency Medical Services (EMS) arrives and relieves the staff to care for the patient.

2. Review of the medical record and resuscitation (Code Blue) notes from 02/17/19 for Patient #903 showed:

a. Patient #903 was a 58-year-old patient admitted on 01/30/19 for schizophrenia and alcohol use disorder. The patient's history showed many medical comorbidities that included: hypertension, hyperlipidemia, coronary artery disease, venous stasis of lower extremities, asthma and morbid obesity.

A 093

Bag. Understanding was verified by return demonstration.

STAFF RESPONSIBLE: Director of Nursing

MONITORING:

Code Blue drills are scheduled once per shift per week to confirm compliance with appropriate response to actual Code Blue incidents for four months followed by Code Blue drills once per shift per month.

The Director of Nursing and/or designee are attending all Code Blue events to confirm immediate initiation of CPR, assignment of Code Blue Leader, placement of patient on a hard surface or utilization of a backboard, assessment of airway, airway management and/or rescue breathing. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

100% of Code Blue events and Code Blue drill documentation are being audited by the Director of Nursing or designee to ensure documentation of immediate initiation of CPR, assignment of Code Blue Leader, placement of patient on a hard surface or utilization of a backboard, assessment of airway, airway management and/or rescue breathing. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Council, Medical Executive Committee and the Governing Board monthly.

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A 093	Continued From page 4	A 093		

b. Review of the psychiatrist progress note dated 02/17/19 at 12:00 PM, showed vital signs of blood pressure 120/51, pulse 89, temperature 97.8 degrees and respirations of 16.

c. On 02/17/19 at 5:30 PM, a staff memberfound Patient #903 in his room unresponsive and not breathing.

d. Document review of the Code Blue form showed that a staff member found the patient unresponsive in his bed at 5:30 PM, then additional staff were notified at 5:32 PM. The notes showed that no detectable pulse was found and that the patient was apneic (cessation of breathing), staff began chest compressions at 5:30 PM. The Code Blue form did not contain documentation addressing the patient's airway or if rescue breathing was provided. At 5:34 PM, the form showed chest compressions continued without addressing airway management or rescue breathing. At 5:34 PM, staff applied the AED to the patient's chest. At 5:40 PM, chest compressions continued without evidence rescue breathing was delivered. At that time the AED detected a nonshockable heart rhythm and did not advise a shock. Care was transferred to the arriving EMS crew at 5:40 PM.

e. A review of nursing resuscitation notes showed that EMS personnel continued chest compressions and rescue measures until 6:03 PM, then declared the patient deceased

3. On 05/17/19 at 1:20 PM, Investigator #9 attempted to reach two staff nurses by telephone (Staff #902 and #903), present during Patient #903's resuscitation, but both attempts were unsuccessful. At 1:45 PM, Investigator #9

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A 093	Continued From page 5 Interviewed the Nurse Educator (Staff #904) regarding her review of Patient #903's resuscitation records and staff she interviewed , present during the Code Blue. Additionally, she reviewed video footage of the resuscitation. Staff #904 identified the following issues: a. The staff member who found the unresponsive patient exited the room to call for help prior to initiating CPR. b. A Code Blue Leader (a designated leader needed to direct and coordinate all components of the resuscitation) was not identified or designated. c. Chest compressions performed on a non-firm surface (mattress) were ineffective and staff struggled to move the patient to the floor due to his large body size. Staff #904 noted the patient was moved to the floor using his bedmattress. d. Backboards were not available during the resuscitation and were not included in the hospital's emergency equipment. e. Staff had difficulty finding a handheld resuscitation bag and mask (a self-refilling bag-valve-mask unit, used for artificial respiration) in the Code Blue bag containing emergency equipment. Item #2 - Emergency Equipment Based on interview and document review, the hospital failed to ensure emergency equipment and supplies were available and accessible to staff during a critical medical emergency.	A 093		

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A 093	Continued From page 6 Failure to provide medical emergency equipment and supplies places patients at risk of inadequate resuscitation efforts that could lead to injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED). The code blue bag inventory includes: - Bandages and dressings. - Airway management supplies: a CPR mask, ambu bag (a self-refilling bag-valve-mask unit, used for artificial respiration), plastic bite stick (used during seizures), nasal cannula and mask with tubing (for oxygen delivery). - EMS supplies (sting swabs, alcohol prep pads, eyewash solution, ice packs, antimicrobial hand wipes, instant glucose, antibiotic ointment, iodine prep pads). 2. On 05/17/19 at 1:45 PM, Investigator #9 interviewed a Nurse Educator (Staff #904) about the Code Blue record. She stated that a back board was not used or available during Patient #903's resuscitation. Staff #904 stated that initially chest compressions were conducted while the patient was lying on his bed, atop a mattress. She noted the patient was moved to the floor, using the bed mattress and then the patient was moved directly onto the floor. A review of the	A 093		

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A 093	Continued From page 7 Code Blue record did not include the time it took for staff to move the patient to the floor.	A 093		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to protect the patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm while performing personal hygiene and dressing activities Findings included: 1. Failure to provide for privacy while performing personal hygiene and dressing activities. 2. Failure to provide personal privacy during physical skin assessments. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient rights. *Due to the scope and severity of deficiencies* under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET.	A 115		

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A 115	Continued From page 8 Cross-reference: Tag A-143. .	A 115		
A 117	PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1) A hospital must inform each patient, or when appropriate, the patient's representative (as *allowed under State law), of the patient's rights*, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: . Based on interview and record review, the hospital failed to provide a non-English speaking patient with an interpreter to translate and explain the "Patient Rights and Responsibilities" upon admission to the hospital (Patient #902). . Failure to provide an interpreter to a non-English speaking patient to translate and explain their patient rights and responsibilities potentially places patients at risk for abuse, neglect or unmet care needs. . Findings included: . 1. Document review of the hospital's policy titled, "Special Needs of Patients - Interpreter and Translator Services," policy # 1001.11 reviewed 08/23/18, showed that patients that are not fluent in English are offered the services of an interpreter by the admitting staff at no cost . The services are to be offered either through IN-Demand Interpreter machine, telephone or an on-site service based on patient's preference. . 2. Record review of Patient #902's medical record	A 117	**CORRECTIVE ACTION:** The leadership team met to review the findings from this survey and discuss an action plan to address findings. The Special Needs of Patients – *Interpreter and Translator Services policy* PC 1001.11, was reviewed with no revisions required at this time. All the InDemand Interpreter service machines were checked and confirmed to be functioning by the COO. The COO was trained by *InDemand on how to confirm the functionality of* the interpreter service machines. The InDemand Interpreter service machines are checked weekly, by the COO, and replaced immediately, by contacting the service provider, when not working properly. Documentation of the weekly checks is maintained on the interpreter service machine. All admissions staff were retrained by the Business Office Director, in person, at mandatory staff meetings to the Special Needs of Patients – Interpreter Services policy. For staff unable to attend this mandatory meeting, individually training was provided prior to their scheduled shift. Focus of the training included: • The use of the InDemand Interpreter service for all patients with limited understanding of English or non-English speaking. If the patient refuses the InDemand Interpreter service, on-site interpreting services will be offered. Patient's refusal to use the InDemand interpreter service or on site interpreting *services will be clearly documented in* their medical record. Staff will continue to attempt completion of all admission paperwork, including the acknowledgement of receipt of patient rights, every 24 hours until documents are thoroughly completed with patient's	6/26/19 7/22/19

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A 117 — Continued From page 9
showed:

-the patient was a 60 year-old patient admitted involuntarily on 01/11/19 due to psychosis and an inability to care for herself.

-the patients primary language was Vietnamese . The patient did not speak English.

-the patient rights notification stated that the patient was unable to sign to acknowledge receipt of patient rights.

-There was no documentation in the medical record that showed that interpreter services were offered or used.

b. Additional document review showed that the licensed independent provider (LIP) did not complete the "Suicide Assessment Tool" on 01/12/19. She wrote on the Suicide Assessment Tool, "No records available and patient is unable to answer questions. Interpreter machine not working."

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3. At the time of the record review, Investigator #9 interviewed the nurse manager (Staff #901) about the apparent lack of interpreter services being offered to the patient. She stated that the admission staff should have offered interpreter services or documented if the patient had refused the interpreter services. She further stated that the LIP should have contacted an interpreter to be available by phone or in person if the interpreter machine was not working.

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A 143 — PATIENT RIGHTS: PERSONAL PRIVACY

A 117 (Plan of Correction):

cooperation. All Business Office staff signed an attestation verifying their understanding and commitment to following the policy and procedure.

All clinical staff, including Nursing, Social Services, and Licensed Independent Providers (LIP) were retrained in person, at mandatory staff meetings to the Special Needs of Patients – Interpreter Services policy. For staff unable to attend this mandatory meeting, individual training was completed prior to working their scheduled shift. (Completion date: 7/22/19)
Focus of the training included the required use of InDemand Interpreter service for all patients who are limited or non-English speaking to complete all assessments. If the patient refuses the InDemand Interpreter service, on-site interpreting services will be offered. Patient's refusal to use the InDemand Interpreter service or on site interpreting services will be clearly documented in their medical record. Staff will continue to attempt completion of all assessments every 24 hours until assessments are thoroughly completed with patient's cooperation. All staff signed an attestation verifying their understanding and commitment to following the policy and procedure.

STAFF RESPONSIBLE: Director of Nursing, Director of Clinical Services, Business Office Director

100% of InDemand Interpreter carts are being audited weekly by the COO, or designee, to ensure that the InDemand Interpreter service is functioning. Non-functioning InDemand interpreter service machines will be replaced and removed from service until they are repaired.

The Business Office Director is auditing 100% of admission paperwork for all patients admitted who are limited or non-English speaking, including the notification of patient rights, to ensure the offer, use, and/or refusal of any interpreting services, including the InDemand

A 143

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A 143	Continued From page 10 CFR(s): 482.13(c)(1) The patient has the right to personal privacy. This STANDARD is not met as evidenced by: . Item #1 - Privacy Curtains Based on observation, interview, and review of policies and procedures, the hospital failed to protect the patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm while performing personal hygiene and dressing activities. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Rights and Responsibilities," policy number1800.1, effective date 12/18, showed that patients have a right to personal privacy. Care is rendered in a way that considers, respects, and protects the personal dignity of each patient. 2. On 05/15/19 at 9:50 AM, Investigator #3 and the Director of Nursing (Staff #301) toured the Child and Adolescent Unit. The investigator observed that there were no privacy curtains for the patient bathrooms in rooms #413 and #415. Without the bathroom privacy curtain, any staff or patient could observe any activity inside the room. Room 415 was assigned to 2 female patients. One of the 2 patients was identified as being on "sexual victimization precautions". In room 413, the male patient (Patient #301) was identified as being on "sexual assault precautions", andwas	A 143	interpreter service is documented. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed. 100% of LIP assessments, which includes the Psychiatric Evaluation, History and Physical, and the Suicide Assessment Tool, for all patients who are limited or non-English speaking are being monitored by the CMO or designee for completion to ensure the offer, use, and/or refusal of any interpreting services, including the InDemand Interpreter service, is documented. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed. 100% of assessments and patient care documentation on patients with limited or non-English speaking is being monitored by the DON or designee for compliance with the appropriate use of InDemand Interpretative services and/or an onsite translator. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Council, Medical Executive Committee and the Governing Board monthly. CORRECTIVE ACTION: The leadership team met to review the findings from this survey and discuss an action plan to address findings. The Patient Rights and Responsibilities policy, PI 1800.1, was reviewed with no revisions required at this time	

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A 143	Continued From page 11 subject to monitoring every 5 minutes because they had previously entered another patient's bathroom while the patient was toileting. 3. Following the observation, Investigator #3 interviewed the Director of Nursing (Staff #301) at 9:50 AM, about the absence of privacy curtains in the patient bathrooms. Staff #301 stated that the patients frequently pull down the curtains. A Program Specialist (Staff #302), stated during an interview at 10:00 AM, that curtains are replaced once they are observed missing in the rooms. Item #2- Skin Checks Based on interview, review of recorded video footage, and review of policies and procedures, the hospital failed to implement and evaluate a standard admission skin check/search process that ensures a patient's right to personal privacy. Failure to implement and evaluate a standard search process leads to inconsistent skin check practices that puts patients at risk for violating their right to personal privacy, risk of psychological harm and loss of personal dignity. Findings included: 1. Record review of the hospital policy titled, "Patient Rights and Responsibilities," policy number 1800.1, effective 12/18, showed that patients have a right to personal privacy. Care is rendered in a way that considers, respects, and protects the personal dignity of each patient. a. Review of the hospital's policy titled, "Skin	A 143	Immediately, all patient rooms and bathrooms were checked by the Director of Plant Operations and confirmed all patient rooms and bathrooms had a privacy curtain in place. A check for privacy curtains was added to the daily room check audit performed by unit staff. All nursing unit staff were retrained by the Director of Nursing and/or designee to the Patient Rights and Responsibilities policy specific to the importance of providing patients their privacy at all time. Focus of this training included confirming on every shift that all patient rooms and bathrooms have privacy curtains in place. Nursing staff who observes a missing privacy curtain will immediately have this replaced by contacting the Facilities manager and replacing them immediately. The Skin Assessment policy, PC 1001.40 was reviewed and revised to include a specific area for all skin assessments to be completed on the units. In all units, with the exception of South Unit, the skin assessment will be completed using the bathroom next to the seclusion room. The seclusion room will not be used for the skin assessment. On the South Unit, the unit bathroom will be the place designated for skin assessments for all patients admitted to South Unit. There are no cameras located in these bathrooms designated for completion of the skin assessment. The revised policy was reviewed and approved by the Quality Council, Medical Executive Committee, and the Governing Board. The Search for Contraband policy, PC 1000.7 was reviewed. It was revised to include all contraband checks will be completed as part of the skin assessment in the designated bathroom next to the seclusion room. On the South Unit, the contraband checks will be completed in the designated unit bathroom. There are no cameras located in these bathrooms designated for completion of the skin assessment. The revised policy was reviewed and approved by the Quality Council, Medical Executive Committee, and the	6/26/19 7/22/19 7/22/19 7/22/19

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	504002	A. BUILDING ______ B. WING ______	C 05/29/2019

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Assessment," policy number 1001.40, revised 05/18, showed that upon arrival on the unit, the patient will go to a private area, remove their clothing in private and don a hospital gown. Once they are gowned, patients will go to a secondary area where a Registered Nurse (RN) will perform the skin assessment while another staff member will inspect the patient's clothing for contraband. After the check, the staff will return all allowed articles of clothing to the patient. At all times the patient's privacy and dignity will be respected.

2. On 05/14/19 between 09:50 and 11:20 AM, Investigator #4 interviewed seven (7) direct care staff about the admissions process at the Kirkland campus. Three (3) staff interviews (Staff #401, #402, #403) revealed the following:

a. The Investigator asked a Registered Nurse (RN) (Staff #401) in the South unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The RN stated that usually 2 staff members perform the initial check, but there have been times when only 1 staff person was available to conduct the skin check and search.

b. The Investigator asked a Program Specialist (Staff #402) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that staff perform

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Governing Board.

All nursing staff, including Program Specialists, were retrained to the revised Skin Assessment and revised Search for Contraband policies in person, at mandatory staff meetings and in person trainings for those who were unable to attend. Focus of the trainings stressed the importance of maintaining the privacy and dignity of patients during the skin assessment and search for contraband by: — 7/22/19

- Staff were trained to the Search for Contraband policy, which includes the requirement that no squatting and/or coughing is to be used during the Search for Contraband.
- Consistently use the designated bathroom next to the seclusion room for all skin assessments. On the South Unit, the unit bathroom will be the designated place for skin assessments.
- Ensuring that the skin assessment and search for contraband is done in an area that is not video recorded using the designated room per revised policy.
- There should never be the need to complete any patient assessment in a room with a camera to ensure patient's privacy.
- Ensuring that two staff members are present throughout the completion of the skin assessment per policy with documentation of both staff on the skin assessment document.
-

STAFF RESPONSIBLE: Director of Nursing and Director of Plant Operations

MONITORING:
All patient bedrooms with bathrooms are being audited daily during room checks by unit staff to ensure that privacy curtains are in place. The Facilities department will be notified and privacy

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skin checks in Room 505 (a seclusion room). The investigator observed that the seclusion room had a camera mounted on the wall near the ceiling. The staff member also stated that 2 people can do the skin checks, but 1 person can do it if it is a male staff member and a male patient.

c. The Investigator asked a Registered Nurse (RN) (Staff #403) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that she performed them alone due to lack of staff, unless the patient showed agitation. She stated that she had patients change into a gown or cover themselves with a blanket in the seclusion room bathroom, and then she performed the skin check in the seclusion room. The Investigator asked about the camera surveillance in the seclusion room. The staff member stated that the camera is turned off unless a patient is in the room for seclusion.

Following the interview, the Investigator asked the unit's Program Manager (Staff #404) about the status of the camera in the seclusion room. The staff member stated that the cameras are always on, but no active monitoring occurs.

3. On 05/14/19 at 10:55 AM, Investigator #3 interviewed a Program Specialist (Staff #302) about the skin check and clothing search process done upon admission. Staff #302 stated part of the skin check process includes having the patient squat and then checking for any visible contraband. Staff #302 indicated the reason for

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curtains will be replaced immediately if any are noted to be missing.

The Director of Nursing and/or designee is confirming compliance by completing weekly audits of the daily room checks. All deficiencies will be corrected immediately to include staff retraining and disciplinary action as needed.

The Facilities department staff is auditing all patient bedrooms with bathrooms, once per week, to ensure that privacy curtains are present. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed.

Nursing Leadership is observing a minimum of one skin assessment and search for contraband on each unit, daily to confirm compliance with the revised Skin Assessment and Search for Contraband policies. A variety of staff members and shifts are being audited to ensure full compliance. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed.

Senior Leaders are interviewing staff on each unit weekly to ensure that staff are able to verbalize the correct procedures regarding the revised Skin Assessment and revised Search for Contraband policies. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed.

Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Council, Medical Executive Committee and the Governing Board monthly.

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having the patient squat was that some patients hide contraband.

4. On 05/15/19 at 2:00 PM, Investigator #10 interviewed a nurse (Staff #1004) assigned to the East Unit of the Kirkland Campus about how staff perform skin checks on the unit. Staff #1004 stated that all patients undergo a skin assessment performed by two nurses as part of the admission process. Staff #1004 confirmed that patients are escorted to the seclusion/quiet room and the initial skin assessment begins in a bathroom (no video camera) where patients are asked to remove all clothing. In the seclusion/quiet room (camera present), one nurse examines the entire skin for cuts, marks, tattoos, wounds, etc., and the second staff member searches the clothing for drugs or weapons. After a patient has completed their skin assessment and clothing search for contraband, then the patients can enter the unit and begin their treatment.

During a subsequent interview at 3:00 PM, the Director of Nursing (Staff #1005), stated that the video camera in the seclusion/quiet room, located in the East unit, is fully functioning. However, conducting skin checks in the unit's seclusion/quiet room is not their practice.

5. On 05/16/19 at 11:50 AM, Investigator #10 and the Risk Manager Coordinator (Staff #1006) reviewed a video recording of a patient's (Patient #1003) skin assessment performed on 05/09/19. A review of the footage showed a patient escorted to the seclusion/quiet room that contains an anteroom and a bathroom. Inside the bathroom (no camera present), the patient

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proceeded to undress himself while the bathroom door was wide open (to the anteroom), then staff handed him a gown to don. The video showed the patient and nurse enter the seclusion/quiet room (camera present), the location for the skin assessment. The seclusion room door was observed opened, when the nurse began examining the patient's hands, arms, chest and back, throughly. Review of the footage showed a second staff member looking through the open door, while leaving the main door (out to the unit) ajar, allowing other patients and staff to view the partially nude patient. The footage showed a third staff member walking in the room, then exit the room, only to return and leave the roomagain. The door remained opened (out to the unit) while the patient removed his underwear and shoes. During review of the footage, the investigator observed that during the exam you can see patients walk pass the open door, allowing individuals to see into the room. After the exam, the patient was given an orange scrub top, bottoms, socks, and shoes, then escorted out of the room(s).

Staff #1006 confirmed that the seclusion/quiet room door was opened to the main hallway during the patient's skin check.

6. On 05/14/19 between 8:50 AM and 12:45 PM, Investigator #10 interviewed seven (7) staff members who provide care to patients in the North Everett campus. Two staff (Staff #1001, Staff #1002) interviews revealed the following:

a. A staff member (Staff #1001) stated that all patients undergo a skin assessment performed by two nurses as part of the admission process. Staff #1001 stated that the skin assessment

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A 143	Continued From page 16 begins in a bathroom (no video camera) where patients are asked to remove all clothing and then taken to a secondary area, usually the seclusion/quiet room (video camera present). One nurse examines the patient's skin for cuts, marks, tattoos, wounds, etc., and the secondstaff member searches the clothing for drugs or weapons. When staff have completed their examination of the patient's clothing and their skin assessment, patients can enter the unit. However if a patient refuses a skin check/assessment, they are placed on a 1:1 observation until they complete the assessment. Staff #1001 verbalized his understanding that the quiet/seclusion room is equipped with a video camera but is not sure if patients are informed of the camera's presence. b. A staff member (Staff #1002) stated that new patients are escorted to the seclusion/quiet room, lead inside the adjacent bathroom (with the door ajar) where they fully undress and don a hospital gown. After they have donned a gown, staff escort the patient inside the seclusion/quiet room where an RN performs the patient's skin check by having the patient remove parts of the gown to expose the patient's skin. Staff member #1002 stated that she will ask patients to squat to see if anything drops, but acknowledged that asking the patient to squat is not included in the hospital's policy. Investigator #10 then asked the staff member if video recordings are conducted for the skin check. Staff #1002 stated that she was unsure if the video camera in the Seclusion/quiet room records the patient's assessment.	A 143		

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7. On 05/15/19 at 10:35 AM, Investigator #10 and the unit's Nurse Manager (Staff #1003) discussed video cameras in the unit. Staff #1003 stated that a video camera is present in the seclusion/quiet room and is constantly monitoring or functioning. The recording function turns on only when there is movement in the room, but video recordings are not available to staff to review. Video recordings are available for review by leadership staff, but for 30 days only.

After the interview, Staff #1003 provided a video recording of a patient's (Patient #1001) skin assessment performed on 05/11/19. A review of the footage showed the patient was escorted to the bathroom, adjacent to the seclusion/quiet room (inside the anteroom). The patient proceeded to undress herself while the bathroom door was wide open (to the anteroom), then staff handed her a gown to don. The video showed the patient and nurse enter the seclusion/quiet room. There the skin check began with the nurse examining the patient's hands, arms, head, chest and back. The nurse removed the patient's underwear and then took off the gown exposing the patient's body. The skin exam continued while the patient was standing in the room, fully undressed with the door opened to the anteroom, while another staff member walked in and out of the room. The video showed the anteroom door was closed to the unit's main hallway. After the exam, the patient was given an orange scrub top, bottoms, socks, and shoes, then escorted out of the room(s).

Staff #1003 stated that skin checks begin in a primary area (bathroom without camera) where patients fully undress, then don a hospital gown

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/24/2019
FORM APPROVED
OMB NO. 0938-0391

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A 143	Continued From page 18 and taken to a secondary location (private area, outside of camera view) to perform the skin assessment. Staff #1003 added that the process may need to be reviewed and revised. .	A 143	**CORRECTIVE ACTION:** The leadership team met to review the findings from this survey and reviewed the Seclusion-Restraint-Physical Hold policy, PC 1000.53. No revisions were required at this time.	
A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be-- *(i) in accordance with a written modification to the patient's plan of care.* This STANDARD is not met as evidenced by: . Based on record review, interview, and document review, the hospital failed to modify the patients' plan of care after placing patients in restraints in 2 of 5 (Patients # 901 and #902) patient records reviewed. . Failure to modify care plans when patients are in restraints, placed patients at risk of harm by not meeting physical and emotional needs. . Findings included: . 1. Document review of the hospital's policy and procedure titled, "Seclusion/Restraint/Physical Hold," policy # 1000.53 reviewed 05/18, showed that updates to the Treatment Plan of Care must be completed within 24 hours to reflect seclusion/restraint intervention and changes in treatment approach if indicated. . 2. On 05/15/19, Investigator #9 conducted a closed record review of five (5) patients placed in	A 166	All Registered Nurses were retrained to the Seclusion-Restraint-Physical Hold policy, specifically to the requirement of updating the Treatment Plan of Care within 24 hours to reflect seclusion/restraint intervention and changes in treatment approach, if indicated. Trainings were completed during mandatory staff meetings and individually with staff that did not attend the staff training. **STAFF RESPONSIBLE:** Director of Nursing **MONITORING:** 100% of seclusions and restraints (mechanical and physical) are reviewed concurrently by Unit Nursing Supervisors on duty to confirm thorough completeness of documentation, including updating of the Treatment Plan within 24 hours of a seclusion, restraint, or physical hold. All deficiencies will be immediately corrected to include staff retraining and disciplinary action as needed. All restraint/seclusion documentation is also reviewed for compliance the following business day by the DON and Risk Manager Monitoring will be ongoing. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Council, Medical Executive Committee and the Governing Board monthly.	7/22/19

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A 166	Continued From page 19 seclusion or restraints. In 2 of 5 records reviewed, (Patients #901 and #902) staff failed to update the patients' care plans to reflect seclusion/restraint interventions. 3. At the time of the record review, Investigator #9 interviewed the Nurse Manager (Staff #901) about the missing treatment plans. The staff member confirmed the finding.	A 166		

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L 000	INITIAL COMMENTS . STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. Onsite dates: 05/15/19 - 05/17/19; 05/29/19 Examination number(s): 2018-17976 2019-3919 2019-3716 2019-5267 2019-5934 2019-6579 Intake number(s): #87770 #89607 #89871 #90190 #90209 #90363 The investigation was conducted by: Investigator(s): # 10 # 9 # 4 # 3 There were violations found pertinent to this complaint. .	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 postmarked by 07/08/19. 4. Return the ORIGINAL REPORT with the required signatures .	
L 320	322-035.1D POLICIES-PATIENT RIGHTS	L 320		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Chief Operating Officer | (X6) DATE 7-8-19

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L 320	Continued From page 1 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: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Item #1 - Privacy Curtains Based on observation, interview, and review of policies and procedures, the hospital failed to protect the patient's right to personal privacy. Failure to provide for privacy puts patients at risk for loss of personal dignity and psychological harm while performing personal hygiene and dressing activities. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Rights and Responsibilities," policy number 1800.1, effective date 12/18, showed that patients have a right to personal privacy. Care is rendered in a way that considers, respects, and protects the personal dignity of each patient. 2. On 05/15/19 at 9:50 AM, Investigator #3 and the Director of Nursing (Staff #301) toured the Child and Adolescent Unit. The investigator observed that there were no privacy curtains for the patient bathrooms in rooms #413 and #415. Without the bathroom privacy curtain, any staff or	L 320		

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patient could observe any activity inside the room. Room 415 was assigned to 2 female patients. One of the 2 patients was identified as being on "sexual victimization precautions". In room 413, the male patient (Patient #301) was identified as being on "sexual assault precautions", and was subject to monitoring every 5 minutes because they had previously entered another patient's bathroom while the patient was toileting.

3. Following the observation, Investigator #3 interviewed the Director of Nursing (Staff #301) at 9:50 AM, about the absence of privacy curtains in the patient bathrooms. Staff #301 stated that the patients frequently pull down the curtains.

A Program Specialist (Staff #302), stated, during an interview at 10:00 AM, that curtains are replaced once they are observed missing in the rooms.

Item #2- Skin Checks

Based on interview, review of recorded video footage, and review of policies and procedures, the hospital failed to implement and evaluate the admission skin check/assessment process that ensures a patient's right to personal privacy, as revealed in 5 of 7 staff interviews and review of 1 Patient's video recorded skin assessment (Patient #1003).

Failure to implement and evaluate a standard search process leads to inconsistent skin check practices that puts patients at risk for violating their right to personal privacy, risk of psychological harm and loss of personal dignity.

Findings included:

State of Washington

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

(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 320	Continued From page 3	L 320		

1. Record review of the hospital policy titled, "Patient Rights and Responsibilities," policy number 1800.1, effective 12/18, showed that patients have a right to personal privacy. Care is rendered in a way that considers, respects, and protects the personal dignity of each patient.

a. Review of the hospital's policy titled, "Skin Assessment," policy number 1001.40, revised 05/18, showed that upon arrival on the unit, the patient will go to a private area, remove their clothing in private and don a hospital gown. Once they are gowned, patients will go to a secondary area where a Registered Nurse (RN) will perform the skin assessment while another staff member will inspect the patient's clothing for contraband. After the check, the staff will return all allowed articles of clothing to the patient. At all times the patient's privacy and dignity will be respected.

2. On 05/14/19 between 09:50 and 11:20 AM, Investigator #4 interviewed seven (7) direct care staff about the admissions process at the Kirkland campus. Three (3) staff interviews (Staff #401, Staff #402, Staff #403) revealed the following:

a. The investigator asked a Registered Nurse (RN) (Staff #401) in the South unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The RN stated that usually 2 staff members perform the initial check, but there have been times when only 1 staff person was available to conduct the skin check and search.

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L 320	Continued From page 4 b. The Investigator asked a Program Specialist (Staff #402) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that staff perform skin checks in Room 505 (a seclusion room). The investigator observed that the seclusion room had a camera mounted on the wall near the ceiling. The staff member also stated that 2 people can do the skin checks, but 1 person can do it if it is a male staff member and a male patient. c. The Investigator asked a Registered Nurse (RN) (Staff #403) in the East unit about the process for conducting initial skin checks and contraband searches for patients once they are admitted to the unit. The interview included questions about the number and types of staff who perform the skin checks, as well as where the exams take place. The staff member stated that she performed them alone due to lack of staff, unless the patient showed agitation. She stated that she had patients change into a gown or cover themselves with a blanket in the seclusion room bathroom, and then she performed the skin check in the seclusion room. The Investigator asked about the camera surveillance in the seclusion room. The staff member stated that the camera is turned off unless a patient is in the room for seclusion. Following the interview, the Investigator asked the unit's Program Manager (Staff #404) about the status of the camera in the seclusion room. The staff member stated that the cameras are always on, but no active monitoring occurs.	L 320		

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L 320	Continued From page 5	L 320		

3. On 05/14/19 at 10:55 AM, Investigator #3 interviewed a Program Specialist (Staff #302) about the skin check and clothing search process done upon admission. Staff #302 stated part of the skin check process includes having the patient squat and then checking for any visible contraband. Staff #302 indicated the reason for having the patient squat was that some patients hide contraband.

4. On 05/15/19 at 2:00 PM, Investigator #10 interviewed a nurse (Staff #1004) assigned to the East Unit of the Kirkland Campus about how staff perform skin checks on the unit. Staff #1004 stated that all patients undergo a skin assessment performed by two nurses as part of the admission process. Staff #1004 confirmed that patients are escorted to the quiet (seclusion) room and the initial skin assessment begins in a bathroom (no video camera) where patients are asked to remove all clothing. In the quiet room/seclusion room (camera present), one nurse examines the entire skin for cuts, marks, tattoos, wounds, etc., and the second staff member searches the clothing for drugs or weapons. When staff have completed their examination of the patient's clothing and their skin assessment, patients can enter the unit.

During a subsequent interview at 3:00 PM, the Director of Nursing (Staff #1005), stated that the video camera in the quiet room, located in the East unit, is fully functioning. However, conducting skin checks in the unit's quiet (seclusion) room is not their practice.

5. On 05/16/19 at 11:50 AM, Investigator #10 and the Risk Manager Coordinator (Staff #1006) reviewed a video recording of a patient's (Patient

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L 320	Continued From page 6 #1003) skin assessment performed on 05/09/19. A review of the footage showed a patient escorted to the seclusion/quiet room that contains an anteroom and a bathroom. Inside the bathroom (no camera present), the patient proceeded to undress himself while the bathroom door was wide open (to the anteroom), then staff handed him a gown to don. The video showed the patient and nurse enter the seclusion/quiet room (camera present), the location for the skin assessment. The seclusion room door was observed opened, when the nurse began examining the patient's hands, arms, chest and back, throughly. Review of the footage showed a second staff member looking through the open door, while leaving the main door (out to the unit) ajar, allowing other patients and staff to view the partially nude patient. The footage showed a third staff member walking in the room, then exit the room, only to return and leave the room again. The door remained opened (out to the unit) while the patient removed his underwear and shoes. During review of the footage, the investigator observed that during the exam you can see patients walk past the open door, allowing individuals to see into the room. After the exam, the patient was given an orange scrub top, bottoms, socks, and shoes, then escorted out of the room(s). Staff #1006 confirmed that the seclusion/quiet room door was opened to the main hallway during the patient's skin check. .	L 320		
L 335	322-035.1G POLICIES-EMERGENCY CARE WAC 246-322-035 Policies and	L 335		

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L 335	Continued From page 7	L 335		

Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment;
This Washington Administrative Code is not met as evidenced by:

.

Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure hospital staff took appropriate immediate actions to address an emergency resuscitation on a patient (Patient #903).

.

Failure to ensure hospital staff had the required knowledge, skills, training and equipment to respond to a patient's medical emergency risks delays in activating and initiating urgent treatment.

Reference: Basic Life Support (BLS) Provider Manual, American Heart Association - 2016: Assess the patient to determine whether he or she is unresponsive. Tap the patient on the shoulder and shout, "Are you all right?" This helps ensure that you don't begin CPR on a conscious person. If the patient is unresponsive, shout for *help and activate the emergency response* system via mobile device (if appropriate) ... to make chest compressions as effective as possible the victim must be placed on a firm surface. If a patient is on a soft surface, such as a mattress, sufficient force cannot be achieved to allow compression of the chest and heart to create blood flow ... Equipment: Backboard or

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L 335	Continued From page 8	L 335		

other firm surface, automated external defibrillator (AED). Optional: barrier mask with one-way valve, gloves, and other personal protective equipment.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff members trained in cardiopulmonary resuscitation (CPR) will verify unresponsiveness and start CPR. The staff member is to direct the announcement of Code Blue (term used by hospitals to activate emergency response for patients requiring immediate resuscitation). Staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED). CPR is to continue until the AED arrives and is attached to the patient to analyze cardiac rhythms. The registered nurse (RN) with the most knowledge of the patient is to act as the Code Blue leader, directing other staff. The Code Blue is to continue until Emergency Medical Services (EMS) arrives and relieves the staff to care for the patient.

2. Review of the medical record and resuscitation (Code Blue) notes from 02/17/19 for Patient #903 showed:

a. Patient #903 was a 58-year-old patient admitted on 01/30/19 for schizophrenia and alcohol use disorder. The patient's history showed many medical comorbidities that included: hypertension, hyperlipidemia, coronary artery disease, venous stasis of lower extremities, asthma and morbid obesity.

b. Review of the psychiatrist progress note dated

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L 335	Continued From page 9	L 335		

02/17/19 at 12:00 PM, showed vital signs of blood pressure 120/51, pulse 89, temperature 97.9 degrees and respirations of 16.

c. On 02/17/19 at 5:30 PM, a staff member found Patient #903 in his room unresponsive and not breathing.

d. Document review of the Code Blue form showed that a staff member found the patient unresponsive in his bed at 5:30 PM, then additional staff were notified at 5.32 PM. The notes showed that no detectable pulse was found and that the patient was apneic (cessation of breathing), staff began chest compressions at 5:30 PM. The Code Blue form did not contain documentation addressing the patient's airway or if rescue breathing was provided. At 5:34 PM, the form showed chest compressions continued without addressing airway management or rescue breathing. At 5:34 PM, staff applied the AED to the patient's chest. At 5:40 PM, chest compressions continued without evidence rescue breathing was delivered. At that time the AED detected a nonshockable heart rhythm and did not advise a shock. Care was transferred to the arriving EMS crew at 5:40 PM.

e. A review of nursing resuscitation notes showed that EMS personnel continued chest compressions and rescue measures until 6:03 PM, then declared the patient deceased.

3. On 05/17/19 at 1:20 PM, Investigator #9 attempted to reach two staff nurses by telephone (Staff #902 and #903), present during Patient #903's resuscitation, but both attempts were unsuccessful. At 1:45 PM, Investigator #9 interviewed the Nurse Educator (Staff #904) regarding her review of Patient #903's

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L 335	Continued From page 10 resuscitation records and staff she interviewed, present during the Code Blue. Additionally, she reviewed video footage of the resuscitation. Staff #904 identified the following issues: a. The staff member who found the unresponsive patient exited the room to call for help prior to initiating CPR. b. A Code Blue Leader (a designated leader needed to direct and coordinate all components of the resuscitation) was not identified or designated. c. Chest compressions performed on a non-firm surface (bed) were ineffective and staff struggled to move the patient to the floor due to his large body size. Staff #904 noted the patient was moved to the floor using his bed mattress. d. Backboards were not available during the resuscitation and were not included in the hospital's emergency equipment. e. Staff had difficulty finding a handheld resuscitation bag and mask (a self-refilling bag-valve-mask unit, used for artificial respiration) in the Code Blue bag containing emergency equipment. .	L 335		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators,	L1165		

L1165 Continued From page 11 L1165

intravenous fluids, oxygen, sterile
supplies, and other equipment
identified in the policies and
procedures, easily accessible to
patient-care staff.
This Washington Administrative Code is not met
as evidenced by:

.
Based on interview and document review, the hospital failed to ensure emergency equipment and supplies were available and accessible to staff during a critical medical emergency.

Failure to provide medical emergency equipment and supplies places patients at risk of inadequate resuscitation efforts that could lead to injury or death.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Code Blue," policy #1000.13 reviewed 05/18, showed that staff are to respond to the location with oxygen and code blue bag from each unit and the automated external defibrillator (AED).

The code blue bag inventory includes:

- Bandages and dressings.

- Airway management supplies: a CPR mask, ambu bag (a self-refilling bag-valve-mask unit, used for artificial respiration), plastic bite stick (used during seizures), nasal cannula and mask with tubing (for oxygen delivery).

- EMS supplies (sting swabs, alcohol prep pads, eyewash solution, ice packs, antimicrobial hand wipes, instant glucose, antibiotic ointment, iodine

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L1165	Continued From page 12 prep pads). 2. On 05/17/19 at 1:45 PM, Investigator #9 interviewed a Nurse Educator (Staff #904) about the Code Blue record. She stated that a back board was not used or available during Patient #903's resuscitation. Staff #904 stated that initially chest compressions were conducted while the patient was lying on his bed, atop a mattress. She noted the patient was moved to the floor, using the bed mattress and then the patient was moved directly onto the floor. A review of the Code Blue record did not provide the time it took for staff to move the patient to the floor. .	L1165		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{A 000}	INITIAL COMMENTS MEDICARE COMPLAINT SURVEY FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation for Hospitals set forth in 42 CFR 482, conducted this survey. Onsite dates: 08/20/19-08/22/19 Intake number (s): #87770 #89607 #89871 #90190 #90327 #90191 #90209 #90163 #90363 The survey was conducted by: Surveyor #4 Surveyor #8 Surveyor #10 During this on-site follow-up survey, Department of Health staff determined that BHC Fairfax Hospital was found to be NOT IN COMPLIANCE with the following Medicare Hospital Conditions of Participation below: 42 CFR 482.12 Governing Body	{A 000}		
{A 043}	GOVERNING BODY CFR(s): 482.12	{A 043}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 9/20/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 043}	Continued From page 1 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... *This CONDITION is not met as evidenced by:* Based on observation, interview, and document review, it was determined that the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body. Failure to ensure staff had the knowledge, skills, training, and equipment to respond to a patient's medical emergency resulting in treatment delay and inappropriate resuscitation measures. Findings included: -The hospital failed to ensure all direct care staff took part in Code Blue Drills as outlined in their submitted Plan of Correction (POC) -The hospital failed to ensure all emergency equipment outlined in their POC was included in their Code Blue drill flow sheets, debriefing sheets and emergency equpment daily invertory cheklists Cross-reference: Tag A-093 Due to the scope and severity of deficiencies detailed under 482.12(f)(2) Emergency Services, the Condition of Participation for Governing Body	{A 043}		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2019
FORM APPROVED
OMB NO. 0938-0391

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{A 043}	Continued From page 2 was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 05/29/19 .	{A 043}		
{A 093}	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: . Item #1- Code Blue Response Based on interview and document review, the hospital failed to ensure all direct care staff took part in Code Blue Drills as outlined in their submitted Plan of Correction (POC). . Failure to ensure all hospital staff had the required knowledge, skills, training and equipment to respond to a patient's medical emergency risks delays in activating and initiating urgent treatment. Findings included: 1. Document review of the hospital's, "Plan of Correction," dated 07/05/19, showed that all staff were retrained to the revised Code Blue policy in person, at staff meetings, and individually. Training focused on immediate emergency response for patients requiring resuscitation and	{A 093}	CORRECTIVE ACTION: The leadership team met to review the findings from this survey. The Code Blue policy, PC 1000.13 was reviewed by the CEO, DON and CMO with no revisions required at this time. Code Blue drills are conducted once per shift, weekly at Fairfax Everett and Monroe locations. Code Blue drills will continue at all locations for four months, then decrease to monthly per shift. Nursing Leadership at all locations will be held accountable through re-education and/or disciplinary action to ensure the drills are conducted as required. The Code Blue drill flow sheet was revised to include backboards to enable staff the ability to document backboards being brought to Code Blue events and drills. The debriefing sheets and emergency equipment daily inventory checklists were revised to include all emergency equipment including the backboard. These forms were approved by Forms Committee on 9/30/19 All nursing staff including, RNs, LPNs and PSs, were retrained, in person at mandatory staff meetings, to the revised Code Blue drill flowsheet. For staff unable to attend this mandatory meeting, individual training was completed. Focus of the training was on the revised form and the requirement that the backboard be brought to all code blues and documented. The Instructions for Emergency Medical Equipment (EME) Checklist document	8/30/19 9/30/19 10/3/19

was also revised to include backboards and the expectation that backboards are audited daily to ensure they are in the designated location and they are in good repair. All nursing staff, including RNs, LPNs and PSs, signed an attestation verifying their understanding and commitment to completing the revised forms.

All Charge Nurses, House Supervisors and members of Nursing Leadership were retrained to the revised emergency medical equipment daily inventory checklist. Focus of the retraining was on the addition of the backboards to the emergency medical equipment daily inventory and the expectation that the backboards be checked daily to ensure they are in the designated location and are in good repair. All Charge Nurses, House Supervisors and members of Nursing Leadership, signed an attestation verifying their understanding and commitment to completing the revised form. — 10/3/19

STAFF RESPONSIBLE: Director of Nursing

MONITORING:

Code Blue drills are scheduled, at all three locations, once per shift per week to confirm compliance with appropriate response to actual Code Blue incidents for four months followed by Code Blue drills once per shift per month. The Director of Nursing and/or designee are attending all Code Blue events to confirm backboards are present. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

Code Blue documentation from Fairfax Everett and Monroe will be forwarded to the Director of Nursing on a weekly basis to confirm compliance with Code Blue drills.

100% of Code Blue events and Code Blue drill documentation are being audited by the Director of Nursing or designee to ensure that the backboard is documented on the Code Blue flow sheet and debrief. All deficiencies are immediately corrected to include staff retraining and disciplinary action as needed.

The Emergency Medical Equipment Daily Checklist will be audited weekly by Nursing Leadership to ensure that backboards are included in the inventory and that staff are documenting the inventory.

Monitoring will be ongoing for four months until compliance is achieved and sustained. All

deficiencies are corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Council and Medical Executive Committee monthly and the Governing Board bi-monthly.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{A 000}	INITIAL COMMENTS MEDICARE COMPLAINT SURVEY FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation for Hospitals set forth in 42 CFR 482, conducted this survey. Onsite dates: 08/20/19-08/22/19 Intake number (s): #87770 #89607 #89871 #90190 #90327 #90191 #90209 #90163 #90363 The survey was conducted by: Surveyor #4 Surveyor #8 Surveyor #10 During this on-site follow-up survey, Department of Health staff determined that BHC Fairfax Hospital was found to be NOT IN COMPLIANCE with the following Medicare Hospital Conditions of Participation below: 42 CFR 482.12 Governing Body	{A 000}		
{A 043}	GOVERNING BODY CFR(s): 482.12	{A 043}	Corrective Action: The Governing Board met on 10/7/19 to review the findings from this survey and directed the CEO to immediately correct all deficiencies identified in this Statement of Deficiencies	10/7/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 10/7/19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 043}	Continued From page 1 There must be an effective governing body that is *legally responsible for the conduct of the hospital.* If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on observation, interview, and document review, it was determined that the hospital failed to meet the requirements at 42 CFR 482.12 *Condition of Participation* for Governing Body. Failure to ensure staff had the knowledge, skills, training, and equipment to respond to a patient's medical emergency resulting in treatment delay and inappropriate resuscitation measures. Findings included: -The hospital failed to ensure all direct care staff took part in Code Blue Drills as outlined in their submitted Plan of Correction (POC) -The hospital failed to ensure all emergency equipment outlined in their POC was included in their Code Blue drill flow sheets, debriefing sheets and emergency equpment daily inventory cheklists Cross-reference: Tag A-093 Due to the scope and severity of deficiencies detailed under 482.12(f)(2) Emergency Services, the Condition of Participation for Governing Body	{A 043}	to meet the requirements of 42 CFR 482.12 specific to the Condition of Participation for Governing Body oversight. The corrective actions included: • the revision of the Code Blue Flow Sheet, • Code Blue Debrief, • Emergency Medical Equipment Daily Inventory, and • Instructions for the Emergency Medical Equipment Checklist. • The completion of Code Blue drills at Fairfax Kirkland, Everett and Monroe. • Ensure staff was retrained to have knowledge, skills and all required equipment to respond to patient's medical emergencies. The Governing Board reviewed and confirmed the revisions to the revised forms. All licensed nursing staff was retrained to the corrective actions. Aggregated data from the Code Blue drills conducted at Fairfax Kirkland, Everett and Monroe was presented by the Director of Nursing. **STAFF RESPONSIBLE:** Chief Executive Officer **MONITORING:** The Governing Board will meet monthly for the next three months until compliance is achieved and sustained. Aggregated data from all code blue drills completed at Fairfax Kirkland, Everett and Monroe will be reported by the Director of Nursing. Monthly updates will be reported to the Governing Board specific to Code Blue drills to confirm compliance. This data will include the documentation of the presence of all Emergency Medical Equipment, to include the backboard. All deficiencies will be corrected immediately to include disciplinary action as needed.	

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{A 043}	Continued From page 2 was NOT MET. THIS IS A REPEAT FAILURE TO MEET THE REQUIREMENTS OF THE CONDITION PREVIOUSLY CITED ON 05/29/19	{A 043}		
{A 093}	EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Item #1- Code Blue Response Based on interview and document review, the hospital failed to ensure all direct care staff took part in Code Blue Drills as outlined in their submitted Plan of Correction (POC). Failure to ensure all hospital staff had the required knowledge, skills, training and equipment to respond to a patient's medical emergency risks delays in activating and initiating urgent treatment. Findings included: 1. Document review of the hospital's, "Plan of Correction," dated 07/05/19, showed that all staff were retrained to the revised Code Blue policy in person, at staff meetings, and individually. Training focused on immediate emergency response for patients requiring resuscitation and	{A 093}	CORRECTIVE ACTION: Item #1: Code Blue Response The leadership team met to review the findings from this survey. The Code Blue policy, PC 1000.13 was reviewed by the CEO, DON and CMO with no revisions required at this time. Code Blue drills are conducted once per shift, weekly at Fairfax Everett and Monroe locations. Code Blue drills will continue at all locations for four months, then decrease to monthly per shift. Nursing Leadership at all locations will be held accountable through re-education and/or disciplinary action to ensure the drills are conducted as required. STAFF RESPONSIBLE: Director of Nursing MONITORING: Code Blue drills are scheduled, at all three locations, once per shift per week to confirm	8/30/19

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH
20425 72nd Ave S, Ste. 310 • Kent, Washington 98032

October 22, 2019

Beckie Shauinger, Chief Executive Officer
Fairfax Behavioral Health-Kirkland
10200 NE 132nd St.
Kirkland, WA 98034

Re: Complaint(s)	Case: #2018-17976.	Intake #87770
	Case: #2019-3919.	Intake #89607
	Case: #2019-3716.	Intake #89871
	Case: #2019-5267.	Intake #90190
	Case: #2019-5934.	Intake #90209
	Case: #2019-6579.	Intake #90363

Dear Ms. Shauinger:

Surveyors from the Washington State Department of Health conducted a state complaint survey at Fairfax Behavioral Health-Kirkland on May 29, 2019. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on July 12, 2019.

Hospital staff members sent a Progress Report dated September 27, 2019 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Behavioral Health-Kirkland's attestation to be in compliance with Chapter 246-322 WAC.

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,

Rosie Tillotson RN MSN

Rosie Tillotson, RN, MSN
Survey Team Leader