STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

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L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) conducted this health and safety survey in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital Licensing Regulations. Onsite dates: 05/30/23 - 06/01/23 Examination number: X2023-380 The survey was conducted by: Surveyor #8 Surveyor #7 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell B79221. During the survey, surveyors investigated issues related to State Complaint 2021-7534.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by June 26, 2023. 4. Return the REPORT electronically with the required signatures.	
L 375	322-035.1o POLICIES-HOUSEKEEPING WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (o) Maintenance	L 375		

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L 375	Continued From page 1 and housekeeping functions, including schedules; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of policies and procedures, the hospital failed to implement its policies and procedures that assure housekeepers use appropriate hand hygiene after removal of gloves. Failure to use hand hygiene may result in the spread of infections. Findings included: 1. Document review of the hospital's policy and procedure titled, "Hand Hygiene, 1600.4.4," PolicyStat ID 11999345, revised 01/23, showed the following: Use alcohol-based hand sanitizer immediately after glove removal. 2. On 05/31/23 at 2:30 PM, Surveyor #8 observed housekeeper (Staff #801) perform a patient turnover room clean of Room #824. Staff #801 double gloved. On two occasions the outer gloves were removed and a clean pair of outer gloves were placed over the existing inner gloves. In both instances hand sanitizer was not used. 3. On 05/31/23 at 2:50 PM, Surveyor #8 interviewed Staff #801 and he acknowledged that hand sanitizer was not used after glove removal and was unaware that hand hygiene was necessary between glove changes of the outer glove. .	L 375	FORM APPROVED	

double gloved. On two occasions the outer gloves

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L 690	Continued From page 2	L 690		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview and document review, the hospital failed to provide and implement a water management plan specific to the hospital, approved by hospital governing body that is designed to reduce the risk of Legionella and other water-borne diseases in the patient population. Failure to implement a hospital-wide water management plan puts patients, staff, and visitors at risk of infection from water-borne pathogens. Reference: Centers for Medicare and Medicaid Services (CMS) Survey & Certification Letter S&C 17-30 (6/2/2017): Subject line: "Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaires' Disease (LD)"- Facilities must develop and adhere to policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in water. The plan must meet the following criteria:	L 690		

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L 690	Continued From page 3 a. Conduct a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. b. Implement a water management program that considers the ASHRAE industry standard and/or the CDC toolkit, to include control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and/or environmental testing for pathogens. c. Specify testing protocols and acceptable ranges for control measures and document the results of testing and provide corrective actions taken when control limits are outside of acceptable ranges. Findings included: 1. Document review of the Evergreen Health Monroe plan titled, "Waterborne Pathogens Control" Date Approved 03/18/19, Version 2, (no policy number) did not include the Fairfax Monroe facility in the document text. It did not include Fairfax Monroe in a risk assessment, testing location, parameter, testing frequency, and parameter ranges that initiate remedial action for Fairfax Monroe. 2. On 05/30/23 at 1:05 PM, Surveyor #8 interviewed Facilities Manager (Staff #804). He stated that the hospital did not have a Water Management Plan specific to Fairfax Monroe and they relied upon Evergreen Health Monroe to monitor for legionella. Residual chlorine measurements were used to assure waterborne pathogens were absent from the water system. Fairfax Monroe did not have data or track residual	L 690		

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L 690	Continued From page 4 chlorine or legionella water data or any other control measure to assure the absence of waterborne pathogens. 3. On 05/31/23 at 4:00 PM, during the exit meeting with hospital staff the Director of Risk Management (Staff # 805) stated that the hospital did have a water management plan and it would be emailed after the meeting. The document was received 06/01/23 at 8:04 AM, and the document was the Evergreen Health Monroe water management plan reviewed and discussed in paragraph 1. .	L 690		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to perform a Pre-Construction Risk Assessment required by hospital policies and procedures. Failure to implement policies or procedures intended to assure a risk assessment is performed prior to construction or maintenance puts patients and staff at risk of harm from	L 710		

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L 710	Continued From page 5 environmental contaminants. Findings included: 1. Record review of the hospital's policy titled "Pre-construction Risk Assessment, EC.02.06.05-2," PolicyStat ID #12647782, last approved 12/22, showed that when demolition, renovation, modification, construction, or general maintenance activities are planned, a team of qualified persons selected from Fairfax Hospital will conduct a pre-construction risk assessment (PCRA) on the impact of the work on the facility activities.	L 710		
	2. On 05/30/23 at 11:30 AM, Surveyor #8 toured the hospital unit accompanied by Program Manager-Unit Manager (Staff #802). A shower room on the unit that had undergone a conversion from a tub to a shower was observed. Staff #802 described the recent project to replace the walk-in tub with a shower. 3. On 05/30/23 at 1:05 PM, Surveyor #8 interviewed the Facilities Manager (Staff #803) asking for information about the shower installation on the unit. Staff #803 stated that the construction was in February 2023, and took about one day to complete. Staff #803 stated that a Pre-Construction Risk Assessment (PCRA) was not done for this project.			
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors;	L 780		

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L 780	Continued From page 6 This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the psychiatric hospital failed to develop a Ligature risk prevention/mitigation plan for the 3 hinges in the hallway and elevator areas to safeguard against ligature risk. Failure to mitigate the ligature risk sources places patients at risk of injury or death from hanging. Findings included: 1. On 05/30/23 at 11:20 AM, Surveyor #7 observed 3 large V-shaped door hinges on the 2 hallway fire doors and the fire door in the elevator cubby area in the South hallway. At the time of the observation, Surveyor #7 noted there were patients in the hallway, but no staff were present in the visible vicinity. 2. On 05/31/23 at 9:49 AM, Surveyor #7 reviewed the Fairfax Behavioral Health Environmental/ Ligature Risk Assessment Prevention/Mitigation Plan and found no evidence of a plan to mitigate the ligature risk related to the hinges on the 3 aforementioned doors. 3. At the time of the review Staff #701 verified there was no mitigation plan for the fire door hinges in the Fairfax Behavioral Health Environmental/ Ligature Risk Assessment Prevention/Mitigation Plan. .	L 780		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and	L1145		

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L1145	Continued From page 7 Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's restraint policy and procedure for documentation in 2 of 3 restraint records reviewed, (Patients #705 and #706). Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. Findings included: 1. Document review of the hospital's policy titled, "Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion", policy number 100.53, last reviewed 09/20, shows that staff will implement the least restrictive, non-physical intervention, the physician will authenticate telephone/verbal orders within 24 hours, and that a face-to-face evaluation will be done within 1 hour by a qualified staff member.	L1145		

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L1145	Continued From page 8 2. On 05/31/23 at 2:07 PM, Surveyor #7 and the Unit Manager (Staff #701) reviewed the restraint chart for Patient #705. The review showed the patient was placed into physical restraints on 04/05/23 at 2:08 PM, Surveyor #7 could find no documentation of a signed face-to-face. 3. At the time of the review Staff #701 verified there was no signed documentation of a face-to-face. 4. On 05/31/23 at 2:52 PM, Surveyor #7 and Staff #701 reviewed the restraint chart for Patient #706. The review showed the following: a. Patient # 706 received the medication Ativan 2 mg IM, for the purpose of chemical restraint and physical restraint on 01/14/23 at 10:42 AM. b. Patient #706 received Benadryl 50 mg/IM and Ativan 2mg IM for the purpose of chemical restraint on 01/14/23 at 3:44 PM. c. The face-to-face documented at 3:44 PM was performed by a Registered Nurse (Staff # 704) who is not a Qualified Registered Nurse (QRN) and has not received the training to perform the face-to-face evaluations. 5. At the time of the observation Staff #701 verified the face-to-face had been documented 4 hours and 2 minutes after the first episode of restraints had been performed, was performed by a nurse who was not a QRN, and that no other face-to-face documentation was found in the chart. Patient # 706 received the medication Ativan 2 mg IM, for the purpose of chemical restraint and	L1145		

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L1150	Continued From page 9	L1150		
L1150	322-180.1D PHYSICIAN AUTHORIZATION WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (d) Staff shall notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that a licensed provider authenticated telephone orders per hospital policy for seclusion or restraint for 2 of 2 restraint records reviewed, (Patients #705 and #706). Failure to ensure that a provider authenticates an appropriate order for restraints risks psychological harm, loss of dignity, and personal freedom. Findings included: 1. Document review of the hospital's policy titled, "Proper Use and Monitoring of Physical-Chemical Restraints and Seclusion" policy #1000.53, last reviewed 06/21, showed telephone/verbal orders shall be authenticated by the Physician within 24 hours. 2. On 05/31/23 at 2:07 PM, Surveyor #7 and the Unit Manager (Staff #701) reviewed the restraint chart for Patient #705. The review showed the	L1150		

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L1150	Continued From page 10 following: a. Patient was placed into physical restraints on 04/05/23 at 2:08 PM. b. A telephone order was placed on 04/05/23 at 2:08 PM and at the time of the review the order had not been authenticated by a provider. 3. At the time of the review Staff #701 verified the restraint order had not been authenticated by a provider. 4. On 05/31/23 at 2:52 PM, Surveyor #7 and Staff #701 reviewed the restraint chart for Patient #706. The review showed the following: a. Patient #706 received the medication Ativan 2 mg IM, for the purpose of chemical restraint and were then placed in physical restraint on 01/14/23 at 10:42 AM. b. A telephone order was placed on 01/14/23 at 12:00 PM and authenticated on 01/17/23 at 9:00 AM, 69 hours after the patient was restrained. c. Patient #706 received Benadryl 50 mg/IM and Ativan 2mg IM, for the purpose of chemical restraint, on 01/14/23 at 3:44 PM. d. A telephone order was placed on 01/14/23 at 3:44 PM and authenticated on 01/17/23 at 9:00 AM, 65 hours and 16 minutes after the patient was restrained. 5. At the time of the review Staff #701 verified the restraint orders had not been authenticated within 1 hour of restraint.	L1150		

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L1375	Continued From page 11	L1375		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Item #1 Hand Hygiene- Med Pass Based on observation, interview, document review, and review of the hospital's policies and procedures, the hospital failed to ensure staff members followed its policy for safe medication administration for 2 of 2 staff observed passing medication. Failure to follow safe medication administration standards risks disease transmission and patient harm. Findings included: 1. Document review of the hospital's policy titled, "Medication Administration, 1000.37" PolicyStat #10946215, last revised 06/21, showed the licensed nurse will use proper hand washing techniques prior to handling medication for administration. 2. On 05/30/23 at 11:11 AM, Surveyor #7 and the Unit Manager (Staff #701) observed a Registered	L1375		

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L1375	Continued From page 12 Nurse (Staff #702) attempt to pass medication to Patient #701. The observation showed the following: a. Staff #702 removed the medications from the medication room without performing hand hygiene (HH).	L1375		

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b. Staff #702 opened the door to Patient #701 room, entered without performing HH, touched the patient then touched the medication. Patient #701 declined the medication and Staff #702 returned the medication to the medication room; Staff #702 then performed HH.

3. Surveyor #7 interviewed Staff #702 who verified he had not performed HH through the process and it was not until the medication was returned to the medication room did he perform HH.

4. On 05/31/23 at 11:47 AM, Surveyor #7 observed a Registered Nurse (Staff #703) walk to the dining hall, and open the door to enter the dining hall. Staff #703 then passed medications to Patient #704. After passing medications Staff #703 opened the door, exited the dining hall, and walked towards the elevator.

5. Surveyor #7 interviewed Staff #703 who verified she had not performed HH after entering or exiting the elevator or opening the door to the dining hall, administering medication, and then exiting the dining hall to return to the main floor. Staff #703 stated she should have performed HH prior to passing the medication and after touching the patient.

Item #2
PRN Pain Medications

#703 opened the door, exited the dining hall, and

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L1375	Continued From page 13 Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff members completed and documented reassessments after each "as needed" (PRN) medication intervention for 2 of 2 medical records reviewed for patients receiving PRN pain meds (Patient #702 and #703). Failure to assess before PRN medication administration and reassess patients after PRN medication administration risks inconsistent, inadequate, or delayed relief of symptoms. Findings included: 1. Document review of the hospital's policy and procedure titled, "Pain Assessment, Reassessment and Management, 1000.22", PolicyStat #10946109, last approved 06/21, showed the following: a. It is the responsibility of all medical staff to screen all patients for the presence or absence of pain. b. All patients will undergo reassessment of pain at least once per shift while awake and after every pain control mechanism employed by patient care providers. Pain control mechanisms include, but are not limited to: i. Medications administered for the control or relief of pain. ii. Medications administered for the control or relief of anxiety. c. As part of the reassessment, the Multidisciplinary team should assess and	L1375		

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L1375	Continued From page 14 document the pain in terms of its duration, characteristics, and intensity as well as the time of the pain, the pain rating, and any use of analgesics. Also include other pain interventions, vital signs, the effectiveness of all interventions, and any side effects or adverse reactions. 2. Review of the Electronic Medical Record "Response to Medications" has drop-down selection boxes for Response to Medication, pain level, and Sedation score. 3. The drop-down selection box for "Response to Medication" as the following: i. Pain relieved ii. Pain not relieved. ii. Effective. iii. Nausea improved. iv. Nausea not improved. v. Breathing improved. vi. Breathing not improved. vii. Agitation improved. viii. Agitation not improved. ix. No withdrawal. x. Allergic reaction. xi. Anxiety relieved. xii. Patient is asleep.	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

(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
L1375	Continued From page 15 4. Pain Level drop-down selection box options show the following: no pain, numeric rating 1-10, or Not Applicable. 5. On 05/30/23 at 3:24 PM, Surveyor #7 and the Unit Manager (Staff #701), reviewed the medical record for Patient #702, the review showed the following: a. On 03/19/23 at 11:26 AM Patient #702 received Acetaminophen for pain control. 3.5 hours later at 3:01 PM the documented response value shows "Effective". Surveyor #7 found no pre-medication assessment and no additional documentation. b. On 03/19/23 at 3:35 PM, Patient #702 received Acetaminophen for pain control. 3 hours and 10 minutes later at 6:45 PM the documented response value shows "Not Effective". Surveyor #7 found no pre-medication assessment and no additional documentation. c. On 03/19/23 at 8:43 PM Patient #702 received Acetaminophen for pain control. 1 hour and 37 minutes later at 10:20 PM the documented response value shows "Effective". Surveyor #7 found no pre-medication assessment and no additional documentation. The remainder of the PRN medication administrations showed the same findings, Effective or Not Effective, with no numeric scale and no pre-medication assessment. 6. On 05/30/23 at 3:57 PM Surveyor #7 and Staff #701 reviewed the medical record for Patient #703, the review showed the following: a. On 02/25/23 at 4:40 PM, Patient #703 received	L1375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING: _____ B. WING _____	06/01/2023

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FAIRFAX BEHAVIORAL HEALTH MONROE	14701 179TH AVE SE MONROE, WA 98272

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L1375	Continued From page 16 Acetaminophen for pain control. 50 minutes later at 5:30 PM, the documented response showed "Effective". Surveyor #7 found no pre-medication assessment and no additional documentation. b. On 02/26/23 at 11:44 PM, Patient #703 received Acetaminophen for pain control. 2 hours and 21 minutes later at 2:05 AM on 02/27/23, the documented response showed "Patient is asleep". Surveyor #7 found no pre-medication assessment and no additional documentation. c. On 02/27/23 at 9:41 AM, Patient #703 received Acetaminophen for pain control. 2 hours and 19 minutes later at 12:00 PM, the documented response showed "Effective". Surveyor #7 found no pre-medication assessment and no additional documentation. The remainder of the PRN medication administrations showed the same findings, Effective or Not Effective, with no numeric scale and no pre-medication assessment. 7. At the time of the review Staff #701 verified the documented responses, and the lack of pre-medication assessments and informed Surveyor #7 she had not been aware there was a drop-down numeric scoring tool. .	L1375		

sent 6/15/23

POC received 6/27/23
POC approved 7/7/23

Fairfax Monroe
Plan of Correction for
State Licensing Survey
05/30/23-06/01/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance & Monitoring procedure
L 375	The CEO & Assistant Administrator (A.A.) met on 5/21/23 to discuss findings from this survey and review the requirements of EVS staff to perform hand hygiene between glove changes. The A.A. and EVS manager re-educated all EVS staff on 6/8/23 regarding the facilities hand hygiene policy requiring staff perform hand hygiene between glove changes. Staff signed an attestation of understanding at the conclusion of their training via sign in sheet.	Assistant Administrator	7/31/23	The EVS manager/designee will perform 30 observations per month of EVS staff to assess: 1. Appropriate hand hygiene is performed between glove changes. Any deficiencies will be corrected immediately to include staff real-time retraining. Staff with continued compliance issues with this requirement may be subject to progressive disciplinary action. Target for compliance is 90% or greater. Results of monitoring will be reported to the Infection Control Committee, the Environment of Care Committee, Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 690	The A.A. met with the Evergreen Facilities Director on 5/21/23 to discuss the findings from this survey and review the requirements pertaining to water management. The Assistant Administrator completed a Water Management Risk Assessment for Monroe on 4/28/23. As a tenant in the Evergreen Hospital building, Fairfax does not meet Evergreens "high risk" criteria to perform additional water testing. Evergreen performs monthly general water testing from their main incoming potable water supply, which would include water being supplied to Fairfax. Effective 7/1/23, the Fairfax Facilities Manager will perform independent monthly water tests. Beginning 7/1/23 Fairfax will include the	Evergreen Facilities Director Assistant Administrator	7/31/23	The Fairfax Facilities Manager will perform monthly water testing at the Monroe location to include testing for Legionella and chlorine. Monitoring will include: 1. Water testing is performed monthly. 2. Water testing results fall within the acceptable parameters for chlorine and Legionella. 3. Water testing results at the Monroe location that are out of the acceptable parameters for chlorine and Legionella will be immediately reported to the Assistant Administrator for follow up. Target for compliance is 100%. Results of monitoring will be reported to the Infection Control Committee, the Environment of Care Committee, Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

	Monroe satellite in the Water Management Program, already in place at the Kirkland location. The Fairfax Facilities Manager will institute monthly water testing at the Monroe location to include monitoring chlorine levels and testing for pathogens such as Legionella. Additional quarterly and annual water monitoring activities for Monroe will be completed in collaboration with Phigenics, an established vendor for Kirkland's Water Management Plan/Program.			
L 710	The CEO met with the CNO and A.A. on 6/21/23, to review the requirements of performing pre-construction risk assessments, per hospital policy. The A.A. will inform the CNO/designee of all dates, locations, and types of construction that are scheduled to occur at the Fairfax Monroe location. The CNO/designee and member of facilities will perform the Infection Control Risk Assessment (ICRA) together prior to the scheduled construction date. The A.A. re-educated all members of the Fairfax facilities team and reminded the Evergreen Director of Facilities of the requirements of performing a pre-construction risk assessment prior to construction inside the Fairfax Monroe location.	Assistant Administrator CNO Evergreen Facilities Director	7/31/23	The CNO/designee will ensure all construction projects have a completed ICRA's and will report monthly: 1. Number of scheduled construction activities. 2. Number of indicated/completed ICRA's. Any construction activities found not to have had an ICRA completed, prior to the implementation of work by facilities staff (i.e. emergency repairs), will have one completed as soon as possible. Target for compliance is 90% or greater. Results of monitoring will be reported to the Infection Control Committee, the Environment of Care Committee Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 780	The CEO met with the CNO on 6/21/23 to review the findings from this survey to discuss the requirements surrounding hall monitoring and ligature risks. The CNO/designee re-educated all nursing staff in June 2023 on the requirements of maintaining staff presence in the hallways and identified the areas of potential increased	CNO	7/31/23	Leadership members will complete 30 camera and in person audits per month to include: 1. Staff are actively monitoring patients in the halls. 2. Staff can identify areas of increased ligature risk on the unit (to include fire door hinges). Any identified non-compliance with the above will be immediately addressed with just in time training by the auditor.

	ligature risk for the Monroe location to include the fire door hinges. Senior leadership camera and in person audit forms were revised to include "staff are actively monitoring patients in the halls" and "staff can identify areas of increased ligature risk on the unit".			Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1145	The CEO met with the CNO on 6/21/23 to review the findings from this survey to discuss the requirements surrounding seclusion/restraint documentation and the face-to-face assessment by a QRN. The CNO retained nursing staff in July 2023 on the Policy *"Proper Use and Monitoring or Physical-Chemical Restraints and Seclusion, 100.53"* to include: 1. Only Providers & Qualified RN's may complete the face-to-face assessment. 2. The Seclusion/Restraint packet, including the face-to-face assessment must be completed and signed for all seclusion or restraint events to include physical holds and chemical restraints. 3. The face-to-face assessment must be completed within 1 hour of the start time of the seclusion/restraint occurrence as evidenced by the date/time next to the QRN's signature.	CNO	7/31/23	The Chief Nursing Officer/designee will audit 30 charts a month (if available) of patients who experience Restraint or Seclusion incidents for the following: 1. A face-to-face assessment is completed and signed/dated/timed. 2. The face-to-face assessment was completed by a Qualified RN. 3. The face-to-face assessment is completed within 1 hour of the incident. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1150	The CEO met with the CMO 6/21/23 to review findings from this survey to discuss the requirements and expectations that the Providers will sign/authenticate seclusion/restraint orders within 24 hours. In July 2023 Providers were re-educated by the Chief Medical Officer on the requirement to sign or authenticate Seclusion/Restraint orders within 24 hours, per hospital policy. The providers are responsible for the daily checking	CMO	7/31/23	The CMO/designee will audit seclusion/restraint orders in 30 (if available) open charts per month to include: 1. Provider orders for seclusion/restraint are signed/authenticated within 24 hours. Providers who do not meet this requirement will meet with the CMO to discuss their non-compliance with hospital policy. Any repeated non-compliance will be subject to progressive disciplinary action up to and including termination of employement.

	of charts for any flagged or unsigned orders and ensuring all telephone orders are signed within 24 hours. Providers signed an attestation of understanding at the conclusion of their training.			Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1375 Item #1	The CEO met with the CNO 6/21/23 to review findings from this survey related to proper hand hygiene by nursing staff prior to medication administration. Nursing staff were re-trained by the CNO/designee in June 2023 on Fairfax's requirements for medication administration which includes; proper hand hygiene prior to medication administration. Staff signed an attestation of understanding at the conclusion of their training via a sign in sheet.	CNO	7/31/23	CNO/designee will observe 30 medication passes a month to ensure: 1. Staff perform hand hygiene prior to medication pass. All deficiencies will be corrected immediately to include just-in-time staff retraining as needed. Target for compliance is 90% or greater. Results of monitoring will be reported to the Infection Control Committee, Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1375 Item #2	The CEO met with the CNO 6/21/23 to review findings from this survey related to nursing's assessment of pain prior to medicating patients and post pain medication administration. The CNO provided re-training to nursing staff, in June 2023, regarding the requirement to document the assessment and reassessment of pain levels pre and post PRN medication administration.	CNO	7/31/23	The CNO/designee will audit 30 patient records a month of patients who received PRN medication for paint to ensure: 1. Patients who receive pain medication have a pain level assessment 0-10 documented in their medical record prior to the administration of pain medication. 2. Patients who receive pain medication have a pain level reassessment 0-10 documented in their medical record after the administration of the medication. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

Chief Operating Officer: Alexandra Hughes MA, MSCP, LMHC Signature: _____ Date: 6/26/23

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

January 5, 2024

Re: State Relicensure Survey X2023-380 Closure

Dear Ms. Janet Huff,

Inspectors from the Washington State Department of Health conducted a hospital relicensing survey beginning May 30, 2023, and ending June 1, 2023. Hospital staff members developed a plan of correction for deficiencies cited during this inspection. This plan of correction was approved on July 7, 2023. This closure letter was pending approval of waivers and follow-up site inspection by the Fire Marshal which has now been completed and approved.

The Department of Health accepts Fairfax Behavioral Health Monroe attestation that they will correct all deficiencies cited under Chapter 246-322 WAC and deficiencies identified by Fire Marshals. We sincerely appreciate your cooperation and hard work during the survey process.

Sincerely,

/s/ Harold Ruppert

Harold Ruppert REHS/RS,
Clinical Care Environmental Consultant