STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	007470	A. BUILDING: _____ B. WING _____	10/23/2023

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NAVOS	2600 SOUTHWEST HOLDEN SEATTLE, WA 98126

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L 000	INITIAL COMMENTS 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: 10/17/23 - 10/18/23, 10/23/23 Examination number: 2023-689 The survey was conducted by: Surveyor #7 Surveyor #8 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell BI1121.	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on 11/16/23. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter.	
L 370	322-035.1N POLICIES-PATIENT WORK 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	L 370		

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L 370	Continued From page 1 services provided: (n) Allowing patients to work on the premises, according to WAC 246-322-180; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to develop and implement a required policy and procedure covering allowing patients to work on the premises. Failure to develop and implement a policy on allowing patients to work on the premises may result in inconsistent practices not authorized by Governing Body putting patients at risk of harm or loss of personal rights. Findings included: 1. On 10/18/23 between 10:30 AM and 12:00 PM, Surveyor #9 and Chief Administrator (Staff #902) reviewed the required policies. Surveyor #9 found no evidence of a policy regarding allowing patients to work. 2. On 10/18/23 at 12:00 PM, Surveyor #9 interviewed Staff #902 regarding a policy for patients working. Staff #902 stated that they do not have a policy and do not allow patients to work. .	L 370		
L 400	322-035.1T POLICY-PATIENT RESEARCH 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	L 400		

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L 400	Continued From page 2 services provided: (t) Research involving patients; This Washington Administrative Code is not met as evidenced by: . Based on record review, the hospital failed to develop and implement a required policy and procedure covering research involving patients. Failure to develop and implement a policy on research involving patients may result in inconsistent practices not authorized by Governing Body putting patients at risk of harm or loss of personal rights. Findings included: 1. On 10/18/23 between 10:30 AM and 12:00 PM, Surveyor #9 and Chief Administrator (Staff #902) reviewed the required policies. Surveyor #9 found no evidence of a policy regarding research involving patients. 2. On 10/18/23 at 12:00 PM, Surveyor #9 interviewed Staff #902 regarding a policy for patient research. Staff #902 stated that they do not have a policy and do not allow patients to participate in research. .	L 400		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed. This Washington Administrative Code is not met as evidenced by:	L 415		

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L 415	Continued From page 3 Based on record review and interview, the hospital failed to ensure that required policies and procedures were reviewed and updated annually. Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety. Findings included: 1. Review of the hospital's policy titled "Policy Management," PolicyStat ID 10890822, last approved 12/19, showed that the policy did not contain the section regarding the annual review as per WAC 246-322. 2. On 10/18/23 between 10:30 AM and 12:00 PM, Surveyor #9 and Chief Administrator (Staff #902) reviewed the policies that are required to be reviewed annually. The review showed the following: a. Admission Criteria, PolicyStat ID 11990077, last approved 07/22. b. Standards of Care, PolicyStat ID 11265384, last approved 02/22. c. Suspicion of Abuse, Neglect, Assault, or Exploitation of an Adult Patient, PolicyStat ID 10916384, last approved 11/21. d. Emergency Medical Procedures, PolicyStat ID 11357844, last approved 05/22. e. Restraint and Seclusion, PolicyStat ID 1090370, last approved 07/22.	L 415		

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L 415	Continued From page 4 f. Transferring Patients to medical hospital or ED, PolicyStat ID 14564076, last approved N/A. g. Medical Records, PolicyStat ID 11248824, last approved 02/22. 3. At the time of the review, Staff #902 verified the dates on the policies that required annual review. Staff #902 stated that some of the policies encompass the entire system and are not all reviewed annually. .	L 415		
L 420	322-040.1 ADMIN-ADOPT POLICIES WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of the hospital's policy and procedure, the hospital's Governing Body failed to implement and maintain mechanisms to monitor and evaluate quality of care and clinical performance by 3 of 4 contracted services (Environmental Services, Language line, and Medicleanse (linen)). Failure to develop a coordinated process to oversee the performance of all contracted patient care services and risks provision of improper or inadequate care and limits the hospital's ability to improve patient outcomes.	L 420		

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L 420	Continued From page 5 Findings included: 1. Document review of the hospital's policy and procedure titled, "Contract Management," PolicyStat ID 12679280, last reviewed 11/22, showed that all contracts which involve patient care and services contain measurable quality metrics and those metrics are reviewed for compliance on a regular basis. 2. On 10/18/23 at 12:30 PM, Surveyor #9 interviewed Director of Environmental Services (Staff #901) regarding the housekeeping contract and review. Staff #901 stated that there were no contract reviews for this contract. 3. On 10/18/23 at 3:00 PM, Surveyor #9 requested copies of the contract reviews for 3 other contracted services. Chief Administrator (Staff #902) stated that they were unable to provide copies of the contract reviews for the Language Line or Medicleanse. .	L 420		
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; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of hospital documents, the hospital's Governing Body failed to appoint an administrator to be responsible for implementing the policies adopted by the	L 435		

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L 435	Continued From page 6 Governing Body and be accountable for all aspects of patient care. Failure to appoint an administrator to direct and oversee all aspects of hospital treatment and policy implementation puts patients at risk of harm from substandard care. Findings included: 1. On 10/18/23 between 11:00 AM and 12:15 PM, Surveyor #9 reviewed the Governing Body meeting minutes from 08/22/22, 09/15/22, 10/13/22, 11/10/22, 12/15/22, 1/24/23, 2/28/23, 3/28/23, 4/25/23, 5/16/23, 6/27/23, 7/25/23, and 08/22/23, and was unable to find evidence of appointment of an administrator. 2. On 10/18/23 at 12:15 PM, Surveyor #9 interviewed the Chief Administrator (Staff #902) and requested documentation of the appointment of the administrator by the Governing Body. The current administrator has been in the role since April 2022. Staff #902 was unable to provide the documentation of appointment. .	L 435		
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; This Washington Administrative Code is not met as evidenced by: .	L 440		

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L 440	Continued From page 7 Based on interview and record review, the hospital's Governing Body failed to appoint a psychiatrist as medical director responsible for directing and supervising medical treatment and patient care twenty-four hours per day. Failure to provide a medical director who directs and supervises medical treatment and patient care twenty-four hours per day puts patients at risk for inadequate or unsafe care. Findings included: 1. On 10/18/23 between 11:00 AM and 12:15 PM, Surveyor #9 reviewed the Governing Body meeting minutes from 08/22/22, 09/15/22, 10/13/22, 11/10/22, 12/15/22, 1/24/23, 2/28/23, 3/28/23, 4/25/23, 5/16/23, 6/27/23, 7/25/23, and 08/22/23, and was unable to find evidence of appointment of a psychiatrist as medical director. 2. on 10/18/23 at 12:15 PM, Surveyor #9 interviewed the Chief Administrator (Staff #902) and requested documentation of the appointment of the medical director by the Governing Body. The current interim medical director has been in the role since September 2022. Staff #902 stated that the Governing Body did not formally appoint the medical director to the role.	L 440		
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:	L 690		

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L 690	Continued From page 8 (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, document review and interview, the hospital failed to ensure that two contracted staff were provided N95 fit testing prior to working on a unit with a Covid patient. Failure to provide respirator fit testing puts staff and patients at risk of transmitting or obtaining infectious disease. Findings included: 1. Document review of the hospital policy titled, "Respiratory Protection Plan for Navos", revised 10/23, showed that all staff who wear respirators are required to be evaluated for their fitness to wear the provided respirator to ensure optimal protection from chemical, physical or biologic agents in the work environment. 2. On 10/17/23 at 8:30 AM, Surveyors were informed by Nurse Manager (Staff #803) that all staff entering patient units that had either a rule-out patient (patient that may have Covid and awaiting confirmation) or a confirmed Covid patient were required to wear N95 masks when on the units. 3. On 10/17/23 at 9:30 AM, Surveyor #9 observed a Mental Health Technician (Staff #801) wearing an N95 respirator mask with a full beard while working on a unit with a patient in isolation for exposure to COVID. Surveyor #9 interviewed	L 690		

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L 690	Continued From page 9 Staff #801 regarding fit testing and Staff #801 stated that they had not been fit tested for the N95 that they were wearing. 4. On 10/18/23 at 8:15 AM, Nurse Manager (Staff #803) stated that fit testing had been completed that morning for Staff #801. On 10/18/23 at 8:45 AM, Surveyor #9 observed Staff #801 wearing an N95 respirator mask with a full beard. 5. On 10/18/23 between 1:30 PM and 4:40 PM, Surveyor #8 conducted an employee personnel record review. Review of records for Staff #801 and Staff #802 showed that the staff had received fit testing after the initiation of this inspection. A review showed that Staff #801, received fit testing on 10/17/23 and Staff #802, on 10/18/23. 6. On 10/18/23 at 4:40 PM, Surveyor #8 interviewed the Labor Relations Manager (Staff #804), who assisted with the employee personnel review. Staff #804 confirmed fit testing for Staff #801 and #802 took place after initiating this inspection. .	L 690		
L 720	322-100.1G INFECT CONTROL-PRECAUTION 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: (g) Identifying specific precautions to prevent transmission of infections; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of	L 720		

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L 720	Continued From page 10 the hospital policies and procedures, the hospital failed to ensure staff members appropriately isolated patients diagnosed with infectious diseases in a timely fashion to prevent the transmission of infections. Failure to ensure staff members appropriately isolate patients diagnosed with infectious diseases in a timely fashion, places staff and other patients at a greater risk of infection from a communicable disease. Findings included: 1. Document review of the hospital policy titled, "Isolation Precautions for Communicable Disease, Inpatient" PolicyStat #12624197, last approved 11/22, showed the following: a. Doffing (removing) of PPE shall occur in the patient's room prior to leaving the room. b. Used PPE items should be discarded into a large paper bag. c. The paper bag should be closed and discarded in its entirety into the dirty linen basket. d. Contact Precautions- For patients with diseases spread by direct contact, including MRS, other multi-drug resistant organisms, scabies etc. e. Contact Enteric Precautions- For patients with disease spread by feces and fecal oral rout. (C-difficile, VRE, uncontrolled diarrhea, etc.) 2. On 10/17/23 at 9:34 AM, Surveyor #7 and a Nurse Manager (Staff #701) toured the 3rd floor. Surveyor #7 observed Patient #701 in room #305,	L 720		

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L 720	Continued From page 11 the "Comfort Room". The observation showed the following: a. Contact Enteric Precautions sign on the door with black marker writing indicating "PPE located by the T". b. A brown paper bag outside the door for trash collection. c. No handwashing sink or alcohol dispenser in room #305 or immediately outside. 3. Surveyor #7 and Staff #701 reviewed the medical record for Patient #701.The review showed the following: a. On 10/12/23 at 1:00PM, a specimen was collected from Patient #701 from the left thigh pustule and resulted on 10/15/23 at 6:05 AM positive for MRSA. b. An order was placed by a provider for Isolation Precautions on 10/15/23 at 10:00 PM. c. The Navos 24-hour Rounds/Observation sheet indicated Patient #701 was transferred from room #312W to the Comfort Room on 10/15/23 at 10:45 PM, 16 hours and 40 minutes after the MRSA results were posted to the Electronic Medical Record (EMR) in EPIC and 45 minutes after the order for isolation was placed. 4. At the time of the observation Staff verified that there was no handwashing sink or alcohol gel inside or immediately outside the Comfort Room, room # 305. 5. At the time of the chart review Staff #701 verified the MRSA positive lab results show "Last	L 720		

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L 720	Continued From page 12 Resulted" 10/15/23 at 6:05 AM, and that Patient #701 was not isolated until 16 hours and 40 minutes later at 10:45 PM. Staff #701 verified the patient was on the incorrect precautions, Contact Enteric precautions, but was only positive for MRSA not any enteric disease .	L 720		
L 935	322-140.6 RECREATION AREA WAC 246-322-140 Patient living areas. The licensee shall: (6) Provide and maintain a safe area or areas for patient recreation and physical activity equal to or greater than twenty square feet for each licensed bed space; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview the hospital failed to provide the patients with a minimum of 20 square feet of recreation area per licensed bed. Failure to provide the patients with a physical recreation area limits physical activity and may cause higher levels of stress and depression as well as lack of motivation. Findings included: 1. On 10/17/23 at 9:27 AM, Surveyor #7 interviewed a Mental Health Technician (MHT) (Staff #702) related to "Outdoor time" for the patients. Staff #702 stated outdoor time is normally at 9:00 AM and 4:00 PM but that the outdoor area was currently closed so there was no "fresh air" time provided to patients and had	L 935		

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L 935	Continued From page 13 been closed since June of 2023. 2. Surveyor #7 requested a copy of the daily schedules for 2nd and 3rd floors. There was no indicated time slot for recreation time. 3. Surveyor #7 interviewed a Nurse Manager (Staff #701) related to recreation options/spaces. Staff #701 identified the computer room as the recreation area that patients can request to use. 4. Surveyor #7 requested the square footage of the computer/recreation room and was informed each floor has a computer/recreation of 308 square feet. 5. Navos Hospital is licensed for 70 beds. This would require a physical activity area of 1,400 sq feet or greater. 6. At the time of the observation Staff #701 verified the 2nd and 3rd floor combined total of 616 square feet did not meet the minimum required 1,400 square feet for the 70 licensed beds. Staff also verified there was no dedicated time for recreation on the schedule but stated patients could request access to the 308 sq ft computer/recreation room. 7. On 10/18/23 at 12:00 PM, the Director of Nursing (Staff #703) verified the outdoor recreation area had been closed since June 10th 2023, 4 months and 8 days ago.	L 935		
L1005	322-160.1A TOILET ROOM-PRIVACY WAC 246-322-160 Bathrooms, Toilet Rooms and Handwashing Sinks. The	L1005		

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L1005	Continued From page 14 licensee shall provide: (1) One toilet, handwashing sink and bathing fixture for each six patients, or fraction thereof, on each patient-occupied floor of the hospital, with: (a) Provisions for privacy during toileting, bathing, showering, and dressing; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to ensure there was 1 shower for every 6 patients as required by WAC 246-322-160. Failure to provide adequate shower facilities decreases the use of needed hygiene and increases the risk of negative patient outcomes. Findings included: 1. On 10/17/23 at 8:30 AM, during the entrance conference Nurse Manager (Staff #803) stated that the census was 34 patients on the 3rd floor and 30 patients on the 2nd floor. 2. On 10/17/23, between 9:00 AM and 11:30 AM, Surveyor #8 toured floors #2 and #3 with Facility Director (Staff #805). Surveyor #8 observed that bathrooms with showers on the floors were reserved for isolation patients and 1 shower was turned off and unavailable to patients. 3. On 10/17/23 at 10:00 AM, Surveyor #7 was told by Staff #805 that 1 of the showers on the 3rd floor was turned off due to a ventilation problem. 4. On 10/17/23 between 1:30 PM and 2:30 PM, Surveyor #8 toured the hospital with Director of Safety and Security (Staff #806) to obtain an	L1005		

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	007470	A. BUILDING: _____ B. WING _____	10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1005	Continued From page 15 accurate count of available showers. a. On the 3rd floor 2 patients were in isolation and 3 shower stalls were made unavailable. 1 shower stall had been shut off due to a ventilation problem. For the remaining 32 patients, 2 shower stalls were available. This ratio was 1 shower per 16 patients. b. On the 2nd floor 1 patient was in isolation and 1 shower stall was made unavailable. Another shower stall was for staff use and unavailable for patients. For the remaining 29 patients 4 shower stalls were available. This ratio was 1 shower per 7.25 patients. 5. On 10/17/23 at 2:15 PM, Staff #806 confirmed the count of available showers.	L1005		
L1070	322-170.2F PHYSICIAN ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (f) Physician orders for drug prescriptions, medical treatments and discharge; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and review of medical records, the hospital failed to ensure staff members followed provider orders for medication administration for 1 of 2 Clinical Institute Withdrawal Assessment (CIWA) patient records	L1070		

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L1070	Continued From page 16 reviewed (Patient #901). Failure to follow medication administration procedures puts patients at risk with medication administration resulting in patient harm and/or death. Findings included: 1. On 10/17/23 at 3:30 PM, Surveyor #9 and Nurse Manager (Staff #904) reviewed the medical chart of Patient #901 who was admitted on 04/13/23 with a diagnosis of Suicidal ideation, Homicidal Ideation, and Substance Use Disorder. The review showed the following: a. On 04/13/23 at 12:30 PM, a provider order for vital signs, Richmond Agitation Sedation Scale (RASS) score, and CIWA score within 15 minutes of administration of Librium was entered in the computer. b. 04/14/23 at 5:00 AM, vital signs, no RASS score, and a CIWA score of 9 were documented. The patient received Librium 25 milligrams orally at 6:01 AM, (a period of approximately 60 minutes). c. On 04/14/23 at 7:48 PM, vital signs, RASS score, and a CIWA score of 9 were documented. The patient received Librium 100 milligrams orally at 8:18 PM (a period of 30 minutes later). 2. At the time of the review, Staff #904 verified the vital sign documentation was not within the timeframe ordered and a RASS score was missing.	L1070		

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L1135	Continued From page 17	L1135		
L1135	322-180.1A PAIN OR RETALIATION 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: (a) Staff shall not inflict pain or use restraint and seclusion for retaliation or personal convenience; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital staff failed to ensure that patients met criteria for imminent risk of harming themselves or others before restraints for violent or self-destructive behavior were applied, in 2 of 2 restrained patient's charts reviewed who were going to court (Patients #702 and #703). Failure to ensure that patients meet criteria, prior to restraint application, places patients at risk of loss of personal freedom and dignity and is a violation of patient rights. Findings included: 1. Document review of the hospital policy titled, "Restraint and Seclusion", PolicyStat #10903970, last approved 07/22, showed the following: a. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience or retaliation by staff. Restraint may only be imposed to ensure the immediate physical safety of the	L1135		

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L1135	Continued From page 18 patient, staff or others, by order of a provider and must be discontinued at the earliest possible time. b. Restraint and seclusion are to be used as a last resort when other, less restrictive interventions have been considered, or tried, and have been determined to be ineffective to protect the patient, staff, or others from harm. 2. On 10/18/23 between 9:49 AM and 11:04 AM Surveyor #7 and a Unit Manager (Staff #701) reviewed Restraint records for Patients #702 and #703. The review showed the following: Patient #702 a. Patient #702 was placed in 2-point bilateral lower extremities (BLE) restraints on 07/12/23 at 10:45 AM, when his behavior was charted as "calm" until 12:15 PM. b. A face-to-face note dated 07/12/23 at 11:13 AM, from a Registered Nurse (Staff #706) shows "Patient has a history of assaultive behavior and remains in assault precautions. Staff and peers in imminent risk of danger due to patients' poor impulse control and aggressive behavior. Based on assessed need due to imminent risk for safety for others, 2 mechanical restraints applied to BLE at 10:45 for out to court appointment. Patient calm and cooperative during process." c. Patient #702 was placed back into BLE restraints at 1:30 PM until 3:45 PM. 3. Surveyor #7 found no evidence of violent, threatening or assaultive behavior during these patients visit to warrant restraint use.	L1135		

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L1135	Continued From page 19 4. Staff #701 verified since Patient #702 had a violent history the process was to place the patient in a wheelchair and utilize BLE any time when taking the patient to court. Staff #701 further verified no violent behaviors warranting restraints were charted prior to the restraint applications. Patient #703 a. Patient #703 was placed in BLE restraints prior to court on 07/27/23 at 11:30 AM and discontinued at 12:00 PM. b. BLE restraints started again at 1:30 PM and discontinued at 1:45 PM. c. BLE restraints started again at 3:00 PM and discontinued at 3:30 PM. d. A note from a Mental Health Technician (MHT) (Staff #707) shows "Patient ordered to court at 11:30, pt placed in two point restraints on ankles due to hostile and threatening behavior, court recessed for lunch at 12. Returned to court at 1:30, pt became loud and verbally abusive and attempted to leave court. Judge informed and proceeding continued without patient. Patient returned to unit at 1:45. Patient ordered back to court to testify by judge at 3:00, pt returned at 3:30 and s/r order discontinued". 5. Surveyor #7 found no evidence of violent, threatening or assaultive behavior prior to restraint use. 6. Staff #701 verified since Patient #703 had a violent history the process was to place the patient in a wheelchair and utilize BLE any time when taking the patient to court. Staff #701	L1135		

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L1135	Continued From page 20 further verified no violent behaviors warranting restraints were charted prior to the restraint applications. .	L1135		
L1395	322-210.3G PROCEDURES-USE OF 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: (g) Use of medications and drugs owned by the patient but not dispensed by the hospital pharmacy, including: (i) Specific written orders; (ii) Identification and administration of drug; (iii) Handling, storage and control; (iv) Disposition; and (v) Pharmacist and physician inspection and approval prior to patient use to ensure proper identification, lack of deterioration, and consistency with current medication profile; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of the hospital policies and procedures, the hospital failed to ensure the return of a controlled substance was witnessed for 1 of 1 controlled substance returned. Failure to appropriately witness the return of a controlled substance can lead to medication errors, medication counts being incorrect and the potential for medication diversion.	L1395		

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L1395	Continued From page 21 Findings Included: 1. Document review of the hospital policy titled, "Automated Drug Dispensing Devices", PolicyStat #13765770, last approved 06/23, showed the following: a. All intact medications removed from the ADDD (Automated Drug Dispensing Devices) and not administered to the patient must promptly be returned electronically and physically placed into the ADDD return bin. b. Return of a controlled substance shall be documented via the ADDD by the medication nurse and a witness. 2. On 10/17/23 at 10:13 AM, Surveyor #7 observed a Registered Nuse (Staff #704) returning 3 medications, Zyprexa, Bactrim and Suboxone, which are controlled substances. The observation showed the following: a. Staff #704 accessed the return drawer, placed all three medications into the return bin then attempted to close the drawer. EPIC popped the drawer open and prompted for a witness. b. Staff #704 asked a Registered Nurse (Staff #705) to come in and witness the return, Staff #705 was about to witness for the return when Surveyor #7 asked what it was that Staff #705 was about to witness to. Staff #705 verified she did not know what the medication was nor was she able to see it since it had been dropped in the return bin. c. Surveyor #7 asked what the process was now to verify the return, Staff #705 called the	L1395		

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L1395	Continued From page 22 pharmacy to open the return bin and Staff #705 was able to verify the return. 3. At the time of the medication return observation Staff #704 verified he dropped the medications before a witness was available and that the process was to have a witness before returning medications into the return bin. .	L1395		

Attachment C2

Navos Hospital
Plan of Correction for
State Licensing (or Medicare Hospital Survey)
10/23/2023

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure;	Target for Compliance
L 370	• Policies will be developed and adopted to address/cover: ○ allowing patients to work on the premises	Laurel Kelso, Hospital Admin	12/10/23	Monthly Policy Review Meetings will include documentation of finalized policy approval. Policy committee will assure completion of policy by 12/10/23. Compliance will be reflected in committee minutes	100% Completion 100%
L 400	• Policies will be developed and adopted to address/cover: ○ research involving patients	Laurel Kelso, Hospital Admin	12/10/23	Monthly Policy Review Meetings will include documentation of finalized policy approval. Policy committee will assure completion of policy by 12/10/23. Compliance will be reflected in committee minutes	100% Completion
L 415	• The Hospital Policy Management Policy will be reviewed and updated to include the annual review cadence ○ All required hospital policies will be reviewed for currency, with automated review triggers set for annual cadence	Laurel Kelso, Hospital Admin Laurel Kelso, Hospital Admin	12/10/23 12/10/23, ongoing	• Monthly Policy Committee will include documentation of updated Policy • Monthly Policy Committee will, ongoing, include ○ a report of any policies needing review so as not to exceed annual cadence, ○ a report of currency compliance for 100% of contracts	100% Completion 100%

Attachment C2

				An annual Policy Report will be provided to the Hospital QAPI and Network Quality Committee, to include currency compliance of 100% of contracts. Any policy not meeting correct review cadence will require an intervention/plan for return to compliance	100% Completion
	• The following policies will be updated to include the annual cadence requirement by 12/10/23: o Admission Criteria o Standards of Care o Suspicion of Abuse, Neglect, Assault, or exploitation of an Adult Patient o Emergency Medical Procedures o Restraint and Seclusion o Transferring Patients to Medical Hospital or ED o Medical Records		12/10/23	Policies will be reviewed in the Monthly Policy Committee to assure policies are up to date and meeting the annual review cadence per requirement. Committee minutes will reflect compliance	100% Completion
L 420	• Using the Hospital's policy "Contract Management," as guidance, each hospital contract involving patient care and services: o will be reviewed for inclusion of measurable quality metrics o will be scheduled for review (in the newly adopted platform) to ensure compliance with quality metrics, as well as a plan for resolution, if targets or standards are not met	Laurel Kelso, Hospital Admin, Navos Hospital Board, Quality Team	12/22/23 ongoing	An audit will be completed by 12/22/23 of 100% of pt. care contracts to ensure: • presence of quality metrics • scheduled annual review of quality metrics A report of contract compliance will be provided to the Board each month (beginning 12/22) for the next 120 days to include • Quality Metrics in place • Quality Metrics reviewed with contract updates, or as needed	100% completion 100% Completion

Attachment C2

				to ensure maintenance of compliance then annually	
	• Training will be provided for all leaders responsible for contract management and monitoring on use of new contracts platform, including accessing active policies and ensuring currency, need for review, and inclusion of quality metrics		12/22/23	Training completion will be reported each month to QAPI (and then up to the Board) for the next 120 days for ongoing compliance	100% Completion
	• The following contracts will be reviewed for inclusion of quality metrics and compliance by 12/22/23: o Environmental Services o Language Line o MediCleanse		12/22/23	The assigned contract monitor/owner will complete the annual review requirements and assure review is uploaded into the contract monitor system	100% Completion
				A report of contract compliance will be provided to the Board each month (beginning 12/22) for the next 120 days to include • Quality Metrics in place • Quality Metrics reviewed with contract updates, or as needed to ensure maintenance of compliance then annually	100% Completion
L 435	• Appointments will be completed and documented at the upcoming Board Meeting for the Hospital Administrator • WAC 246-322-040 will be reviewed by the board to ensure understanding of requirements for future appointments and related documentation	Navos Hospital Board	11/28/23	The Board will include documentation of the appointment of Administrator in the Board Meeting minutes for this and any future hospital executive leadership transitions.	100% Completion
L440	• Appointments will be completed and documented at the upcoming Board Meeting for the interim Chief Medical Officer	Navos Hospital Board	11/28/23	The Board will include documentation of the appointment of the Chief Medical Officer in the Board Meeting minutes for	100% Completion

Attachment C2

	• WAC 246-322-040 will be reviewed by the board for full awareness of requirements for future appointments and related documentation			this and any future hospital executive leadership transitions.	
L 690	◦ The hospital policy "Respiratory Protection Plan for Navos" has been updated to include alternatives for staff with facial hair to comply with the policy ○ Education will be provided to all staff on the revised respiratory protection plan, including approved options for staff with facial hair by 12/10/23	Dr. Rebecca Richardson, Infection Prevention	12/10/23 12/10/23	Updated Policy Approval will be documented in the policy committee minutes. Managers will provide education to all staff on the revised fit testing protocol and report out at the next scheduled Infection Prevention Committee on compliance	100% Completion 95%
	• All current staff-both contract and regular-will be fit tested for N-95 mask		12/22/23	Compliance with standard for staff fit testing will be reviewed in the Infection Prevention Committee by 12/22/23. Verification of completed fit testing for all staff will be documented and maintained in the staff personnel file. Managers will review all employees for compliance by 12/22/23. A plan will be developed for any staff not in compliance to assure standards are maintained	Completion 95%
	◦ On an ongoing basis the hospital will schedule and require annual fit testing for all staff. New staff will receive fit testing during the onboarding process. Staff will be advised and educated on PPE alternatives and requirements for individuals with facial, per policy			Managers will monitor fit testing compliance rates for all staff. Compliance will be reported quarterly to the Infection Prevention Committee. The infection Prevention Committee will review for compliance with policy/procedure. Any fall outs will require an intervention/plan for return to compliance	95%

Attachment C2

L 720	• All nursing staff and providers will be notified that the "Comfort Room" will no longer be used for isolation due to the lack of handwashing facilities and appropriate disposal for contaminated items	Dr. Rebecca Richardson, Infection Prevention Laurel Kelso, Hospital Admin	12/22/23	Managers will provide and maintain record of all RN and Provider notifications and will monitor until compliance has been met. This will be documented and reported at each scheduled Infection Prevention Committee meetings until compliance reached	95%
			12/22/23	Nursing leaders will monitor 100% of patients where isolation has been ordered. Each occurrence will be reviewed for compliance with procedure and each scheduled Infection Prevention Committee. The infection Prevention Committee will review 100% of patients with ordered isolation to assure compliance with required procedures until compliance has been reached for 3 consecutive months. Compliance rates will be reviewed at each hospital QAPI on an ongoing basis. Any fall outs will require an intervention/plan for return to compliance	100%
	◦ All nurses and providers will be educated on the need to notify hospital administration for any patient isolation implementation. This communication will be used to remind and prevent further use of this area for isolation		12/22/23	All nursing staff and providers will attest to their understanding of the need to notify hospital administration of the need for a patient to be placed in isolation. Managers will maintain record of all RN and Provider notifications and will monitor until compliance has been met. This will be documented and	95%

Attachment C2

				reported at each scheduled Infection Prevention Committee meetings until compliance reached	
				Nursing leaders will monitor 100% of patients where isolation has been ordered. Each occurrence will be reviewed for compliance with procedure at each scheduled Infection Prevention Committee. The infection Prevention Committee will review 100% of patients with ordered isolation to assure compliance with required procedures until compliance has been reached for 3 consecutive months	100%
	• A new process was developed and will be implemented: The medical provider team will indicate when an order for labs may result in a critical value and subsequent need for patient isolation. The lab will now contact the patient floor directly following a critical lab result		12/22/23	Medical leaders will monitor 100% of orders resulting in patient isolation for timeliness compliance of reporting of cultures requiring patient isolation. Each occurrence will be reviewed for compliance with procedure at each scheduled Infection Prevention Committee. The infection Prevention Committee will review 100% of patients with ordered isolation to compliance with policy standards until compliance has been reached for 3 consecutive months	100%
	○ All Nurses and Providers will be educated on the new lab process starting the week of 12/4		12/22/23	Managers will provide and maintain record of all RN and Provider education and will monitor until compliance has been met. This will be documented and reported at each scheduled Infection Prevention Committee meetings until	95%

Attachment C2

				compliance reached, and recorded in the minutes	
L 935	• The Fresh Air Break Outdoor area was re-opened as part of the Elopement Mitigation Plan, resulting in a return to compliance with physical space requirements • Future Fresh Air Break closures will include a review of physical space requirements	Laurel Kelso, Hospital Admin	11/15/23 Ongoing	None Needed Leaders will report all closures or anticipated closure of any hospital space in the next scheduled monthly QAPI meeting. QAPI will be review each closure or anticipated closure to ensure compliance with standard	Completed 100%
L1005	• Isolation implementation requires Administrator notification. This notification will be used to identify isolation implementation that supports availability of the required number of showers and toilets for the remaining patients	Laurel Kelso, Hospital Admin	12/1/23	Nursing leaders will monitor 100% of patients where isolation has been ordered. Each occurrence will be reviewed for compliance with procedure at each scheduled Infection Prevention Committee. The infection Prevention Committee will review 100% of patients with ordered isolation to assure compliance with required procedures until compliance has been reached for 3 consecutive months. Any fall outs will require an intervention/plan for return to compliance	100%
	The 2nd and 3rd floor showers are now functional, increasing facilities to the required ratios	Nathan Butts, Director of Environmental Services	11/20/23	General staff notification of shower availability was provided	100% Completion
	Isolation Policy Update will be reviewed with all nursing staff to ensure awareness and understanding of shower ratio requirements			All nursing staff will attest to their understanding of the new process and related policy around shower	95%

Attachment C2

				availability. Managers will maintain record of all RN attestations and will monitor until compliance has been met. This will be documented and reported at each scheduled Infection Prevention Committee meetings until compliance reached	
L1070	• The current CIWA Protocol will be reviewed by an interdisciplinary team to o ensure clarity, and to o identify improved triggers for reassessment and VS monitoring	Cameron Livingston, Director of Nursing, James Kilgus, Pharmacist Ronni Tecsi, Clinical Educator	12/22/23	Leaders will present CIWA protocol at the scheduled monthly Hospital QAPI meeting, to include the interdisciplinary review and any change in practice or policy. QAPI will maintain record of discussion and any updates to practice or policy.	100% Completion
	• The current CIWA Protocol will be reviewed with all nurses to ensure awareness and understanding of current protocol		12/22/23 Ongoing	Nursing leaders will provide and maintain record of all nurse review/training of CIWA protocol and will monitor until compliance has been met. This will be documented and reported at each scheduled Hospital QAPI meeting until compliance reached	95%
				A review of 100% CIWA implementations will be completed as they occur using a "tracer" audit to ensure all elements are compliant with protocol, including dosing and vital signs, for 60 days	95% 100%
				Compliance rates will be reviewed at each hospital QAPI on an ongoing basis. Any fall outs will require an intervention/plan for return to compliance. CIWA review will return to	95%

Attachment C2

				routine monitoring after 60 days of compliance with target	
L1135	• Restraint and Seclusion Protocol for Court transport will be reviewed with Court Transport staff person for: ○ understanding of "Least Restrictive" principles and use of restraints only for current (not historical) imminent risk of harm ○ Need for orders, monitoring for those being restrained	Cameron Livingston, Director of Nursing, Laurel Kelso, Hospital Admin	11/14/23 11/20/23	Managers will provide and maintain record of all Court Transporter reviews of the seclusion and restraint protocol. Managers will monitor until compliance has been met. This will be documented and maintained in the staff personnel file. Using a weekly tracer, nurse managers will complete a review of 100% of restraint events and will monitor for compliance with no restraint use for those transported to court for 60 days. Compliance will be reviewed at each hospital QAPI ongoing. Any fall outs will require an intervention/plan for return to compliance. Will return to routine weekly monitoring of restraint events after 60 days of compliance with target	100% 100%
	○ Restraint use for Court Transport staff will be added to the Position-specific orientation checklist for all new nurse and mental health technicians		11/28/23	The director of nursing will assure position specific orientations for court transport staff will include the seclusion and restraint protocol. Supervisors are responsible for completing all new staff employee position specific orientations and maintaining record in the employee personnel file	Completion

Attachment C2

L1395	• All nursing staff will review the medication disposal policy/protocol and demonstrate competence of policy knowledge with attestation of understanding completed	Cameron Livingston, Director of Nursing	12/22/23	Managers will complete policy reviews and competence attestations with all nursing staff. Records will be maintained within staff personnel file. Managers will monitor until compliance has been met	95%
	• Video monitoring/auditing of disposal will be completed by Pharmacy daily. Pharmacy will follow up on all "returns" and "wasting" for adherence to protocol	Jim Kilgus, Pharmacy Director	12/22/23	Disposal will be monitored and traced daily for compliance with standard around appropriate disposal, including witness participation for 60 days. Compliance will be reviewed at each monthly hospital QAPI meeting. Any fall outs will require an intervention/plan for return to compliance Will return to routine medication dispensing monitoring after 60 days of compliance	95%

Laurel Kelso, Director of Hospital Operations

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

January 19, 2024

Laurel Kelso
2600 SW Holden Street
Seattle, WA 98126

Dear Ms. Kelso,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Navos Behavioral Health Hospital on 10/17/23 – 10/23/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 11/29/23.

Hospital staff members sent a Progress Report dated 01/18/24, that indicates all deficiencies have been corrected. The Department of Health accepts Navos Behavioral Hospital's attestation that they are now in compliance with Chapter 246-322 WAC.

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

Sincerely,

Samantha Roe, MSN, RNC-OB

Samantha Roe, MSN, RNC-OB
Survey Team Leader