State of Washington					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		013250	B. WING		10/14/2021
	PROVIDER OR SUPPLIER	MODAL HEALTH 104 W 57	TH AVE	STATE, ZIP CODE	
1142/1142		SPOKAN	IE, WA 9920		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
L 000	100 INITIAL COMMENTS		L 000		
	STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. On site dates: 10/06/21 - 10/08/21 Offsite dates: 10/14/21		AMAZONA TITLOGRAFIA	A written PLAN OF CORRECT required for each deficiency listed Statement of Deficiencies.	
				EACH plan of correction states must include the following:	
				The regulation number and/or the number;	tag
				HOW the deficiency will be correct	eted;
	Examination numb	er: 2021-847		WHO is responsible for making the correction;	ne
	The survey was co	nducted by:		WHAT will be done to prevent	i
	Surveyor #5 Surveyor #17			reoccurrence and how you will me continued compliance; and	onitor for
	The Washington Fi	re Protection Bureau life safety inspection (See		WHEN the correction will be com	pleted.
	Shell # K5GN21).			3. Your PLANS OF CORRECTION be returned within 10 calendar dathed the date you receive the Stateme	ys from
	During the course of the survey, surveyors assessed issues related to complaint #2021-11377.			Deficiencies. Your Plans of Corremust be received electronically by November 5, 2021.	ection
	·			Return the REPORT electronic the required signatures.	cally with
L 315	322-035.1C POLIC	IES-TREATMENT	L 315		
,	WAC 246-322-035 Procedures. (1) Th develop and impler written policies and consistent with this	e licensee shall ment the following I procedures chapter and			
Stata Form	services provided:	(c) Providing			

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

TITLE

(X6) DATE

	State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE S	
- ,	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		013250	B. WING		10/14	4/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
	NORTHWEST BEHAV	YORAL HEALTH SPOKANE	H AVE E, WA 99204		,	
		TEMENT OF DEFICIENCIES	E, WA 99204	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
L 315	Continued From pa	ge 1	L 315		A CONTRACTOR OF THE CONTRACTOR	
	or arranging for the treatment of patient This Washington Ad as evidenced by:					
	Item #1 Active The	гару			į	
	hospital failed to en measures were pro attempts to engage treatment measure attend groups as di of 2 patients review Failure to provide a level and intensity reing hospitalized versions.	at review and interview, the sure that active treatment evided or demonstrated a patients in alternative active is when they chose not to rected by hospital policy for 2 and (Patient #502 and #503). Active treatment at a sufficient results in affected patients without all active treatment covery, thereby delaying their				
	Findings included:					
	Document review procedure titled," P Care-Scope of Services.	v of the hospital's policy and lan for Provision of vices," policy number 100.12, showed the following:				
	allow treatment to t	es distinctive programing to be tailored to the level of gree of illness present.	-C-Access accessions and access to the control of t			
	b. Programming inc psycho-educationa recreational therap	cludes group therapy, I groups, and expressive and ies.				
	therapy, provided b	sts of multiple avenues of by many disciplines. These are based upon the plans and	- Landers - Land			

State Form 2567 STATE FORM

	vvasnington	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	ETED .
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
		013250	B. WING		10/1	4/2021
			DRESS, CITY, ST	TATE, ZIP CODE		
	PROVIDER OR SUPPLIER	104 W 5Ti		•		
INLAND	NORTHWEST BEHA	"AD AT 15E AT TH	E, WA 99204			
(X4) ID PREFIX	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
TAG	ALGOD TON TON			DEFICIENCY)		
L 315	Continued From pa	age 2	L315			
	treatment plan and	mented in the individualized I include individual treatment, portive family therapy, and				
	schedule includes	s conducted daily, and the daily a variety of activities based supational therapy groups as noeducational or milieu-based				
	procedure titled. "I	of the hospital's policy and ndividual Supportive Therapy plicy number 400.04, reviewed the following:	A description of the state of t			
	a. A Social Worker Professional (LP) individuals at the h	r (SW) or Licensed will provide psychoeducation to nospital.				
	b. The SW and the extent of the need therapy.	e Physician will determine the for individual supportive				
	patient in the patient the psych-social a supportive therapy	document all contacts with the ent's medical record including assessment, education provided interventions, patient in for the next session.	,			
	procedure titled."	of the hospital's policy and Alternative Programing," policy eviewed 12/01/20, showed the				
	treatment for all p	ipports a model of active atients and the primary therapy provided by a variety aclude social services, activitying.				

State of	State of Washington (ya) pare survey						
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		013250	B, WING		10/14/2021	10/14/2021	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE			
	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5T	H AVE E, WA 99204				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPL	ETE	
L 315	Continued From pa	age 3	L315				
	for each patient that	I treatment plan is developed at directs the specific focus of see patient as well as other tions.	A CONTRACTOR OF THE CONTRACTOR				
:	medical condition, appropriate for the services and altern	a patient's psychiatric or group interventions are not patient to realize active native therapeutic interventions planned, and implemented for	- Andrews				
	attending physicial the need for altern development of an	eatment team, led by the n, is responsible for recognizing ative treatment interventions, appropriate treatment plan, the plan, and documentation nterventions.					
	Registered Nurse assigned to condu	social worker, activity therapist, or Mental Health Technician act educational or therapeutic lible for documenting the group nedical record.					
	group intervention for providing the g and provide individual will chart the inter- discussed or the e	a patient misses an individual, the staff member responsible roup will seek out the patient dual therapy. The staff member vention, including what was educational/activity provided, the to the intervention, and the toward meeting treatment		,			
	unable to attend g	tinues to refuse group or is group for greater that 24 hours, Director or Charge Nurse will b Illing an ad hoc meeting of the	е				

State of Washington						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/14/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	IORAL HEALTH SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
L 315	Continued From pa	ge 4	L 315			
	treatment plan or d interventions more individual basis rath	evise the patient's current evelop a new plan with appropriately done on an ner that a group intervention.				
	interventions in the progress note secti interventions, the mintervention, the pa	ne patient will document these medical record under the on, including date/time of the nodality and the focus of the tient's response to the ogress toward treatment goals.				
	Director of Quality a #501) reviewed the #502 who was adminvoluntary patient self-injurious ideation had a history of sui Post-Traumatic Str. Document review in therapy attendance	2:45 PM, Surveyor #5 and the and Infection Control (Staff medical record for Patient litted on 09/08/21 as an due to suicidal and on and behavior. The patient cide attempts, depression, less Disorder, and anxiety. Including review of the active records from 09/09/21 28 days) showed the following:				
	09/17/21, showed t goal included atten- improve coping skil psychoeducation gr	Plan Problem Sheet dated hat the patient's short-term ding group programming to lls daily. The patient will attend roup daily, group therapy with aily, and activity therapy total of 4 groups).				
		nd no evidence that the patient group or received alternate 28 days.	1			
		nd no evidence that the patient onal group or received for 7 of 28 days.				

	vvasnington				AVAL DATE	CHDVCV	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDERALICATION NOMBER.	A. BUILDING:				
			, umo	n wino		.,,,,,,	
		013250	B. WING		10/1	4/2021	
NAME OF E	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE			
		104 W	5TH AVE				
INLAND	NORTHWEST BEHAV	IORAL HEALTH SPOK	ANE, WA 99204	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
L 315	Continued From pa	ige 5	L 315				
	attended an activity treatment for 13 of	•					
	attended morning or received alternate t	nd no evidence that the pation communication group or creatment for 7 of 28 days.					
	attended evening c	d no evidence that the patie ommunication group or reatment for 10 of 28 days.	nt				
	Plan Update Works 09/23/21, 09/27/21 was attending 3 or #5 found no eviden or more groups dai evidence the patier	d on the Master Treatment sheets for 09/16/21, 09/20/2, and 10/04/21, that the patimore groups a day. Surveyonce that the patient attended by for 12 of 28 days and no not attended all 4 groups attended plan for 17 of 28 days	ent or 3				
	Update Worksheet that the patient was Programming" and for 2 hours now plate 5 found no evidence interventions identifications.	e Master Treatment Plan showed a box check "Yes" placed on "Specialized a written note stated, "off 1 aced back on 1:1." Surveyor se of alternative therapeutic fied, planned, and rected by hospital policy.	1 #				
	Update Worksheet "Suicidal," added to section titled, "Prog documents," place Surveyor #5 found therapeutic interve	Master Treatment Plan showed a problem of the problem list. In the gress toward Goal," staff d on alternative programmir no evidence of alternative ntions identified, planned, as rected by hospital policy.					

	Washington		LOW LINETING	r construction	(X3) DATE S	SURVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E CONSTRUCTION	COMPL	
MULTINE	o. John Lond		A, DOILDING.			
		013250	B. WING		10/1	4/2021
NAME OF E	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
		104 W	5TH AVE			
INLAND	NORTHWEST BEHA	ORAL HEALTH SPOK	NE, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L 315	Continued From pa	age 6	L 315			
	the hospital offered group in the mornin communication group process groups, and therapy twice daily, and stated that star group attendances 4. On 10/07/21 at a Director of Quality #501) reviewed the #503 who was adm for an attempted supatient's history inc Disorder, Borderlin Oppositional Defia review including reattendance records	e review, Staff #501 stated the dan opening communication and an a closing oup in the evening, daily and activity therapy/recreations. Staff #501 verified the findir ff should be documenting and alternate therapy. 10:45 AM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient in the discount of the medical record for Patient in the discount of the medical record for Patient in the discount of the series of the personality Disorder, and ince Disorder. Document oview of the active therapy is from 09/12/21 through is showed the following:	al ng ne			
	09/15/21, showed goal included atter improve coping sk psychoeducation of	Plan Problem Sheet dated that the patient's short-term ading group programming to ills daily. The patient will atte group daily, group therapy wild daily, and activity therapy (total of 4 groups).	nd h			
	b. Surveyor #5 fou attended a proces treatment for 8 of 2	and no evidence that the pations of	ent			
i	c. Surveyor #5 fou attended a recreat alternate treatmen	nd no evidence that the pational group or received to for 6 of 20 days.	ent ,			
	d. Surveyor #5 fou attended an activit treatment for 7 of	ind no evidence that the pati by group or received alternate 20 days.	ent 9			

STATEMEN	Washington IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		013250	B. WING		10/	14/2021
NAME OF I	DDOVADED OD CHERNIER		ADDRESS, CITY, S	STATE ZIP CODE		
	PROVIDER OR SUPPLIER	104 W	5TH AVE	5		
INLAND	NORTHWEST BEHAV	AUDVI HEVITH	NE, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L 315	Continued From pa	age 7	L 315			
	attended morning of received alternate to f. Surveyor #5 foun attended evening of	nd no evidence that the patie communication group or treatment for 4 of 20 days. d no evidence that the patier communication group or			·	
	g. Staff documente Plan Update Works and 09/29/21 that t more groups a day evidence that the p groups daily for 6 o	treatment for 4 of 20 days. d on the Master Treatment sheets for 09/16/21, 09/22/21 he patient was attending 3 or . Surveyor #5 found no ratient attended 3 or more of 20 days and no evidence the 4 groups directed by the				
	Update Worksheet the patient was pla Programming" and programming." Sur alternative therape	e Master Treatment Plan shows a box check "Yes" the ced on "Specialized a written note stated, "1:1 eveyor # 5 found no evidence utic interventions identified, emented as directed by hospi	of			
		ed the finding and stated that sumenting group attendances py.				
	Item #2 Monitoring Precautions	of Patients on Enhanced				
	review the hospital implement a syster of and provided ap patients who had b	y, observation, and document failed to develop and m to ensure staff were notific propriate monitoring for seen placed on enhanced ions for 3 of 3 patients (Patie	ed			

State of Washington

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION ::	(X3) DATE COMP	SURVEY LETED
		013250	B. WING		10/1	4/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5T SPOKAN	H AVE E, WA 9920	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 315	Continued From pa	ige 8	L 315			
	#507, #508 and #5	09).				
	self-harm, harm to staff members, pos	communicate patients' risk of other patients or harm to unit sed a threat to the health and s and staff, which could result d death.				
	Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Aggression and Sexual Victimization: Prevention and Response and Notification Plan," policy number 500.05F, reviewed 01/18/21, showed the following:		The state of the s			
			A.O.			
	behaviors/precurso	rve patients for specific rs to sexually acting out violations, sexual aggression,	A 142000 A			
	b. Maintain an awai at all times	reness of the patient location				
	c. Communicate an	d document signs of concern			T TO THE PERSON OF THE PERSON	
	d. Conduct observa	ition rounds as ordered			ANTIPANA PRACTICAL ALABAMA	
	procedure titled, "S	f the hospital's policy and uicide Precautions," policy viewed 07/16/21, showed the				
	Precaution order da need. The physician	Il reevaluate the Suicide aily to determine continued order for discontinuance of s is initiated when the patient o longer at risk			THE PROPERTY OF THE PROPERTY O	
	b. Patients on Suici	de Precautions will be				

State Form 2567 STATE FORM

State of	Washington					
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	TORAL HEALTH 104 W 5TI SPOKANI	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 315	Continued From pa	ge 9	L 315			
	identified by an "S" written on the unit census boards. The Suicide Prevention box will be check on the Observation sheet.					
	c. Staff will closely monitor the patient on the unit					
	d. When conducting rounds, staff shall observe the patient directly.					
	2. On 10/06/21, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) observed staff provide patient rounding observations for patients on enhanced precautions, reviewed rounding documentation, and interviewed staff related to monitoring of patients on enhanced precautions. Surveyor #5 observed the following: a. From 9:52 AM until 10:02 AM, Surveyor #5 interviewed a Mental Health Technician (MHT) (Staff #504) and observed Staff #504 perform patient rounding observations. During interview with Surveyor #5, Staff #504 stated that she was monitoring Patient #507, #508, and #509 for enhanced suicide precautions.					
	Registered Nurse (enhanced monitoring precaution orders for and #509. The proventient #508 was of #507 and #509 wer	rveyor #5 interviewed a Staff #505) about patients on an and reviewed enhanced or Patient #501, #507, #508, vider order review showed that an Suicide Precautions. Patient e not on Suicide Precautions. 509 were on Sexual tions.				
	interviewed an MH Staff #506 perform	until 11:08 AM, Surveyor #5 I (Staff #506) and observed patient rounding observations. nat she was monitoring Patient				

	VVasnington IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		013250	B. WING		10/1	4/2021
NAME OF !	DROVIDED OD STIDDI IED	L	DRESS, CITY, S	TATE, ZIP CODE		
	PROVIDER OR SUPPLIER	104 W 5T			•	
INLAND	NORTHWEST BEHAV	ひつじょし ほにんしてい	E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 315	Continued From page 10		L 315			
	#508 and #509 for and Patient #509 for Precautions. Surve there were any other Aggression Precaut At this time, Survey Patient #501 was of Precautions. Survey reviewed the observe the review showed been receiving enhaggression. d. At this time, State #510 should be on	enhanced suicide precautions or Sexual Aggression eyor #5 asked Staff #506 if er patients on Sexual ations. Staff #506 stated "no." eyor #5 specifically asked if on Sexual Aggression eyor #5 and Staff #506 evation record for Patient #501. It that the patient should have nanced monitoring for sexual eff #506 also stated that Patient sexual aggression precautions vior, but she didn't know if he	200			
	reviewed the order	rveyor #5 and Staff #505 s for Patient #510. The review t was only on "cheeking"				
	the hospital did no	e findings, Staff #501 verified t have an effective process in at staff provided the appropriating ing for the appropriate patient.	е			
	Item #3 Implemer Precautions and C	ntation of Enhanced Observational Monitoring				
4	hospital failed to ir patients were plac monitoring and en patients reviewed	v and document review the nplement a system to ensure ed on appropriate observationa hanced precautions for 2 of 3 (Patient #501 and #502).	al			
	timely manner put	ent enhanced precautions in a s patients at risks of an unsafe nment, psychological harm, an	d			

State of	<u> Washington</u>				(VO) DATE	CLIDVEY
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKAN		•		
11127 (112		OI OIVAI	IE, WA 99204	PROVIDER'S PLAN OF CORRECT	CION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L 315	Continued From pa	age 11	L 315	•		
	serious injury or death.					
	Findings included:					
	· ·	w of the hospital's policy and				
	procedure titled, "S	Suicide Precautions," policy				
	number 500.05C3,	reviewed 07/16/21, showed				
	risk for suicide and	Itions are used for patients at I/or self-destructive behavior,				
	which requires inte	nsive support, close				
	observation, freque	ent re-assessment, and e measures to ensure the	CONTRACTOR OF THE PROPERTY OF			
	emotional and phys	sical welfare of patients at all				
	times. All suicide th	hreats, gestures, and attempts				
	are considered ser to immediately. Sta	rious and are to be responded aff observe patients on Suicide				
	precautions with a	n increased level of vigilance.	***************************************			
	Document review	of the hospital's policy and				
	procedure titled, "S	Sexual Aggression and Sexual				
	Notification Plan."	ention and Response and policy number 500.05F,				
	reviewed 01/18/21	, showed that the provision of	а			
	safe, therapeutic e	nvironment of care includes patient to patient sexual				
	incidents as well a	s any verbal or physical threat	3			
	of sexual incident.	The policy provides a plan for				
	Monitoring the pati	rly warning signs and ient with suspected potential fo	or			
	sexual aggression	/victimization and implementin	g			
	intervention steps	to minimize the risk of sexual s assessed for risk factors for				
	Sexual aggression	s assessed for risk factors for /victimization are placed on				
	Sexually Acting Ou	ıt (SAO)-Aggression or				
	SAO-Victimization	precautions.				
	Document review	of the hospital's policy and				
	procedure titled, "F	Fall Risk Assessment and ber 500.16, reviewed 11/18/20	,		•	
	showed the following					

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		013250	B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		,
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKAN	H AVE E, WA 99204			
(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 315	Continued From pa	age 12	L315			
	a. When a patient f	falls while hospitalized staff				
	i. Initiate Fall Preca interventions as for Precautions upon A	autions (implement all r a patient placed on Fall Admission).	Andrew of the Control			
	ii. Document the fa record.	ll in the patient's medical				
•	iii. Initiate Post Fall Treatment Plans a	l and Fall Risk Individual nd inventions as appropriate.				Automotive
	Director of Quality #501) and a Regis reviewed the mediplan of care for Pa on 10/04/21 for the The medical reconsistory of a broken resulting in pain ar patient utilized a sl	11:20 AM, Surveyor #5, the and Infection Control (Staff tered Nurse (Staff #502) cal record and discussed the tient #501 who was admitted a treatment of Schizophrenia. It is discussed that patient had a hip with complications and alteration in mobility and the hopping cart to assist with mission to the hospital. The efollowing:				
	Nurse Admission A patients Fall Risk a assessment show include all diagnos ambulation assisti and mental status	22:30 PM, the Registered Assessment showed the as low. Review of the ed that the nurse failed to sis including substance use, ve devices (wheelchair/walker in the assessment.)			
	Flow Sheet shows walker for ambula related to a history	1:15 AM, the Daily Nursing ed that the patient was using a tion related to an unsteady gai y of a hip fracture. The patient e the walker and the hospital	t			

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/14/2021
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	DDRESS, CITY,	STATE, ZIP CODE	
	NORTHWEST BEHAV	/IORAL HEALTH SPOKAN	TH AVE IE, WA 99204	1	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OLD BE COMPLETE
L 315	Continued From pa	age 13	L 315		
!	then provided the patient with a wheelchair.				
	c. Surveyor #5 found no evidence the patient was placed on Fall Precautions.				
	verified the finding hospital provided v	with Surveyor #5, Staff #501 and stated that the walker the vas too small, so the hospital nt with a wheelchair to assist	Contract of the Contract of th		
	Director of Quality #501) reviewed the #502 who was addinvoluntary patient self-injurious ideat had a history of su	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient nitted on 09/08/21 as an due to suicidal and ion and behavior. The patient licide attempts, depression, ress Disorder, and anxiety. The following:	е		
	off a wound from a pulled the wound of inches long by .5 inches	e patient pulled the steri-strips a prior self-harm event and edges apart approximately 2.5 nch wide. The patient was not m precautions until 09/13/21.			
	The patient had a 09/20/21 and 09/2	e patient fell and hit her head. dditional fall episodes on 11/21. The patient was not cautions until 09/21/21.			
7	behaviors with a p	e patient had inappropriate beer. Surveyor #5 found no ent was placed on Sexual autions.			
	5. At the time of the that precautions he timely.	ne review, Staff #501 verified nad not been implemented			

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SU COMPLE	
		013250	B. WING		10/14	/2021
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>	DRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHAN	/IORAL HEALTH SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 315	Continued From pa	age 14	L315		A A Printer	
L 320	322-035.1D POLIC	CIES-PATIENT RIGHTS	L 320			
	WAC 246-322-035 Procedures. (1) The develop and imple written policies and consistent with this services provided: patient rights accompation of and 71.34 Reposting those right place for the patient This Washington A as evidenced by:	ne licensee shall ment the following d procedures s chapter and (d) Assuring ording to chapters RCW, including ts in a prominent				
	hospital failed to e protected by failur detailing the risks, prescribed psycho demonstrated by #501, #502 and #					
	consent for presc including schedul medications viola details of the risks	that patients receive informed ribed psychotropic medications ed and PRN (as needed) tes the patient's rights to receive, benefits, and alternatives for nedications prior to	e			
	Findings included	t:				
	Document revi "Medication-Invol	ew of the hospital's policy titled luntary Use of Antipsychotics fo	, r			

STATEMEN	VVASNINGTON IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/14/2021		
	PROVIDER OR SUPPLIER	(IODAL HEALTH 104 W 5TI	H AVE	TATE, ZIP CODE			
INLAND	NORTHWEST BEHAV	SPOKANE SPOKANE	, WA 99204				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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	·		L 320				
	issued 10/01/18, st administration of a	s," Policy Number 500.04, date nowed that prior to the ntipsychotic medications, an de to obtain informed consent.	Consideration of the Constitution of the Const				
	Document review of the hospital's policy and procedure titled, "Patient's Rights and Responsibilities," Policy Number 100.11, issue date 10/01/28, showed that involuntary patients have the right to refuse psychiatric medications, except medications ordered by the court under						
	except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber, make an informed decision regarding the use of anti-psychotic medication, and have the right to not consent to the administration of anti-psychotic medications beyond the hearing conducted pursuant to RCW 71.05.320 (2).						
	consent form titled Specific Authorizat Medications," date Risperidone (an art Thorazine (an anti) (an antipsychotic ranxiolytic medication), Seroe	of the hospital's preprinted , "Inland Behavioral Health ion for Psychotropic d 02/19, showed that httipsychotic medication), psychotic medication), Abilify hedication), Lorazepam (an on), Zyprexa (an antipsychotic quel (an antipsychotic	And the second s				
	Lamictal (a mood antidepressant me antidepressant/antidepressant/antidepressant me anti-depressant mervous System Sof Attention-Deficit medications required.	en (a hypnotic medication), stabilizer), Prozac (an edications), Trazodone (an tianxiety medication), Vistaril medication), Cymbalta (an edication), Adderall XR (Centra Stimulant used for the treatment Myperactivity disorder) were ring informed consent. 11:20 AM, Surveyor #5, the and Infection Control (Staff			·		

	Washington	WAY EDON (IDED (CHED) TED/CLIV	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONOTROCTION	COME	COMPLETED	
PRINCE LINE	w. www						
		013250	B. WING		10/	14/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
		104 W 5T					
INLAND	NORTHWEST BEHA	コヘアスト ひにんしては	E, WA 99204				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
L 320	Continued From pa	age 16	L 320			E	
	plan of care for Pa as an involuntary p danger to others o history of Schizoph medications. The i provider ordered F Lorazepam, Zypre Surveyor #5 found documents or atte in the medical reco	2:45 PM, Surveyor #5 and the					
	#501) reviewed the #502 who was addinvoluntary patient self-injurious ideal had a history of supost-Traumatic St Psychiatric Evaluation 7:54 AM, showed continue taking he which included Travistaril. Additional Thorazine, Loraze Surveyor #5 found	and Infection Control (Staff e medical record for Patient mitted on 09/08/21 as an adverse due to suicidal and tion and behavior. The patient slicide attempts, depression, tress Disorder, and anxiety. The tion completed on 09/09/21 at that the patient consented to the current home medications azodone, Prozac, Lamictal, and provider orders included epam, Zyprexa, and Ambien. It is no informed consent empt to obtain informed consent ord.	1				
	that the records for contain evidence attempt to obtain stated that she we providers to determine the stated that the meaning	ne findings, Staff #501 verified or Patient #501 and #502 did no of informed consent or an informed consent. Staff #501 buld contact the patient's mine if the consent was with the provider's office. Staff #501 edical record should have ent for the administration of					

STATEMEN	Washington IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMF	SURVEY
AND PLAN	OF CORRECTION	IDERTH TOTALION HOMBEL	A. BUILDING: _			
		013250	B. WING		10/1	14/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	FATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 57 SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L 320	Continued From pa	age 17	L 320			The second secon
	Psychotropic medic	cations or at minimum an onsent should have been				
	Director of Quality #501) reviewed the #503 who was adm for an attempted sipatient's history incomples of the patient's history incomples of the patient's history incomples of the patient's history incomples of the patient of the p	10:45 AM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient nitted as an involuntary patient uicide on 09/11/21. The cluded Post Traumatic Stress e Personality Disorder, and nce Disorder. The Psychiatric ted on 09/12/21 at 9:00 AM, atient would continue home Medical History and Physical AM showed the home ed Trazadone, Abilify, rax (Vistaril). Additional er admission included Ativan, exa, and Ambien. Surveyor #5 consent documents or attemp consent in the medical record. 9:00 AM, Staff #501 verified le to obtain evidence that the ained informed consent for cation administration for 2, and #503.	t .			
L 370	WAC 246-322-035 Procedures. (1) TI	ne licensee shall ment the following d procedures s chapter and (n) Allowing	L 370	·		

	Washington T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	בובט
		013250	B. WING		10/14/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
	NORTHWEST BEHA\	/IORAL HEALTH ORONANI				
		ATEMENT OF DEFICIENCIES	E, WA 99204	PROVIDER'S PLAN OF CORRECTI	ON	(X5) COMPLETE
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
L 370	Continued From pa	age 18	L 370			
	according to WAC 246-322-180; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of the hospital's policies and procedures, the hospital failed to establish an approved written policy and procedure addressing patients working at the facility as part of their treatment plan.				a de la companya de l	
·						
	procedure risks sta	approved written policy and aff confusion and delay in int's request to work on the				
	Findings included:	•				
	have a policy or pr	showed that the hospital did not cocedure in place for allowing coording to WAC 246-322-180.	and all of the second s			
	interviewed the Inf #1707) about the Information to work as	10:26 AM, Surveyor #17 fection Preventionist (Staff hospital's policy for allowing s part of their treatment plan. I that the hospital did not have a vork.		·	or o	
L 380	322-035.1P POLIC	CIES-EQUIP MAINTENANCE	L 380			
	written policies an consistent with thi services provided inspecting, repairi electrical, biomed	he licensee shall ement the following d procedures s chapter and : (p) Cleaning,				

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPI	
		013250	B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	DRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHA	/IORAL HEALTH				
INLAND			E, WA 99204	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OLD RE	COMPLETE DATE
L 380	Continued From pa	age 19	L 380			
	This Washington A as evidenced by:	dministrative Code is not met	1000			
	Based on docume	nt review and interview, the				
	preventative maint	I to ensure that routine enance of ice machines was hospital asset management				
	maintenance of ice	and document preventative e machines at required interval operable ice machines that iton or dealys in care.	S			
	Findings included:	•				
	Record review of machines showed occurs at bi-annual	of the work order for the ice I that preventative maintenance al cycle.	•			
	work orders for Fo K42320, K42053, preventative main	of the preventative maintenanc ollet ice machines K42052, K42050 showed that the tenance was due on 04/21/21. were not marked as completed ich occurred during the survey.	a management	-		
	interviewed the Fa about the ice made confirmed that the maintenance reconnal not been com- as required. Staff purchase order for 08/10/21. Staff #1	10:00 AM, Surveyor #17 acilities Manager (Staff #1701) whine maintenance. Staff #1701 are most recent preventative ords for the four ice machines appleted in the work order system #1701 showed the surveyor are cleaning equipment dated 1701 stated that these items form the maintenance.				

State of Washington STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(AZ) WOLTH EL GONOTTO			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _				
4		013250	B. WING		10/14/2021		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	DDRESS, CITY, S	TATE, ZIP CODE			
		104 W 51					
INLAND	NORTHWEST BEHAN		E, WA 99204	PROVIDER'S PLAN OF	CORPECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
L 560	Continued From pa	age 20	L 560			4	
	į	IING-INFECT CONTROL	L 560	•			
	WAC 246-322-050 shall: (6) Provide a orientation and appropriate for all staff, including Infection control; This Washington A as evidenced by: Based on record rehospital failed to eannual infection control or the staff of the staff th	Staff. The licensee and document propriate training ang: (d) Administrative Code is not met eview and interview, the ansure that staff completed partrol training for 2 of 10 staff					
	reviewed (Staff #1 Failure to ensure s control training pla transmission of inf	staff complete ongoing infection ices patients and staff at risk of fection.	T F				
	Record review of course titled, "Rap	of the syllabus for the training old Regulatory - Non-Clinical, at infection control training was	The second secon				
	conducted a person Human Resource resources genera The file review shad a coo	1:30 PM, Surveyor #17 connel file review with Director of s (Staff #1704) and a human list (Staff #1705) for ten staff. owed that a housekeeper (Staft k (Staff #1704) did not have ontrol training in their file.					
	Staff #1704 about training. Staff #17 annual trainings for other topics, via the staff #1704 about 1000 annual trainings for the staff #1704 annu	ew, Surveyor #17 interviewed t ongoing infection control 04 stated that all staff take or infection control, amongst he Rapid Regulatory training. rmed the missing annual trainir	ng				

STATEMEN	VVASNINGTON IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
 					40/4	1/2021
		013250	B. WING		1 10/14	114041
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
INI AND	NORTHWEST BEHA	/IORAL HEALTH				
INLAND		OI OIWIII	E, WA 99204	PROVIDER'S PLAN OF CORRECTI	ION I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
L 560	Continued From pa	age 21	L 560			1
	for Staff #1702 and	l #1703.			·	
L 575	322-050.6G ORIEN	NTATION-PATIENT RIGHTS	L 575		AAAAAA	
	WAC 246-322-050 shall: (6) Provide a	Staff. The licensee nd document	A A A A A A A A A A A A A A A A A A A		Adomini	
	orientation and app	propriate training				
	for all staff, including: (g) Patient rights according to chapters 71.05 RCW and 71.34 RCW and patient abuse; This Washington Administrative Code is not met				-	
				•	į	
	as evidenced by:					
	Based on record re	eview and interview, the nsure that staff completed				
	annual patient righ reviewed (Staff #1	ts training for 2 of 10 staff				
	Failure to ensure s rights training plac care and violation	staff complete ongoing patient es patients at risk of unsafe of their rights.				
	Findings included:	-				
	1. Record review of course titled. "Rap	of the syllabus for the training id Regulatory - Non-Clinical,				
·	2020," showed that part of the training	it patient rights training was a				
	conducted a perso	1:30 PM, Surveyor #17 onnel file review with Director of				
	Human Resources resources general The file review sho	s (Staff #1704) and a human ist (Staff #1705) for ten staff. owed that a housekeeper (Staff				
	annual patient righ	k (Staff #1704) did not have hts training in their file.				
	3. During the revie Staff #1704 about	ew, Surveyor #17 interviewed ongoing patient rights training.	- Cooperation of the Cooperation			

State of Washington		(X2) MULTIPLE CONSTRUCTION (X3) DAT			SURVEY		
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	waren.		CONSTRUCTION	COMPLETED	
		013250		B. WING		10/1	4/2021
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
INLAND	NORTHWEST BEHAN	IORAL HEALTH	104 W 5TH	AVE , WA 99204			
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES / FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
L 575	Continued From pa	age 22		L 575			
	Staff #1704 stated trainings for patien via the Rapid Requ	that all staff take and t rights, amongst oth llatory training. Staff sing annual training f	er topics, #1704				
L 615	322-050.9A TB-MA	NTOUX TEST		L 615			
	WAC 246-322-050 shall: (9) In additio WISHA requirement from tuberculosis is staff person to have or starting service, thereafter during the association with the tuberculin skin tesmethod, unless the Documents a previous skin test, which is millimeters of induforty-eight to seven Documents meeting this subsection will preceding the date (iii) Provides a written department or health department or health department skin test presents staff person's health will be wil	Staff. The licenseen to following onts, protect patients by requiring each re upon employment and each year ne individual's e hospital: (a) A to by the Mantoux e staff person: (i) rious positive Mantouten or more ration read at onty-two hours; (ii) ong the requirements thin the six months e of employment; or ten waiver from authorized local to stating the Mantoux a hazard to the	JX of				
To the state of th	hospital failed to e	review and interview, ensure that staff rece g and testing for tube files reviewed (Staff	eived erculosis for				
	Failure to screen	and test staff prior to	their start		·		

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/14/2021	
		L	DDRESS, CITY, S	TATE ZIP CODE		
	ROVIDER OR SUPPLIER	104 W 57			٠	
INLAND	NORTHWEST BEHAV	IORAL HEALTH SPOKAN	E, WA 99204			445)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 615	Continued From pa	age 23	L 615			
	of work risks patient and staff exposure to tuberculosis infection.		100		The state of the s	
	Findings included:					
	"Tuberculosis (TB) Pathogen Exposur- reviewed 10/01/18, a purified protein d chest x-ray depend history of TB vaccin two weeks of hire. control nurse will d 2. Record review of showed that a mer #1706) had no doo	f the hospital's policy titled, Screening and Airborne e Plan," Policy #300.04, , showed that staff will receive eriviative (PPD) test for TB or ding on test results or prior nation or testing within the first The infection previontion and ocument these results. of personnel files for 10 staff intal health technician (Staff cumented employee health tuberculosis screening or				
	reviewed personne review, the surveyor Preventionist (Staft health records for Preventionist state documentation for was missing at the	1:30 PM, Surveyor #17 el files. At the conclusion of the or interviewed the Infection ff #1707) about the employee Staff #1706. The Infection ed that she could not find Staff #1706 and confirmed it e time of review.				
L 718	WAC 246-322-100 The licensee shall implement an effe infection control process.	mum: (f) Provisions onsultation	L 715			

State of Washington					CONOTRIOTION	(X3) DATE	SUBVEY
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:		CONSTRUCTION		LETED
		013250		B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHAV	/IORAL HEALTH	104 W 5TH SPOKANE	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L 715	Continued From pa	age 24		L 715			
	equipment and supinfluence the risk or (ii) Providing consultation appropriate proced for cleaning, disinfesterilizing; (iii) Providing direct particular din-service eduction providing direct particular din-service eduction and in-service eduction providing direct particular dispossion of the providence o	oplies which may f infection; altation regarding lures and products acting and iding infection for orientation cation for staff tient care; (iv) dations, consistent and local methods of safe sal of: (A) and liquid wastes; wastes including of sharps; dministrative Code i tion, interview, and de al failed to have an eff tess to ensure that pa for use did not exceed oration date. patient care supplies of tient care supplies of trer's expiration date inadequate medical to fectious organisms. w of the hospital's po Nursing Supplies and tion," policy number of the showed that month will monitor for expiration will monitor for expiration will monitor for expiration	ocument fective atient care d their do not places treatment blicy and 500.10C, ly the tion dates				
	Nurse Managers v	, snowed that month vill monitor for expiral s and equipment in the dication rooms. The l	tion dates he nursing				

State of	Washington				1	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/14	/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	ORAL HEALTH 104 W 5TI SPOKANI	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L 715	Continued From pa	ge 25	L 715	•		
	Managers will disca expired/damaged s	ard and replace all upplies and equipment.			ALIMENTAL AND	
	Director of Quality a #501) inspected as	0:02 AM, Surveyor #5 and the and Infection Control (Staff supply cupboard and a supply ast. Surveyor #5 observed the	The state of the s		The state of the s	
	a. McKesson Electi manufacturer's exp packages.	rode tabs (4 packages) with a iration date of 02/16/20-4	The state of the s		e de la companya de l	
	b. Hydrogen Perox manufacturer's exp	ide (1 bottle) with a piration date of 11/20.				
	c. Hydrogen Perox manufacturer's exp	ide (1 bottle) with a piration date of 06/21.				
	d. Size 7 Sterile lat manufacturer's exp	ex gloves (7 packages) with a piration date of 01/31/21.				
	e. Size 6 Sterile lat manufacturer's exp	ex gloves (4 packages) with a piration date of 04/30/21.				
	3. At the time of the verified the finding supplies.	e observation, Staff #501 and removed the expired				
L 825	322-120.8B HOUS	EKEEPING CLOSETS	L 825			
	The licensee shall:	service facilities on ag: (b) sets: (i) Equipped 'entilated to the				

State Form 2567 STATE FORM

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
		013250	B. WING		10/1	4/2021
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
INLAND I	NORTHWEST BEHAV	ORAL HEALTH SPOKAN	TH AVE NE, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L 825	Continued From pa	ige 26	L 825			
	This Washington A as evidenced by:	dministrative Code is not met				
	Based on observat failed to ensure ho equipped with shel	ion and interview, the hospital usekeeping closets were ving.				A. A
	shelving limits the	usekeeping closets with ability of housekeeping staff to ely and make them readily hen needed.				
	Findings included:					
	Facilities Manager janitorial closets or Each floor has a conserves two patient	3:45 PM, Surveyor #17 and the (Staff #1701) inspected the in the second and third floor. entral janitorial closet that care units. The inspection to closets were not equipped	e			
	interviewed Staff #	oservation, Surveyor #17 1701 who confirmed that equipped with shelving.				
L1065	322-170.2E TREA	TMENT PLAN-COMPREHEN	S L1065			
	retained, including limited to: (e) A contreatment plan de	licensee shall upervision and r, and discharge patient admitted or g but not emprehensive veloped within a multi-disciplinary				

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	CONSTRUCTION	(X3) DATE S	
		013250	B. WING		10/14	1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI		TATE, ZIP CODE		
	NORTHWEST BEHA	/IORAL HEALTH SPOKANE	1 AVE E, WA 99204			
HATMIAD			ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5) COMPLETE
(X4) ID PREFIX TAG	(EXCUIDEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	DATE
L1065	appropriate, by the		L1065			
•	modified by a men professional as inc patient's clinical co	tal health licated by the ondition; (iii)				
i	Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan;					
	This Washington A as evidenced by:	Administrative Code is not met				
	Item #1 Comprehe	ensive Master Treatment Plan				i.
	hospital failed to e developed an Indi Treatment Plan for behavioral and mo	w and record review, the ensure that staff members vidualized Comprehensive or all patients that included edical problems, as 3 of 3 charts reviewed (Patient #503).				
	Comprehensive T	the development of a reatment Plan for behavioral lems puts patients at risk for onsistent, and delayed				,
	Findings included	4				
	procedure titled.	ew of the hospitals policy and "Treatment Planning," policy reviewed 12/01/20, showed the				
	completed within the nursing asse assessment, me	eatment Plan (MTP) is 72 hours of admission following ssment, initial psychiatric dical history and physical, and)			
State Forn	1 2567		6899	R4F811	If continua	tion sheet 28 of

	Washington	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI F	CONSTRUCTION	(X3) DATE	
	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMP	LETED
		013250	B. WING		10/1	4/2021
NAME OF E	PROVIDER OR SUPPLIER	I	ADDRESS, CITY, S	TATE, ZIP CODE		
		104 W 5	TH AVE			
INLAND	NORTHWEST BEHAV	<u> </u>	NE, WA 99204	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1065	Continued From pa	age 28	L1065			
	psychosocial assessments.					
!	assessments have	eam will meet after all been completed to review all d completed the initial MTP.				
	Nursing Assessme	Physical as well as the ent will guide the psychiatric ing medical problems to be TP medical problem list				
	impressions of the plan goals.	ms are to match the clinical patient and their specific care	3			
	e. A Medical Treati any acute/chronic identified.	ment Plan will be initiated for actively treated medical issue	S			
	f. Chronic but stab no active treatmer require a reason fo	le medical conditions requiring nt can be deferred. These or deferral.	g			
	Treatment Plans, may be revised at new information is revision. For exam	tment Plan, Individual or the Treatment Plan Update any time by the team when obtained justifying addition of ple, following seclusion or et symptoms, or other change aming	r			
	addition of a new	oe documented through the problem on the MTP and associated Individual Treatme	nt			
	Director of Quality	11:20 AM, Surveyor #5, the y and Infection Control (Staff stered Nurse (Staff #502) lical record and discussed the		·		

STATEMEN	VVASTINGTON IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		013250	B. WING		10/	14/2021
	PROVIDER OR SUPPLIER	STREET AU 104 W 5T	DRESS, CITY, ST H AVE E, WA 99204	TATE, ZIP CODE	*	
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L1065	plan of care for Pa as an involuntary p danger to others or history of Schizoph use disorder and w medications mana showed the following. The patient had complications resumbility and the passist with mobility hospital. b. The Medical Histompleted on 10/0 following medical ii. Chronic right hip that the patient repambulate, and than needed a wheelch iii. Hip pain with strucken he lays back iii. Acute Cystitis a iv. Diarrhea, v. A Medical/Psyc Apnea, Irregular hamphetamine abuinappropriate beh c. The Psychiatric untimed) showed and nicotine depending nosis was list	tient #501 who was admitted patient for danger to self and a in 10/04/21. The patient had a prenia with methamphetamine was non-compliant with gement. The medical recording: a history of a broken hip with alting in pain and alteration in attent utilized a shopping cart to prior to admission to the story and Physical Exam post/21 at 9:55 AM, showed the problems: a pain since an accident in 2016 ported using a shopping cart to a the patient reported that he pair to get around, araightening out the right knee of the patient of the patient reported that he pair to get around, and was taking an oral antibiotic thin the patient of Asthma, Sleep peartbeat, Schizophrenia and use, and socially and sexually				

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIDENTIFICATION NUMBER		` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		013250		B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	REET ADD	RESS, CITY, S	TATE, ZIP CODE		
		ACENITE I	4 W 5TH				
INLAND	NORTHWEST BEHA		OKANE	, WA 99204	PROVIDER'S PLAN OF CORREC	CTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO!	L N)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY))ULD BE	COMPLETE DATE
L1065	•			L1065			
	nonadherence with cluster B personali disorder severe. d. On 10/05/21 at 2	etamine use disorder seventreatment plan, rule out ty disorders, and nicotine 2:00 PM, a Nursing Orde	e use				
	showed "wheelcha	ir related to hip pain."					
	e. On 10/05/21 at sexual aggression	2:00 PM a provider order precautions.	red				
	treatment team on no evidence a Psy identified and doci #5 found no evide Problems including asthma, alteration assistive devices.	wed the MTP completed 10/05/21. Surveyor #5 chiatric Problem/s was umented on the MTP. Sunce that Acute Medical g acute cystitis, pain, dia in mobility including the nicotine dependence, or t behaviors were identified the MTP.	rrhea, use of				
	the findings and s	ne review, Staff #501 con tated that staff should ha d chronic problems on th	ıve	a constant			
,	Director of Quality #501) reviewed th #502 who was ad involuntary patien self-injurious idea suicide attempts.	2:45 PM, Surveyor #5 at and Infection Control (Size medical record for Pat mitted on 09/08/21 as and to due to suicidal gestures tion. The patient had a ham Depression, Post-Traum and Anxiety. The medical e following:	staff ient is and istory of iatic				
	showed that the p	ne Medical History and P patient had attempted sui ad superficial lacerations d area and the left forear	icide by s on the			,	

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ER/CLIA JMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		013250		B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	IORAL HEALTH	104 W 5Tł SPOKANE	1 AVE E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L1065	Continued From pa	nge 31		L1065			
	antibiotic ointment ordered, and the pa (low blood magnes	and dressing chang atient had Hypomag ium) not replaced.	es were nesemia				
	Evaluation showed for suicidal ideation arm. The patient has sexual abuse. Her Depressive Disorder	7:54 AM, the Psychic that the patient was a and attempt by cut ad a history of physi admitting diagnosis er, Generalized Anx nic Post-Traumatic S	s admitted ting her cal and was major iety				
	dated 09/10/21. Su that any Psychiatric Problems, or Chro	ewed the patient's aster Treatment Plan irveyor #5 found no c Problems, Acute Minic/Stable Medical Flacumented on the	evidence /ledical Problems	Total Control of the			
	the findings and st	e review, Staff #501 ated that staff shoul I chronic problems o	d have				
	Director of Quality #501) reviewed the #503 who was adr for an attempted s patient's history incomposer bisorder. Borderlir	10:45 AM, Surveyor and Infection Control medical record for nitted as an involunt uicide on 09/11/21. cluded Post-Traumane Personality Disorunce Disorder. The refollowing:	ol (Staff Patient tary patient The atic Stress der, and				
	09/12/21 at 11:12	story and Physical c AM, showed the foll	owing:	***************************************			
	i. Acute medical p injury, difficulty am	roblems including bl abulating, abrasions	unt head to				

STATEMEN	VVasnington AT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		013250	B. WING		10/	14/2021
	PROVIDER OR SUPPLIER	104 W 5T		TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	<u> </u>	E, WA 99204		CODDECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1065	Continued From pa	age 32	L1065			
	chronic patellar su	nees and abdomen, and bluxation (kneecap moves e of the body when it slides out				
	ii. A History of mult history of violence	tiple suicide attempts and a and aggression.				
	b. The Psychiatric 09/12/21 (untimed	Evaluation completed on), showed the following:				
·	hormone therapy a	sgender Male to Female with admitted after an attempted efully crashing a motor vehicle.	- Control			***************************************
	ii. Multiple abrasio lacerations to the the left knee.	n and abrasions and head and knee with stitches to				
	Borderline Person	osychiatric diagnosis was ality Disorder, Post-Traumatic and Oppositional Defiance				
	v. History of multip	ole suicide attempts.				
į	completed on 09/	Nurse Admission Assessment 11/21 at 6:00 PM, showed the if 6/10 in the forehead, right ns, and abdomen and sustained 19/08/21.				
	treatment team of no evidence a Psy identified and doc #5 found no evide Problems including integrity, pain, sui	wed the MTP completed by the n 09/15/21. Surveyor #5 found ychiatric Problem/s was sumented on the MTP. Surveyor ence that Acute/Chronic Medical g wound/alteration in skin cide/self-harm, or altered ntified and documented on the				
State Form	2567		6899	R4F811	If continue	ation sheet 33 c

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I * '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		013250		TATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD 104 W 5T		TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	CODAL CIPALTIE	E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
L1065	Continued From pa	nge 33	L1065			
	Master Treatment I	Plan.				
	the findings and sta	e review, Staff #501 confirmed ated that staff should have I chronic problems on the MTP.				
	Item #2 Treatment Treatment Plan (IT	Plan Interventions/Individual P)				
	hospital failed to in that interventions for problems were deveach problem iden Plan and Treatmer	v and record review, the applement a system to ensure or psychological and medical veloped and documented for tified on the Master Treatment of Plan Updates for 3 of 3 (#501, #502, and #503).			CASE TO THE PARTY OF THE PARTY	
	treatment intervent	and implement individualized tions puts patients at risk for nsistent, and delayed			ANALYSIS (ACCOUNTS)	
	Findings included:					
	procedure titled. "7	w of the hospitals policy and Freatment Planning," policy eviewed 12/01/20, showed the				
	number and link to	c problem will be identified by a o a problem specific Individual FP) for example Suicidal				
	b. Each medical p letter and link to a example Diabetes	roblem will be identified by a specific medical ITP for ITP.				
	c. An identified ne	ed for alternative programming				

State of	<u> Washington</u>		I 0/00 1/10 2151	E CONSTRUCTION	(X3) DATE	SURVEY
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		LETED
AND PLAN	O. COMMEDITOR		A. DUILDING.			
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		104 W 5T	H AVE			
INLAND	NORTHWEST BEHAV	NORAL HEALTH SPOKAN	E, WA 99204			1
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
L1065	Continued From pa	age 34	L1065			
	treatment plan con	t this time and an individual appleted specifying what the and what measurable goal are patient progress.	a salawasan			
	long-term goals, sp include treatment r duration, team me	clude measurable short and becific interventions planned to modality, frequency and mber responsible for follow-up, the degree possible, the	a recent			Carlo Maria
	Director of Quality #501) and a Regis reviewed the mediplan of care for Pa as an involuntary panger to others of history of Schizophuse disorder and v	and Infection Control (Staff tered Nurse (Staff #502) cal record and discussed the tient #501 who was admitted patient for danger to self and a n 10/04/21. The patient had a nrenia with methamphetamine was non-compliant with gement. The medical recording:				
	complications resumobility and the pa	a history of a broken hip with ulting in pain and alteration in atient utilized a shopping cart to prior to admission to the				
	b. The Medical His completed on 10/0 following medical	story and Physical Exam 05/21 at 9:55 AM, showed the problems:	To comment of			
	that the patient rep	pain since an accident in 2016 ported using a shopping cart to t the patient reported that he pair to get around,	,			
	ii. Hip pain with str	aightening out the right knee	1			

State of	Washington		····		Y	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		013250	B. WING		10/14	1/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		•
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5TI SPOKANI	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
L1065	Continued From pa	ige 35	L1065			
	when he lays back,		***************************************		-	
	iii. Acute Cystitis ar	nd was taking an oral antibiotic,				
	iv. Diarrhea,					
	Apnea, Irregular he	iatric History of Asthma, Sleep eartbeat, Schizophrenia and			L	
	amphetamine abus behaviors.	e, and socially inappropriate				
	untimed) showed the and nicotine depen	Evaluation (undated and hat the patient had Hepatitis C dence. The admitting days Schizoaffective				
	disorder-bipolar su mania, methamphe nonadherence with	b-type most recent episode etamine use disorder severe, treatment plan, rule out ty disorders, and nicotine use			***************************************	
	d. On 10/05/21 at 2 showed "wheelcha	2:00 PM, a Nursing Order ir related to hip pain."	W			
	e. On 10/05/21 at 2 sexual aggression	2:00 PM a provider ordered precautions.				
	dietary consult. A n 10/04/21, showed and a 35-pound we PM, a provider ord	:00 AM, a provider ordered a sutritional Assessment dated protein calorie malnutrition eight loss. On 10/06/21 at 1:00 er showed a Special Diet of evere protein-calorie catalolism.				
	developed and imp medical problems assessments inclu	no evidence that ITP's were blemented for psychiatric and identified through patient ding acute cystitis, pain, alteration in mobility including				

	Washington	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1		COMPL	ETED .
		013250	B. WING	The state of the s	10/14	4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		100 AL HEALTH 104 W 5T	H AVE			.*
INLAND	NORTHWEST BEHA	SPOKANI	E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L1065	Continued From pa	age 36	L1065			
	the use of assistive dependence, nutrit loss, or sexually ac	ional deficiency with weight				
	the hospital had pro	e review, Staff #501 stated that eprinted ITP's that could be that staff should have used the				
	Director of Quality #501) reviewed the #502 who was adm involuntary patient self-injurious ideati suicide attempts, D	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient nitted on 09/08/21 as an due to suicidal gestures and ion. The patient had a history of Depression, Post-Traumatic and Anxiety. The medical record following:				
	showed that the pa drug overdose, ha left temporal head antibiotic ointment	e Medical History and Physical attent had attempted suicide by a superficial lacerations on the area and the left forearm and and dressing changes were attent had Hypomagnesemia sium) not replaced.				
	Evaluation showed for suicidal ideation arm. The patient h sexual abuse. Her Depressive Disord	7:54 AM, the Psychiatric I that the patient was admitted In and attempt by cutting her I ad a history of physical and I admitting diagnosis was major I er, Generalized Anxiety I nic Post-Traumatic Stress	,			
	develop and imple	nd no evidence that ITP's were mented for psychiatric and identified through patient iding wounds,				

STATEMEN	VVasnington IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE S COMPL	
7						
		013250	B. WING		10/14	1/2021
NAME OF F	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L1065	Continued From pa	ige 37	L1065			
	hypomagnesemia,	sexual victimization.				
	problems including inappropriate sexual restraint/seclusion, multiple falls occurrevidence the hospi implemented ITP's 5. At the time of the the staff should have Treatment Plan documents.	e review, Staff #501 stated that ve utilized the Individual cuments.				
	Director of Quality #501) reviewed the #503 who was adm for an attempted supatient's history incorder, Borderlin	10:45 AM, Surveyor #5 and the and Infection Control (Staff medical record for Patient nitted as an involuntary patient uicide on 09/11/21. The sluded Post-Traumatic Stress e Personality Disorder, and noe Disorder. The record following:				
	a. The Medical His 09/12/21 at 11:12 /	tory and Physical completed AM, showed the following:				
	injury, difficulty am forehead, arms, kn chronic patellar su	oblems including blunt head bulating, abrasions to lees and abdomen, and bluxation (kneecap moves e of the body when it slides out	- Constitution of the Cons			
	ii. A History of mult history of violence	iple suicide attempts and a and aggression.				
	b. The Psychiatric 09/12/21 (untimed)	Evaluation completed on), showed the following:				

State of	Washington		Laverin	CONCEDUCTION	(X3) DATE	SURVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		PLETED
		013250	B. WING		10/	14/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHAV	/IORAL HEALTH				:
INLAND		OI O.C.	E, WA 99204	PROVIDER'S PLAN OF COF	RECTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	COMPLETE DATE	
L1065	Continued From pa	age 38	L1065			
	i. Adolescent Transgender Male to Female with hormone therapy admitted after an attempted suicide by purposefully crashing a motor vehicle.					
	ii. Multiple abrasion and abrasions and lacerations to the head and knee with stitches to the left knee.					
	Borderline Persona	sychiatric diagnosis was ality Disorder, Post-Traumatic nd Oppositional Defiance				
	v. History of multip	le suicide attempts.				
	completed on 09/1	Nurse Admission Assessment 1/21 at 6:00 PM, showed the 6/10 in the forehead, right s, and abdomen and sustained 6/08/21.				,
	were developed and medical proble assessments inclu	nd no evidence that ITP's and implemented for psychiatricems identified through patient ding wound/alteration in skin ide/self-harm, or altered				
	problems including alternative program peers, and purging	nt's hospitalization, additional gracified attempt/self-harm, mming, bully behaviors with groccurred. Surveyor #5 found ospital developed and s.			,	
	the finding and sta	e review, Staff #501 verified Ited that the staff should have ual Treatment Plan documents				
	Item #3 Treatmen	t Plan Updates				

STATEMEN	Washington IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDEMINITION HOMBELY.	A. BUILDING:			
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER		•	STATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5T SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L1065	Continued From pa	age 39	L1065			
	hospital failed to er current a nursing c reflected the patier nursing care to be needs, as demons reviewed (Patient #	and record review, the insure that staff members kept har plan for each patient that in 's current goals and the provided to meet the patient's trated by 3 of 3 patients #501, #502, and #503). That treatment plans are kept has at risk for inappropriate, lelayed treatment.		·		
	Findings included:					
	procedure titled, "T	w of the hospitals policy and Freatment Planning," policy viewed 12/01/20, showed the				
	least once a week clinical changes in	atment Plan (MTP) is update at or sooner If warranted by condition or other factors et of medical issues, alternative				
	b. A Treatment Pla completed at least completion of the I	an Update (TPU) will be t every seven days from the MTP.	en e			A constant of the constant of
	c. Progress toward each problem.	d short-term goals is noted for				
	on the Master Pro noted. This may in	tus of a problem will be noted blem List, with a date change nclude discontinuing a goal that extending further a goal date.				
	e. For each new a a new Individual T	ctive problem, the team initiate reatment Plan (ITP). Alternativ	s e			

State Form 2567 STATE FORM

	<u> Washington</u>	L	(VO) MILITIPLE	CONSTRUCTION	(X3) DATE	SURVEY	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION		COMPLETED	
		013250	B. WING		10/	14/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
		(IODAL HEALTH 104 W 5T					
INLAND	NORTHWEST BEHAN	0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0	E, WA 99204		TOTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
L1065	Continued From pa	age 40	L1065			on the state of th	
	MTP can be added plan documented in specifying measure patient progress.	Is not already identified on the lat any time and the alternative in the individual treatment plan able goals in order to track	Acceptance of the control of the con				
	goals or intervention	reviewed to see if revisions in ons are indicated.					
•	unwilling to engage treatment team mu an alternative plan	that a patient is unable or e in traditional programming the ust update the plan to include to engage the patient in es that address the patient's					
	Director of Quality #501) and a Regis reviewed the medi plan of care for Pa as an involuntary page to others of history of Schizopluse disorder and version of the schizopluse disorder and page #501.	11:20 AM, Surveyor #5, the and Infection Control (Staff tered Nurse (Staff #502) cal record and discussed the Itient #501 who was admitted patient for danger to self and a in 10/04/21. The patient had a in an					
	dietary consult. A 10/04/21 at 12:27 has severe proteir chronic inadequat methamphetamine 35-pound unintent months and visua and fat wasting visuader eyes, and in for the patient was	8:00 AM, a provider ordered a Nutritional Assessment dated PM, showed that the patient n-caloric malnutrition related to e oral nutrient intake and e abuse. The patient had a tional weight loss in less than 6 I appraisal showed muscle loss sible at the temples, triceps, nterosseous muscle. The plans a high protein diet, and extra ks. On 10/06/21 at 1:00 PM, a					

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
VIAD I FUIA	V. 30(1)(10)				40/4	14/2021
		013250	B, WING		1 10/	TIEVE 1
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
INLAND	NORTHWEST BEHA	/IORAL HEALTH SPOKAN	H AVE E, WA 99204			
1			E, VVA 33204	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1065	Continued From pa	age 41	L1065			
	provider order show portions for severe malnutrition/hypero	wed a Special Diet of large protein-calorie catalolism.				
	Update was compl or that an Individua to address the nuti	no evidence a Treatment Plan leted, the MTP was updated, al Treatment Plans was initiated ritional deficiencies. Surveyor nce that staff were monitoring y intake.	İ			
	the finding and sta should be updated identified and that	e review, Staff #501 confirmed ted that the Treatment Plans I when there are new problems dietary intake as well as a Id have been conducted with				
	Director of Quality #501) reviewed the #502 who was addinvoluntary patient self-injurious ideal suicide attempts.	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient mitted on 09/08/21 as an due to suicidal gestures and tion. The patient had a history of Depression, Post-Traumatic and Anxiety. The medical record of following:				
	by patient pulling to	e patient committed self-harm the steri-strips off a wound fron event and pulling the wound oximately 2.5 inches long by .5				
- Parkity	b. On 09/13/21, 0 09/22/21, and 09/ restraints/seclusion	9/15/21, 09/16/21, 09/20/21, 23/21 the patient was placed ir on.				A-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7-7
	c. On 09/14/21, th	ne patient fell and hit her head.				

State of Washington			CONSTRUCTION	(V3) DATE	SUBVEY			
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N		` ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		013250		B. WING		10/1	4/2021	
NAME OF F	PROVIDER OR SUPPLIER	-			TATE, ZIP CODE			
INLAND	NORTHWEST BEHAV	IORAL HEALTH	104 W 5TH SPOKANE	H AVE E, WA 99204				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED I SC IDENTIFYING INFOR	3Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
L1065	Continued From pa	nge 42		L1065				
	d. On 09/16/21, the patient was placed on Alternative Programing.		d on			٠,		
	e. On 09/19/21, the patient had inappropriate behavior of a sexual nature with a peer.		ropriate er.	TOWARD TO THE TOWARD TOWARD TO THE TOWARD TO THE TOWARD TO THE TOWARD TOWARD TO THE TOWARD TOWARD TOWARD TO THE TOWARD TO THE TOWARD TO				
	f. On 09/20/21, the ground with superfineck.	patient was found icial lacerations to t	on the the anterior	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
	g. On 09/21/21, the	e patient fell.		Atten				
	h. On 09/26/21, the strangulation and v hospital for evaluat	vas sent to an acut	suicide by e care					
	Surveyor #5 review Update Worksheet 09/23/21, 09/27/21 showed that on 09/placed on Alternati the Update Worksheets for 09/10/04/21 were blar evidence that the hpatients treatment current goals and talls, restraint, suic inappropriate sexu falls. No problems Treatment Plan.	is for 09/16/21, 09/2, and 10/04/21. The /20/21 a Problem ove Programing waneet. The Problem of the Updat /16/21, 09/23/21, 0 ak. Surveyor #5 four plan to reflect the plan to reflect the pide attempt, self-hall behavior, new w	20/21, e review of "Suicidal as listed on List e 9/27/21, and and no vised the catient 's lated to the arm, ounds, or					
	5. At the time of th the findings and st should be updated new problems sho Master Treatment	ated that the Treati at least weekly an uld also be added Plan.	ment Plan d that the to the				Accounts to	
1	C On 10/07/21 of	10:45 AM Surveyo	r#5 and the	1			1	

State of	<u> Washington</u>		Т		CONCENTION	(X3) DATE	SURVEY
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	-n. !		CONSTRUCTION		LETED
AND PLAN	OF CORRECTION	IDEM HUNWHOM MOMIDE	'	A. BUILDING: _			
]	B. WING		10/4	4/2021
		013250				1 10/1	7,4041
NAME OF F	PROVIDER OR SUPPLIER				FATE, ZIP CODE		
INII ANID	NORTHWEST BEHAV	ハヘじょし ひこんしてひ	04 W 5TH				
INLAND			POKANE	, WA 99204		DESCRION	(VE)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIC	LL DN)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
1110					DEFICIENCY)		
L1065	Continued From pa	age 43		L1065			
	Director of Quality	and Infection Control (S	taff				
	#501) reviewed the medical record for Patient #503 who was admitted as an involuntary patien						
	#503 who was adn	nitted as an involuntary	patient				
•	tor an attempted St	uicide on 09/11/21. The cluded Post-Traumatic S	Stress				Language
	Disorder, Borderlin	e Personality Disorder,	and				
	Oppositional Defia	nce Disorder. The recor	d				ļ
	review showed the	following:					
	a On 09/16/21 the	patient attempted suici	de bv				
	strangulation and v	vas placed on Alternativ	'e				
	Programming relat	ed to the 1:1 status for	suicide				
	attempt.						
	b. On 10/04/21 the	patient was found purg	ing.				
	c. On 10/05/21 the	patient was placed on ming for Bullying peers.					
	Surveyor #5 review	ved the Master Treatme	nt Plan				
	Update worksheet	dated 10/05/21. The Up of identify or address the	paate				
	purging or hullving	behavior that resulted i	n				
	Alternative Progra		*				
		_	tad that				
	7. At the time of the	e finding, Staff #501 sta updated the worksheet t	neu mat o reflect				
	current care order	apuateu the worksheet t ed.					
		• •					
L1120	322-170.3F OT SE	ERVICES		L1120			
	MAC 246 222 470) Dationt Care					
	WAC 246-322-170 Services. (3) The						
	provide, or arrange						
	and therapeutic se	ervices prescribed by					
1	the attending profe	essional staff,					
1	including: (f) Occu	ipational therapy ted and supervised by					
	Services coordina	tou and supervised by					

	Washington	WAY PROVIDED/OFFICE/OFFI	(Y2) MILITIDI C	CONSTRUCTION	(X3) DATE S	SURVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	COMPLETED	
		013250	B, WING		10/14/2021	
NAME OF S	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		104 W 5				
INLAND	NORTHWEST BEHAN	NORAL HEALTH SPOKAN	IE, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETE DATE
L1120	Continued From pa	age 44	L1120			
L1120	an occupational the experience working patients, responsible occupational theral the patient's comprehen; This Washington A as evidenced by: Based on interview facility failed to ensure the services were integrated to ensure the services are integrated to ens	erapist with g with psychiatric ple for integrating py functions into rehensive treatment administrative Code is not met and document review, the sure that Occupational Therapy grated into patient's atment plans. In at Occupational Therapy rated into patient's atment plans places hospital receiving incomplete eatment. In 1:20 AM, Surveyor #5, the and Infection Control (Staff tered Nurse (Staff #502) cal record and discussed the eteratment of Schizophrenia. It is a showed that patient had a paround in mobility and the hopping cart to assist with a patient reported that he needed a ground. The patient reported phtening out the right knee				
	2. At the time of th	ne record review, during arveyor #501 about how the				

	<u>Vashington</u>		·	OVOLAND TIPE C	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPFIDENTIFICATION			CONSTRUCTION		LETED
AND PLAN	A COMMECTION	,		A. BUILDING, _			
		013250		B. WING	A STATE OF THE STA	10/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		*
		"OD41 [[m.1] T]"	104 W 5TH				
INLAND N	IORTHWEST BEHAV	/IORAL HEALTH	SPOKANE	, WA 99204			Ī
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
L1120	Continued From pa	age 45		L1120			
	hospital assesses perform Activities of and fit of assistive the walker provided it was too short for provided the patier stated that the hos Therapy and Physical referral from the previdence of referral 3. On 10/08/21 at 8 Officer (Staff #508 provided Physical as Services, but that the Occupational Therfollow up to see if available via a con 4. On 10/08/21 at that the hospital di Therapist and that a requirement. 5. On 10/14/21, St. communication from	patients mobility, a of Daily Living (ADI devices, Staff #50 d to the patient did the patient, so the at a wheelchair for pital provided Occ cal Therapy servic rovider. Surveyor # al. 3:30 AM, the Chief and Recreational the hospital did no apist. He stated h Occupational Ther tracted service. 11:00 AM, Staff #5 d not have an Occ she did not know arveyor #5 receive am Staff #501 stati	Ls), and use 1 stated that not work as hospital mobility. She upational tes on 15 found no 15 found no 16 Executive ospital Therapy the mploy and the would apy was 16 that this was 17 dan Emailing that the 18 t				
	communication from hospital did have a Physical Therapy	a contract for Occu	ipational and				
	 Surveyor #5 fou hospital had a pro- Occupational Thei into patient compri development and 	cess in place to er rapy Services were ehensive treatmer	nsure e integrated nt plan				
L1140	322-180.1B ASSA	ULTIVE INCIDEN	TS	L1140			

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF COUNTRY OF THE		A. BOILDING.			
		013250	B. WING		10/1	14/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
	NORTHWEST BEHA	104 W 5			÷	
INLAND			IE, WA 99204	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1140	Continued From pa	age 46	L1140			
		Patient Safety and				
	Seclusion Care. (1) The licensee		·		
	shall assure seclus	sion and restraint				
	are used only to the duration necessary	e extent and v to ensure the				
	safety of patients,	staff, and				
	property, as follow	s: (b) Staff shall				1
	document all assa	ultive incidents in				
	the clinical record	and review each				
	incident with the a supervisor;	hhiohiiare	Į.			
	This Washington	Administrative Code is not met				
İ	as evidenced by:					
·	hospital failed to c	w and document review the capture and document each it in the patient's medical pisodes of restraint reviewed #505).				
	natients during res	re use, monitor and evaluate straint/seclusion, and documer to restraint/seclusion episodes and death.	nt			
	Findings included	;				
	"Proper Use and Restraints and Se 1300.22, reviewed restraint/seclusion	ew of the hospital's policy titled Monitoring of Physical/Chemical Physical/Chemical Physical, which was policy number do 19/21, showed the use of a will be thoroughly documente bedical record and includes the	al			
	the hospital's poli	nt and/or family were informed of icy on the use of in and consent for notification.	of			, www
	b. The initial asse	essment of the patient related t	o			

	Washington IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	i .		COMP	FELEN
		013250	B. WING		10/1	14/2021
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHAV	104 W 5				
		0, 0.0	NE, WA 99204	PROVIDER'S PLAN OF C	ORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
L1140	Continued From pa	зge 47	L1140			disease.
	restraint/seclusion	use.				
!	c. Documentation of restraint/seclusion	of each episode of including:	To the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th			A A A A A A A A A A A A A A A A A A A
	i. the circumstance restraint/seclusion,	es that led to the use of				A MARAMANA MARIA
	ii. specific behavior	rs,	1			
	iii. detailed descrip event,	otion of events leading up to the	e l			SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN THE SAN TH
	iv. consideration of interventions,	r failure of non-physical				, and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second
	v. rational for the u	use of restraint/seclusion,				
	vi. notification of the appropriate,	ne patient's family, when	A CANADA			
	vii. written orders f discontinuation,	for use-including each order fo	or			
	viii. behavioral crite restraint/seclusion	eria for discontinuation of n,				
	ix. informing the pa	atient of behavioral criteria for				
	x. check of approp	priate restraint application,			,	
	xi. the initial in-per evaluations of the	rson and subsequent patient,	A. A. A. A. A. A. A. A. A. A. A. A. A. A			a series
	xii. 15-minute asse status,	essments of the patient's	·			
	xiii. continuous mo	onitoring of the patient and the	:			

State Form 2567 STATE FORM

	VVASNINGTON IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COM	LETED
		013250	B. WING		10/	14/2021
		I	DRESS CITY S	TATE, ZIP CODE		
	PROVIDER OR SUPPLIER	104 W 5T		· · · · · · · · · · · · · · · · · · ·		
INLAND	NORTHWEST BEHAV	//ODAL UEALTH	E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO I DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L1140	Continued From pa	nge 48	L1140			
	xiv. debriefing of the patient with the staff, xv. any injuries sustained, and the treatment received for these injuries,					V.
	xvi. time of initiation restraint/seclusion,	n and termination of the				
	xvii. treatment plan episode of restrain interventions to pre	review/revision following the t/.seclusion including treatment event further use.				
	Director of Quality #501) reviewed the #502 who was add involuntary patient self-injurious ideating a history of su	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient nitted on 09/08/21 as an due to suicidal and ion and behavior. The patient icide attempts, Depression, ress Disorder, and Anxiety. The following:				
	stated that staff plate hold and administed including 1mg of A	4:50 PM, a Progress Note aced the patient in a physical ered intramuscular medication tivan (an anxiolytic medication) exa (an antipsychotic				A A A A A A A A A A A A A A A A A A A
·	record of a provide	and no evidence in the medical er order, evaluation, monitoring as described in the hospital's	3			A. A. A. A. A. A. A. A. A. A. A. A. A. A
	that the medical re	ne finding, Staff #501 verified ecord did not contain required taff #501 was unable to locate nentation.	ACCOUNTY OF THE PROPERTY OF TH			

STATEMEN	Washington IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			
		013250	B, WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5TH SPOKANE	1 AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
L1140	5. On 10/07/21 at 4 Chief Nursing Office discharge medical was admitted on 05 Suicidal Ideation, A Post-Traumatic Str. The patient had a histrangulation, cuttin aggressive behavior On 06/07/21, a prowas placed in restribehaviors including Nurse and attempt Technician. Survey documentation in the finding and stathere was any documentation.	er (Staff #507) reviewed the record for Patient #505 who 5/25/21 for the treatment of anxiety, Bipolar Disorder, ess Disorder, and Depression. Instory of suicide attempts by and over-dose and or with behavioral outbursts. Vider order showed the patient aint for violent and destructive assaulting a Registered ing to punch a Mental Health for #5 found no restraint the medical record. The finding, Staff #507 verified the decord with the auditors. At 7 stated he was unable to	L1140			
L1145	WAC 246-322-180 Seclusion Care. (*) shall assure seclusare used only to the duration necessary safety of patients, property, as follow observe any patient seclusion at least	sion and restraint e extent and y to ensure the staff, and s: (c) Staff shall nt in restraint or every fifteen ng as necessary, and tions and	L1145			

	VVASNINGTON IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		013250	B. WING		10/1	14/2021
			DDEGG OUTV 07	TATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	AIE, AIP GODE		
INLAND	NORTHWEST BEHAV	COMAL TIME ALTII	E, WA 99204			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETE DATE
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	
L1145	ļ		L1145			AAA AAA
	This Washington A as evidenced by:	dministrative Code is not met				January .
	Item #1 Failure to I Restraint Documer	Follow Policy Regarding ntation				
	hospital's policies a failed to ensure that hospital's restraint	eview and review of the and procedures, the hospital at staff members followed the policy and procedure for s for 2 of 3 records reviewed #504).				
	procedures places	stablished policies and spatients at risk of physical and n and possible violation of	1			- Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Cont
	Findings included:					
	"Proper Use and N Restraints and Se	ew of the hospital's policy titled, Monitoring of Physical/Chemica clusion," policy number I 09/21, showed the following:	ıl			
	have a staff member patient to provide	ced in mechanical restraint will ber within arm's length of the immediate response should the any physical distress.				
	while in restraint/s includes signs of a use of restraint/se integrity, mental s	be assessed every 15 minutes seclusion. The assessment any injury associated with the eclusion, circulation and skin tatus, level of distress and as for discontinuation of the n.				
	c. Range of motion	on and release of limbs will be very 1 hour.				

	vvasnington	WAY DROVED TO LEGICLE	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		OONOTHOUTION	COMP	LETED
, , , , , , , , , , , , , , , , , , ,						
		013350	B. WING		10/1	4/2021
		013250		TATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	IATE, ZIP GODE		
ΙΝΙ ΔΝΠ	NORTHWEST BEHA	/IORAL HEALTH SDOKAN				
11427110		OI OIT III	E, WA 99204	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1145	Continued From page 51		L.1145			
	d. Fluids and oppo- offered every 2 hou	rtunity for toileting shall be urs.				
	e. Vital signs shall clinically indicated,	be taken upon initiation and as but at least every 2 hours.				
	sheet titled, "Inland Seclusion/Restrain	of the hospital's restraint flow I Northwest Behavioral Hospita nt/Chemical 15-minute Flow nowed the following:				
	monitor vital signs, safety checks ever 30 minutes for 1 he	Chemical Restraints staff are to , neuro status and perform ry 15 minutes for 1 hour, every our and then every 1 hour for 4 ed by the physician.	1			
	more frequently as	is to occur every 15 minutes or appropriate to the patients al, and safety needs.				
	elimination, respira	dration, circulation, hygiene and atory status, patient condition, onse, and staff interventions d at least every 15 minutes.				
	Director of Quality #501) reviewed the #502 who was addinvoluntary patient self-injurious ideal had a history of surpost-Traumatic St Documentation in showed the patien	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient mitted on 09/08/21 as an due to suicidal and tion and behavior. The patient slicide attempts, Depression, tress Disorder, and Anxiety. The patient's medical record at was in restraint/seclusion on 1, 09/16/21, 09/20/21, 09/22/21				

	<u> Washington</u>	T	EDICITY I	(YO) MITTED C	CONSTRUCTION	(X3) DATE	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	ER/GLIA JMBER:		CONSTRUCTION		LETED
VIIDITUM	C. COMMENTON	·		, bollonio			
		013250		B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
		MODAL BEALTH	104 W 5TH				
INLAND	NORTHWEST BEHA			, WA 99204		ODBECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	Y FULL !	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
L1145	Continued From pa	age 52		L1145			
L1145	a. On 09/13/21, the physical, 4-point m restraint. Surveyor staff monitored and signs, neuro status minutes for 1 hour and then every 1 h hospital policy for prestraint. b. On 09/15/21, the physical, 4-point m restraint. Surveyor staff monitored and signs, neuro status minutes for 1 hour and then every 1 h hospital policy for restraint. Surveyor evaluated and doc hydration, circulation respiratory status, response, and staminutes as directed c. On 09/16/21, the and chemical rest evidence that staff the patient's vital schecks every 15 minutes for 1 hour hours as directed receiving chemical evaluation docum and untimed.	e patient was placed nechanical, and chen #5 found no evidence documented the pass, and safety checks, every 30 minutes for a hour for 4 hours as dipatient receiving cheme hanical, and cher #5 found no evidence documented the pass, and safety checks four for 4 hours as dipatient receiving cheme four for 4 hours as dipatient receiving cheme four for 4 hours as dipatient receiving cheme four for 4 hours as dipatient receiving cheme four for 4 hours as dipatient condition, but four for 4 hours as dipatient condition, but four four four four four four four four	nical ce that atient's vital every 15 or 1 hour irected by emical din in dical ce that atient's vital every 15 or 1 hour directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical directed by emical				
	documentation fo	Surveyor #5 found no r the episode of rest	raint.				-0426
	e. On 09/22/21, th	ne patient was place	d in	,			

State of	vvasnington				Town DATE	CUDVEY 1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE :	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			•
*						
		013250	B. WING		10/1	4/2021
	20 0 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PTBEET AD	DDESS CITY S	STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		•	JIGLE, All OODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH CPOKANI				
		SFORAN	E, WA 99204		ION	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETE
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
iAG				DEFICIENCY)		
. 42 4-	O-uth	- F2	L1145			
L1145	,		[[1170			
	restraint. The recor	d review showed the following				
	conflicting docume					
	-					
	i. On 09/22/21 at 4	On 09/22/21 at 4:09 PM, a provider ordered				
	physical and mechanical restraint, and seclusion.			•		
ĺ						
		untimed Seclusion and				
	Restraint Note sho	wed the patient received				
		and mechanical restraint, and				
	seclusion.					
	iii On naissist of	Seclusion/Restraint/Chemical				
	111. On USIZZIZI, a v	eet showed that the patient				
	was placed in a ph	ysical hold at 4:04 PM,				
	4-point-mehanical	restraint at 4:04 PM, and				
	received chemical	restraint at 6:15 PM, and the				
	restraint was remo					
	iv. On 09/22/21 at	8:16 PM, the Post Intervention	1			
	Nursing Summary	showed the patient was				
	physically restraine	ed and in seclusion.				
		h4. r= .1 .444.				
ĺ	v. On 09/23/21 (un	able to decipher time				
	documented), the l	Face to Face Evaluation				
	showed the patien	it calmed after an				
	intra-iviuscular inje	ction was delivered.				
	Surveyor #5 was !!	nable to determine the type/s				
	of restraint the pati					
		the every 15-minute Flow				
	Sheet contained or	nly 2 entries, one at 4:22 PM				
	and one at 5:11 PN	M. Both entries contained only				
	the patient vital sig	ns. Surveyor #5 found no				
	evidence that staff	monitored and documented				
	the patient's vital s	igns, neuro status, and safety				
	checks every 15 m	inutes for 1 hour, every 30				
	minutes for 1 hour	and then every 1 hour for 4				
	hours as directed t	by hospital policy for patient	1			
	receiving chemical	restraint. Surveyor #5 found				
		evaluated and documented				

	<u> Washington</u>	WAY DOOMDEDONED TO TO IN	(Y2) MITHTIDIE	CONSTRUCTION	(X3) DATE	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION		PLETED
AND PLAN	OF COMMEDITION		, boileoino			
	•	013250	B, WING		10/1	14/2021
MAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		104 W 5T				
INLAND	NORTHWEST BEHA	VIORAL HEALTH SPOKAN	E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L1145	Continued From pa	age 54	L1145			
	elimination, respira	tion, circulation, hygiene and atory status, patient condition, onse, and staff interventions at utes as directed by hospital				
,	the findings and st	e review, Staff #501 verified ated that the hospital was nt process improvement				A CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR OF THE CONTRACTOR
·	Chief Nursing Office discharge medical was admitted on 0 Acute Psychosis a Documentation in 06/10/21 the patie	the medical record showed on nt physically attacked staff and sical and Chemical restraints.				
	monitored and do- signs, neuro statu minutes for 1 hour and then every 1 l	und no evidence that staff cumented the patient's vital s, and safety checks every 15 r, every 30 minutes for 1 hour hour for 4 hours as directed by patient receiving chemical				
	incomplete and di	n documentation entries were d not contain all evaluation d by hospital policy.	in the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th			
	c. 2 of 4 evaluatio undated and untir	n documentation entries were med.	a constant			
	the incomplete er	he finding, Staff #507 verified htries and the undated and hto the medical record.				

State of	Washington					- OTEN EN
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COME	PLETED
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			A. BOILDATO.			
		013250	B. WING		10 <i>l</i>	14/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, S	TATE, ZIP CODE		
	NORTHWEST BEHAV	MORAL HEALTH 104 W 51				
INLAND	NORTHWEST BEHAV	SPOKAN	E, WA 99204		PRECEION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
L1145	Continued From pa	age 55	L1145			
	Item #2 Updating t	ne Treatment Plan				
	hospital failed to m after placing patien	and document review, the odify the patients' plan of care its in restraints/seclusion for 3 reviewed (Patient #502,				
	restraints/seclusion	are plans when patients are in n, placed patients at risk of ng physical and emotional				
	Findings included:					
	"Proper Use and N Restraints and Sec	w of the hospital's policy titled, lonitoring of Physical/Chemica clusion," policy number 09/21, showed the following:				
	is dangerous to the restraint/seclusion	nt has presented behavior that emselves or others so that were indicated, a review and treatment plan is indicated.				
	b. The Registered the treatment plan	Nurse will review and update within 8 hours.				
	identification of the further instances of	atment plan will reflect the problem, goals to prevent f restraint/seclusion, fine alternative approaches.	To the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of th		C	
	d. Responsibility of	f each intervention assigned.				
•	e. Review of the pl	an with the patient.	Louissa Africa			
	Director of Quality	2:45 PM, Surveyor #5 and the and Infection Control (Staff e medical record for Patient				

STATEMEN	Washington IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION		SURVEY PLETED
		013250	B. WING		10/	14/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
INLAND	NORTHWEST BEHA	VIORAL HEALTH SPOKAN	H AVE E, WA 99204			-
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	involuntary patient self-injurious ideat had a history of su Post-Traumatic St Documentation in showed the patien 09/13/21, 09/15/21 and 09/26/21. Surveyor #5 found episodes that the reviewed or modifibehaviors that indisubsequent restrations. At the time of the finding and staupdated the Treat 4. On 10/07/21 at Chief Nursing Offidischarge medical was admitted on Chemical restrain evidence that the updated to reflect 5. On 10/07/21 at Chief Nursing Offidischarge medical was admitted on Suicidal Ideation, Post-Traumatic Some patient had a strangulation, cut	nitted on 09/08/21 as an due to suicidal and ion and behavior. The patient icide attempts, Depression, ress Disorder, and Anxiety. The patient's medical record t was in restraint/seclusion on 1, 09/16/21, 09/20/21, 09/22/21 no evidence for 6 of 6 restrain patient's treatment plan was ied reflecting the dangerous icated restraint/seclusion and int episodes.	t			

	VVasnington		260 10 4	CONCEDUCTION	(X3) DATE	SURVEY
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		LETED
AND PLAN	OF CORRECTION	IDEASII IOMION NOMBER	a. Building: _			
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
		104 W 5T				
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKANI	E, WA 99204			,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
1.1145	Continued From pa	age 57	L1145			
Liito	Documentation in to patient as placed in 06/07/21. Surveyor patient's Treatment the episode of rest. 6. At the time of the the findings and states.	he medical record showed the restraint on 06/01/21 and #5 found no evidence that the t Plan was updated to reflect		,		
		TO ODOTO MILONO	L1265			
L1265	322-200.3F RECO	RDS-OBSERVATIONS	L1200			
	The licensee shall and filing of the fol the clinical record patient receives in outpatient services observations and expatient's clinical trees.	for each period a patient or s: (f) Significant events in the				
	hospital failed to e documented patiet hospital policy for East Unit (#501, # #511, #513, #514, #520, #521, #522, #528, #529, #530, Failure to monitor risks failure to ens	v and document review the nsure staff monitored and nt dietary intake as directed by all patients located on the 2 506, #507, #508, #509, #510, #515, #516, #517, #518, #519, #523, #524, #525, #526, #527, #531, #532, and #533). and document dietary intake sure that patients receive the on that could lead to ent outcomes, harm, and death				

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY LETED	
		013250	B. WING		10/1	4/2021
NAME OF I	PROVIDER OR SUPPLIER		ET ADDRESS, CITY,	STATE, ZIP CODE		
	NORTHWEST BEHAV	AODAI UEALTU	V 5TH AVE KANE, WA 9920	4		
(X4) ID PREFIX TAG	SUMMARY STA	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	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
L1265	Continued From pa	age 58	L1265			
	Findings included:		-			
	procedure titled, "N Intake," policy num 10/01/28, showed		ood			
	and recording patie	are responsible for monitoring ent's food intake after each and prescribed by the	ng			
	"Daily Assessment form of percentage observations inclu- appetite change, p	rill record food intake on the t Progress Note (DAP)" in the e of meal eaten and general ding, subjective reports of patient requires prompts to tions, accepts offered snack	he il eat,			
	less than adequate	t the physician if meal intak e to meet nutritional needs ignificant change in the	e is			
	Director of Quality #501) and a Regist reviewed the med plan of care for Pass an involuntary	11:20 AM, Surveyor #5, they and Infection Control (Staffstered Nurse (Staff #502) ical record and discussed the tient #501 who was admitted patient for danger to self aron 10/04/21. The record reving:	he ed nd a			
	a. On 01/05/21 at dietary consult.	8:00 AM, a provider ordere	ed a			
	showed the patier	sessment dated 10/04/21, nt suffered from protein calc a 35-pound weight loss in le he dietician ordered high pr	ess			

	Washington		1	(VO) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL			CONSTRUCTION	COMPL	
AND PLAN	O CONNECTION			A. DUILDING			
		013250		B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER	ST	REET ADDI	RESS, CITY, ST	TATE, ZIP CODE		
			4 W 5TH				
INLAND	NORTHWEST BEHAV	SF	POKANE,	WA 99204		TOTION	WEY
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL .SC IDENTIFYING INFORMATION	L N)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
L1265	Continued From pa	age 59		L1265			
	snacks every morning, evening and at bedtime and large protein portions (1.5X) for each meal.		time neal.				
	showed a Special I	1:00 PM, a provider orde Diet of large portions for nutrition/hypercatalolism	severe				·
	in the medical reco	inable to locate any infor ord related to the patient' ce with meal intake.	mation s meal				
	contained 20 docu Utensil Tracking Fi	ff #501 located a binder ments titled "Patient Meaorm." Staff #501 stated to adividual forms for staff take and utensil tracking e unit.	al and that the to				
	contained forms forms (Unit (Patient #530 contain any forms #509, #524, #525, Of the 17 forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms forms fo	ew showed that the binder or 3 patients no longer or , #531, #532) and did no for 8 current patients (#526, #527, #528, and for current patients (#501, #513, #514, #515, #516, #521, #522, #523, and for each of dietary intake entry for #5 found no other dietary intake for those poctober. The form for Pa	n the of 508, #529) . #506, 8, #517, #533), y for #515, patients		* ·		
	#501 was blank. 5. On 10/08/21 at that the 2 other ir intake, but that the that they were told and utensil counts	11:00 AM, Staff #501 standard and the staff on 2 East stated to no longer document s. She stated that they shintakes and utensil countries.	ated menting to her intake hould be				

	Washington		(VO) MULTIDLE	CONSTRUCTION	(X3) DATE SURVEY	
STATEMEN AND PLAN	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED	
		013250	B. WING		10/14/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	FATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH 104 W 5T SPOKAN	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETE	
L1265	Continued From pa	nge 60	L1265			
L1375	322-210.3C PROC MEDS	EDURES-ADMINISTER	L1375			
	WAC 246-322-210 Medication Service shall: (3) Develop a procedures for pres and administering i according to state a and rules, including Administering drug This Washington A as evidenced by:	es. The licensee and implement scribing, storing, medications and federal laws g: (c)				
	hospital documents nursing staff position medication adminis	tion, interview, and review of s, the hospital failed to ensure vely identified a patient prior to stration for 2 of 3 medication served (Patients #506 and				
	standards can lead wrong patient, wro	afe medication administration d to administration errors - ng dose, wrong time, or sulting in patient harm or death		•		
	Findings included:					
	procedure titled, N policy number 28, that staff must pos before administeric check the patient's approved identifier	w of the hospital's policy and fledication Administration," reviewed 05/13/18, showed sitively identify the patienting a medication. Staff must identification with 2 hospitalies (i.e. date of birth, name band ask the patient (when his/her name.	1			

STATEMEN	Washington T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		013250	B. WING		10/14/20:	21
NAME OF P	ROVIDER OR SUPPLIER			TATE, ZIP CODE		
INLAND I	NORTHWEST BEHAN	/IORAL HEALTH 104 W 5T SPOKANI	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE COM	(X5) MPLETE DATE
L1375	Continued From pa	age 61	L1375		i de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de la companya de l	
	Director of Quality #501) inspected the and observed med Surveyor #5 observing (Staff #503) administration window. Surving ambulatory patient room window. Surving the patients by birthdate. 3. At this time, during about the hospital policy was verify their armbanusually removed the could identify the patient identification hospital policy was verify their armbanusually removed the could identify the patient admitted for not familiar with the state their name. 4. On 10/06/21 at that Staff #503 had identifiers prior to stated the hospital Surveyor #5 and Sphotograph list had window and noted recognizable in the	2:00 AM, Surveyor #5 and the and Infection Control (Staff e medication room on 2 East lication administration. Wed a Licensed Practical Nurse ister medications to spresenting to the medication veyor #5 observed Staff #503 their name and ask them their ing interview with Surveyor #5 spolicy and procedure for on, Staff #503 stated that the sto ask their birthdate and and She stated that patients had a while. She stated if she was e patient, she would have them 9:10 AM, Staff #501 verified do not utilized 2 patient medication administration. She utilized name and date of birth staff #501 reviewed the patient many of patients were not eir photo related to photo patient non-cooperation with ed.				
L1485	322-230.1 FOOD	SERVICE REGS	L1485			
	WAC 246-322-230 Services. The lice	0 Food and Dietary ensee shall: (1)				

State of Washington STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		042050	B. WING		10/1	4/2021
		013250	DDRESS, CITY, S'			
	PROVIDER OR SUPPLIER	104 W 5		····		
INLAND	NORTHWEST BEHAV	7.0 D.A.1. 1127 A.[T.L.]	IE, WA 99204		FOODDECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE
L1485	Continued From pa	age 62	L1485			
	Comply with chapte	ers 246-215 and				
	failed to implement	tion and interview, the hospital t policies and procedures Washington State Retail Food 5-215 WAC).				
	Failure to follow for patients at risk from	od safety standards places n food borne illness.				
	Findings included:					
	Item #1 - Cooling					
	Surveyor #17 insp surveyor observed applesauce coolin The observation s covered in a conta depth. No cooling	m 10:30 AM to 12:30 PM, ected the hospital kitchen. The lacontainer of freshly made g in the walk-in refrigerator. howed the sauce was stored ainer that was 6 to 8 inches in log documenting the time and polling the item was available.	or y			
	interviewed the Di about cooling prac confirmed that the product. Staff #17	ervation, Surveyor #17 etary Manager (Staff #1708) ctices at the facility. Staff #170 ere was no cooling log for the 08 also confirmed that the t be covered while cooling.	8		•	
	Reference: Wash WAC 246-215-03	ington State Retail Food Code 515	1			No.
	Item #2 - Time will Health Control.	thout Temperature as a Public			·	333
	1. Record review	of the hospital policy titled,				

State of Washington			E CONCEDITORION	(Y3) DATE	SUBVEY	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF COUNTROL		A, BUILDING:			
		013250	B. WING		10/1	4/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		104 W 5T	H AVE	•		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKANI	E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
L1485	Continued From pa	age 63	L1485			
27.00	•	_				
	"IVIEAL Frays for the	Communities," Policy # 0/30/18, did not show that the				
	hospital had establ	ished a process for timing food				
	trays when delivere	ed to the unit as a means for				
	time as a public he	alth control.				
	0.0.40/00/04 =10	200 AM Surveyor #1 and the				
	2. On 10/06/21 at 8	9:00 AM, Surveyor #1 and the (Staff #1701) inspected the				
	nourishment room	on unit 3 East. The Surveyor				
	observed unmarke	d food trays resting on the				
	counter. During the	e observation, the Surveyor				
	asked Staff #1701	about the process for delivery				
	of food trays to the	unit. Staff #1701 stated that				
	the nospital had ide	entified that dietary staff were notes in food deliveries to the unit				
	when the hospital	conducted an internal audit.				
	·					
	3. On 10/06/21 at 9	9:18 AM, Surveyor #5 and the				
	Director of Quality	and Infection Control (Staff e patient kitchen area located				
	on 2 Fast Surveyo	or #5 observed 3 patient trays				
	containing breakfa	st type foods sitting on the sink				
	and counter. The t	rays were undated and				
•	untimed.					
	1 At the time of ch	oservation, Surveyor #5 and	1			
	Staff #501 asked the	he Registered Nurse (Staff				
	#505) when the tra	lys had arrived and if they were				
	for a patient or to b	be discarded. Staff #505 stated				
	that the trays were	for patients who were sleeping				
	during breakfast til	me, and that the trays had beer	1			
	sitting there about	20-30 minutes. At the time of 501 verified that the trays were				
	not dated or timed					
		•				
	5. On 10/06/21 fro	m 10:30 AM to 12:30 PM,				
	Surveyor #17 cond	ducted an inspection of the				
	interviewed the Di	e inspection, the Surveyor etary Manager (Staff #1708)				
	about the process	of tray delivery. Staff #1708				
	apout the process	J. 1147 GO. 1017. G. 1111. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		<u> </u>		

State of	Washington		т		TOWN DATE	OLIDVEY
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	LETED
AND PLAN	UI CONNECTION	DERTH OF HOMBER	A. BUILDING:			
		013250	B. WING 10/		4/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		
		104 W 5T	H AVE			
INLAND	NORTHWEST BEHAV	NORAL HEALTH SPOKAN	E, WA 99204			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
L1485	Continued From pa	age 64	L1485			
		s new to the hospital and was				
	not sure of the prod					
	C O= 10/06/01 of 1	12:15 PM, Surveyor #17				
	observed meal ser	vice for the patients, which				
	included preparation	ons for trays to the unit. A				
	Dietary Aide (Staff:	#1709) preparing the rery wrote the date and time of				
	preparation on the	container rather than the time		,		
	the item would be I	beyond use for time as a public				
	health control.		į			
	7. At the time of the	e observation, Surveyor #17				
	interviewed Staff#	1709 about the process for				
	routinely writes the	#1709 stated that she time of preparation on the				
	containers. Staff #	1709 stated that it is up to the				
	clinical staff to mar	nage the food once it is it and ensure that it is disposed				
	of when needed.	it allu elisure iliat it is disposed				
	•	0 0 0 0 1 2 E 0 1 0 0 E				
	Reference: Washir WAC 246-215-035	ngton State Retail Food Code,				
İ	VVAC 240-2 10-000	30				
İ						
		•				
					•	
			-			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S			E CONSTRUCTION 02 - NEW	(X3) DATE S COMPL	
013250		B. WING		10/0	7/2021
NAME OF PROVIDER OR SUPPLIER		·	TATE, ZIP CODE		
INLAND NORTHWEST BEHAVIORAL HEALT	104 W 5TI H SPOKANI	H AVE E, WA 99204			
(X4) ID SUMMARY STATEMENT OF DEFICE (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING II	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S 000 INITIAL COMMENTS		S 000			
This report is the result of an una and life safety State-licensure sur at Inland Northwest Behavioral He Spokane, Washington on 10/7/20 representative of the Washington Fire Protection Bureau (WSP/FPI was conducted in concert with the State Department of Health surve the physical tour of the facility I we by the Director of Plant Ops who deficiency noted during this surve. The facility is licensed for 100 beautime of this survey the census was a triangle of the survey the census was used in accordance with 42 of the facility is a three story structure (1-1-1) hour construction construes to grade and is protected by sprinkler system and an automat alarm system with corridor smoked. The facility is not in compliance we safety Code as adopted by the Compliance of the State Fire Marshal 32863 The surveyor was from: Washington State Patrol Office of the State Fire Marshal	evey conducted ealth in 121 by a 121 by a 121 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by a 131 by	- Liverine			

State Form 2567 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

K5GN21

State of Washington (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 02 - NEW B. WING 10/07/2021 013250 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 104 W 5TH AVE INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 S 000 Continued From page 1 PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 954-2746 DSFM D.A. Rogers 11/18/21 S 211 S 211 NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based upon observations and staff interviews on S211 NFPA 101 Means of 10/07/2021 during the physical tour of the facility Egress-General The Director of Plant Operations was between approximately 0900 and 1130 hours the retrained by the Corporate Facilities facility has failed to maintain the means of egress Manager to the NFPA 101 means of as being readily available for full instant use in the egress sections for new health care event of fire. This could cause an inability or occupancies: Sections 18.1.3.6 to delay in the evacuation of staff in the event of an 18.1.3.9, 18.2, 18.4.3.3, 18.4.3.4, A18.2.2 emergency which would endanger patients, staff to A 18.2.5.7.3.2 (C). and/or visitors. Chairs and storage items were relocated out of the exit corridors and The findings include: monitoring will be added to monthly EOC rounds going forward to call for a -There were multiple freestanding chairs and correction if it does happen again. combustible storage items in cardboard boxes in

State of	Washington				T	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	02 - NEW		
					40.000.0004	
	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	013250	B. WING		<u> 10/07</u>	7/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
1816 43175	NODELBAICOE DELLA	104 W 5TH	H AVE			
INLAND	NORTHWEST BEHAV	SPOKANE SPOKANE	, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 211	Continued From pa	ige 2	S 211			
0 2 1 1	the first floor Outpa SE-Storage exit co -1 (the north gate) way from the East open when tested of The above was dis the Director of Plar unaware the chairs allowed to be in the	of 2 exit gates to the public Courtyard failed to unlatch and due to inoperative hardware. cussed and acknowledged by at Ops who said they were and stored items were not ecorridors and that the north		" The North gate deadbolt in the Courtyard was removed and repla a new deadbolt and tested for pro function. Director of Plant Oper 11/18/2021	ced with per	
	gate was inoperative. 2012 NFPA 101-18.2.1, 7.1.10.1			11/18/2021 Monthly EOC rounds a line added to specifically check corridors for obstructions and will checked monthly (ongoing). Work will be created for any deficiencies corrected going forward. A quarterly, recurring work order vadded to verify that the courtyard are lubricated and functioning pro (ongoing). Monitoring will be ongoing for 4 muntil compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retrain needed. Aggregated data will be reported Environment of Care Committee, Quality Committee, the MEC mor to the Governing Board quarterly. Target for compliance 100%	exit be c orders s and will be doors perly nonths ning as to the nthly and	444004
S 325	NFPA 101 Alcohol (ABHR)	Based Hand Rub Dispenser	S 325			11/18/21
	i					

State of	Washington					T	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION 02 - NEW	(X3) DATE SURVEY COMPLETED	
		013250		B. WING		10/0	7/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		ACCAL LICATED	104 W 5T	H AVE			
INLAND	NORTHWEST BEHAN	MORAL HEALTH	SPOKANI	E, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 325	Continued From pa	age 3		S 325			
	Alcohol Based Har	nd Rub Dispenser (A	BHR)			-	
	ABHRs are pro 8.7.3.1, unless all	otected in accordance	e with				
	conditions are	met:					
		at least 6 feet wide.	ihi in				
	*Maximum in 0.32 gallons	ndividual dispenser c	apacity is				
	(0.53 gallons in	n suites) of fluid and	18 ounces			1	*
	of Level 1						
	aerosols.	shall have a minimu	m of 4 foot				
	horizontal	Sign have a minimu	0, ,				
	spacing.				•		
	*Not more th of fluid or 135	an an aggregate of	10 gallons				
		ol are used in a single	e smoke				
	compartment						
	outside a stora individual dispense	ige cabinet, excludin	g one				
	per room.						
	*Storage in a greater than five	a single smoke comp	artment				
	gallons compli	es with NFPA 30.					
	*Dispensers	are not installed with	nin one				
	inch of an ignition source.						
		over carpeted floors	are in				
	sprinklered smoke						
	compartments	i. i not exceed 95 perc	ont				
	alcohol.	not exceed as beig	GHL				
	*Operation o	of the dispenser shal	comply				
	with Section	- 40 2 2 6/44\					
	18.3.2.6(11) or *ABHR is pro	r 19.3.2.b(11). otected against inap	oropriate				
	access.						
	18.3.2.6, 19.3. 460, 482, 483, and	2.6, 42 CFR Parts 4 I	03, 418,				

State of	Washington	T	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY COMPLETED		
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	02 - NEW		
			D 14/11/0		4010-	voona.
		013250	B. WING		<u> 10/07</u>	//2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		104 W 5TH	H AVE			
INLAND	NORTHWEST BEHA	MUKAL HEALIH SPOKANE	, WA 99204			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 325	Continued From pa	age 4	S 325		The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	
		-9 - ·				
	485					
	This STANDARD Based upon observed 10/07/2021 during campus between a hours, the facility halcohol based hand installed improperly rub coming in contresulting in a fire capatients, staff and/order the findings included. The findings included the findings included the compartment of the findings included the compartment of the findings included the compartment of the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findings included the findin	yl-ABHR-dispenser installed ight switch in the 3E Nurses yl-ABHR-dispenser installed outlet in the third floor Chart yl-ABHR-dispenser installed ight switch in the 2E and 2W scussed and acknowledged by nt Ops who said the dispensers iously observed to be above		S325 NFPA 101 Alcohol Bases Rub Dispenser (ABHR) " Alcohol based hand rub dispenser removed from above electric sources and relocated to safe loceliminate the safety risk. " All EOC members were informate what would cause such a deficient October EOC Meeting (Nov. 2nd) ensure we are properly inspecting EOC rounds. " EVS Staff and the Engineer was retrained on the proper placemental alcohol bases hand rub dispense 11/5/2021. Director of Plant Operations 11/18/2021 Monthly EOC rounds alcohol hand sanitizer dispensers proper inspecting methods this was in creating work orders for any deficiencies and corrected going Monitoring will be ongoing for 4 muntil compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraineded. Aggregated data will be reported Environment of Care Committee, Quality Committee, the MEC most to the Governing Board quarterly.	ensers cal ations to med on acy in the to g during were at of rs on unds will y located s. With ill result forward. honths to the attory and as to the attory and	
	2012 NFPA 101-10 418, 460, 482, 483	8.3.2.6, 42 CFR Parts 403, 3, and 485		Target for compliance 100%		

State of	Washington					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDPLAN	YD FEAN OF GORREG HON IDEATH IOATION NOMBER.		A. BUILDING:	02 - NEW	·	
		013250	B. WING		10/0	7/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	ORAL HEALTH 104 W 5T				
		SPUKAN	E, WA 99204	1	ON.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
S 345	Continued From pa	ge 5	S 345			
S 345	NFPA 101 Fire Alar Maintenance	m System - Testing and	S 345			11/18/21
·	A fire alarm system accordance with ar with the requirement Electric Code, and and Signaling Code	- Testing and Maintenance is tested and maintained in approved program complying approved program complying of NFPA 70, National NFPA 72, National Fire Alarm e. Records of system enance and testing are readily PA 70, NFPA 72				
	Based on record re 10/07/2021 betwee hours, the facility he testing of the fire al in failure of the sys could result in a de failure or in the detoccupant notification and/or visitors within the findings includ. The facility failed to indicating smoke disperoximate instal. The above was distingular to the process of Plant 10/07/2021 between conducted with the process of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the stat	e: provide documentation etector sensitivity testing had thin one year of installation I date of 7-2018). cussed and acknowledged by the Ops who said he is unsure if educted as that was prior to his		S 345 NFPA 101 Fire Alarm Sys Testing and Maintenance The sensitivity testing (EC 02.03.0 was performed on 10/22/2018, as annual each year since. Due to a misunderstanding of the request, Director of Plant Operations was a provide the information during the inspection. The sensitivity test was in the Director of Plant Operations during the inspection and has been annually each year since. The sentest will continue to be completed Director of Plant Operations 11/18/2021 The Director of POperations will be more focused of details of each request going forwensure proper reports are provide an inspection. Monitoring will be ongoing for 4 misspections.	the unable to s on site s office en tested asitivity.	
	NFPA 101 (2012 ed	d) 18.1.1.1.1, 18.3.4.1, 9.6.1.3,		until compliance is achieved and sustained.		

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State of Washington (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 02 - NEW B. WING 10/07/2021 013250 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **104 W 5TH AVE** INLAND NORTHWEST BEHAVIORAL HEALTH SPOKANE, WA 99204 (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 345 S 345 Continued From page 6 All deficiencies will be corrected 2.1, NFPA 72 (2010 ed) 1.1.1, 14.4.4.3.1 immediately to include staff retraining as needed. Aggregated data will be reported to Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100% 11/18/21 S 712 S 712 NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This STANDARD is not met as evidenced by: S 712 NFPA 101 Fire Drills Based upon record review and staff interviews on The 3rd quarter night shift fire drill was 10/07/2021 during document review between performed on 10/8/2021. The drill was approximately 1130 and 1230 hours the facility performed late (as per the fire drill matrix) has failed to conduct all fire drills as required by and to ensure drills are not performed late NFPA 101. This could potentially result in the staff again the Engineer will be scheduled to and facility being unaware of an inoperative fire perform any drills if the Director of Plant alarm system as well as resulting in a failure of Operations is not available. staff to train in a life-like fire situation which could then result in staff not responding in a The Director of Plant Ops trained the coordinated manner in the event of an actual fire Engineer on how to perform Fire Drills by or other emergency, endangering patients, staff, 11/5/2021. Director of Plant Operations and/or visitors.

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION 02 - NEW	(X3) DATE S COMPL	
	·	013250	B. WING		10/0	7/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
INLAND	NORTHWEST BEHAV	/IORAL HEALTH SPOKANE	H AVE E, WA 99204			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED TO T	.D BE	(X5) COMPLETE DATE
S 712	Continued From pa	age 7	S 712	44/49/2024		-
	indicating a night significant conducted as the drill.	not provide documentation hift fire drill for 3rd quarter of		The Engineer will be trained to perform a fire drill alone by the Dir Plant Operations Additionally he with charge of the next two drills in 202 DPO to help) to ensure he is prepier a drill without assistance forward. Monitoring will be ongoing for 4 muntil compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retrain needed. Aggregated data will be reported to Environment of Care Committee, Quality Committee, the MEC mon to the Governing Board quarterly. Target for compliance 100%	rector of will be in 21 (with ared to going onths as	
	-					

Plan of Correction for State Licensing Hospital Survey 10/06/21-10/14/21

Monitoring procedure; Target for Compliance	batemita3 fo ata0 noitoarro	PlaisnoqsəЯ	How the Deficiency Will Be Corrected	geT TedmuM
Groups will be monitored to confirm compliance droups will be monitored to confirm compliance with documentation of alternative active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of patients not attending Groups will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality for monthly and to the Committee and MEC monthly and to the Governing Board quarterly.	1202/81/21	Director of Clinical Services Chief Nursing Officer	322-035.1C POLICIES TREATMENT The CEO, the Director of PI and the Director of Clinical Services Individual Supportive Therapy and Education Policy and the Individual Supportive Therapy and Education Policy and the Changes were needed to this policy. The Alternative Programming Policy was reviewed and revised to reflect the Therapist is responsible for meeting individually with patients that do not attend group. The revised Alternative Programming Policy was reviewed and approved by the Governing Board on November 12th. The Clinical Service Staff and Nursing staff responsible for groups were retrained to the revised Alternative Programming Policy to confirm compliance with documentation of active Policy to confirm compliance with documentation of active of Care Policy and the Individual Supportive Therapy Policy as of Care Policy and the Individual Supportive Therapy Policy as and the CNO and completed by November 25th, 2021.	STET
Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of sustained. Ongoing monitoring of 50% of Precaution Orders will continue monthly.		Chief Nursing Officer	Item #2: The CEO, the Director of PI, the Risk Manager and the CNO met to review the Suicide Precautions Policy, Sexual Aggression and Sexual Victimization Prevention and Response and Notification Plan policy and no changes were needed to these policies. All licensed Nursing Staff and MHT's were retrained to: • Communicate and document signs of concern • Conduct observation rounds ordered	

Target for compliance >/= 90% Governing Board quarterly. Committee and MEC monthly and to the Aggregated data will be reported to Quality include staff retraining as needed. All deficiencies will be corrected immediately to

All deficiencies will be corrected immediately to Precaution Orders will continue monthly. Assignment Sheets, Observation Sheets and HCS to %02 fo gnitorinom gniognO .benistsus compliance of 90% or greater is achieved and Monitoring will be ongoing for 4 months until to be ordered. reviewed to make sure no new Precautions need patients along with their Precautions will be During morning report with Providers, all patient precautions and observation levels. to confirm compliance with documentation of Observation Sheets and HCS Precaution Orders Monitoring of all Nursing Assignment Sheets,

Target for compliance >/= 90%

include staff retraining as needed.

Committee and MEC monthly and to the

Aggregated data will be reported to Quality

Governing Board quarterly.

aggression and sexual victim. acting out, including boundary violations, sexual Observe patients for specific behaviors to sexually

• Lead Nurse is responsible for communicating with the discontinue Precautions when patient is no longer at will discontinue Suicide Precautions and will assess and • The Physician reevaluates Suicide Precautions daily and

Team. patient Observation Form and communicate with the sheet, the 24 Hour Nurse Report and the individual Lead Nurse is responsible for updating the Assignment changed and/or discontinued.

Med Nurse and MHT's when levels of precautions are

Mursing Chief

changes were needed to these policies. Plan policy and the Fall Risk Assessment and Care Policy and no Sexual Victimization Prevention and Response and Notification to review the Suicide Precautions Policy, Sexual Aggression and The CEO, the Director of PI, the Risk Manager and the CNO met ftem #3

The Physician reevaluates Suicide Precautions daily and All licensed Nursing Staff and MHT's were retrained to:

Lead Nurse is responsible for communicating with the risk. discontinue Precautions when patient is no longer at will discontinue Suicide Precautions and will assess and

changed and/or discontinued. Med Nurse and MHT's when levels of precautions are

sure no new Precautions need to be ordered. along with their Precautions will be reviewed to make During morning report with Providers, all patients

Team all patient precautions. patient Observation Form and communicate with the sheet, the 24 Hour Nurse Report and the individual Lead Nurse is responsible for updating the Assignment

interventions for patients on Fall Precautions, The Fall Risk Assessment with a focus on key

Officer

	observation
	to level suoioerq at precious level of
	redirection
	ot behavior, does not respond to
	o Threatening harm to self and others
	they place themselves at risk or harm
	o Disorganization or Confused to the degree that
	Combative
	O Homicidal
	toubnoosim\noiseanggA lsuxac
	o Agitation Agitation o
	○ Actively suicidal
	observation include but are not limited to:
	Reasons that the RN may increase the level of
	Supervisor, but requires Provider's order
	Increases to 1:1 status may be initiated by the House
	the RN, then the RN will notify the House Supervisor.
	 If a change to status is needed to 1:1, as identified by
	notified as soon as possible of the change in condition.
	patient's condition changes. The physician will be
	• The RM may increase the level of observation if the
	observation on patient's when conditions warrant it.
	Ensuring patient's safety by increasing the level of
	conditions warrant it.
	and precautions is addressed on admit and daily when
	Confirming that each individual level of observation
	compliance:
	sheets for each patient on their unit to confirm
	Lead Murse is responsible for auditing all Observation
	unit.
	the order sheet to each Lead Murse each day on each
	House Supervisor is responsible for providing a copy of
·	orders that are printed out each day at 0700. The
	Additional training was provided on Active Precautions Add 00\text{V0} text does too betains are test assesses.
	patients on Fall Precautions.
	Communication with the Treatment Team on all
	Plan with appropriate interventions.
	documentation of Fall Risk in the individual Treatment

The Medical Director and Director of Pharmacy will Monitor 100% of the INBH Specific Authorization for Psychotropic Medications Consent Form monthly to confirm compliance with Policy. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of sustained. Ongoing monitoring of 50% of Psychotropic Consents will continue. Psychotropic Consents will be corrected immediately to include staff retraining as needed. All deficiencies will be corrected immediately to include staff retraining as needed. Committee and MEC monthly and to Quality Governing Board quarterly. Governing Board quarterly. Target for compliance >/= 90%	1707/81/71	Medical Director Director of Pharmacy Chief Nursing Officer	The CEO, the Medical Director, the Director of PI, the Director of Pharmacy and the CNO met to review the Medication- Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient's Rights and Responsibilities Policy, no revisions needed at this time. The Medical Director met with the Providers to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy and the Patient Rights and Involuntary Patients Policy and the Patient Rights and Perior to administering medications. The Providers are prior to administering medications. The Providers are responsible for reviewing the risk and benefits of medications with each patient and obtaining written consent. The CNO met with all licensed Nursing staff to reeducate on with each patients and obtaining written consent. Provider then goes into HCS and adds order stating administration of a written consent prior to medication administration of a written consent prior to medication. Provider then goes into HCS and adds order stating or Providers meets with patient and gets consent form signed Provider then goes into HCS and adds order stating the Provider meets with patient and sade consent form the Providers The Med Room Nurse will the patient. The Med Room Nurse will check the Consent form make sure then was obtained. The Med Room Nurse will the patient. The Med Room Nurse will the patient.	7350
			Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions).	

Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Infection Control Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. All deficiencies will be reported to the Quality Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly.	1202/21/21	Director of Human Resources	322.050.6D TRAINING INFECTION CONTROL The CEO, the Director of PI and the Director of Human Resources met to review finding from the survey and discuss corrective actions. The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Infection Control. Staff with incomplete required trainings to Infection Control will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	0957
Monitoring process includes the Director of Plant Ops responsible for maintaining all documentation specific to the cleaning of ice machines. Environmental of Care rounds will be completely monthly to confirm compliance with revised process. Aggregated data will be reported to the EOC, process. Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%	1202/21/21	Director of Plant Ops	322.035.1P POLICIES EQUIPMENT MAINTENANCE The CEO, the Director of PI and the Director of Plant Ops met to review survey findings related to the lack of documentation of maintenance of the ice machines. The Director of Plant Ops implemented a process that includes a vendor responsible for maintaining the ice machines quarterly. Documentation will be kept in the DPO's office. Ice Machine cleaning will be performed by November 15th. An inspection sticker will be put on the side of the ice machine to verify last date cleaned.	. гз80
The Director of PI and the Leadership Team will be reviewing and updating Hospital Policies annually. All revised and updated policies will be reported to MEC and Governing Board quarterly. Target compliance is 100%	1202/81/21	Director of Quality	322.035.1N POLICIES PATIENT WORK The CEO, the Director of PI and the CNO met to review the current Patient Employment Policy that was issued October $\mathbb{1}^{s_{r}}$, 2018. Patient Employment Policy was reviewed with no required. The Hospital Leadership Team was reeducated to the Patient The Hospital Leadership Team was reeducated to the Patient Employment Policy by November $\mathbb{1}^{2^{t_{h}}}$.	0287

Target for compliance 100%.				
Governing Board quarterly.			immediately.	
Committee, and the MEC monthly and to the	Ì		expired/damaged supplies and/or equipment will be discarded	
Infection Control Committee, the Quality			having any expired/damaged supplies and/or equipment. All	
			of supplies and equipment to confirm compliance with not	
Monitoring will be ongoing Aggregated data will be reported to the			The CEO directed the Infection Control Nurse to review 100%	
			corrective actions.	
compliance with disposal of all expired items.		Murse	CNO met to review the findings from the survey and discuss	
rooms, Med Rooms and Lab room to confirm		Control	The CEO, the Director of Pl, the Infection Control Nurse and the	STZ7
Environment of Care rounds monthly to all Exam	T707/CT/7T	Infection	322.100.1E INFECTION CONTROL PROVISIONS	
The Infection Control Nurse will complete	12/13/2021	401420341	SNOISH TO GETTO THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF THE TEXT OF TH	
			completed immediately.	
recent county of the same			Any staff that are missing their TB Assessment/Test will be	
Target for compliance 100%.			proof within the first two weeks of hire.	
Governing Board quarterly.			screening and testing and/or chest x-ray or TB Vaccination	
Committee, and the MEC monthly and to the			Plan Policy. Focus of this training included the need for TB	
Infection Control Committee, the Quality			Tuberculosis (TB) Screening and Airborne Pathogen Exposure	I
And of he reported to the Aggregated data will be reported to the			the Infection Control Nurse and the Clinical Educator on the	
Committee.		Educator	The Divisional Director of Clinical Services-Nursing reeducated	
and reported to the Infection Control		Clinical	potestipos majanijų sariaijo į iliaijo ir ir ir ir ir ir ir ir ir ir ir ir ir	
Employee Health Files will continue Quarterly		legigil	needed at this time.	
of 2002 of 2008 of 2008 of 2008 of 2008 of 2008 of			and Airborne Pathogen Exposure Plan Policy, no revisions	
compliance of 90% or greater is achieved and		Nurse	Clinical Educator met to review the Tuberculosis (TB) Screening	•
Nonitoring will be ongoing for 4 months until		Control	The CEO, the Director of PI, the Infection Control Nurse and the	
of the Employee Health Files weekly.	T707/CT/7T	Infection	322.050.9A TB-MANTOUX TEST	5797
The Infection Control Nurse will Monitor 100%	1202/81/21	401420341	LOGITATION TO THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Target compliance is 100%				
Governing Body quarterly.			work until required trainings are completed.	
·	i.		have not completed required trainings will not be scheduled to	
Committee and MEC monthly and to the			trainings will be completed by November 25th, 2021. Staff that	
All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality		Resources	required trainings to Patient Rights will be notified. All required	
required trainings to be completed by their staff. All deficiencies will be corrected immediately.		Human	training specific to Patient Rights. Staff with incomplete	
The Department Directors are responsible for all		Director of	100% of employee files to confirm compliance with all required	
are not compliant with Patient Rights Training. The Department Directors are reconsible for all	l l	34:Q	The CEO directed the Director of Human Resources to review	
Department Directors weekly of any staff that			corrective actions.	
trainings completed by staff and notify the			Resources met to review finding from the survey and discuss	
Human Resources will download all required			The CEO, the Director of PI and the Director of Human	SZST
Monitoring process includes the Director of Monitoring process will download all required			322.050.6G ORIENTATION PATIENT RIGHTS	
Po Totage Director of	1000/61/61			
- Viete - Addition				

100% of Treatment Plans will be monitored weekly to confirm compliance with the Treatment Plan containing interventions for Behavioral and Medical problems. The interventions need to be developed and documented and identified on the Masster Treatment Plan and the Treatment Plan and the Treatment Plan Compliance of 90% or greater is achieved and compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Sustained. Ongoing monitoring of 50% of Ireatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed.		Director of Clinical Services	Item #2: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Mursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that interventions for psychological and medical problems are developed and documented for each problem identified on the Master Treatment Plan and the Treatment Plan Updated.	
100% of Treatment Plans will be monitored weekly to confirm compliance with the Comprehensive Treatment Plan including Behavioral and Medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality include staff retraining as needed. Committee and MEC monthly and to the Governing Board quarterly.	1202/81/21	Director of Clinical Services	The CEO, the Director of PI, the Medical Director, the Director. The CEO, the Director of PI, the Medical Director, the Director. Treatment Planning Policy, no revisions needed at this time. The Director of Clinical Services reeducated all Providers, Clinical Services staff, and Mursing staff on the Treatment Planning Policy. Focus of this training included the need to develop an Individualized Comprehensive Master Treatment Plan for all patients that includes behavioral and medical problems.	\$9017
The Director of Plant Ops will monitor appropriate use of shelf space and further need for additional shelving in closets. Findings will be corrected immediately. Target compliance is 100%	1202/21/21	Director of Plant Ops	322.120.8B HOUSEKEEPING CLOSETS The CEO, the Director of Pl and the Director of Plant Ops met to review the findings from the survey and discuss corrective actions. The CEO directed the Director of Plant Ops to order the shelves for the closets and install them as soon as possible.	5787

100% of Treatment Plans will be monitored weekly to confirm compliance with addressing any patient that has an OT Evaluation ordered any patient that has an OT Evaluation ordered and the OT recommendations will be incorporated into the Treatment Plan. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will be corrected immediately to include staff retraining as needed. All deficiencies will be reported to Quality include staff retraining as needed. Committee and MEC monthly and to the Governing Board quarterly. Governing Board quarterly.	1202/21/21	Director of Clinical Services	322.170.3F OT SERVICES The CEO, the Director of PI, the Medical Director, the Director of Clinical Services, the RD, and the CNO met to review the Treatment Planning Policy, no revisions needed at this time. The Director of Clinical Services reeducated all Providers, Clinical Services staff, the RD and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to integrate any services ordered by the Provider into the comprehensive treatment plan and patient care processes. The process is as follows: The Provider will enter an order for the patients needing OT Assessment into HCS. The Social Worker will call INHS and schedule the OT Assessment.	77750
Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% 100% of Treatment Plans will be monitored weekly to confirm compliance with a Treatment Plan Update being done on any patient that has and/or medical concerns and will contain compliance of status, change of precautions and/or medical concerns and will contain interventions addressing that specific concern. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. Treatment Plans will be corrected immediately to include staff retraining as needed. Committee and MEC monthly and to the Governing Board quarterly. Governing Board quarterly.		Director of Clinical Services	Item #3: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Mursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that any change of status, change of precaution and/or medical concerns noted that a Treatment Plan Update needs to be done with interventions addressing that specific concern.	

	included:			Target for compliance 100%
	Policy and the Seclusion/Restraint Packet. Focus of this training	Officer		Governing Board quarterly.
	Monitoring of Physical/Chemical Restraints and Seclusion	Nursing		Committee and MEC monthly and to the
	The CNO reeducated all Mursing staff on the Proper Use and	Chief	ļ.	Aggregated data will be reported to Quality
	' " - "	, , , ,		and/or designee.
	Policy, no revisions needed at this time.			All deficiencies will be followed up by the CNO
	Monitoring of Physical/Chemical Restraints and Seclusion			Monitoring will be ongoing
	Manager and the CNO met to review the Proper Use and			Meeting.
STIIT	The CEO, the Director of PI, the Medical Director, the Risk			Ash The Flash incident during the Flash
	322.180.1C RESTRAINT OBSERVATIONS		12/13/2021	100% review of Seclusion/Restraint Packets
	tneited to gniteindeb bas		, , , , , ,	340/040 44:044-073
[continuous monitoring of patient and care provided,			
	restraint application, face to face assessment and			
	criteria for discontinuation, check for appropriate			
	seclusion/restraint, informing patient of behavioral			
	to noiseunitroosib rot airetieria for discontinuation			
	notification of patient's family, written orders for use,			
	events leading up to event, failure of interventions,			
	including specific behaviors, detailed description of the			
	Documentation of each episode of seclusion/restraint			
	restraint and seclusion use			
	of batelar traited and to tramssasse laitini ant	:		
	consent for notification.		ű.	
•	Hospital Policy on the use of restraint/seclusion and			
	That the patient and/or family was informed of			Target for compliance 100%
	included:	Officer		Governing Board quarterly.
	Policy and the Seclusion/Restraint Packet. Focus of this training	BuisruM		Committee and MEC monthly and to the
	Monitoring of Physical/Chemical Restraints and Seclusion	TeidD		Aggregated data will be reported to Quality
	The CNO reeducated all Nursing staff on the Proper Use and			and/or designee.
				All deficiencies will be followed up by the CNO
	Policy, no revisions needed at this time.			Monitoring will be ongoing
	Monitoring of Physical/Chemical Restraints and Seclusion			capture all Seclusion/Restraint incidents.
	Manager and the CNO met to review the Proper Use and			24 hours of incident during the Flash Meeting to
77740	The CEO, the Director of PI, the Medical Director, the Risk			Reports and Seclusion/Restraint Packets within
	322-180.1B ASSAULTIVE INCIDENTS		12/22/21	100% review of Hospital Report, Incident
	fnamssassA			
	Treatment Plan will be updated to reflect the OT	_		
	the Assessment Tab			
	OT Assessment will be put in the patient's chart under			

Intake percentage and general observations.		Intake Policy, no revisions needed at this time.	
100% review of the Nursing Flowsheets for		the CNO met to review the Monitoring and Recording Food	
Tracking Forms for Intake percentage		The CEO, the Director of PI, the Medical Director, the RD and	L1265
100% review of the Patient Meal and Utensil	1202/21/21	322.200.3F RECORDS OBSERVATIONS	
100% review of Trestment Plans within 24 hours of incident. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%		Item #2 The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • When a patient ends up in seclusion/restraint a review and modification of the treatment plan is indicated. • The RN will review and update the Treatment Plan within 8 hours included: • The updated Treatment Plan will reflect the instances of seclusion/restraint, interventions to define alternative approaches with responsibility of interventions assigned interventions assigned Review of the updated plan with the patient • Review of the updated plan with the patient	
		 A staff member will be within arm's length of the patient to provide immediate response should the patient experience any physical distress The patient will be assessed every 15 minutes will in seclusion/restraint. This assessment includes, distress/agitation and release of limbs will be done seclusion/restraint. Range of motion and release of limbs will be done minimally every 1 hour. Pluids and toileting will be offered every 2 hours indicated, but at least every 2 hours. Vital signs will be taken upon initiation and as clinically indicated, but at least every 2 hours indicated, but at least every 2 hours indicated, but at least every 2 hours indicated but at least every 1 hours every 15 hours For Chemical Restraints staff are to monitor vital signs, inductor of attus and perform safety checks every 15 hours neuro status and perform safety checks every 15 hour and then every 1 hour for 4 hours or as directed by the then every 1 hour for 4 hours or as directed by the 	

			greater than 2 inches in depth.	
			time and temperature for cooling items when using a pan	
	,		training included the need for a Cooling Log to document the	
			staff on the newly revised Leftover Food Policy. Focus of this	
Target for compliance 100%			The DPO and Dietary Manager reeducated all Dietary Kitchen	
Governing Board quarterly.				
Committee and MEC monthly and to the			Policy to reflect the proper procedure for cooling food items.	
Environment of Care Committee, the Quality		Plant Ops	current Leftover Food Policy and they revised and updated the	
Aggregated data will be reported to		Director of	The Director of Plant Ops and Dietary Manager reviewed the	
and/or designee.				
All deficiencies will be followed up by the DPO			discuss corrective actions.	
Monitoring will be ongoing			Dietary Manager met to review the findings of survey and	
done weekly to confirm compliance.			The CEO, the Director of PI, the Director of Plant Ops and the	73482
100% review of the Leftover food cooling will be	12/23/2021		322.230.1 FOOD SERVICES REGS	
Target for compliance >/= 90%				
Governing Board quarterly.			or photograph) and ask the patient to state his/her name.	
Committee and MEC monthly and to the			2 Hospital approved identifiers (i.e. date of birth, name band,	
Aggregated data will be reported to Quality		Officer	included that staff must check the patient's identification with	
and/or designee.		BnishuM	Medication Administrations Policy. Focus of this training	
All deficiencies will be followed up by the CNO		TəidƏ	The CNO reeducated all licensed Nursing staff on the	
continue:				:
lliw sessed bem to %02 to gnirotinom gniognO			revisions needed at this time.	
90% or greater is achieved and sustained.			met to review the Medication Administration Policy, no	
Monitoring will be ongoing for 4 months until			The CEO, the Director of PI, the Medical Director, and the CNO	57511
30 med passes will be audited each month	12/13/2021		322.210.3C PROCEDURES-ADMINISTER MEDS	
			sbean lanoitirtun teem ot etsupeba nath seel	
			Program staff will alert the Provider if meal intake is	
Target for compliance >/= 90%			sccepted suscks.	
Governing Board quarterly.			prompts to eat, requests for extra portions and	
Committee and MEC monthly and to the			general observations including not eating requiring	
Aggregated data will be reported to Quality	,		Flowsheet in the form of percentage of meal eaten and	
and/or designee.			Program staff will record food intake on the Mursing	
All deficiencies will be followed up by the CNO			recording patients food intake after each meal	
monthly.			• Program staff are responsible for monitoring and	
Intake and Nursing Flowsheets will continue		Offlicer	training included:	
Is9M Ineited to %02 to gninotinom gniognO		Mursing	Monitoring and Recording Food Intake Policy. Focus of this	
90% or greater is achieved and sustained.		Chief	The CNO reeducated all Nursing and MHT staff on the	
Monitoring will be ongoing for 4 months until				

		item would be beyond use for time as a public health control.
	Manager	delivered to the unit. The time will need to be the time that the
Target for compliance 100%	Dietary	process for timing and dating food trays when they are being
Governing Board quarterly.		Communities Policy. Focus of this training included the new
Committee and MEC monthly and to the	Plant Ops	Dietary Kitchen staff on the newly revised Meal Trays for the
Environment of Care Committee, the Qualit	Director of	The Director of Plant Ops and Dietary Manager reeducated all
Aggregated data will be reported to the		
and/or designee.		delivered to the unit as a means for public health control.
All deficiencies will be followed up by the D		reflect the procedure for timing/dating food trays when
Monitoring will be ongoing		Communities Policy and they revised and updated the policy to
communities weekly to confirm compliance		Dietary Manager met to review the Meal Trays for the
100% review of the meal trays brought to th		The CEO, the Director of PI, the Director of Plant Ops and the
, , , , , , , , , , , , , , , , , , , ,		Item #2:



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

December 14, 2021

Rlynn Wickel CEO Inland Northwest Behavioral Health 104 W 5th Avenue Spokane, WA 99204

Dear Mr. Wickel:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Inland Northwest Behavioral Health from October 6-14, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on December 14, 2021.

A Progress Report is due on or before January 12, 2022 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please sign and return the original reports and Plans of Correction to me at the electronically at tyler.henning@doh.wa.gov.

Please contact me if you have any questions. I may be reached at 360-236-2918. I am also available by email at tyler.henning@doh.wa.gov.

Sincerely, Tyler Henning

Tyler Henning, ScM, MHS

Survey Team Leader

APPROVED

By Kimberly Bloor at 1:53 pm, Nov 08, 2021

Inland Northwest Behavioral Health Plan of Correction for State Licensing Hospital Survey 10/06/21-10/14/21

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
S211	 NFPA 101 Means of Egress-General The Director of Plant Operations was retrained by the Corporate Facilities Manager to the NFPA 101 means of egress sections for new health care occupancies: Sections 18.1.3.6 to 18.1.3.9, 18.2, 18.4.3.3, 18.4.3.4, A18.2.2 to A 18.2.5.7.3.2 (C). Chairs and storage items were relocated out of the exit corridors and monitoring will be added to monthly EOC rounds going forward to call for a correction if it does happen again. The North gate deadbolt in the East Courtyard was removed and replaced with a new deadbolt and tested for proper function. 	Director of Plant Operations	11/18/2021	Monthly EOC rounds will have a line added to specifically check exit corridors for obstructions and will be checked monthly (ongoing). Work orders will be created for any deficiencies and corrected going forward. A quarterly, recurring work order will be added to verify that the courtyard doors are lubricated and functioning properly (ongoing). Monitoring will be ongoing for 4 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 Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100%
\$325	 NFPA 101 Alcohol Bases Hand Rub Dispenser (ABHR) Alcohol based hand rub dispensers were removed from above electrical sources and relocated to safe locations to eliminate the safety risk. All EOC members were informed on what would cause such a deficiency in the October EOC Meeting (Nov. 2nd) to ensure we are properly inspecting during EOC rounds. EVS Staff and the Engineer were retrained on the proper placement of alcohol bases hand rub dispensers on 11/5/2021. 	Director of Plant Operations	11/18/2021	Monthly EOC rounds will continue to monitor for improperly located alcohol hand sanitizer dispensers. With proper inspecting methods this will result in creating work orders for any deficiencies and corrected going forward. Monitoring will be ongoing for 4 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 Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly.

				Target for compliance 100%
S 345	NFPA 101 Fire Alarm System- Testing and Maintenance The sensitivity testing (EC 02.03.05 EP3) was performed on 10/22/2018, as well as annual each year since. Due to a misunderstanding of the request, the Director of Plant Operations was unable to provide the information during the inspection. The sensitivity test was on site in the Director of Plant Operations office during the inspection and has been tested annually each year since. The sensitivity test will continue to be completed.	Director of Plant Operations	11/18/2021	The Director of Plant Operations will be more focused on the details of each request going forward to ensure proper reports are provided during an inspection. Monitoring will be ongoing for 4 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 Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100%
S 712	NFPA 101 Fire Drills The 3 rd quarter night shift fire drill was performed on 10/8/2021. The drill was performed late (as per the fire drill matrix) and to ensure drills are not performed late again the Engineer will be scheduled to perform any drills if the Director of Plant Operations is not available. The Director of Plant Ops trained the Engineer on how to perform Fire Drills by 11/5/2021.	Director of Plant Operations	11/18/2021	The Engineer will be trained to perform a fire drill alone by the Director of Plant Operations Additionally he will be in charge of the next two drills in 2021 (with DPO to help) to ensure he is prepared to perform a drill without assistance going forward. Monitoring will be ongoing for 4 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 Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100%
			and the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second s	

Inland Northwest Behavioral Health Progress Report for State Licensing Hospital Survey 10/06/21-10/14/21

Tag Number	How Corrected	Date Completed	Results of Monitoring
#L315 – 322- 035.1C POLICIES TREATMENT	Item #1: The Clinical Service Staff and Nursing staff responsible for groups were retrained to the revised Alternative Programming Policy to confirm compliance with documentation of active treatment. Staff were also retrained on the Plan for Provision of Care Policy and the Individual Supportive Therapy Policy as well. Training was initiated by the Director of Clinical Services and the CNO and completed by November 25th, 2021.	12/13/2021	Item #1: 100% of records of patients not attending Groups will be monitored to confirm compliance with documentation of alternative active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of patients not attending Groups will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed November: 60%- Re-education done by DSC and assigned a Group Facilitator. Daily spot checks to be done by DSC. December: 87%*- Director of Quality met with Social Workers and Recreational Therapists and re-educated them on Policy and Procedure on 12/21/2021. January so far: 99%
	 Item #2: All licensed Nursing Staff and MHT's were retrained to: Maintain awareness of patient at all times Communicate and document signs of concern Conduct observation rounds ordered Observe patients for specific behaviors to sexually acting out, including boundary violations, sexual aggression and sexual victim. The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk. Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of 	12/13/2021	Item #2: Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed. November: 89%*- Re-education done to Providers to communicate when discontinuing Precautions. Lead Nurse is running a precaution report 3 times/day to make sure all information is correct. December: 91% January so far: 95%

Progres Repor Rec. 1/11/22 Appad: 1/12/22

- precautions are changed and/or discontinued.
- Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team.

Item #3: All licensed Nursing Staff and MHT's were retrained to:

- The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk.
- Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of precautions are changed and/or discontinued.
- During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered.
- Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team all patient precautions.
- The Fall Risk Assessment with a focus on key interventions for patients on Fall Precautions, documentation of Fall Risk in the individual Treatment Plan with appropriate interventions.
- Communication with the Treatment Team on all patients on Fall Precautions.
- Additional training was provided on Active Precautions orders that are printed out each day at 0700. The House Supervisor is responsible for

12/13/2021

Item #3: Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered.

Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly.

All deficiencies will be corrected immediately to include staff retraining as needed.

November: 89%*- Re-education done to Providers to communicate when discontinuing Precautions. Lead Nurse is running a precaution report 3 times/day to make sure all information is correct.

December: 91%

January so far: 95%

- providing a copy of the order sheet to each Lead Nurse each day on each unit. Lead Nurse is responsible for auditing all Observation sheets for each patient on their unit to confirm compliance. Confirming that each individual level of observation and precautions is conditions warrant it.
- addressed on admit and daily when
- Ensuring patient's safety by increasing the level of observation on patient's when conditions warrant it.
- The RN may increase the level of observation if the patient's condition changes. The physician will be notified as soon as possible of the change in condition.
- If a change to status is needed to 1:1, as identified by the RN, then the RN will notify the House Supervisor. Increases to 1:1 status may be initiated by the House Supervisor, but requires Provider's order
- Reasons that the RN may increase the level of observation include but are not limited to:
 - o Actively suicidal
 - Aggression/Agitation
 - Sexual Aggression/misconduct
 - Homicidal
 - Combative
 - Disorganization Confused to the degree that they place themselves at risk or harm
 - o Threatening harm to self and others
 - o Intrusive behavior, does not respond to redirection
 - o Failure to maintain safety at precious level of observation

	Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions).		
#L320 - 322.035.1D- POLICIES PATIENT RIGHTS	The Medical Director met with the Providers to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy specific to obtaining written consent prior to administering medications. The Providers are responsible for reviewing the risk and benefits of medications with each patient and obtaining written consent. The CNO met with all licensed Nursing staff to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy. Focus of this training included confirmation of a written consent prior to medication administration. The process will go as followed: Psychotropic Consent form was added to Admit packet for Providers Provider meets with patient and gets consent form signed Provider then goes into HCS and adds order stating Consent received for each Psychotropic medication that they reviewed with the patient. The Med Room Nurse will check the Consent tab in HCS before giving any Psychotropic medications to make sure that consent was obtained.	12/13/2021	The Medical Director and Director of Pharmacy will Monitor 100% of the INBH Specific Authorization for Psychotropic Medications Consent Form monthly to confirm compliance with Policy. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Psychotropic Consents will continue. All deficiencies will be corrected immediately to include staff retraining as needed. November: 78%*- Re-education done to Providers and Med nurses on process. Changed our process to make it easier on the Med Nurses to upload the form into HCS. December: 88%*- One Provider is delinquent in doing the Consent form. This Provider was re-educated. January so far: 100%

	Consent form will be given to Med Room Nurse to file in patients chart		
# L370- 322.035.1N- POLICIES PATIENT WORK	The CEO, the Director of PI and the CNO met to review the current Patient Employment Policy that was issued October 1 st , 2018. Patient Employment Policy was reviewed with no revisions required. The Hospital Leadership Team was reeducated to the Patient Employment Policy by November 12 th .	12/13/2021	The Director of PI and the Leadership Team will be reviewing and updating Hospital Policies annually. All revised and updated policies will be reported to MEC and Governing Board quarterly. Target compliance is 100% November: 100% December: 100%
# L380- 322.035.1P- POLICIES EQUIPMENT MAINTENANCE	The CEO, the Director of PI and the Director of Plant Ops met to review survey findings related to the lack of documentation of maintenance of the ice machines. The Director of Plant Ops implemented a process that includes a vendor responsible for maintaining the ice machines quarterly. Documentation will be kept in the DPO's office. Ice Machine cleaning will be performed by November 15th. An inspection sticker will be put on the side of the ice machine to verify last date cleaned.	12/13/2021	Monitoring process includes the Director of Plant Ops responsible for maintaining all documentation specific to the cleaning of ice machines. Environmental of Care rounds will be completely monthly to confirm compliance with revised process. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% November: 100% December: 100%
# L560- 322.050.6D- TRAINING INFECTION CONTROL	The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Infection Control. Staff with incomplete required trainings to Infection Control will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Infection Control Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% November: 88%*- Each Director was given their list of employees that were non-compliant and each employee came in to do their education.
			December: 95%

# L575- 322.050.6G- ORIENTATION PATIENT RIGHTS	The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Patient Rights. Staff with incomplete required trainings to Patient Rights will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Patient Rights Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% November: 88%*- Each Director was given their list of employees that were non-compliant and each employee came in to do their education. December: 95%
# L615- 322.050.9A- TB-MANTOUX TEST	The Divisional Director of Clinical Services- Nursing reeducated the Infection Control Nurse and the Clinical Educator on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of this training included the need for TB screening and testing and/or chest x-ray or TB Vaccination proof within the first two weeks of hire. Any staff that are missing their TB Assessment/Test will be completed immediately.	12/13/2021	The Infection Control Nurse will Monitor 100% of the Employee Health Files weekly. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 100% of Employee Health Files will continue Quarterly and reported to the Infection Control Committee. Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%. November: 90%*- Employees notified that needed a TB test and/or X-ray. December: 95%
# L715- 322.100.1E- INFECTION CONTROL PROVISIONS	The CEO directed the Infection Control Nurse to review 100% of supplies and equipment to confirm compliance with not having any expired/damaged supplies and/or equipment. All expired/damaged supplies and/or equipment will be discarded immediately.	12/13/2021	The Infection Control Nurse will complete Environment of Care rounds monthly to all Exam rooms, Med Rooms and Lab room to confirm compliance with disposal of all expired items. Monitoring will be ongoing Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%. November: 95% December: 100%

# L825- 322.120.8B- HOUSEKEEPING CLOSETS	The CEO directed the Director of Plant Ops to order the shelves for the closets and install them as soon as possible.	12/13/2021	The Director of Plant Ops will monitor appropriate use of shelf space and further need for additional shelving in closets. Findings will be corrected immediately. Target compliance is 100% November: 100% December: 100%
# L1065- 322.170.2E- TREATMENT PLAN COMPREHENSION	Item #1: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to develop an Individualized Comprehensive Master Treatment Plan for all patients that includes behavioral and medical problems.	12/13/2021	Item #1: 100% of Treatment Plans will be monitored weekly to confirm compliance with the Comprehensive Treatment Plan including Behavioral and Medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% November: 75%*- Re-education done to Providers and Nursing regarding addressing all Medical problems. December: 90%
	Item #2: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that interventions for psychological and medical problems are developed and documented for each problem identified on the Master Treatment Plan and the Treatment Plan Updated.	12/13/2021	Item #2: 100% of Treatment Plans will be monitored weekly to confirm compliance with the Treatment Plan containing interventions for Behavioral and Medical problems. The interventions need to be developed and documented and identified on the Master Treatment Plan and the Treatment Plan Updates. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. November: 75%*- Re-education done to Providers, Social Workers and Nurses on the need to have interventions listed on the Updates December: 90%
	Item #3: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment	12/13/2021	Item #3: 100% of Treatment Plans will be monitored weekly to confirm compliance with a Treatment Plan Update being done on any patient that has a change of status, change of precautions and/or medical

	Planning Policy. Focus of this training included the need to ensure that any change of status, change of precaution and/or medical concerns noted that a Treatment Plan Update needs to be done with interventions addressing that specific concern.		concerns and will contain interventions addressing that specific concern. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% November: 75%*- Re-education done to Providers, Social Workers and Nursing on needing to address any changes with patients and address that specific concern in Treatment Plan meeting. December: 90%
# L1120- 322.170.3F- OT SERVICES	The Director of Clinical Services reeducated all Providers, Clinical Services staff, the RD and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to integrate any services ordered by the Provider into the comprehensive treatment plan and patient care processes. The process is as follows: • The Provider will enter an order for the patients needing OT Assessment into HCS. • The Social Worker will call INHS and schedule the OT Assessment. • OT Assessment will be put in the patient's chart under the Assessment Tab Treatment Plan will be updated to reflect the OT Assessment	12/13/2021	100% of Treatment Plans will be monitored weekly to confirm compliance with addressing any patient that has an OT Evaluation ordered and the OT recommendations will be incorporated into the Treatment Plan. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% November: 85%*- Re-education done to Providers, Social Workers and Nursing to address on Treatment Plans any patient being referred for PT/OT Evaluations. December: 100%
# L1140- 322.180.1B- ASSAULTIVE INCIDENTS	The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • That the patient and/or family was informed of Hospital Policy on the use of restraint/seclusion and consent for notification. • The initial assessment of the patient related to restraint and seclusion use	12/13/2021	100% review of Hospital Report, Incident Reports and Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting to capture all Seclusion/Restraint incidents. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% November: 87%*- Nursing Staff reeducated on doing the Staff Debriefing form. December: 100%

#L1145- 322.180.1C- RESTRAINT OBSERVATIONS	Documentation of each episode of seclusion/restraint including specific behaviors, detailed description of the events leading up to event, failure of interventions, notification of patient's family, written orders for use, behavioral criteria for discontinuation of seclusion/restraint, informing patient of behavioral criteria for discontinuation, check for appropriate restraint application, face to face assessment and continuous monitoring of patient and care provided, and debriefing of patient Item #1: The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: A staff member will be within arm's length of the patient to provide immediate response should the patient experience any physical distress The patient will be assessed every 15 minutes will in seclusion/restraint. This assessment includes, circulation, skin integrity, mental status, level of distress/agitation and readiness for discontinuation of seclusion/restraint. Range of motion and release of limbs will be done minimally every 1	12/13/2021	Item #1: 100% review of Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% November: 100% December: 100%
OBSERVATIONS	Focus of this training included:		Aggregated data will be reported to Quality Committee and MEC
	immediate response should the		November: 100%
			Beddinger. 10070
	seclusion/restraint. This		
	skin integrity, mental status, level of		
	discontinuation of		
	seclusion/restraint.		
	Range of motion and release of		
	hourFluids and toileting will be offered		
	every 2 hours		
	 Vital signs will be taken upon 		,
	initiation and as clinically indicated,		
	 but at least every 2 hours For Chemical Restraints staff are to 		
	monitor vital signs, neuro status and		
	perform safety checks every 15		
	minutes for 1 hour, every 30 minutes for 1 hour and then every 1		
	hour for 4 hours or as directed by		
	the Provider		
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	Item #2: The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • When a patient ends up in seclusion/restraint a review and modification of the treatment plan is indicated. • The RN will review and update the Treatment Plan within 8 hours • The updated Treatment Plan will reflect the identification of the problem, goals to further prevent instances of seclusion/restraint, interventions to define alternative approaches with responsibility of interventions assigned • Review of the updated plan with the patient	12/13/2021	Item #2: 100% review of Treatment Plans within 24 hours of incident. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% November: 85%*- Re-education done to Nurses on the need to address the incident in the Treatment Plan meeting. December: 100%
# L1265- 322.200.3F- RECORDS OBSERVATIONS	The CNO reeducated all Nursing and MHT staff on the Monitoring and Recording Food Intake Policy. Focus of this training included: • Program staff are responsible for monitoring and recording patients food intake after each meal • Program staff will record food intake on the Nursing Flowsheet in the form of percentage of meal eaten and general observations including not eating requiring prompts to eat, requests for extra portions and accepted snacks. Program staff will alert the Provider if meal intake is less than adequate to meet	12/13/2021	100% review of the Patient Meal and Utensil Tracking Forms for Intake percentage 100% review of the Nursing Flowsheets for Intake percentage and general observations. Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Patient Meal Intake and Nursing Flowsheets will continue monthly. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% November: 75%*- Re-education done to Nurses and MHT's. CNO made new form that made the charting easier and we started that form on 12/13/2021. December: 94%
# L1375- 322.210.3C- PROCEDURES- ADMINISTER MEDS	nutritional needs The CNO reeducated all licensed Nursing staff on the Medication Administrations Policy. Focus of this training included that staff must check the patient's identification with 2 Hospital approved identifiers (i.e. date of birth, name band, or photograph) and ask the patient to state his/her name.	12/13/2021	30 med passes will be audited each month Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of med passes will continue. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%

	·		November: 91% December: 93%
# L1485-322.230.1- FOOD SERVICES	Item #1: The Director of Plant Ops and Dietary Manager reviewed the current Leftover Food Policy and they revised and updated the Policy to reflect the proper procedure for cooling food items. The DPO and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Leftover Food Policy. Focus of this training included the need for a Cooling Log to document the time and temperature for cooling items when using a pan greater than 2 inches in depth.	12/13/2021	Item #1: 100% review of the Leftover food cooling will be done weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% November: 91% December: 95%
	Item #2: The CEO, the Director of PI, the Director of Plant Ops and the Dietary Manager met to review the Meal Trays for the Communities Policy and they revised and updated the policy to reflect the procedure for timing/dating food trays when delivered to the unit as a means for public health control. The Director of Plant Ops and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Meal Trays for the Communities Policy. Focus of this training included the new process for timing and dating food trays when they are being delivered to the unit. The time will need to be the time that the item would be beyond use for time as a public health control.	12/13/2021	Item #2:100% review of the meal trays brought to the communities weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% November: 92% December: 95%

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PO Box 47874 • Olympia, Washington 98504-7874

October 26, 2021

Rlynn Wickel CEO Inland Northwest Behavioral Health 104 W 5th Avenue Spokane, WA 99204

Dear Mr. Wickel:

This letter contains information regarding the recent survey of Inland Northwest Behavioral Health by the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau. Your state licensing survey was completed on 10/14/2021.

During the survey, deficient practice was found in the areas listed on the attached Statements of Deficiencies (CMS 2567). A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 calendar days after you receive this letter. All corrections for **Fire Life Safety** issues must be completed within **35 days** of the survey exit date (11/18/21). All corrections for the **Health survey** must be completed within **60 days** of the survey exit date (12/13/21).

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;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected.
 When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring procedure including time frame, number of planned observations and the target for compliance.

A sample Plan of Correction has been enclosed for reference. You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return the original reports and Plans of Correction to me at the electronically at tyler.henning@doh.wa.gov.

If more than 35 days for Fire Life Safety corrections is required and/or more than 60 days for Health corrections is required, the hospital must request an **extension/waiver**. The extension/waiver request must include: the facility name; Medicare provider number and/or State license number, date of inspection; citation number; description of deficiency; description of circumstances that will not allow you to meet current deadlines; revised date of when you expect to correct the deficiency; timetable of events leading to correction (i.e. new equipment receive date, new equipment install date etc.); and steps you will take to mitigate risk to patients while the deficiency is being corrected.

Requests for extensions/waivers must be submitted to the undersigned.

Please contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plans of Correction. I may be reached at 360-236-2918. I am also available by email at tyler.henning@doh.wa.gov.

I want to extend another "thank you" to you and to everyone that assisted us during the survey.

Sincerely,

Tyler Henning, ScM, MHS Survey Team Leader

Tyler Henning

Enclosures: DOH Statement of Deficiencies

WSP Fire Inspection Report Sample Plan of Correction



STATE OF WASHINGTON DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

January 12, 2022

Rlynn Wickel CEO Inland Northwest Behavioral Health 104 W 5th Avenue Spokane, WA 99204

Dear Mr. Wickel:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Inland Northwest Behavioral Health from October 6-14, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on December 14, 2021.

Hospital staff members sent a Progress Report dated January 11, 2022 that indicates all deficiencies have been corrected. The Department of Health accepts Inland Northwest Behavioral Health's attestation to be in compliance with Chapter 246-320 WAC.

If there were fire life safety deficiencies identified in your report, the Deputy Fire Marshal will perform an on-site revisit after the correction date to verify those corrections.

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

Sincerely,

Tyler Henning, ScM, MHS

Survey Team Leader

Tyler Henning