	OF CORRECTION	IDENTIFICATION NUMBER:	With A. BUILDING:	Ser COMPL	ETED
W. Swith St.	ROVIDER OR SUPPLIER	012792	B, WING	an an an a' su an	9/2022
1	BEHAVIORAL HEALTH I	MONROE 14701 1	79TH AVE SE DE, WA 98272	(rest) ឆ្លាំស្រាស់ សារសារ សារសារ សារសារ សាមការ	There is a
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSO IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLET DATE
L 000	INITIAL COMMENTS	land herden in fielder of a solaristic of an difference of the	L 000	t m _i ng minit constep	1.438
	The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-324 Private Alcohol and Chemical Dependency Hospitals, conducted this health and safety survey. On site dates: $3/4/08/22 - 3/4/09/22$		1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.		
			2. EACH plan of correction statement must include the following:		
		ite dates: 04/08/22 - 04/09/22 nination number: 2022-158		The regulation number and/or the tag number;	
				HOW the deficiency will be corrected;	
and the second se	The survey was conducted by: Surveyor #7 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection (See		WHO is responsible for making the up more set of your correction;		
)			WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and		
	Shell # LOTH21).			WHEN the correction will be completed.	
		te safety inspection (See		3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by March 21, 2022.	
				4. Return the REPORT electronically with the required signatures.	
L 435	322-040.4 ADMIN-AE	MINISTRATOR	L 435	the required signatures. Some all all of a view view of the second secon	
	WAC 246-322-040 Ge Administration. The g body shall: (4) Appoin administrator respons implementing the poli the governing body;	governing it an ible for		 Sind, Weirk versige matching a visu pill Sind, Weirk versige matching a visu pill Sindmentalis or a applicht sider of the sumaption Cool and subset of the industry with a back or application Cool and subset of the matching and subset of the subs	
ate Form 256 BORATORY D	Charles and a loss had here the	SUPPLIER REPRESENTATIVE'S ŞIGNATUR	E in	TITLE 0	X6) DATE
ATE FORM			6899	LOTH11 If continue	tion sheet 1

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TATEMENT	Washington r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ONSTRUCTION		SURVEY PLETED
			A. BUILDING:			(
	e ¹	012792	B. WING		03	/09/2022
	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH N	40NROE 14701 1	NDRESS, CITY, STATE 79TH AVE SE 1E, WA 98272	, ZIP CODE		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) Complete Date
L 435	Continued From page	e 1	L 435			
	This Washington Adn as evidenced by:	ninistrative Code is not met				
	Based on interview a					
	to appoint an adminis	Ital's Governing Body failed strator to be responsible for				
	implementing the pol Governing Body and aspects of patient car	be accountable for all			· .	
	Failure to have an ad	ministrator to direct and				
		f hospital treatment and n, puts patients at risk of rd care.				
	Findings included:					
	Surveyor #9 and Sun representatives of the Director of Risk Mana (Staff # 902) and Ass (Staff #901). The sun Governing Body mee 08/04/21, 11/12/21, a Governing Body mee	a hospital's Governing Body, agement and Compliance istant Director of Nursing veyors reviewed the ting minutes from 05/10/21, nd 02/11/22. Review of the ting minutes showed no ing Body had appointed the			·	
	interviewed Staff #90 meeting minutes to d	30 PM, the surveyors 2 and asked if there were ocument the appointment of cutive Officer (CEO) as nospital.				
:		pointment of the current r for the hospital reflected in				

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AND PLAN	r of deficiencies DF correction	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	A, BUILDING	LE CONSTRUCTION A SEA SALES (1997)	(X3) DATE SURVEY COMPLETED
\$ (<u>)</u>	e (a seconda da companya d	012792	B,WING	τ	03/09/202
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	TATE, ZIP CODE	ver el composición
FAIRFAX	BEHAVIORAL HEALTH		179TH AVE SE OE, WA 98272		stander ander
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	TATEMENT OF DEFICIENCIES ICYMUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	DI ID PREFIX SY TAG	FROVIDER'S PLAN OF GORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COM
l se di se di sino. L		ا اینیسکیا بریا به سری اینان ، محاد پریزی	1940 J J		an an an aighte
L 440	322-040.5 ADMIN-	AEDICAL DIRECTOR	L 440	Alanger on the Carlor and the second	
	WAC 246-322-040 (Administration. The body shall: (5) Appo as medical director directing and super- treatment and patient	Int a psychiatrist responsible for rising medical		्राः स्वयंत्रस्य व्यक्तः व्यक्ति स्वयंत्रः स्वयंत्र सम्बद्धाः वयप्रविद्यारः स्वयंत्र स्वयंत्रियं स्वयंत्रः व्यक्तिताः व्यक्तिः स्वयंत्रियं	na Adjunat bij
	hours per day; This Washington Ad as evidenced by:	ministrative Code is not met			
Y	hospital's Göverning psychiatrist as medi directing and superv patient care twenty-			and have a second second and the second second	on control (* 1945) 28 d 1947: 28 d 1948: 28 d 1948: 29 d 1948: 29 d 29 d 29 d 20 d 20 d 20 d 20 d 20 d 20 d 20 d 20
	and supervises med	medical director who directs Ical treatment and patient Irs per day puts patients at r unsafe care.		in the decident to a construction of a construction of the construction of the construction of the state of the construction of the construction of the construction of the construction of the construction of the construction of the construction o	odan (paraja) agada Paraja d
	1. On 03/09/22 betw Surveyor #9 and Surveyor #9 and Surveyor for the Surveyor of the Director of Risk Man	een 12:10 PM and 12:45 PM, veyor #7 interviewed e hospital's Governing Body, agement and Compliance sistant Director of Nursing		 หลังจะกระการกระจึง เป็น และ ได้ได้ระบาทสายสายสายสายสาย หรือไม่มีการสายสายสายสายสาย สายส่วน การกระจาสายสายสายสาย สายส่วน การกระจาสายสายสายสาย 	an an star a star fair an
	(Staff #901). The su Governing Body me 08/04/21, 11/12/21, a Governing Body me	rveyors reviewed the eting minutes from 05/10/21, and 02/11/22. Review of the eting minutes showed no ing Body had appointed the		נסברא ני שה אינע נוים לליכולי בראשול לקעמישה קמינים ללושר הבי היהור מוצע קרמות מעמש לא מתבימת הגים הידילור לומות היילולים לו מנוינטלולומה ה	angener a Angener
	Interviewed Staff #90	:35 PM, the surveyors)2 and asked if there were locument the appointment of		ระการสาราชการสาราช เป็นสาราชการสาราชการสาราช เป็นสาราชการสาราชการสาราชการสาราชการสาราชการสาราชการสาราชการสาราชกา เป็นสาราชการสาราชการสาราชการสาราชการสาราชการ	entities and a second

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATË SURVEY COMPLETED
214	· . · ·	012792	B. WING		03/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	· · · · · ·
AIRFAX I	BEHAVIORAL HEALTH	MONROE	179TH AVE SE OE, WA 98272		· · · · · · ·
(X4) ID PREFIX + TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
L.440	Continued From pag	le 3	L 440	allen en en der ein der felden der eine der eine der eine der eine der eine der der der eine der der eine der d	
	the current medical of	director for the hospital.			
		pointment of the current he hospital reflected in the		• •	
L 460	322-040.8B ADMIN	RULES-PRIVILEGES	L 460		
	WAC 246-322-040 C Administration. The body shall: (8) Requ professional staff by concerning, at a min Delineation of privile This Washington Ad as evidenced by:	governing ire and approve laws and rules imum: (b)		·	
	hospital failed to ma	review and interview the intain provider appointments npliance with the psychiatric laff bylaws.			
	appointments and p where they are seel	it all staff have current rivileges for the hospital ng patlents puts patlents at rd care and poor outcomes.			
	Findings included:				
	dated 06/17, showe	of the "Medical Staff Bylaws," d that the hospital grants or a maximum of two years n appointments.			
		eyor #9 reviewed r 3 providers currently seeing natric hospital. The review			

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If continuation sheet 4 of 8

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY
) (- 199		012792	B. WING		03/09/202
and the second secon	ROVIDER OR SUPPLIER	TREET.	ADDRESS, CITY, S	TATE, ZIP CODE	สมักษณะสุดราบการจาก จ
FAIRFAX	BEHAVIORAL HEALTH	WANDE	79TH AVE SE \ E, WA 98272		ANTE DESCRIPTION - ANTENNA
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) (1534-11518-21	ID PREFIX MAG	EROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S (EACH CORRECTIVE ACTION S)	HOULD BE
L 460	Continued From pa	ge 4	1/L 460	રે જણાવ	na staty and a state
	showed 2 of 3 prov appointments.	ders had expired		an an antain the antain the second and the second the second second second second second second second second s The second s	bi serri da Erena I.a
	#903) had an appol credentialing file that period from 04/18 to	actice Registered Nurse (Staff ntment letter in their at indicated their appointment o 04/20. Staff # 903 had been y extension for 90 days.		an the backfung of the analysis and sensitive comparison of the transmission comparison of the	nalagin ar (1979) (1989) tei gala ja
		teff # 904) had an 1 their credentialing file that Intment period from 10/18 to		 And pathog p to the second seco	and and a state of the second state of the se
	interviewed the Dire Compliance (Staff #	review, the surveyor ctor of Risk Management and 902) who confirmed the two apsed appointments.		n - 194 Geodericalius in Aprile e 1946 in	s for a state of the
L1150	322-180.1D PHYSIC	CIAN AUTHORIZATION	L1150	 Item to day white item to came In the day of the second angle In the second angle In the second angle 	au vin is anniara 👔 👘
	WAC 246-322-180 F Seclusion Care. (1) shall assure seclusion are used only to the duration necessary safety of patients, st property, as follows:	The licensee on and restraint extent and to ensure the aff, and		· · · · · · · · · · · · · · · · · · ·	ે પુરુષ છેલા છેલા છે. આ પુરુષો છે કાર તેમણા છ
· · · · · · · · · · · · · · · · · · ·	notify, and receive a a physician within or initiating patient rest sociusion;	uthorization by, he hour of		a and a service of the analysis of the analysis of the service of	Station and Station of Station and Station
	Based on record rev	iew, interview, and review of procedures, the hospital a licensed provider	-	્યું અન્યત્રી માન પ્રદેશને અન્ય નામ પ્ર આજ રે બંધ વિચિત્રી સિંદાએ પ્રાથ્વમાં વિચ્ ચુલ્લી મહ્ત્વનું અંબેલ્ફોર્ટ સ્વિવૃત્તી પૈ	, ages − s (¹¹) Fu os de ses at (2
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	Vashington		(X2) MULTIPLE C	ΟΝΕΤΕΙΙΟΤΙΟΝ	0/01 0 000 -	A ITALIEN	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE S COMPL		
		012792	B. WING	<u></u>	03/0	09/2022	
AME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
AIRFAX I	BEHAVIORAL HEALTH	MONROE	79TH AVE SE E, WA 98272	n Altonia			
(X4) 1D PREFIX TAG	, (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) Complete Date	
L1150	Continued From pag	ge 5	L1150				
	for seclusion or rest	one orders per hospital policy raint for 1 of 2 seclusion or iewed (Patient #703).					
	appropriate order fo	at a provider authenticate an r seclusion risks loss of dignity, and personal					
	Findings included:						
	"Proper Use and Mc	of the hospital's policy titled politoring of Physical-Chemical usion" policy # 1000.53, last wed:					
	a. telephone/verbal by the Physician wit	orders shall be authenticated hin 24 hours.		1		(
	performed by the Ph	aluation of the patient shall be hysician or Qualified QRN) within one hour.					
	assessed every 15 i signs of injury, circu	nts or seclusion will be min, assessment to include: lation and skin integrity, of distress and agitation, tinuation of					
	the chart for Patient that the patient had restraint on 07/02/2 telephone order on	50 PM Surveyor #7 reviewed #703. The review showed been place in a physical 1. Staff had obtained a 07/02/21 at 7:00PM. At the re order had not been					
		finding Staff #701 verified iatrist signature on the					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION CONSTRUCTS AV.	(X3) DATE SURVEY
1 1		012792	B.WING		03/09/2022
-	ROVIDER OR SUPPLIER BEHAVIORAL HEALTH	MONROE 14701 1	ADDRESS, CITY, ST 179TH AVE SE DE, WA 198272	ana an Tara an	nalemens and as selements
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLE
L1150	Continued From pag	e6 /	. L115 0	S 16 19	denne og biskt.
	telephone order for r	estraint/seclusion.			
na manta a su a	the chart of Patient # telephone order for r 3:25 PM, the patient	estraint dated 09/24/21 at was placed in physical		n Constanting, algoridhean an Einin an gelonar 1898, 6999 (da Einin an genored Schlagter Process	and de Bigan (b. 1997) de les de Bigan (b. 1997) de Bigan (b. 199
		the order, they failed to nd time of the authentication.	f (* - - -	an tan baharan ata a sara	
	date and time were n	Inding Staff #701 verified the alssing from the of the telephone restraint		તેમાં આવ્યાનું પ્રેન્ગાન્ડ ગાહ્ય પ્રેલ્ફા કે હત્યકા પ્રેલ્ડા પ્રે ગાહ્ય કે લોક્ટેલ કે હત્વકા પ્રાથમિત્ર ગાંધી વચ્ચત હત્વા કાર્ય પ્રેલ્ડિંગ કે ગા	1911年1月1日 2月11日日 - 1911年 - 1月1日日 - 1911年
) L1260	322-200.3E RECORI WAC 246-322-200 C	DS-SIGNED ORDERS	L1260	स्वास्तर्थः अन्युर्धः विकास्तः स्वास् स्वयंद्र सिल्सिन् सुरक्षान्द्रः स्वतंत्र्यः स्वयंद्रः स्वास्त्रद्रः सः चेन्न्र्युर्धः स्वयंत्र्यः स्वित् स्वार्य्यक्रम् स्वयंत्रस्य स्वयंत्रम् स्व	a shiqdh Salaa Baal qibyaa
	The licensee shall en and filing of the follow the clinical record for patient receives inpati	sure prompt entry ring data into each period a		ા તોલ્લાનું પ્રજ્યાસ્થ લગાવા કે લીંગ કે . આ દીધિના પ્રજ્યાસ્થ્યના કે	and here is a series of the se
	outpatient receives inpati outpatient services: (i orders for: (i) Drugs theraples; (ii) Therap	e) Authenticated or other		and a station of a station of the second	
	(ill) Care and treatme standing medical ordi care and treatment of	nt, including ars used in the			
	except standing medi orders; This Washington Adm	cal emergency Inistrative Code is not met			
	as evidenced by: Based on document r policy, the hospital fai	eview of the hospital's			3
	healthcare providers	authenticated orders for the patients according to the			
ate Form 256					
TATE FORM	ep las	(161)	6869 · , L	OTH11	lf continuetton sheet 7
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State of V	Vashington				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING;	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
* 		012792	8, WING		03/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP GODE	
FAIRFAX	BEHAVIORAL HEALTH N	IONROE	9TH AVE SE E, WA 98272		
(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 SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE . COMPLETE
L1260	Continued From page	97	L1260		
	admission, medicatio	uthenticate orders for ns, and treatment risks and/or inadequate patient			
	Findings included:				
	"Ordering and Prescr Requirements," policy showed that all order	of the hospital policy titled ibing- General y number 11, dated 03/21, s entered into computerized ust be electronically signed			
	Assistant Director of reviewed the medical review showed that I	records of a patient. The ne orders for admission, vital s were not authenticated			
	3. Staff #901 confirm not being authenticat	ed the finding of the orders ed within 48 hours.			
State Form 25	67]

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If continuation sheet 8 of 8

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: S1		(X3) DATE SURVEY COMPLETED	
		012792	B. WING	······································	03/	09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	E, ZIP CODE		
FAIRFAX	BEHAVIORAL HEALTH	MONHOE	79TH AVE SE E, WA 98272		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
S 000	Initial Comments	· · · · · · · · · · · · · · · · · · ·	S 000			
	and Life Safety re-c at Fairfax Behaviora Washington on 03/0 the Washington Sta Bureau. The survey with the Washington health survey teams the facility I was acc	sult of an unannounced Fire ertification survey conducted I Health Monroe, in Monroe 9/2022 by a representative of te Patrol, Fire Protection was conducted in concert a State Department of Health a. During the physical tour of companied by the Facilities sed any deficiency noted				
	The existing section was used in accorda The facility is a two s basement, of Type II grade. The facility is sprinkler system thro alarm system with co	of the 2012 Life Safety Code ance with 42 CFR 482.41. story structure, without a I construction with exits to protected by a Type 13 fire oughout and an automatic fire orridor smoke detection.				
	of this survey the ce The facility is not in a	compliance with the 2012 Life oted by the Centers for				
	The following citation the survey:	ns were documented during				
	The surveyor was:	•				
1997 - 1997 - 1997 1997 - 1997 - 1997	Brendan Magee Deputy State Fire Ma 38402	arsha)		an 1960 - ^{Nora} n Angeloù	e on the second s	s Sangto orden sign Constant annanda
	The surveyor was fro Washington State Pa			en e		
e Form 256 ORATORY D		SUPPLIER REPRESENTATIVE'S SIGNATUR		ЯПЕ		(X6) DATE
TE FORM		en e	64339 LOT	H21	li continua	ation sheet 1 o
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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: S1			e Survey Pleted
	•	012792	B. WING		03	09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE	,	
FAIRFAX	BEHAVIORAL HEALTH	14701 1	9TH AVE SE			
		MONRO	E, WA 98272			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
S 000	Continued From page	e 1	S 000			
	Office of the State Fi					
	Fire Protection Burea					
	2803 156th Ave SE					
	Bellevue, WA 98007					
	Telephone: (360) 481	-3933				
S 346	NFPA 101 Fire Alarm	System Out of Service	S 346			
	Fire Alexand Out	- Constant				
	Fire Alarm - Out	or Service fire alarm system is out of				
	services for more	and alarm system is out of				
		24-hour period, the authority				
	having	a not ponot no automy				
	jurisdiction shall shall be	be notified, and the building				
)		approved fire watch shall be				
	provided for all	tected by the shutdown until				
	the fire alarm	dected by the shutdown billin			·	
		returned to service.				
	9.6.1.6					
		not met as evidenced by:				
		and staff Interview on cument review between				
		nd 1130 hours the facility				
	has failed to have a w					
	instituting an approve	d fire watch in the event of a				
	failure of the fire alarr	n system. This could result		· ·		
	in an inadequate fire	watch which may result in a				
	delay of fire detection					
		ng patlents, staff, and/or				1.
	visitors within the faci	nty.				
	The findings include:					
	- The facility was una	ble to provide				
		tituting an approved fire				
1		a failure of the fire alarm				1

State Form 2567 STATE FORM

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	f of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: S1			e survey Pleted
		012792	B. WNG		03	/09/2022
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
AIRFAX	BEHAVIORAL HEALTH	MONROE	79TH AVE SE E, WA 98272			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED T(DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
S 346	Continued From page	ge 2	S 346			
	system.					
	NFPA 101 (2012 ed) 19.1.1.1.1, 19.3.4.1, 9.6.1.6				
	the Facilities Directo Evergreen Health M Fire Alarm system, a that they would insti	ussed and acknowledged by or who stated that the ionroe Hospital manages the and was under the impression tute a fire watch if needed. I have their own policy in				
S 354	NFPA 101 Sprinkler	System Out of Service	S 354			
- -	Where the sprir extent and duration of the i determined, areas o	m - Out of Service hkler system is impaired, the impairment has been r ed are inspected and risks are				
	determined, recommendatio	ns are submitted to				
	other authorities	and the fire department and				
	the sprinkler system is out of	on have been notified. Where service for more than 10				
	hours in a 24-hour period, the build affected are	ling or portion of the building				
	provided until the sprinkler system	n approved fire watch is n has been returned to				
	service. 18.3.5.1, 19.3.5	.1, 9.7.5, 15.5.2 (NFPA 25)				

STATE FORM

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If continuation sheet 3 of 4

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PRINTED: 03/11/2022 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING: S1	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		012792	B. WNG		03	/09/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
AIRFAX	BEHAVIORAL HEALTH	MONROE	79TH AVE SE E, WA 98272			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
S 354	Continued From pag	e 3	S 354	· · ·		
	Based on observatio 03/09/2022 during de approximately 1100 a has failed to have a v instituting an approve failure of the fire spri- result in an inadequa result in a delay of fir endangering patients the facility. The findings include: - The facility was una documentation for ins watch in the event of system.	ed fire watch in the event of a nkler system. This could ite fire watch which may e detection and suppression, s, staff, and/or visitors within able to provide stituting an approved fire a failure of the fire sprinkler 19.1.1.1.1, 19.3.5.1, 9.7.5,				
	the Facilities Director Evergreen Health Mc Fire sprinkler system impression that they	nroe Hospital manages the , and was under the would institute a fire watch if roe shall have their own				

STATE FORM

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If continuation sheet 4 of 4

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Fairfax Behavioral Health Monroe Plan of Correction for State survey Case # 2022-158 Date on site- 3/8/2022-3/9/2022

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance	Action Level indicating need for change of POC
L 435	322-040.4 ADMIN- ADMINISTRATOR WAC 246-322- 040 Governing Body and Administration. The governing body shall: (4) Appoint an administrator responsible for implementing the policies adopted by the governing body.	The CEO, CMO, COO, and the Director of Risk Management and Performance Improvement met to review all survey findings on 3/21/22. The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Executive Officer in compliance with the policies adopted by the governing body. On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Christopher West as the Chief Executive Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board.	Chief Executive Officer	3/10/2022	The Chief Executive Officer and/or designee will confirm compliance with all governing bylaws by ensuring appropriate and timely appointment of the Chief Executive Officer as required. In the event of a change in the Chief Executive Officer, an ad hoc committee meeting of the Governing Board will reconvene to appoint a hospital administrator as required by the Governing Bylaws. All actions are documented in the Governing Board minutes. Target for compliance is 100%. This monitoring has no end date.	< 100%

Mai Deler Reud 711122 3/28/22 Approval 715122 4/4/22

		Appointment of the Chief Executive Officer was confirmed and documented In the Governing Board minutes.				
L 440	322-040.5 ADMIN- MEDICAL DIRECTOR WAC 246-322- 040 Governing Body and Administration The governing body shall: (5) Appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day	The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Governing Board bylaws were reviewed by the Chief Executive Officer, Chief Medical Officer and Chief Operating Officer. No revisions required at this time. The Governing Board directed the Chief Executive Officer to comply with the Governing bylaws and Medical Staff bylaws by immediately appointing a Chief Medical Officer in compliance with the policies adopted by the governing body. On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Dr. Aaron Andersen as the Chief Medical Officer of Fairfax Behavioral Health. The motion was moved and	Chief Executive Officer	3/10/2022	The Chief Executive Officer and/or designee will confirm compliance with all governing bylaws and Medical Staff bylaws by ensuring appropriate and timely appointment of the Chief Medical Officer as required. In the event of a change in the Chief Medical Officer an ad hoc committee meeting of the Governing Board will reconvene to appoint a qualified Chief Medical Officer as required by the Governing Bylaws and Medical Staff bylaws. All actions are documented in the Governing Board minutes. Target for compliance is 100%. This monitoring has no end date.	< 100%
L 460	322-040.8B ADMIN RULES- PRIVILEGES WAC 246-322- 040 Governing Body and Administration. The governing body shall: (8) Require and approve	approved by the Governing Board. The CEO, CMO, COO, and the Director of Risk Management and Performance met to review all survey findings on 3/21/22. The Medical Staff bylaws, Rules, and Regulations were reviewed by the CEO, Chief Medical Officer and COO on 3/21/22. No revisions required at this time. 100% of credential files for all providers was completed by the Medical Staff	CEO, CMO COO	5/9/2022	The Medical Staff Coordinator will review 100% of provider credential files to confirm compliance with Medical Staff bylaws. On an ongoing basis, the medical staff coordinator will complete monthly audits of files to confirm ongoing compliance Additionally, the Medical Staff Coordinator will ensure each providers credentialing file is updated after each Medical Executive	< 90%

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	professional	and instar to confirm somellows with	I]		1
	1 '	coordinator to confirm compliance with			Committee meeting to reflect current	
	staff bylaws and	the Medical Staff bylaws.			appointment dates.	
	rules					
	concerning, at a	Providers with lapsed privileges were	ļ I		All appointments are documented in	
	minimum: (b)	temporarily suspended from providing			the Medical Executive Committee	
	Delineation of	further services until the completion of			monthly and reported to the	
	privileges	the credentialing and privileging process			Governing Board quarterly.	
		was completed. Providers with lapsed				
		privileges were credentialed and			Target for compliance is 100%. This	
J		approved for requested privileges at an			audit has no end date.	
		ad-hoc Medical Executive Committee				
		meeting. The Medical Executive				
		Committee chair and the Medical Staff				
		Coordinator were re-educated by the				
		CEO and the Director of Risk				
		Management on the requirement of				
		provider privileging and credentialing all				
		providers for a period of two years per				
		Medical Staff Bylaws. The Medical Staff				
		Coordinator implemented a tracking				
		spreadsheet to alert her three months]
		in advance of upcoming provider re-				
		appointments and confirm timely				
	1	completion of the credentialing and				
		privileging process per the Medical Staff				
		bylaws.				
	322-180.1D	The CEO, CMO, COO, and the Director of	Chief Medical	5/9/22	100% of all seclusion or restraint	< 90%
L 1150	PHYSICIAN	Risk Management and Performance met	Officer	5/5/22	orders will be monitored by the	× 5076
11130	AUTHORIZATION	to review all survey findings on 3/21/22.	Officer		Director of Performance Improvement	
	AUTHORIZATION	to review an survey informs on 5/21/22.				
	WAC 246-322-	The Seclusion and Restraint policy was			and/or designee to confirm compliance with Provider	
	180 Patient					
	Safety and	reviewed with no revision required at this time.			authentication of all verbal orders,	
	,	uns ume.			including seclusion and restraint	
	Seclusion Care	All Devidence and devide de l'			orders within 24 hours.	
		All Providers were reeducated to policy			Authentication of verbal orders	
		# 1000.53 Proper Use and Monitoring of			required provider signature, date and	
		Physical-Chemical Restraints and			time.	
		Seclusion by 5/1/22. Training focused				,
		on the requirement to authenticate			Aggregated data will be reported in	
		verbal orders by signing, dating and			Quality Council, Medical Executive	

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	timing the orders within 24 hours. Additionally, all providers are required to sign date and time all orders written by them at the time of the order. All Fairfax Providers signed an attestation indicating understanding expectation to comply with hospital policy.			Committee monthly and to the Governing Board quarterly. Noncompliance with this requirement by any provider will participate in 1:1 remediation with the Chief Medical Officer. Continued non-compliance will include disciplinary action up to and including termination of employment.	
				Target for compliance is > or = 90% for 4 consecutive months.	
L 1260 SIGNED OR WAC 246-3 200 Clinical Records		Chief Medical Officer	5/9/22	A consecutive months. Monitoring of 10 charts per month per unit will be completed by the Performance Improvement Director and/or designee to confirm compliance with policy. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported in Quality Council, Medical Executive Committee monthly and to the Governing Board quarterly. Providers not compliant with hospital policy will participate in 1:1 remediation with the Chief Medical Officer. Continued non- compliance may be met with disciplinary action up to and including termination of employment. Target for compliance is > or = 90% for	< 90%

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By submitting this Plan of Correction, the Fairfax Behavioral Health does not agree that the facts alleged are true or admit that it violated the rules. Fairfax Behavioral Health submits this Plan of Correction to document the actions it has taken to address the citations.

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			Minder and the second s
NFPA 101 Fire Alarm	The CEO, CMO, COO, Facilities Director and the	Director	The Director of Facilities and/or
System Out of		of	designee will review 100% personnel
S 346 required fire alarm		Facilities	files of all facilities staff to confirm
system is out of	on 3/9/2022		training completion of all facilities
services for more			related policies specific to fire and
hour period, the	The Fire Watch policy was not reviewed by the		safety, including procedure to access
authority having	fire marshal during this life safety survey,		policies. All deficiencies will be
jurisdiction shall be	however, the policy was in place.		corrected immediately to include
huiding shall be	The "Interim Life Safety Measures" policy was		retraining as needed or disciplinary
evacuated or an	reviewed by the CEO and DPO. No revisions		action if required.
approved fire watch	required at this time.		
provided for all			New facilities staff hired will be
parties left			
children until the			The amployee orientation and
fire alarm system has			annually thereafter including process
been returned to	required policies for training purposes and use		ြန္မာ access facilities related policies.
service.	during regulatory surveys. Documentation of		
9.6.1.6	training located in personnel file.		The Director of Facilities will keep a
			spreadsheet with the names of all staff
	The Director of Facilities retrained all facilities		in his department and the date of their
	staff to the policy "Interim Life Safety Measures"		signed attestation. Aggregated data is
	for EvergreenHealth Monroe, which would		reported to the Quality Council and
	apply to Fairfax as the Hospital Fire Life Safety		Medical Executive Committee monthly
	System covers the Fairfax space, which is leased		and to the Governing Board quarterly
	from EvergreenHealth.		for the next 4 months until compliance
	Additionally, the Director of Facilities retrained		is achieved and sustained.
	all facilities staff on how to access facilities		
	policies, location of policies and content of		Target for compliance is 100%

		comprehension of all training provided and understanding of policy compliance.	
	NFPA 101 Sprinkler	The CEO, CMO, COO, Facilities Director and the	Director
354	System Out of Service.	Director of Risk Management and Performance	of
	Where the sprinkler	Improvement met to review all survey findings	Facilities
	system is impaired, the	on 3/9/2022	
	extent and duration of the impairment	The sprinkler system policy "Interim Life Safety	
	has been	Measures" that covers the sprinkler system was	
	determined, areas or	not reviewed by the fire marshal however, the	
	are inspected and	policy was in place.	
	risks are determined,		
	recommendations	The CEO retrained the Director of Facilities to	
	are submitted to	the location of all facilities policies and content	
	designated	of policies. Training focused on accessing all	
	representative, and	required policies for training purposes and use	
	the fire department	during regulatory surveys. Documentation of	
	and other authorities	training located in personnel file.	
	having junisdiction		
	have been notified. Where the snrinkler	The Director of Facilities retrained all facilities	
	system is out of	statt to the policy "Interim Life Safety Measures"	
	service for more than	for EvergreenHealth Monroe, which would	
	10 hours in a 24-hour	apply to Fairfax as the Hospital Fire Life Safety	
	period, the building	System covers the Fairfax space, which is leased	
	building	from EvergreenHealth.	
	evacuated or an	Additionally, the Director of Facilities retrained	
	approved fire watch is provided until the	all facilities staff on how to access facilities	
	sprinkler system has	policies, location of policies and content of	
	been returned to	policies by 4/26/22.	
	service. 18.3.5.1, 19.3.5.1,	All facilition staff sizes of strastation of	
	25)	comprehension of all training provided and	
		understanding of policy compliance.	

đ Behavioral Health, submits this Planer Correction to document the actions it has taken to address the citations.

Christopher West, CEO:

Date: 2/29/27

Fairfax Behavioral Health, Monroe Progress Report for State Licensing Survey Case #2022-158 (3/8/22-3/10/22)

Tag Number	How Corrected	Date Completed	Results of Monitoring
	The Governing Board bylaws were reviewed by the Chief Executive Officer,	3/10/22	Compliance March 100%
L435	Chief Medical officer and Chief Operating Officer No revisions required at this time		April 100% May 100%
	Onicei. INO fevisione required at any unic.		June 100%
	The Governing Board directed the Chief		There has been as about in the ObjeConsulting Officer since the surrout with The
	Executive Officer to comply with the	r	There has been no change in the Chief Executive Officer since the survey exit. The
	Governing bylaws and Medical Staff	ť	Governing Board meeting minutes reflect the appointment of the current Chief
	bylaws by immediately appointing a Chief. Executive Officer in compliance with the		Executive Officer, Christopher West.
	policies adopted by the governing body.		The Governing Board will reconvene to hold an ad-hoc meeting in the event a new hospital administrator is appointed
	On 3/10/22 an ad-hoc Governing Board	1	
	Christopher West as the Chief Executive	,	
	Officer of Fairfax Behavioral Health. The	đ.,	
	motion was moved and approved by the		
	Governing Board. Appointment of the Chief		
	Executive Officer was confirmed and		
	documented in the Governing Board	4	
1. 1. 2.	meeting minutes.		
6 16	The Governing Board bylaws were	3/10/22	Compliance March 100%
L440	Chief Medical officer and Chief Operating		April 100%
	Officer. No revisions required at this time.		May 100%
			June 100%
, 1	The Governing Board directed the Chief		
-	Executive Officer to comply with the		There has been no change in the Chief Medical Officer since the survey exit. The
	Governing bylaws and Medical Staff		Governing Board meeting minutes reflect the appointment of the current Chief
*	Chief Medical Officer in compliance with		

Planue Ce Roud 7/1/22 Approvel7/1/22

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í		L460		
The Medical Executive Committee chair and the Medical Staff Coordinator were re-educated by the CEO and the Director of Risk Management on the requirement of provider privileging and credentialing of all providers for a period of two years per Medical Staff Bylaws. The Medical Staff Coordinator	Any Providers with lapsed privileges were temporarily suspended from providing further services until the completion of the credentialing and privileging process was completed. Providers with lapsed privileges were credentialed and approved for requested privileges at an ad-hoc Medical Executive Committee meeting.	The Medical Staff Bylaws, Rules, and Regulations were reviewed by the CEO, Chief Medical Officer, and COO on 3/21/22. No revisions required at this time. A review of all the credentialling files for current providers at Fairfax was completed by the Medical Staff coordinator to confirm compliance with the Medical Staff Bylaws.	On 3/10/22, an Ad-Hoc Governing Board Meeting was convened. The Governing Board recommended the appointment of Dr. Aaron Andersen as the Chief Medical Officer of Fairfax Behavioral Health. The motion was moved and approved by the Governing Board and documented in the Governing Board meeting minutes.	the policies adopted by the governing body.
· · · · · · · · · · · · · · · · · · ·	· · ·		· · · · · · · · · · · · · · · · · · ·	
	April: no meeting neid May: Yes Quarterly Governing Board Meeting minutes reflect credentialling appointments. 2022 Q1: Yes 2022 Q2: To be held in July 2022	H 0 7		The Governing Board will reconvene to hold an ad-hoc meeting in the event a new Chief Medical Officer is appointed.
	inutes reflect credentialling appointr	Audit ting minutes reflect credentialling requests and approvals.		o hold an ad-hoc meeting in the eve

EvergreenHealth "Interim Life Safety Measures" policy and the Fairfax "Fire Watch"		The sprinkler system policy "Interim Life		_
and accessibility of hospital policies and an understanding of the content of the				
All facilities staff have signed an attestation of understanding regarding the location		by the fire marshal during this life safety survey; however, the policy was in place.		
Compliance	4/26/22	The "Fire Watch" policy was not reviewed	S346	
		All Fairfax Providers signed an attestation to comply with hospital policy.		
-		computerized entry of orders must be authenticated within 48 hours.		
May 100% June 90%		General Requirements" by 5/1/22 Provider training focused on		
March 80% April 90%		All Providers were reeducated to the policy titled, "Ordering and Prescribing-		
Computerized orders entered by Providers are authenticated within 48 hours.		revision required at this time.		
Compliance	5/9/22	The Ordering and Prescribing - general requirements policy was reviewed with no	L1260	
committee meeting reiterating the importance and requirement to sign, date and time seclusion/restraint packets within 24 hours.	· · · · · · · · · · · · · · · · · · ·	All Fairfax Providers signed an attestation indicating understanding expectation to comply with hospital policy.		
6/30/22 Chief Medical Officer addressed Providers in the Medical Executive		of the order.		<u> </u>
June 89%		providers are required to sign date and time all orders written by them at the time		·`
April 94%	-	orders within 24 hours. Additionally, all		
March 94%		the requirement to authenticate verbal		
Provider signature, date and time.		Seclusion by 5/1/22. Training focused on		
Seclusion/Restraint verbal orders authenticated within 24 hours to include:		#1000.53 Proper Use and Monitoring of Physical-Chemical Restraints and		
Compliance		All Providers were reeducated to policy	L1150	
		credentialing and privileging process per the Medical Staff bylaws		
		confirm timely completion of the		Hundhage Aug
. <u>.</u> .		alert her three months in advance of		

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Signature:	The Director of Facilities retrained all facilities staff on how to access facilities policies, location of policies and content of policies by 4/26/22.	The Director of Facilities trained all facilities staff to Fairfax policy LS.01.02.01-1 "Fire Watch" as well as EvergreenHealth Monroe's policy "Interim Life Safety Measures" which would apply to Fairfax as the Hospital Fire Life Safety System covers the Fairfax space, which is leased from EvergreenHealth.	The CEO retrained the Director of Facilities to the location of all facilities policies and content of policies. Training focused on accessing all required policies for training purposes and use during regulatory surveys. Documentation of training located in his personnel file.	Safety Measures" that covers the sprinkler system was not reviewed by the fire marshal however, the policy was in place.
Christopher West , CEO			April 4 4 May 4 4 June 4 4 Compliance maintained at 100%	policy. # employees # attestations March 4 4

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