Washington State Department of Health

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 _____	07/23/2015

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

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY This State hospital licensing survey was conducted 7/21/2015 - 7/23/2015 by Lisa Sassi, RN, MN and Alex Giel, REHS, PHA. Joyce Williams, RN, BSN participated as an orientee. The Washington Fire Protection Bureau conducted the fire life safety inspection on 7/21/2015. ASE #DN1P11 BHC Fairfax Hospital(Psychiatric) HAC. FS. 00000004	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, if monitoring, what are the benchmarks to assure continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked August 28, 2015. 4. Return the ORIGINAL REPORT with the required signature(s) on the first page.	
L 355	322-035.1K POLICIES-STAFF ACTIONS 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: (k) Staff actions upon: (i) Patient elopement; (ii) A	L 355		

By signing, I understand these findings and agree to correct as noted:
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 8/26/15

Received 8.28.15 Hosa

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L 355	Continued From Page 1 serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This WAC is not met as evidenced by: . Based upon observation, interview and review of policy and procedure, the facility failed to implement patient incident reporting. Findings: 1. In review of facility policy titled, "Incident Reporting: Healthcare Peer Review (HPR) Occurrence Reporting System" (Reviewed/Revised 4/15) under the "Definitions" section it stated, "Occurrence (Incident Type): that which is not consistent with the routine care of a patient and/or the desired operations of the facility. The results of this event require or could have required (near miss) unexpected medical intervention...or had the potential to cause an unexpected physical or mental impairment." In the section B on page 1 it listed examples of Serious Injuries/Event which included "Injury/Physical harm to patients..." On page 3 under the "Procedure" section it stated, "Any facility employee or staff member who discovers, is directly involved in or is responding to an event/occurrence is to complete or direct the completion of a Healthcare Peer Review (HPR) form. This form is referred directly to the facility Risk Manager within 72 hours of completion." The timeline for staff completion of the form was designated under item C.a. as to occur "at the	L 355		

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L 355	Continued From Page 2 time of the event". 2. On 7/22/2015 between 1:30 and 2:30 PM while on a tour of the 1 North unit Surveyor #1 interviewed the environmental services manager (Staff Member #10) and the administrative Staff Coordinator (Staff Member #11) about patient access to the locked laundry room. Both staff members indicated that it was considered off-limits for unsupervised patient access. 3. On 7/22/2015 between 1:30 PM and 2:30 PM Surveyor #1 observed Patient #3 exit a locked laundry room by her/himself (no staff member present). The patient asked the surveyor if her/his own head was bleeding. The surveyor noted that the patient had a scalp wound that was bleeding. The patient was then escorted to facility staff for attention to the bleeding wound. 4. On 7/23/2015 at 2:00 PM Surveyor #2 inquired about whether an incident report had been submitted by staff for the event that occurred involving Patient #3. The facility staff were unable to locate a report. At that time the Chief Nursing Officer (Staff Member #5) stated that s/he did not think the event should generate a need for an incident report. Then s/he stated that the lack of direct patient supervision while present in the laundry room should have at least generated an incident report.	L 355		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and	L 415		

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L 415	Continued From Page 3 procedures annually or more often as needed. This WAC is not met as evidenced by: Based on review of policy and procedure, the facility failed to assure that policies and procedures were reviewed and updated at least annually. Findings: 1. In review of policy and procedure titled, "Developing and Implementing Policies and Procedures" (Revised 5/2013) on page 2 under section A.1. it stated, "All policies are reviewed by the Department Heads on an annual basis and brought to the appropriate committee for full review and approval on an annual basis". 2. In review of the following policies and procedures it was noted that the review date did not occur within the past 12 months: Patient Rights and Organizational Ethics (04/05); Patient Rights to Care and Treatment (04/04); Admission Procedures and Triage of Patients with Potentially Transmissible Infections (03/2014); Major Medical Emergency Treatment (January 2014); General Health/Emergency (January 2014); Patient Elopement (January 2014), Abuse Assessment and Reporting (05/2014) and Patient Death/Suicide (January 2014).	L 415		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which	L 690		

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L 690	Continued From Page 4 includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This WAC is not met as evidenced by: . Based on observation, interview and review of policy and procedures, the facility failed to ensure disinfection activities to prevent and control infections. Item #1 Hand Hygiene Findings: 1. In review of facility policy titled, "Medication Administration" (Revised 8/2014) on page 2 under item 4.b.ii. it stated, "The licensed nursing staff will use proper hand washing techniques prior to handling medication for administration." Further specifics related to handling medications were not included. Information about hand hygiene related to medication administration was not included in the facility policy titled, "Hand Hygiene" (Revised 3/2014). 2. On 7/21/2015 at 9:20 AM a nurse (Staff Member #1) was observed administering medications to Patient #1 and Patient #2. The system for medication administration included patients coming to a designated window at the nurse's medication room to obtain the medication. The medication nurse did not perform hand hygiene after doing tasks in the medication room and prior to initiating access to medications from electronic medication storage unit. The nurse did not perform hand hygiene after medication administration to Patient #1 (including, but not	L 690		

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L 690	Continued From Page 5 limited to, handling a paper cup filled with water used by the patient during medication administration) and prior to proceeding to Patient #2. At that time the nurse acknowledged that s/he did not perform hand hygiene prior to handling patient's medications. Item #2 - Cleaning Patient Care Equipment Reference: CDC Centers for Disease Control and Prevention: Infection Prevention during Blood Glucose Monitoring and Insulin Administration (Rev date 2/6/2013) page 6 under Blood Glucose Meters stated in part: "If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be used". Reference: In review of the One Touch Ultra Mini User Guide (Rev date: 07/2009) on page 20 it provided a section on "Caring for your system." it stated in part, "To clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter". Findings: 1. In review of the hospital's policy and procedure titled, "Cleaning Agents Selection" (Revised 10/2014) on page 2 it stated, the disinfectant agent to be used on glucometers was a 1:10 bleach wipe solution and the frequency was "after each use and daily." In the same policy on page 3 it stated, "the vital signs machine should be wiped down after each use, using a bleach wipe."	L 690		

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L 690	Continued From Page 6 2. On 7/22/2015 between the hours of 9:30 and 10:30 AM Surveyor #1 observed an LPN (Staff Member #13) remove a blood pressure cuff from a patient arm and place the vital signs machine behind the nurse's station without disinfecting the machine. 3. On 7/21/2015 at 11:45 AM Surveyor #1 interviewed a LPN (Staff Member #12) about the routine use of glucometers for testing patient blood sugars. S/he described the testing process and stated that after using the glucometer s/he would wipe down the meter with a "Sani Hand Wipe" (an alcohol based product; not bleach wipes). 4.On 7/23/2015 at 12 PM, Surveyor #3 observed a medication nurse (Staff Member #8) on 2 West perform a blood sugar check on Patient #5 who was an insulin-dependent diabetic. Upon completion of the blood sugar check, s/he cleaned the glucometer with an alcohol wipe. S/he stated that normally the glucometer would be cleaned with a bleach wipe but the facility had been out of bleach wipes for a couple of days. 5. On 7/22/2015 at 8:30 AM during a tour of Central Unit, Surveyor # 3 interviewed a medication nurse (Staff Member #9) about the procedure for cleaning glucometers upon completion of blood sugar checks on insulin dependent patients. S/he stated that glucometers were cleaned between patient uses with bleach wipes. S/he noted that bleach wipes had not been available in the facility for a couple of days and therefore s/he used an alcohol wipe instead.	L 690		

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L 690	Continued From Page 7 Item #3 - Adequacy of a Product Used to Disinfectant Equipment Findings: On 7/21/2015 at 11:45 AM Surveyor #1 interviewed an LPN (Staff Member #13) about the process of disinfecting glucometers. The staff member identified that s/he used Sani-Hand Wipes. It was determined at that time that the alcohol content in "Sani Hand Wipes" was 65.9% (below adequate concentration for disinfection).	L 690		
L 695	322-100.1B INFECT CONTROL-REVIEW WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (b) A review process, using definitions and criteria established by the infection control committee, to determine if staff and patient infections are nosocomial; This WAC is not met as evidenced by: Based on interview, the facility failed to establish and implement an effective hospital-wide infection control program, which included a review process, using definitions and criteria established by the infection control committee, to determine if staff and patient infections were nosocomial. Findings: On 7/23/2015 at 1:30 PM during an interview between Surveyor #2 and the Medical Director of	L 695		

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L 695	Continued From Page 8 Infection Prevention (Staff Member #6), s/he acknowledged that the facility had not established a process to determine whether staff and patient infections were nosocomial. The facility had initiated defining a process during an infection outbreak in April 2015 but a formal process had not been developed to-date.	L 695		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This WAC is not met as evidenced by: Based on observation, document review, and review of hospital's policy and procedures, the hospital failed to provide a safe and clean environment for patients. Item #1 Off Limit Areas Findings: 1. In review of the hospital's policy and procedure titled, "Patient Observation Policy" (Effective Date 5/2011), step"G." stated the following, "While monitoring hallways and patient care areas ensure patients are: not in rooms or areas that are designated "off limits" areas to patients." The policy did not identify which areas were considered "off limits." 2. On 07/22/2015 between the hours of 1:30 PM and 2:30 PM, Surveyor #1 observed Patient #3 come out of the laundry room in the North unit.	L 780		

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L 780	Continued From Page 9 The patient came up to the surveyor and asked if s/he was bleeding on the top of her/his scalp. Surveyor #1 observed blood ooze from a scrape on Patient #3's scalp and the surveyor asked how the incident occurred. The patient stated in part, that s/he hit her/his head on the "dryer door" in the laundry room. Surveyor #1 asked if patients can be in the laundry room unsupervised (as the patient was). The environmental service manager (Staff Member #10) replied in part, "The laundry room is considered off limits to patients". The administrative Staff Coordinator (Staff Member #11) confirmed that the laundry room was considered an "off limits" area. Item #2 Clean Environment Findings: 1. In review of the contractual agreement with "Open Works" (the environmental services provider) on page 5 of the work schedule it stated, "to wash/wipe down walls as needed to remove spots, 7 days a week". 2. On 7/21/2015 at 10:15 AM Surveyor #1 observed a housekeeper (Staff Member #15) clean a patient room (room #117) on the North unit. The housekeeper did not clean the pencil markings along the patient's wall. 3. On 7/21/2015 at 10:30 AM Surveyor #1 observed holes in the wall in patient's bathroom (for room #139) on the North unit. The toilet paper dispenser was removed leaving several holes in the dry wall. 4. On 7/21/2015 at 1:30 PM Surveyor #1 observed graffiti all over the walls in room #708 on West 1 unit. This was confirmed by the Chief Operating	L 780		

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L 780	Continued From Page 10 Officer (Staff Member #14). Item #3 - Safe Environment: Findings: On 07/21/2015, between the hours of 2:00 PM and 3:00 PM, Surveyor #1 observed an "L" shape plumbing fixture (backflow prevention device) protruding from the wall inside the laundry room on the East unit (adolescent unit). The fixture was on the right side above door frame. A soiled linen container with the lid down was positioned underneath the fixture allowing access. The fixture was also not in plain sight of the viewing window to the laundry room. The plumbing set-up provided a potential risk for ligature harm.	L 780		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; This WAC is not met as evidenced by: Based on observation, document review and review of hospital's policies and procedures, the hospital failed to provide a safe and clean environment for its patients. Findings:	L 880		

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L 880	Continued From Page 11 1. In review of the hospital's policy and procedure titled, "Bed Making" (Effective Date 01/2000), Contributors: Infection Control Committee; "Purpose: The surveillance, prevention and contro of infection". The policy lacked actual procedures for surveillance of beds and infection control measures to prevent infection transmission from beds. The policy only identified how to make a bed. 2. In review of hospital's contractual agreement with "OpenWorks" (the environmental services provider) on page 8 under "Patient Discharge/Move" it stated, "to sterilize mattress as needed". 3. On 7/21/2015 between the hours of 10:00 AM and 3:00 PM during a tour of the facility Surveyor #1 observed 6 of 12 torn patient mattresses. This was confirmed by the Chief Operating Officer (Staff Member #14). During the same time Surveyor #1 observed food debris underneath the mattress in room #710 on the West 1 unit.	L 880		
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, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This WAC is not met as evidenced by:	L1165		

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L1165	Continued From Page 12 Based on observation, interview and policy and procedure review, the facility failed to assure the availability and use of intravenous solutions as a part of emergency supplies. Finding: 1. On 7/21/2015 at 2:00 PM during a tour of the 1 North nursing station, Surveyor #2 noted that intravenous solutions were not located in the unit's medical emergency supply bag. The surveyor asked a nurse (Staff Member #2) about the availability of intravenous fluids for administration in the event of a patient medical emergency. S/he stated that intravenous fluids were not available for patient care. This finding was confirmed on 7/22/2015 at 2:00 PM in a follow-up interview with a facility pharmacist (Staff Member #3) related to the facility in general. 2. In review of policies titled, "General Health/Emergency (Reviewed/Revised: January 2014) and "Major Medical Emergency Treatment" (Reviewed/Revised: January 2014), it was noted that the procedures did not address the securing or use of emergency medical supplies for patient care in medical emergency situations.	L1165		
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 WAC is not met as evidenced by: Item #1 - Food Storage	L1485		

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L1485	Continued From Page 13 Based on observation and interview, the facility failed to assure that food storage code 246-215-03351 and 2009 FDA Food Code 3-305.11 were adhered to. Findings: 1. On 7/21/2015 at 2:00 PM during a tour of the 1 North nursing station, Surveyor #2 noted that boxes containing patient food items were located on the floor of the nursing station. The food items for distribution included tea, popcorn and oatmeal. During that time period, the charge nurse (Staff Member #4) acknowledged that food items were located on the floor due to storage space limitations in the nurses' station. Reference: WAC 246-215-03351; Preventing contamination from the premises-Food storage (2009 FDA Food Code 3-305.11). (1) Except as specified in subsections (2) and (3) of this section, FOOD must be protected from contamination by storing the FOOD: ...(c) At least six inches (15 cm) above the floor. Item #2 - Food Debris Based on observation, the facility failed to comply with chapters 246-215, Washington Administrative Code (WAC) for food service. Findings: 1. On 07/22/2015 at 11:00 AM Surveyor #1 observed food debris accumulation on a meat slicer intended to be ready for use. 2. On 07/22/2015 at 11:15 AM Surveyor #1	L1485		

By signing, I understand these findings and agree to correct as noted:

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 _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET 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
L1485	Continued From Page 14 observed food debris on a clean knife and the knife was stored in a soiled knife rack. Reference: Washington State Retail Food Code, WAC 246-215-04600(1) 3. On 07/22/2015 at 11:30 AM Surveyor #1 observed severe accumulation of residue growing inside the juice dispenser. To prevent contamination of product, the unit must be cleaned to preclude accumulation of soil residue. Reference: Washington State Retail Food Code, WAC 246-215-5605(5)(d)	L1485		
L1490	322-230.2A FOOD SERVICE-24-HR MANAGER WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (a) Incorporating ongoing recommendations of a dietitian; This WAC is not met as evidenced by: Based on review of the medical record and interview, the facility failed to ensure that dietary recommendations were incorporated into the patient's dietary plan. Findings: 1. In review of the medical record of a 14 year old patient (Patient #4) admitted on 4/8/2015 for treatment of severe recurrent psychotic depression, suicidal ideation and abdominal pain, it was noted that the patient had a dietary consult completed on 4/9/2015. The consult was provided	L1490		

By signing, I understand these findings and agree to correct as noted:

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 _____	07/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND STREET 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
L1490	Continued From Page 15 because the patient had an eating disorder and was anorexic. The dietician made specific recommendations about modifications for breakfast and lunch dietary intake to address the eating disorder and daytime anorexia. The patient was discharged on 4/17/2015. In review of the medical record there was no indication that the recommendations had been incorporated into the patient's care; including, but not limited to, the multidisciplinary care plan. 2. In a follow-up interview between the dietician and Surveyor #2 on 7/23/2015 at 2:30 PM, she indicated that there was not a policy and procedure that addressed how dietary consults were managed, including incorporation into the patient's plan of care. The dietician stated that s/he did not have a practice of making clinical entries into the multidisciplinary treatment plan. S/he stated that s/he thought the nursing staff spoke to the attending provider(s) about recommendations completed by the clinical dietician.	L1490		

By signing, I understand these findings and agree to correct as noted:

Fairfax Behavioral Health - Kirkland
Plan of Correction for State Licensing Survey (July 21 - 23, 2015)

Tag Number	WAC	Responsible Individual(s)	Date of Correction Completed (or will be completed)	How Corrected	How Monitored to Prevent Recurrence	Results of Monitoring: Compliance Level
L 355	322-035.1K POLICIES-STAFF ACTIONS	Dr. John Beall, CNO; Darcie Johnson, DPI/RM	9/30/2015	An incident report was entered regarding the patient injury on 7/23/15. The CNO was retrained by the Director of Performance Improvement and Risk Management regarding reportable incidents on 8/21/15. The Director of Performance Improvement and Risk Management will retrain clinical staff regarding reportable incidents at staff meetings by Sept. 30, 2015.	Unit shift reports will now include a review of incidents, e.g., injuries, and confirmation that a corresponding incident report was filed. Nurse Managers and the Director of Performance Improvement will review the House Charge Report and Midas entries to ensure compliance with the timely reporting of incidents.	100%
L415	322-035.2 P&P-ANNUAL REVIEW	Dr. Cynthia Mason, Intake Manager; Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead; Dr. John Beall, CNO; Lewis Cox, Social Services Manager	9/30/2015	All policy and procedure manuals out of compliance with annual approval will be presented for approval at Quality Council on 9/15/15. On an on-going basis, policies and procedures will presented for approval at a minimum annually. Training for any policy content changes related to clinical staff will be conducted by the ACNO and will be completed by September 30, 2015. As applicable, training regarding other policy content changes will be conducted by the policy manual owner(s).	Policy and Procedure Manual Review will now be a standing agenda item on Quality Council. Policy Manual Owners will be prompted to present their manuals for approval prior to the due date.	100%
C415	324-035.2 P&P - ANNUAL REVIEW					

Revised 9.28.15 Darcie Rn
Approved 9-1-15 Theresa RN

L 690	322-100.1A-INFECT CONTROL-P&P	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead	9/30/2015	The "Medication Administration" Policy was updated to address proper hand hygiene prior to and after medication administration. The "Hand Hygiene" Policy was updated to address medication administration. All Sani-Hands product will be removed and replaced with PDI 70% alcohol wipes by 8/28/15. The "Cleaning Agent Selection" Policy was updated to reflect the new cleaning agent for BP cuffs and Vital Signs Machines. Glucometers will be replaced with devices that can be cleaned with bleach wipes by 8/28/15. By 9/30/15, the Infection Control Nurse will train all direct care staff to the aforementioned policies, and nursing staff will additionally be trained to new glucometers and cleaning agent. The policy will be submitted for approval to Quality Council on 9/15/15.	The Infection Control Nurse will do weekly audits to observe all direct care staff to ensure the use of proper hand hygiene and to ensure that appropriate cleaning agents are being used throughout the hospital, based on the device and manufacturer's recommendations. The Infection Control nurse will monitor the ordering supply list and ensure the hospital only orders approved products. New patient care items and disinfecting products will be reviewed and approved by the Infection Control Committee quarterly. All patient care items and disinfecting products will be reviewed by Infection Control Committee annually. Nurse Managers are to monitor units weekly to ensure the correct product is being used.	90%
L 695	322-100.1B INFECT CONTROL-REVIEW	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead	9/15/2015	The policy titled "Classifications of Infections" dated 4/2014 was reviewed by Primary Care Lead and Infection Control Nurse and determined to include determinations to distinguish between nosocomial and community acquired infections. Policy 1600.1.5 states that the Infection Control Practitioner uses "the CDC/NHSN classification." The Infection Control Nurse conducted education with the primary Care Lead on 8/6/15. The policy will be submitted for approval to Quality Council on 9/15/15.	Policy titled "Classifications of Infections", along with all Infection Control Policies, will be reviewed at least annually. Nosocomial infections are reviewed monthly at Quality Council to ensure compliance with identification protocols and process implementation.	100%
C 695	324-100.1b INFECT CONTROL-REVIEW					

Revised 8-28-15 [illegible]

L 780	322-120.1 SAFE ENVIRONMENT	Dr. John Beall, CNO; Chris O'Higgins, Director of Support Services	9/30/2015	The scope of work for Housekeepers will be clarified in an addendum to services by 9/4/15, which will specify that Housekeepers are responsible for cleaning substances such as dirt and grime. It is the responsibility of unit staff to notify facilities to address any damage caused by writing utensils. The Director Support Services or designee will train housekeepers by 9/25/15. The Policy and procedure titled "Patient Observation Policy" will be updated to specify "off limit" patient areas to ensure patient safety. The updated policy will be present to Quality Council for approval on 9/15/15. The Nurse Educator will train to the Housekeepers' scope of work and to the aforementioned policy at unit meetings by 9/30/15.	Compliance will be assessed at weekly management rounds and environmental rounds.	90%
L 880	322-140.1i ROOM FURNISHINGS	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead; Chris O'Higgins, Director of Support Services	10/2/2015	The policy titled "Terminal Bed Cleaning" was revised to specify when and how to clean hospital beds. Replacement mattresses were ordered and any compromised mattresses will be disposed of and replaced by 10/2/15. The policy will be presented to Quality Council for approval on 9/15/15. The Infection Control Nurse will train Housekeeping staff at staff meetings by 9/30/15.	The policy titled "Terminal Bed Cleaning" along with all Infection Control Policies, will be reviewed annually. The Infection Control Nurse will observe House Keeping to ensure that beds are cleaned according to policy at least weekly.	90%

Received 8.26.15 Illinois DPH

L 1165	322-180.2 EMERGENCY SUPPLIES	Dr. John Beall, CNO	9/30/2015	The Director of Pharmacy will ensure that the IV fluids are readily available in an emergency as well as secure and not accessible to patients. The Director of Pharmacy will present the policy regarding intravenous fluids in emergency situations to Quality Council on 9/15/15. The ACNO updated the policy, "Major Medical Emergency Treatment" to reflect this practice change. The policy will be presented for approval at Quality Council on 9/15/15. The Nurse Educator will train all nurses in the process of starting a peripheral IV, initiating an IV infusion, and continued care of the IV site and the abovementioned policies by 9/30/15. All nurses will receive this training in their new employee orientation and as an annual refresher. All necessary supplies will be ordered to safely adopt this process change. Supplies include: IV start Kit, IV tubing, IV catheter/needle sets; Saline Flushes, and IV Fluids.	At Fairfax's annual training nurses will be given an annual competency evaluation. The expected minimum competence level is 90%. Pharmacy will conduct weekly inspections to ensure IV solutions are not expired and stored appropriately. The expectation is 100% compliance.	90% 100%
L 1485	322-230.1 FOOD SERVICE REGS	Dr. John Beall, CNO	9/30/2015	Patient food items and paper products found on unit floors were removed on 7/21/15. Food and paper products are now stored at least 6 inches above the floor. Space was allocated to store food and paper items, and food and paper items are now stored in cabinets. The Nurse Educator will train unit staff at unit meetings by 9/30/15 regarding food and paper product storage. The juice dispenser, meat slicer, and knives were cleaned on 7/21/15. Food debris is now properly cleaned, as per policy and procedure as it relates to the WAC for food service. The Food Services Manager trained Dietary Staff to the policy and procedure as of 7/31/15.	Weekly management rounds will assure compliance with this code. The Food Services Manager will ensure ongoing compliance through daily observation.	90%
C1400	324-230.1 FOOD SERVICE REGS					

Received 8.24.15 Dept.

L 1490	322-230.2A FOOD SERVICE-24-HR MANAGER	Dr. John Beall, CNO	9/30/2015	A policy and procedure will be developed and implemented by the CNO and ACNO to address dietary consult management and the patient's multidisciplinary plan of care. The policy will be submitted for approval to Quality Council on 9/15/15. The Nurse Educator will train clinical staff to the aforementioned policy at unit meetings by 9/30/15.	Monthly chart audits will be conducted to ensure compliance with the requirement that dietary recommendations are incorporated into the multidisciplinary care plan.	100%
K144	NFPA 101 LIFE SAFETY CODE STANDARD	Chris O'Higgins, Director of Support Services	8/7/2015	A remote stop switch was installed on 8/7/15.	Compliance will be monitored on the monthly environmental rounds.	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.						

Received 8.26.15 Thesia R

Fairfax Behavioral Health - Kirkland Progress Report for State Licensing Survey (July 21 - 23, 2015)					
Tag Number	**WAC**	**Responsible Individual(s)**	**Date of Correction Completed**	**How Corrected**	**Results of Monitoring: Compliance Level**
L 355	322-035.1K POLICIES-STAFF ACTIONS	Dr. John Beall, CNO; Darcie Johnson, DPI/RM	9/30/2015	An incident report was entered regarding the patient injury on 7/23/15. The CNO was retrained by the Director of Performance Improvement and Risk Management regarding reportable incidents on 8/21/15. The Director of Performance Improvement and Risk Management will re-trained at clinical staff regarding reportable incidents at staff meetings, management meetings, and individually as of Sept. 30, 2015.	100%
L415	322-035.2 P&P-ANNUAL REVIEW	Dr. Cynthia Mason, Intake Manager; Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead; Dr. John Beall, CNO; Lewis Cox, Social Services Manager	9/30/2015	Identified policies and procedures and the manuals out of compliance were approved at Quality Council on 9/15/15. Policy and procedure manuals are presented for approval at a minimum annually. Training related to clinical staff was conducted by the CNO, ACNO, and Nurse Educator, at scheduled trainings and staff meetings as of September 30, 2015.	100%
C415	324-035.2 P&P - ANNUAL REVIEW				

L 690	322-100.1A INFECT CONTROL-P&P	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead	9/30/2015 11/1/15 (revised date for glucometers)	The "Medication Administration" Policy was updated to address proper hand hygiene prior to and after medication administration. The "Hand Hygiene" Policy was updated to address medication administration. All Sani-Hands product were removed and replaced with PDI 70% alcohol wipes effective 8/28/15. The "Cleaning Agent Selection" Policy was updated to reflect the new cleaning agent for BP cuffs and Vital Signs Machines. A manufacturer, Accucheck, was identified for replacement glucometers. However, at the time of ordering, it was determined that Accucheck ceased production of the control solution. We have identified a new manufacturer, Nova Biomedical. The representative is scheduled for an in-person presentation of the device on 10/21/15. An order will be placed at on that date, and the Nurse Educator will complete training by 11/1/15. By 9/30/15, the Infection Control Nurse will train all direct care staff to the aforementioned policies. The policy was approved at Quality Council on 9/15/15.	90%
L 695	322-100.1B INFECT CONTROL-REVIEW	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead	9/15/2015	The policy titled "Classifications of Infections" dated 4/2014 was reviewed by Primary Care Lead and Infection Control Nurse and determined to include determinations to distinguish between nosocomial and community acquired infections. Policy 1600.1.5 states that the Infection Control Practitioner uses "the CDC/NHSN classification." The Infection Control Nurse conducted education with the Primary Care Lead on 8/6/15. The policy was approved at Quality Council on 9/15/15.	100%
C 695	324-100.1b INFECT CONTROL-REVIEW				

L 780	322-120.1 SAFE ENVIRONMENT	Dr. John Beall, CNO; Chris O'Higgins, Director of Support Services	9/30/2015	The scope of work for Housekeepers was clarified in an addendum to services effective 9/4/15, which now specifies that Housekeepers are responsible for cleaning substances such as dirt and grime. It is the responsibility of unit staff to notify facilities to address any damage caused by writing utensils. The housekeepers were trained regarding this distinction as of 9/25/15. The Policy and procedure titled "Patient Observation Policy" was updated to specify "off limit" patient areas to ensure patient safety and was approved at Quality Council on 9/15/15. The Nurse Educator will train to the Housekeepers' scope of work and to the aforementioned policy at unit meetings as of 9/30/15.	**90%**
L 880	322-140.1i ROOM FURNISHINGS	Michael Carpenter, Infection Control Nurse; Dr. Roedel, Primary Care Lead; Chris O'Higgins, Director of Support Services	10/2/2015	The policy titled "Terminal Bed Cleaning" was revised to specify when and how to clean hospital beds. Replacement mattresses were ordered and compromised mattresses were disposed of and replaced as of 10/2/15. Compromised mattresses are now disposed of and replaced as identified. The policy was approved at Quality Council on 9/15/15. The Infection Control Nurse trained Housekeeping staff at staff meetings as of 9/30/15.	90%

L 1165	322-180.2 EMERGENCY SUPPLIES	Ajay Sinha, Director of Pharmacy	9/30/2015	The Director of Pharmacy ensures that the IV fluids are readily available in an emergency as well as secure and not accessible to patients. The policy regarding intravenous fluids in emergency situations was approved at Quality Council on 9/15/15. The ACNO updated the policy, "Major Medical Emergency Treatment" to reflect this practice change. The policy was approved at Quality Council on 9/15/15. The Nurse Educator trained nurses in the process of starting a peripheral IV, initiating an IV infusion, and continued care of the IV site and the abovementioned policies by 9/30/15. The Nurse Educator will conduct additional trainings for identified nurses to ensure competency by 11/15/15. All nurses now receive this training in their new employee orientation and as an annual refresher. All necessary supplies will be ordered to safely adopt this process change. Supplies include: IV start Kit, IV tubing, IV catheter/needle sets; Saline Flushes, and IV Fluids.	100% (weekly inspections)
L 1485	322-230.1 FOOD SERVICE REGS	Dr. John Beall, CNO	9/30/2015	Patient food items and paper products found on unit floors were removed on 7/21/15. Food and paper products are now stored at least 6 inches above the floor. Space was allocated to store food and paper items, and food and paper items are now stored in cabinets. The Nurse Educator trained unit staff at unit meetings as of 9/30/15 regarding food and paper product storage. The juice dispenser, meat slicer, and knives were cleaned on 7/21/15. Food debris is now properly cleaned, as per policy and procedure as it relates to the WAC for food service. The Food Services Manager trained Dietary Staff to the policy and procedure as of 7/31/15.	**90%**
C1400	324-230.1 FOOD SERVICE REGS				

L 1490	322-230.2A FOOD SERVICE-24-HR MANAGER	Dr. John Beall, CNO	9/30/2015	A policy and procedure was developed and implemented by the CNO and ACNO to address dietary consult management and the patient's multidisciplinary plan of care. The policy was approved Quality Council on 9/15/15, and the Nurse Educator trained clinical staff to the aforementioned policy at unit meetings effective 9/30/15.	100%
K144	NFPA 101 LIFE SAFETY CODE STANDARD	Chris O'Higgins, Director of Support Services	8/7/2015	A remote stop switch was installed on 8/7/15.	100%
By submitting this Progress Report on the 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

October 28, 2015

Darcie Johnson, MSW, CPHQ
PI/Risk Management Director
Fairfax Hospital
10200 NE 132nd St.
Kirkland, WA 98034

Dear Ms. Johnson,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Fairfax Hospital in Kirkland on July 21 to July 23, 2015. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on September 1, 2015.

Hospital staff members sent a Progress Report dated October 19, 2015 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Hospital in Kirkland's attestation to be in compliance with Chapters 246-320 and 246-322 of the 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,

Lisa Sassi

Lisa Sassi, RN, MN
Survey Team Leader