Received 5/19/21 11:30 Am barbara bla Phard-Edward Persones DEPARTMENT OF HEALTH AND HUMAN _RVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 504014 B WING 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TÁG DEFICIENCY) **INITIAL COMMENTS** A 000 A 000 MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety complaint investigation. Onsite dates: 04/20/21, 04/21/21, and 04/22/21 Case numbers: 2020-16014, 2021-2227 Intake numbers: 107480, 110171 The investigation was conducted by: Investigator #13 investigator #3 The DOH investigators found violations pertinent to the complaints. A 144 PATIENT RIGHTS: CARE IN SAFE SETTING A 144 CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on interview and document review, the hospital failed to protect patient rights for care in a safe environment by:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(Patients #1302 and #1306).

 Not implementing its policies and procedures for investigating and reporting sexual behavior between patients for 2 of 6 records reviewed

> TITLE CEO

(X6) DATE

Any deficiency statement ending with an asterist (*) 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.

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					RM APPROVED <u>10. 0938</u> -0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
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A 144	Continued From page	1	A	144			
•	history, observation a	bservation alerts based on nd interview of patients hospital for 1 of 6 patients 01).					
	3. Not ensuring a port Room on the adolesce or by staff unless they	ion of the Nolsy Activity ant unit is visible on camera enter the room.			•		
	and procedure for inve- sexual activity on the u appropriate observation record puts patients at psychological harm. Fi	risk for physical and ailure to be able to observe ns puts patients at risk for					
	Findings included:						
	Document review of "Sexual Aggression an Prevention and Respondated 01/18/21 shower	d Sexual Victimization: nse & Notification Plan.*					
	a. The Charge Nurse a immediately separate p sexual behavior or who engaged in sexual beh	atients upon discovery of are alleged to have					
	parents/guardians as a	be reported to the parents			(
1	c. Risk Manager or des Local/State Police in all ntercourse cases that i	sexual assault.				<u>.</u>	

DEPARTMENT OF HEALTH AND HUMA. ERVICES

		ID HUMANRVICES MEDICAID SERVICES			()		FORM	05/07/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRU			(X3) DATE S COMPL	URVEY
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	ROVIDER OR SUPPLIER ORTHWEST BEHAVIOR	AL HEALTH		STREET ADD 104 W 5TH A SPOKANE	E ,	U4/2	2/2021	
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A 144	Continued From page	•	A	144				
	Agencies, i.e.: Child F required by state state	Protective Services (CPS) as Ites.						
	e. Risk Manager or de documentation in the alleged incident, notifi and patient response.							
The state of the s	Investigator #13 show PM the patient reporter #1304)that he had sex (Patient # 1306) on 11	/15/20 at 8:30 PM in the attent #1302 was afraid						
		with Investigator #13 on Staff #1304 showed that:						
	a. Staff #1304 intervier and Patient #1306 tog encounter.	wed both Patient #1302 ether about the sexual						
	b. Staff #1304 did not r Patient #1302 or #1300 have their parents calle	6, as they had declined to		r Salanda de la composição de la composi			***************************************	
	incident because she b age of consent. One pa	notify CPS or police of the pelieved age 13 was the atlent involved in the old and the other patient						
1	4. During an interview v 02/05/21 at 10:00 AM , Quality/Interim Risk Ma							

DEPARTMENT OF HEALTH AND HUMA PRINTED: 05/07/2021 **ERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 504014 B. WING 04/22/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INLAND NORTHWEST BEHAVIORAL HEALTH 104 W 5TH AVE SPOKANE, WA 99204 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 144 Continued From page 3 A 144 a. Verified that the parents were not called, nor were CPS or police notified of the incident. Steff #1303 stated that the hospital's policy was not followed. b Staff #1303 stated that during the investigation the two involved patients told Staff #1303 where the encounter took place and that the patients were aware that it was not visible on the video cameras. 5. Observation by Investigator #13 on 04/21/21 of the Noisy Activity Room on the Adolescent Unit showed an angled wall that prevents direct observation from the hall or nurse's station. 6. During an interview with Investigator #13 on 01/29/21 at 10:30 AM, a mental health technician (Staff #1301) stated there are a couple of corners in the activity room that are not visible. 7. During an interview with Investigator #13 on 02/05/21 at 10:00 AM stated that during the investigation, all video tapes were reviewed and nothing was seen. 8. During an Interview with Investigator #13 on 04/22/21 at 9:45 AM Staff #1305 verified that a portion of the Noisy Activity Room on the Adolescent Unit is not visible without entering the room. 9. Document review of the hospital's policy,

"Sexual Aggression and Sexual Victimization: Prevention and Response at & Notification Plan," number 500.05F,dated 01/18/21 showed that:

 a. Action Steps included early identification by Intake/Admission staff for patients with potential

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	for sexual aggression victimization. b. The Intake/Admission completes the high rise and identifies either seasonal victimization are the RN accepting the accepting the accepting the accepting staff as for sexual aggression/patient on SAO- Aggree Precautions. 10. On 11/07/20 patient the adolescent unit with Intake Assessment data sexual molestation by accurrent legal process unit. The psychiatric evaluation. 11. The psychiatric evaluation. 12. Patient #1301's medinclude Sexual Victimization. 13. Patient #1301's medinclude Sexual Victimization. 14. During an interview.	and potential for sexual on staff/Unit Nurse k visual notification alert exual aggression and /or nd conducts a hand off with admission on the unit. essesses patient risk factors Victimization and places ession or SA)O- Victim at #1301 was admitted to h suicidal ideation. The fed 11/07/20 documents family members and underway. elluation dated 11/08/20 at history of sexual abuse dical record does not eation precautions. dical record does not	A	144			
] 1	he patient should have	been placed on kual victimization should					

		ND HUMAI ERVICES MEDICAID SERVICES				F	NTED: 05/07/2021 FORM APPROVED 3 NO. 0938-0391	
STATEMENT	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CO	(X3)	(X3) DATE SURVEY COMPLETED		
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	PATIENT RIGHTS: FABUSE/HARASSME CFR(s): 482.13(c)(3) The patient has the rof abuse or harassme. This STANDARD is a sased on record revitospital failed to protein that all team member need for specialized on history, observation a Failure to ensure cleaned for specialized of aggression or sexual may cause serious pharm to patients. Findings included: 1. Hospital policy titles Sexual Victimization: Notification Plan" num 01/18/21 showed that a. Early identification assesses patients for abused/assaulted, usi patient, family/guardia hospitalizations/placer agencies, and availab history.	REE FROM INT Ight to be free from all forms ent. Inot met as evidenced by: Inot met as evidenced by	1	145				
	b. Intake/admission sta the high risk visual not	aff/Unit nurse completes ification alert and identifies						

		ID HUMAN SERVICES MEDICAID SERVICES			()		PRINTED: 05/07/202 FORM APPROVED MB NO. 0938-039	
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	as appropriate, then of RN accepting the admost accepting the adolescent unit with adolescent unit with the adolescent with the adolescent and victimization should have been places and	ion of sexual victimization, conducts a hand-off with the nission on the unit. Issess patient risk factors for limization and places sision or SAO-Victim Int #1301 was admitted to the suicidal ideation. The ted 11/07/20 documents family members and underway. Ituation dated 11/08/20 at history of sexual abuse Idical record does not reation precautions. Idical record does not reation as part of the With investigator #13 on with the Medical Director, stated that the patient ed on precautions and the ould have been included in treatment team. PM the Spokane Police arding a police report taken ing bitten on the breast and toot in her crotch during her aged perpetrator was	A	145				

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A 145	Continued From page	7	A 145		,	
	8. Hospital policy titles Cases of Patient Sext dated 10/01/18 shows	d "Suspected or Confirmed al Activity" policy #500.43 ad that:				
	a. information regarding activity with another popular by instituting Sexual A Victimization Precaution	ng continued risk of sexual atient will be communicated gggression and/or ons.				
	b. Treatment team to inappropriate behavior could include discharge	treatment plan; the plan				
	#1310, #1311 and #13 sexual familiarity or se	ints #1302, #1306, #1309, 12). 3 of 4 were not put on xual aggression or sexual ns after sexually acting out		,		
	10. Five of 6 medical re investigator #13 shows were not updated after behavior (Patients #1302, #1309, #1310,	ed that the treatment plans sexualy acting out				
	04/22/21 at 12:45 PM,	t not updating observation ent plans after sexually				
	PATIENT RIGHTS: RES SECLUSION CFR(s): 482.13(e)(4)(i)	STRAINT OR	A 166			
	The use of restraint or s	eclusion must be				

DEPARTMENT OF HEALTH AND HUMA. ERVICES

		D HUMAN SERVICES MEDICAID SERVICES			v j	FOR	D: 05/07/2021 MAPPROVED D: 0938-0391	
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A 166	(i) in accordance with patient's plan of care. This STANDARD is not assert the patient's plan of care. Based on record revie policy and procedures modify the patient's plantients in restraints or records reviewed (Patients in restraints or seclusion harm by not meeting the needs. Findings included: 1. Document review of procedure titled, "Prop Physical/Chemical Respolicy # 300.22, last rear review and modificate indicated when an episoccurs. The registered update the treatment polaced in seclusion or records reviewed (Patients).	a written modification to the ot met as evidenced by: w and review of hospital, the hospital failed to an of care after placing r seclusion for 3 of 3 ient #301, #302, #303). plans for patients are in puls patients at risk of heir physical and emotional fithe hospital's policy and er Use and Monitoring of etraints and Seclusion," eviewed 09/20, showed that ion of the treatment plan is sode of restraint/seclusion if nurse will review and alan within 8 hours. Igator #3 conducted a f 3 patients who were restraints. In 3 of 3 patient ent #301, #302, #303), e patient's care plans to	A	166				

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A 166	Continued From page	9	A	166			
	to, an ongoing prograr improvement in indical evidence that it will medical errors. (2) The hospital must it trackadverse patien (c) Program Activities (2) Performance improvements are analyze their causes, a actions and mechanism	n Scope Include, but not be limited in that shows measurable tors for which there is identify and reduce measure, analyze, and t events covernent activities must ad adverse patient events, and implement preventive ins that include feedback	A	286			
	who assumes full legal for operations of the ho administrative officials accountable for ensurin (3) That clear expectal established. This STANDARD is no . Based on document res	ibilities, The hospital's anized group or individual authority and responsibility espital), medical staff, and are responsible and ng the following: tions for safety are at met as evidenced by: view and interviews, the evelop and implement its nemt Plan related to					

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

PRINTED: 05/07/2021 FORM APPROVED OMB NO. 0938-0391

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A 286	patients. Failure to include all ream and ensure all n	nembers of the treatment nembers are educated may ychological harm to patients.	A	286				
	titled "Prevention of S Action Plan" dated 11/ patients using "STOP, included only educatir Technicians (MHTs) or 2. The plan did not included the plan did not included the plan to be expected.	mprovement Project (PIP) exual Acting Out Behaviors /17/20 Included educating . THINK, TALK". The plan ng Mental Health n "STOP, THINK, TALK".			·			
	provided to Investigate written note in the upp all social workers had 01/14/21.	the course content was or #13 that had a hand er right corner stating that been educated on with investigator #13 on		The second secon				
	04/20/21 at 9:10 AM, to Services, Staff #1305 :	he Director of Clinical	TOTAL AND					
	5 There is no sign in ro is no evidence in the ei system that education	ster for the training. There lectronic education tracking was provided.					And the second s	
	04/22/21 at 9:42 AM, a #1309 stated she was a	with Investigator #13 on a Registered Nurse, Staff aware of the "STOP, a, but had been educated						

		& MEDICAID SERVICES			OMBIN	M APPROVE O. 0938-039
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A 286	at her previous emp	ge 11 lloyer. Staff #1309 had at this hospital on the	A 286			
			·			
RM CMS-2567(02-99) Pravious Versions Obs	toleta Event ID: ZBNY	V11 Facility	D. 013250	If continuation cheet	

Facility (D. 013250

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If continuation sheet Page 12 of 12

DEPARTMENT OF HEALTH AND HUMAN JERVICES

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F continuation sheet 1 of 6

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L 000	INITIAL COMMENT	5	L 000				
	STATE COMPLAINT	INVESTIGATION					
	(DOH) in accordance Administrative Code Private Psychiatric a	ite Department of Health e with Washington (WAC), Chapter 246-322 and Alcoholism Hospital ed this health and safety					
		v dates: 12/28/20-03/03/21 dates: 04/20/21, 04/21/21,					
	Case Numbers: 2020 Intake Numbers: 107	0-16014, 2021-2227 7480, 110171					
	Investigators # 13 an	d #3					
	There were violations complaint.	s found pertinent to this					
L 325	322-035.1E POLICIE	S-ABUSE PROTECTION	L 325				
1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	WAC 246-322-035 Porcedures. (1) The lidevelop and implementation policies and proposistent with this classification provided: (e) against abuse and neaccording suspected in according to the provided provided provided and provided and provided and provided are provided and provided and provided are provided and provided and provided and provided and provided are provided and provided and provided and provided and provided are provided and provi	licensee shall ant the following rocedures hapter and) Protecting eglect and ncidents isions of					
	s evidenced by; Based on interview ar	ninistrative Code is not met					
Form 2567 RATORY DIF		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE	
1	7 '	ewell	-	CEO		As A DUIL	

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State of Washington				FORM APPROVED
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L 325 Continued From page	91	L 325		
hospital failed to imple procedures for invest behavior between parent of the hospital for 2 or (Patients #1302 and a Failure to ensure that and procedure for investual activity on the physical and psychological and psychologica	ement its policies and igating and reporting sexual tients on the Adolescent Unit f 5 patients reviewed #1306). I staff members follow policy estigating and reporting unit puts patients at risk for ogical harm. If the hospital's policy, and Sexual Victimization: onse & Notification Plan," 5/20 showed that: and facility leadership patients upon discovery of o are alleged to have	L 325		
allegations will need to or guardians of those	be reported to the parents			
c. Risk Manager or de Local/State Police in a intercourse cases that	ll sexual assault.			
d. Risk Manager or des Agencies, i.e.: Child Pr required by state statut	otective Services (CPS) as			
e. Risk Manager or des documentation in the m atleged incident, notific and patient response.	signee oversees nedical record re: the ations, staff interventions,			

State of	State of Washington FORM APPROVED							
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NAME OF I	ROVIDER OR SUPPLIER	STREET A	DORESS, CITY, S	STATE, ZIP CODE				
INLAND I	NORTHWEST BEHAVIOR	AL HEALTH 104 W 5 SPOKAN	TH AVE IE, WA 99204					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD GROSS-REFERENCED TO THE APPROP DEFICIENCY)	LD BE COMPLETE				
L 325	Continued From page	2	L 325					
	2. Review of Patient # showed that on 12/02/reported to a social whad sex with another patient #1302 was afrogregnant. 3. On 01/29/21 at 2:25 #1304 showed that: a. Staff #1304 interview and Patient #1306 togencounter. b. Staff #1304 did not reparents called their parents called c. Staff #1304 did not report incident because she beage of consent. One paincident was 16 years of was 14 years old. 4. On 02/05/21 at 10:06 with Investigator #13, the Quality/Interim Risk Mata. Verified that the parewere CPS or police not #1303 stated that the hefollowed. b. Staff #1303 stated that video tapes were reviseen.	#1302's medical record /20 at 5:00 PM the patient briker (Staff #1304) that he patient (Patient # 1306) on in the noisy activity room. aid Patient #1306 might be 8 PM, an interview with Staff wed both Patient #1302 ether about the sexual notify parents of either 6, as they had declined to ed. notify CPS or police of the pelieved age 13 was the estient involved in the old and the other patient D AM during an interview the Director of mager (Staff #1303): onts were not called, nor ified of the incident. Staff cospital's policy was not at during the investigation, viewed and nothing was						
ate Form 2567		at during the investigation]		

PRINTED: 05/07/2021 FORM APPROVED

STATEMEN	Washington TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MILTIDUE /	CONSTRUCTION		RM APPR
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			SURVEY PLETED
		013250	B WING_		1	C (22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	F ZID CODE		/22/2021
INLAND N	ORTHWEST BEHAVIOR			L, ZIF GUUE		
	CONTRACT DELIMATOR	ne neaeir	NE, WA 99204			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF	CORRECTION	(X5
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	THE APPROPRIATE	COMPL DAT
L 325	Continued From page	3	L 325			
	the two involved patie	nts told Staff #1303 where				
	the encounter took pla	ice and that the patient				
	cameras (Patients #13	not visible on the video 302 and #1306).				
- 1						
1	5. Document review of "Sexual Aggression ar	rtne nospital's policy, nd Sexual Victimization:				
1	Prevention and Respo	nse & Notification Plan "				
	last review dated 05/0	5/20 showed that:				
	a. Action Steps include	ed early identification by				}
- 1	Intake/Admission staff	for patients with notential				1
]	for sexual aggression a victimization.	and potential for sexual				
.	Arcernzanon.					
· · [1	b. The Intake/Admissio	n staff/Unit Nurse			ļ	
14	completes the high risk	Visual notification alert] [
	and identilies either se: 80xual victimization an	xual aggression and/or d conducts a hand off with				
	the RN accepting the a	dmission on the unit.				
9	c. The Nursing Staff as	sesses patient risk factors				
	or sexual aggression/\ palient on SAO- Aggres	/ictimization and places				
	Precautions.	asion of SAO- Victim				
ϵ	3. On 11/07/20 nations s	#1301 was admitted to the				
Į a	idolescent unit with sui	cidal ideation. The intake				
ρ.	Assessment dated 11/0	7/20 documents sexual				
p	nolestation by family m process underway.	embers and current legal				
7	. The psychiatric evalu	ation dated 11/8/20 at				
8	34 AM describes the h	nistory of sexual abuse		•		
a	nd victimization.					
8.	. Patient #1301's medic	eal record dogs not				
In	clude Sexual Victimiza	tion precautions.				
9.	Patient #1301's medic	al record does not				
om 2587 FORM						

	State of Washington FORM APPROVED							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			E SURVEY		
, AND LEAN	IDENTIFICATION NUMBERS		A. BUILDING:			PLETED		
		24222	מאוונים			С		
		013260	B. WING_		0,	1/22/2021		
NAMEOFP	ROVIDER OR SUPPLIER			STATE, ZIP CODE				
INLAND N	IORTHWEST BEHAVIOR	AL HEALTH 104 W 5	TH AVE JE, WA 99204					
(X4) ID PREFIX	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID.	PROVIDER'S PLAN OF CORRECT	NC	(X5)		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE		
				DEFICIENCY)				
L 3 25	Continued From page	94	L 325					
	include Sexual Victimi	Ization as part of the						
	treatment plan.			}				
	10. During an interview	w between Investigator #13		·				
	and the Medical Direc	tor, (Staff#1311) on						
	04/21/21 at 9:00 AM,	Staff #1311 stated that the een placed on precautions						
	and the sexual victimiz	zation should have been	Í					
	included in the discuss	sion with the treatment						
	team.							
I 340	322-035.1H PROCED	HOEG BEHAVIOD	1 040					
	OZE-000: IN FILOUED	CUEO-BEHAVIOR	L 340					
	WAC 246-322-035 Pol							
	Procedures. (1) The lice develop and implement	censee shall						
	written policies and pro	n (ne ronowing Ocedures				.		
ŀ	consistent with this cha	apter and						
	services provided: (h) i assaultive, self-destruc	Managing						
	out-of-control behavior							
ļ	(i) Immediate actions a	and conduct;						
	(ii) Use of seclusion an consistent with WAC 2-							
	other applicable state s							
	(iii) Documenting in the							
	record; This Mashinatan Admir	data-tion On the Control						
	es evidenced by:	nistrative Code is not met						
	,		-	,		•		
	Based on record review policy and procedures,	v and review of hospital						
	mplement its policies a	ine nospital falled to ind procedures for the use						
(of restraints/seclusion b	by not modifying the	,					
	patient's plan of care fo Patient #301, #302, #3	r 3 of 3 records reviewed						
	ranoni #301, #302, #3	ພວງ.						
F	allure to modify care p	lans for patients in						
r	estraints or seclusion p	outs patients at risk of			:			
ate Form 2587			<u> </u>					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING.		
		013250	B WING	·		C
VAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		/22/2021
NLAND N	ORTHWEST BEHAVIOR	AL HEALTH 104 W 5	TH AVE			
		8POKA1	NE, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPI COMPI DAT
L 340	Continued From page	5	L 340			
	harm by not meeting t needs.	their physical and emotional				
	Findings included:					
	procedure titled, "Prop Physical/Chemical Re policy # 300.22, last re a review and modifical indicated when an epi	f the hospital's policy and per Use and Monitoring of straints and Seclusion," eviewed 09/20, showed that tion of the treatment plan is sode of restraint/seclusion d nurse will review and plan within 8 hours.				
	clinical record review o placed in seclusion or records reviewed (Pati	igator #3 conducted a of 3 patients who were restraints. In 3 of 3 patient ient #301, #302, #303), ne patient's care plans to int interventions.				
13	Staff #1303 on 0422/21	with the Director of Quality, 1 at 12:45 PM, Staff #1303 al pollicy was not followed.				
]					ļ	
				•		
		-	1		ì	

Reserved 5/17/21 4:40(11).
Dev Deve Ste Chard Edica INLAND NORTHWEST REHAVIORAL HEALTH

CMS PLAN OF CORRECTION

	By submitting this Plan of Correction, the Hospital does not agree that the facts alleged are true or admit that it violated the rules. The Hospital submits this Plan of Correction to document the actions it has taken to address the citations.	
Tag # A 144	PATIENT RIGHTS: CARE IN SAFE SETTING	
	CORRECTIVE ACTION:	
	The CEO, Medical Director and Director of Quality met to review the findings of this survey and reviewed the policy titled, Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan with no revisions required.	
	All nursing staff including RNs and MHTs were retrained to the Sexual Aggression and Sexual Victimization policy immediately. Training focused on:	
	 Appropriate investigation and reporting of sexual behavior The need to separate patients upon discovery of sexual behaviors or who alleged to have engaged in sexual behaviors Notification of parents/guardians per policy Notification of local/state police in all sexual assault, intercourse 	5/31/2021
•	 Notification of localistate poince in an sexual assault, intercourse cases that involve minors Notification of Child Protective Services (CPS) as required by state statutes 	
	Training was initiated and completed by 5/31/2021. Evidence of training is filed in staff's personnel file.	
	STAFF RESPONSIBLE: The Director of Quality and Risk Manager	
	MONITORING: Monitoring of 100% of patients placed on Sexual Acting Out (SAO) precautions to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed.	
	Threshold for acceptable compliance: >90%	
	Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	
Tag # A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT	
	CORRECTIVE ACTION:	
	The CEO, Medical Director and Director of Quality met to review policies on Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan, and Suspected or Confirmed Cases of Patient Sexual Activity. No revisions required at this time.	

INLA. D NORTHWEST BEHAVIORAL HEALTH

CMS PLAN OF CORRECTION

		· • · · · · · · · · · · · · · · · · · ·
	All direct patient care staff, including Intake/Admission staff were trained to the Sexual Aggression and Sexual Victimization Prevention and Response, Notification plan. Training focused on: • Early identification by intake/admission staff via assessment of patient history for being sexually abused/assaulted • Completion of a high risk visual notification alert by the intake/admission staff that identified either sexual aggression or sexual victimization • Proper hand-off of patient's assessment and high risk visual notification with RN accepting the admission on the unit • Nursing staff responsibility for assessing patient risk factor for sexual aggression/victimization and • Patient placed on appropriate SAO precautions Training was initiated immediately and completed by 5/31/2021. Evidence of training is filed in staff's personnel file. STAFF RESPONSIBLE: Director of Quality and Risk Manager MONITORING: Monitoring of 100% of patient's on SAO precautions reviewed to confirm compliance with hospital policy. Monitoring is ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	5/31/2021
Tag # A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CORRECTIVE ACTION: The CEO, Medical Director and Director of Quality met to review the policy titled, Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion. No revisions required at this time.	
	All Registered Nurses, Providers and Social Workers were retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion with key focus on: Required review and modification of the treatment plan when an episode of seclusion/restraint occurs The RN reviews and updates the treatment plan within eight hours of the seclusion/restraint intervention	5/31/2021
	Training was initiated immediately and completed by 5/31/2021. Evidence of training is located in the personnel file.	

INLAND NORTHWEST BEHAVIORAL HEALTH

CMS PLAN OF CORRECTION

J		
	STAFF RESPONSIBLE: Director of Quality and Clinical Educator MONITORING: Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. 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. Threshold for acceptable compliance: >90% Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	
Tag # A 286	PATIENT SAFETY	
	CORRECTIVE ACTION:	
	The CEO, Medical Director and Director of Quality met to review the Performance Improvement Plan titled "Prevention of Sexual Acting Out Behaviors Action Plan dated 11/17/20. The PIP Plan was updated to state that all members of the treatment team will be educated on the "Stop, Think, Talk" Group and handout. The revised Plan was reviewed and approved by the Quality Council Committee on 5/17/2021.	
	All members of the treatment team including nursing staff, therapists, medical staff and extenders were educated about "Stop, Think, Talk" by the Director of Quality and Risk Manager. Training was initiated immediately and completed by 5/31/2021. Evidence of staff training is filed in staff's personnel file.	5/31/2021
	Training included emphasis on the patient behaviors that are not allowed and the Group content of "Stop, Think, Talk".	
	STAFF RESPONSIBLE: Director of Quality and Risk Manager.	
	MONITORING: Monitoring of 100% of Group notes on "Stop, Think, Talk" will be reviewed to confirm compliance with the group occurring. 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.	
;	Threshold for acceptable compliance: >90%	
	Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.	

INLA (D NORTHWEST BEHAVIORAL HEALTH

CMS PLAN OF CORRECTION

Tag # L 325	POLICIES-ABUSE PROTECTION	
		Т
	CORRECTIVE ACTION:	
	The CEO, Medical Director and Director of Quality met to review the findings of this survey and reviewed the policy titled, Sexual Aggression and Sexual Victimization: Prevention and Response & Notification Plan with no revisions required.	
	All nursing staff including RNs and MHTs were retrained to the Sexual Aggression and Sexual Victimization policy immediately. Training focused on:	
	 Appropriate investigation and reporting of sexual behavior The need to separate patients upon discovery of sexual behaviors or who alleged to have engaged in sexual behaviors Notification of parents/guardians per policy 	
	 Notification of local/state police in all sexual assault, intercourse cases that involve minors 	
	 Notification of Child Protective Services (CPS) as required by state statutes 	
	Training was initiated and completed by 5/31/2021. Evidence of training is filed in staff's personnel file.	
	STAFF RESPONSIBLE: The Director of Quality and Risk Manager	
	MONITORING: Monitoring of 100% of patients placed on Sexual Acting Out (SAO) precautions to confirm compliance with hospital policy. Monitoring will be ongoing for four months until compliance is achieved and sustained. All deficiencies are corrected immediately to include staff retraining as needed.	
	Threshold for acceptable compliance: >90%	
	Aggregated data is reported to the Quality Council Committee and Medical Executive Committee monthly and to the Governing Board quarterly.	
Tag # L 340	PROCEDURES-BEHAVIOR	
	CORRECTIVE ACTION:	
	The CEO, Medical Director and Director of Quality met to review the policy titled, Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion. No revisions required at this time.	
	All Registered Nurses, Providers and Social Workers were retrained to the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion with key focus on:	

INLAND NORTHWEST BEHAVIORAL HEALTH

CMS PLAN OF CORRECTION

May 17th, 2021

- Required review and modification of the treatment plan when an episode of seclusion/restraint occurs
- The RN reviews and updates the treatment plan within eight hours of the seclusion/restraint intervention

Training was initiated immediately and completed by 5/31/2021. Evidence of training is located in the personnel file.

STAFF RESPONSIBLE: Director of Quality and Clinical Educator

MONITORING: Monitoring of 100% of patients placed in seclusion or restraints are reviewed to confirm compliance with hospital policy. 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.

Threshold for acceptable compliance: >90%

Aggregated data is reported to the Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly.

Facility Name: Inland Northwest . navioral Health

Case/Intake Number: 2020-16014/107480

Investigative Report Off-site State Investigation

Facility Address: 104 W. 5th Ave. Spokane, WA 99204

Laboratory Director: N/A

CLIA Number: N/A

Credential Number: 60882652

Medicare Number:

Shell Number: ZBBNW11

Date(s) of Investigation: 12/28/20-03/03/21

State Licensing Priority: B

Federal Certification Priority: N/A

Intake Details: (List of concerns reported in the original complaint.)

A 14 y/o female was sexually assaulted by another adolescent in the facility; experienced bullying and threats regarding her sexuality and religion without staff intervention; was not supervised nor counseled when she cut her arms with metal and cardboard and was provided no first aid for those cuts.

Allegation/s: (The allegation/s listed below is what the department has jurisdiction and authorization to investigate. An allegation is considered an assertion of improper practice or condition that could result in a violation of facility law or rule.)

- 1. Allegation: The facility failed to provide care in a safe environment as required in WAC 246-322-170 Patient Care Services [provide adequate care by admitting only patients for whom the hospital has adequate staff, services and equipment].
- 2. The facility failed to develop and/or implement policies and procedures regarding abuse of patients under WAC 246-322-035 Policies and Procedures.
- 3. The facility failed to educate and supervise staff providing care in the adolescent unit as required in WAC 246-322-050 Staff.

Investigative Process Included: (This is what the investigator did in terms of methods employed to conduct inquiry.)

1. The investigator interviewed the complainant by telephone on 11/25/20 at 11:30 AM to clarify complaint and gather additional information.