State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: ______ B. WING ______	09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 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. Onsite dates: 09/03/19 to 09/05/19 Examination number: X2019-811 The survey was conducted by: Surveyor #1 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection.	L 000	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 postmarked by September 26, 2019. 4. Return the ORIGINAL REPORT with the required signatures	
L 535	322-050.5A CURRENT CPR CARDS WAC 246-322-050 Staff. The licensee shall: (5) Assure all patient-care staff including those transporting patients and supervising patient activities, except licensed staff whose professional training exceeds first-responder training, have within thirty days of employment: (a) Current cardiopulmonary resuscitation cards from instructors certified by the American Red Cross, American Heart	L 535		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorothy L. Sawyer
TITLE: CEO
(X6) DATE: 09-23-2019

Plan of correction Rec 9/23/19 [initials] Plan of Correction Approved [initials] 9/24/19

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L 535	Continued From page 1 Association, United States Bureau of Mines, or Washington state department of labor and industries; This Washington Administrative Code is not met as evidenced by: . Based on personnel record review and interview, the hospital failed to provide evidence of current cardiopulmonary resuscitation cards (CPR) for hospital staff in 2 of 10 personnel files reviewed (Staff #101 and 106). Failure to provide CPR training for staff places patients at increased risk of injury or death. Findings included: 1. On 09/04/19 at 11:30 AM, Surveyor #1 reviewed 10 personnel files with the hospital's human resources manager (Staff #104). During the review, Surveyor #1 observed that 2 of 10 files reviewed did not have documentation of CPR training; a licensed practical nurse (Staff #101) and an intake clinician (Staff #106). 2. During the observation in an interview with the resource manager, she stated that she was aware that CPR training documentation was missing and that managers were notified. .	L 535		
L 595	322-050.7B INSERVICE ED-STAFF (7) Make available an ongoing, documented, in-service education program, including but not limited to: (b) For patient care staff, in addition to (a) of this subsection, the following training: (i)	L 595		

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L 595	Continued From page 2 Methods of patient care; (ii) Using the least restrictive alternatives; (iii) Managing assaultive and self-destructive behavior; (iv) Patient rights pursuant to chapters 71.05 and 71.34 RCW; (v) Special needs of the patient population, such as children, minorities, elderly, and individuals with disabilities; (vi) Cardiopulmonary resuscitation; and (vii) First-aid training; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital's policy and procedure, the hospital failed to ensure that medical staff were provided in-service training on least restrictive alternatives, including restraints and seclusion, for 6 of 6 medical staff members reviewed (Staff #107, #108, #109, #110, #111, and #112). Failure to provide staff training on least restrictive alternatives, restraints, and seclusion risks violating patient rights and unsafe care of patients. Findings included: 1. Record review of the hospital policy titled, "Seclusion and Restraint," Policy # 500.05D1; effective date; 10/18, stated, that the leadership team has developed seclusion and restraint training and competency protocols that are required for all clinical staff prior to patient intervention. 2. On 09/04/19 at 2:00 PM, Surveyor #1 reviewed 6 medical staff files with the human resource manager (staff #104) and the medical staff	L 595		

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L 595	Continued From page 3 credential manager (Staff #106). During the review, Surveyor #1 observed that 6 of 6 medical staff did not have documentation of restraint training. 3. During the review, Surveyor #1 interviewed the human resource manager. She indicated that they were in the process for training all medical staff and that 2 medical staff members not on the reviewed list had completed the seclusion and restraint training. .	L 595		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This Washington Administrative Code is not met as evidenced by:	L 615		

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L 615	Continued From page 4	L 615		

.

Based on document review, interview, and review of policy and procedures the hospital failed to implement policies designed to protect patients from tuberculosis (TB) for 2 of 10 personnel files reviewed (Staff #101, and Staff #102).

Failure to implement policies designed to protect patients from tuberculosis puts patients, visitors and staff at risk of harm from infection.

Findings Included:

1. Document review of the hospital document titled, "Tuberculosis Screening and Airborne Pathogen Exposure Plan," Policy # 300.04; effective date 10/01/18, showed that all employees will receive a purified derivative test (PPD) skin test with in the first five days of employment.

2. On 09/04/19, between 10:00 and 11:55 AM, Surveyor #1 reviewed 10 personnel files. Two of 10 files reviewed showed no documentation of TB screening for the following staff:

a. Registered Nurse (Staff #102) Hire Date: 07/29/19

b. Licensed Practical Nurse (Staff #101) Hire Date: 05/08/19

3. During the observation, in an interview with the human resource manager (Staff #103), she stated that she was aware of the problem and would work towards closing the gap.

4. On 09/04/19 at 3:00 PM, the infection control officer (Staff #113) showed documentation that she initiated TB screening for one staff member,

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L 615	Continued From page 5 staff member #101, during survey. .	L 615		
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 review of hospital policies and procedures, the hospital failed to ensure that staff members performed specific precautions to prevent transmission of infections. . Failure to adhere to appropriate infection control precautions places patients and staff at risk for infection. . Findings included: . Item #1 - Hand Hygiene . 1. Document review of the hospital's policy and procedure titled, "Hand Hygiene," Policy # 300.73 reviewed 10/01/18, showed that hand hygiene (HH) should be performed after contact with patients and prior to administration of medications.	L 690		

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L 690	Continued From page 6 . 2. On 09/03/19 at 9:00 AM, Surveyor #9 observed a licensed practical nurse (LPN) (Staff #901) administer medication to patients through the window of the medication room. She administered medications to 3 patients without performing HH prior to or after giving patients their medications. . 3. At the time of the observation, the Director of Nursing (DON) (Staff #902) stated that the LPN had not followed hospital policy regarding HH. . Item #2 - Drinking in Medication Room . 1. Document review of the hospital's policy and procedure titled, "Standard Precautions/Protocol for use of Protective Equipment," Policy # 300.59 reviewed 10/01/18, stated that employees are prohibited from eating or drinking in patient care areas including medication rooms. . 2. On 09/03/19 at 9:00 AM, Surveyor #9 observed a LPN (Staff #901) administering medications to patients through the window of the medication room. The LPN had a personal drink on the counter next to the area where she was administering medications to patients. . 3. At the time of the observation, the DON (Staff #902) stated that the LPN was not following hospital policy regarding personal drinks in the medication room.	L 690		
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,	L 780		

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L 780	Continued From page 7 staff and visitors; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to implement systems to maintain a clean and sanitary environment for patients. Failure to maintain a clean and sanitary physical environment puts patients and staff at risk of harm from environmental contaminants. Findings included: 1. On 09/03/19 at 11:45 AM, Surveyor #1 toured the 3rd floor east patient unit. The tour included an inspection of patient rooms and communal spaces. Surveyor #1 observed that the consult room where patients can make private phone calls had several holes on the walls and ceiling. 2. On 09/03/19 at 2:20 PM, Surveyor #1 interviewed the Plant Manager (Staff #105) in regards to what systems were in place for how work repairs get completed for the facility. The plant manager stated that the normal process is that housekeeping or nursing would place a work order whenever they see something that needed repair. After further review of the work orders, the plant manager stated that he did not receive a work order for the holes in the walls and ceiling in the consult room on 3 east. .	L 780		
L 805	322-120.6A WATER-BACKFLOW WAC 246-322-120 Physical Environment. The licensee shall: (6) Provide an adequate supply of hot and cold	L 805		

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L 805	Continued From page 8	L 805		

running water under pressure meeting the standards in chapters 246-290 and 246-291 WAC, with: (a) Devices to prevent back-flow into the potable water supply system;
This Washington Administrative Code is not met as evidenced by:
.
Based on observation, interview and review of manufacturer's instructions for installation, the hospital failed to install ice machine drain lines according to manufacturer's instructions.

Failure to install ice machine drain lines properly risks contamination of the water and ice supply.

Findings included:

1. The manufacturer's instructions for installation of the Follett Symphony series ice machines states, "Plumbing - Note: Connect and run a dedicated drain line to wall or floor drain. An air break should be provided."

2. On 09/03/19 at 1:40 PM, Surveyor #1 inspected a nourishment room on 3 east in the patient care unit floor. The surveyor observed that the drain line from a Follett Symphony series ice machine was connected directly to the plumbing underneath the hand sink.

3. On 09/04/19 at 9:00 AM, Surveyor #1 interviewed the facility's plant manager (Staff #105) regarding the ice machine drain line on patient unit 3 east. The surveyor and the plant manager went to the nourishment room on patient unit 2 east to observe the ice machine drain line. Surveyor #1 observed with the plant manager that the ice machine on 2 east patient care unit was plumbed exactly the same way as

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L 805	Continued From page 9 the ice machine on 3 east. The plant manager reviewed the manufacturer's manual which indicated that the drain lines were installed incorrectly. .	L 805		
L 810	322-120.6B WATER-TEMPERATURE WAC 246-322-120 Physical Environment. The licensee shall: (6) Provide an adequate supply of hot and cold running water under pressure meeting the standards in chapters 246-290 and 246-291 WAC, with: (b) Water temperature not exceeding 120 F automatically regulated at all plumbing fixtures used by patients; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to ensure that hot water supplied for handwashing did not exceed 120 degrees Fahrenheit. Failure to ensure hot water temperature does not exceed 120 degrees Fahrenheit risks injury from scalds to patients and staff. Findings included: 1. On 09/03/19 at 10:00 AM, Surveyor #1 used a thin-stemmed thermometer to assess the temperature of water from a handwashing sink in the kitchen area. The temperature was assessed at 131.7 degrees Fahrenheit. 2. At the time of the observation, the Dietary Manager (Staff #103) confirmed the temperature	L 810		

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L 810	Continued From page 10 at 131.7 degrees Fahrenheit and stated that he would put in a work order to turn it down. .	L 810		
L1040	322-170.1C TRANSFER PATIENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval by the receiving facility prior to transfer; and (iii) Immediately notifying the patient's family. This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of the hospital's policy and procedures, the hospital failed to ensure that staff members notified the receiving facility, and gave a provider-to-provider report regarding the condition of patients being transferred for emergency treatment in five of six transfers (Patients #908, #909, #910, #911 and #912). . Failure to notify the receiving hospital to report the transferring patient's condition promotes a lack of care continuity and places patients at risk of sub-optimal care. . Findings included: . 1. Document review of the hospital's policy and procedure titled, "Emergency Medical Treatment/Medical Send Out for Change of	L1040		

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L1040	Continued From page 11 Condition." Policy #500.13D reviewed 09/01/19, showed that when transferring patients for 911 emergency treatment, the provider or the RN will call the receiving facility to inform them of the patient's transfer and condition. For Non-911 emergency treatment, the RN will call the emergency department of the receiving facility and provide a nurse-to-nurse report and confirm the name of the accepting provider. Patients are transferred to the receiving emergency room (ER) per transport agreements. Additionally, the hospital's provider is to write an order for transfer. When the patient returns from the outside hospital, the nurse is to conduct a post ER visit reassessment. . 2. Document review of the transfer agreement between the hospital and Deaconess Medical Center (DMC), signed on 09/26/18, showed that the transferring physician and the receiving physician should confer and agree jointly to the appropriateness of the transfer. Document review of the transfer agreement with Sacred Heart Medical Center (SHMC) (not signed or dated) showed that prior to patient transfer the transferring physician shall contact and secure a receiving physician to determine the appropriateness of transfer. . 3. On 09/04/19 at 1:00 PM, Surveyor #9 reviewed the medical records of the following patients transferred to ER and found the following: . a. Patient #908 was transferred to SHMC on 08/12/19 for a complaint of abdominal pain. Record review showed there was no order for transport, no documented provider conversation, and no record of a mode of transport. Additionally, there was no post ER reassessment conducted by the nurse when the patient returned	L1040		

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L1040	Continued From page 12 from the ER. . b. Patient #909 was transferred to SHMC on 06/16/19 between 10:00 and 11:00 AM for a complaint of generalized weakness, slurring speech and right sided weakness. A nursing note stated that a hospital provider approved transfer to the hospital after assessing the patient. There was no documented provider assessment and no order for transport found in the record. The nurse noted a conversation with the SHMC ED nurse, but did not record the nurse's name as per policy. . c. Patient #910 was transferred to DMC on 06/28/19 around 3:15 PM for headache and visual changes. Record review showed no order for transport, no documented provider-to-provider conversation, and no mode of transport. There was no post ER assessment conducted by the nurse when the patient returned to the hospital on 06/29/19 at 2:00 AM. . d. Patient #911 was transferred to DMC on 07/08/19 at 5:00 PM for suturing of a laceration on the left arm. The nursing note stated that a provider evaluated the patient and ordered transport to DMC. Record review showed no documented provider assessment, no order for transport and no documented provider-to-provider conversation. Additionally there was no post ER assessment when the patient returned to the hospital. e. Patient #912 was transferred to SHMC on 08/02/19 at 2:10 PM following an injury in the gym. Record review showed no documented provider assessment, no order for transport and no documented provider-to-provider conversation. There was no post ER assessment conducted by the nurse when the patient returned	L1040		

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L1040	Continued From page 13 to the hospital. . 3. At the time of the medical record review, Surveyor #9 asked the DON (Staff #902) about documentation and orders for transport to other facilities. She stated that a work group had been convened to address the issues. On 09/05/19 the Nurse Manager (Staff #903) provided an updated transfer policy, transfer paper work and post ER assessment paper work developed to address the gaps in documentation of patient transfers.	L1040		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS 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: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital	L1065		

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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1065	Continued From page 14 failed to ensure that staff developed an initial treatment plan that included a chronic medical condition that required active treatment for 2 of 2 patients with insulin-dependent diabetes mellitus (IDDM) (Patients #906, and #907). . Failure to develop care plans to address patient care needs could lead to failure to adequately monitor a medical condition. . Findings included: . 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," Policy #500.21D reviewed 10/01/18, showed that the initial treatment plan and master treatment plan includes the initiation of a medical treatment plan for any acute/chronic actively treated medical issue identified. . 2. On 09/05/19 at 2:30 PM, Surveyor #9 reviewed the medical records of Patients #906 and #907, both of whom were insulin dependent diabetics being treated with daily insulin dosing and sliding scale insulin dosing (insulin dose is based on the blood sugar level before the meal or at bedtime). This required blood glucose monitoring at regular intervals. Document review of the initial treatment plans and master treatment plans for both patients did not identify the diagnosis of IDDM or treatment goals related to the diagnosis. . 3. At the time of the medical record review, Surveyor #9 asked the nurse manager (Staff #903) about adding active/chronic actively treated medical problems to the treatment plan. She agreed that hospital policy had not been followed in the records reviewed.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: ______ B. WING ______	09/05/2019

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L1145	Continued From page 15	L1145		
L1145	322-180.1C RESTRAINT OBSERVATIONS 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: (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 interview, record review, and review of the hospital's policy and procedures, the hospital failed to modify the patients' plan of care after placing patients in restraints in 4 of 5 patient records reviewed (Patients #901, #903, #904 and #905); the hospital failed to ensure that staff members followed the hospital's restraint policy and procedure regarding informing the patient of the reason for restraint/seclusion and the criteria for release in 2 of 5 records reviewed (Patients #902 and #903); and the hospital failed to ensure that staff documented notification of a provider and obtaining an order within one hour of seclusion /restraint of patients in 4 of 5 records reviewed (Patients #901, #902, #903 and #904) . Failure to modify care plans when patients are in restraints, placed patients at risk of harm by not meeting physical and emotional needs and violation of patient's rights. . Findings included:	L1145		

State of Washington

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	013250	A. BUILDING: ____ B. WING ____	09/05/2019

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INLAND NORTHWEST BEHAVIORAL HEALTH	**104 W 5TH AVE SPOKANE, WA 99204**

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L1145	Continued From page 16 . Item #1 - Modify Treatment Plans . 1. Document review of the hospital's policy and procedure titled, "Seclusion & Restraint: Physical/Mechanical/Chemical," Policy # 500.05D1 updated 03/27/19, showed that the nursing staff are to update the "Treatment Plan of Care" within 24 hours to reflect seclusion/restraint intervention and updates or changes in the patient's treatment plan. . 2. On 09/04/19 at 3:00 PM, Surveyor #9 reviewed medical records and found the following: . a. Patient #901 had orders for physical restraint on 03/31/19, 04/03/19 and 04/04/19. The patient's treatment plan was not updated to reflect these episodes. . b. Patient #903 had orders for physical restraint on 07/09/19, 07/10/19 and 07/19/19. The patient's treatment plan was not updated to reflect these episodes. . c. Patient #904 had an order for physical restraint on 06/08/19. The patient's treatment plan was not updated to reflect this episode. . d. Patient #905 hand an order for seclusion on 04/22/19. The patient's treatment plan was not updated to reflect this episode. . 3. At the time of the medical record review, Surveyor #9 asked the nurse manager (Staff #903) about updating patient's treatment plans after episodes of restraint or seclusion. She agreed that hospital policy had not been followed in the records reviewed. .	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L1145	Continued From page 17 Item #2 - Educating Patients Regarding Reason for Restraint/Criteria for Release . 1. Document review of the hospital's policy and procedure titled, "Seclusion & Restraint: Physical/Mechanical/Chemical," Policy # 500.05D1 updated 03/27/19, showed that the RN is to ensure that the rational for seclusion/restraint is communicated to the patient in understandable terms and identifies behavioral criteria for discontinuation. . 2. On 09/04/19 at 3:30 PM, Surveyor #9 reviewed the medical records of Patients #902 and #903 and found the following: . a. Patient #902 was placed in seclusion on 07/21/19 at 11:50 AM. The criteria for discontinuation was not reviewed with the patient. . b. Patient #903 was placed in a physical hold on 07/19/19 at 10:30 AM. The criteria for discontinuation had not was not reviewed with the patient. . 3. At the time of the medical record review, Surveyor #9 asked the nurse manager (Staff #903) about advising patients' of the criteria for release from restraint or seclusion. She agreed that hospital policy had not been followed in the records reviewed. . Item #3 Notifying the Provider of Seclusion/Restraint . 1. Document review of the hospital's policy titled, "Seclusion & Restraint: Physical/Mechanical/Chemical," Policy # 500.05D1 updated 03/27/19, showed that the RN obtains a written or telephonic order from the	L1145		

State of Washington

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L1145	Continued From page 18	L1145		

physician.

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2. On 09/04/19 at 3:00 pm , Surveyor #9 reviewed the medical records of Patients #901, #902, #903 and #904 and found the following:

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a. Patient #901 was placed in a physical hold on 04/03/19 at 7:45 PM. The RN signed the order at 7:45 PM and the provider did not sign the order until 04/04/19 at 12:12 PM. The "Read Back Completed" statement on the order was not checked. On 04/04/19 at 6:39 AM, the patient was again placed in a physical hold and the RN signed the order at 7:07 AM, the provider signed at 12:12 PM. The "Read Back Completed" statement on the order was not checked.

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b. Patient #902 was placed in a physical hold on 07/21/19 at 11:51 AM. The RN and the Provider dated but did not time the order. The "Read Back Completed" statement was not checked. The patient was placed in a hold on 08/06/ 19 at 7:15 PM. The provider signed the order on 07/07/19 at 8:45 AM. The RN checked the "Read Back Completed" but did not date and time the order.

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c. Patient # 903 was placed in a physical hold on 07/10/19 at 12:00 PM. The RN did not date, time, or sign the order. On 07/09/19 at 2:43 PM, the patient was placed in a hold. The RN dated, timed, signed, and marked the "Read Back Completed" statement. The provider signed the order but did not date and time his signature.

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d. Patient #904 was placed in a hold at 6:15 PM on 06/08/19. The RN dated and time the order for 06/08/19 at 6:22 PM; however, the "Read Back Completed" statement was not checked. The provider did not sign, date or time the order.

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State of Washington

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L1145	Continued From page 19 3. At the time of the medical record review, Surveyor #9 asked the nurse manager (Staff #903) about documenting written and telephonic orders for seclusion/restraint. She agreed that hospital policy had not been followed in the records reviewed.	L1145		
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 interview, record review and policy and procedure review, the hospital failed to ensure that a licensed provider wrote an order for restrictive intervention for 2 of 7 episodes reviewed (Patients #903 and #904). . Failure of a provider to write an order for the use of restrictive intervention could lead to poor documentation and monitoring for patient's condition. . Findings included: . 1. Document review of the hospital's policy and procedure titled, "Seclusion & Restraint: Physical/Mechanical/Chemical," Policy #	L1150		

State of Washington

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L1150	Continued From page 20 500.05D1 updated 03/27/19, showed that the RN assesses the need for restrictive intervention and obtains a written or telephonic order from the physician. . 2. On 09/04/19 at 2:30 PM, Surveyor #9 reviewed the medical records of Patients #903 and #904 and found the following: . a. Record review of an order for a physical hold for Patient #903 on 07/10/19 at 12:00 PM was not signed by the provider or the nurse. . b. Record review of an order for a physical hold for Patient #904 on 07/10/19 at 6:22 PM was not signed by the provider. . 3. At the time of the medical record review, Surveyor #9 confirmed with the Nurse Manager (Staff #903) that hospital policy had not been followed regarding restrictive intervention orders.	L1150		
L1285	322-200.3J RECORDS-THERAPIES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (j) Description of therapies administered, including drug therapies; This Washington Administrative Code is not met as evidenced by: . Based on interview and record review, the hospital failed to ensure that permanent records documented when staff tested blood glucose levels and administered insulin coverage with	L1285		

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L1285	Continued From page 21 sliding scale insulin for two patients diagnosed with insulin-dependent diabetes mellitus. (Patients #906 and #907). . Failure to ensure permanent documentation of blood glucose levels, insulin administration, and coverage with sliding scale insulin could lead to poor continuity of care and patient harm. . Findings included: . On 09/04/19, Surveyor #9 reviewed the medical records of patient #906 and #907 and specifically the Medication Administration Records (MAR). Surveyor #9 was unable to determine from the review of the MAR if blood glucose levels were measured four times daily. Additionally, the MAR did not reflect that insulin had been given for elevated blood glucose levels as ordered by the provider. Following the record review at 3:30 PM, Surveyor #9 interviewed the Nurse Manager (Staff #903) and the Quality/Risk Director (Staff #904) regarding the finding. On 09/05/19 at 8:30 AM, the Quality/Risk Director (Staff #904) stated the facility worked with their information technology support staff and developed a permanent record that showed on the MAR the patient's blood glucose levels and any required subsequent treatment with insulin dosing. The proposed MAR format was shared with Surveyor #9 at that time,	L1285		

State of Washington

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	013250	A. BUILDING: **02 - NEW** B. WING ______	**09/03/2019**

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S 000	INITIAL COMMENTS This report is the result of an unannounced fire and life safety state license survey conducted at Inland Northwest Behavioral Health in Spokane, Washington on September 3, 2019 by a representative of the Washington State Patrol, Fire Protection Bureau (WSP/FPB). The survey was conducted in concert with the Washington State Department of Health survey team. The facility's Director of Plant Operations accompanied the WSP/FPB surveyor during the physical tour of the facility. The facility is licensed for 100 beds and at the time of this survey the census was 49. The facility first accepted patients on September 28, 2018. The new section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41 - Hospitals, Condition of Participation: Physical environment. The facility is a three story approximately 70,000 square foot structure of Type II construction with exits to grade and have all-weather surface discharges to the public way. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with smoke detection. The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Barbara A Maier Deputy State Fire Marshal	S 000		

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: **02 - NEW** B. WING ______	**09/03/2019**

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S 000	Continued From page 1 31000 The surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road Union Gap, WA 98903	S 000		
S 521	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interviews on September 3, 2019 between approximately 0815 and 1400 hours the facility has failed to ensure dampers in the facility were inspected within twelve months after installation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC), ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every	S 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: **02 - NEW** B. WING ____	09/03/2019

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S 521	Continued From page 2 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients, staff, and visitors by not limiting the spread of smoke. The findings include, but are not limited to: The facility was unable to provide documentation of damper testing twelve months after installation. The above was discussed and acknowledged by the director of plant operations who stated contractor was to inspect on September 3 & 4, 2019. Surveyor witnessed the arrival of the contractor for the inspection.	S 521		

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	INITIAL COMMENTS This report is the result of an unannounced fire and life safety state license survey conducted at Inland Northwest Behavioral Health in Spokane, Washington on September 3, 2019 by a representative of the Washington State Patrol, Fire Protection Bureau (WSP/FPB). The survey was conducted in concert with the Washington State Department of Health survey team. The facility's Director of Plant Operations accompanied the WSP/FPB surveyor during the physical tour of the facility. The facility is licensed for 100 beds and at the time of this survey the census was 49. The facility first accepted patients on September 28, 2018. The new section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41 - Hospitals, Condition of Participation: Physical environment. The facility is a three story approximately 70,000 square foot structure of Type II construction with exits to grade and have all-weather surface discharges to the public way. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with smoke detection. The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Barbara A Maier Deputy State Fire Marshal	S 000		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorothy L. Sawyer — TITLE: CEO — (X6) DATE: 09-26-2019

State of Washington

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S 000	Continued From page 1 31000 The surveyor was from: Washington State Patrol Fire Protection Bureau 2715 Rudkin Road Union Gap, WA 98903	S 000		
S 521	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interviews on September 3, 2019 between approximately 0815 and 1400 hours the facility has failed to ensure dampers in the facility were inspected within twelve months after installation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC), ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every	S 521		

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013260	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - NEW B. WING ______	(X3) DATE SURVEY COMPLETED 09/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 521	Continued From page 2 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all patients, staff, and visitors by not limiting the spread of smoke. The findings include, but are not limited to: The facility was unable to provide documentation of damper testing twelve months after installation. The above was discussed and acknowledged by the director of plant operations who stated contractor was to inspect on September 3 & 4, 2019. Surveyor witnessed the arrival of the contractor for the inspection.	S 521		

Inland Northwest Behavioral Health
Plan of Correction for DOH Visit 11/14/19

Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-050	L535	Current CPR Cards - Hospital failed to provide evidence of current CPR cards for hospital staff in 2 of 10 personnel files	The identified staff members have been removed from the schedule and will not participate in patient care until they are able to provide BLS certification. Software is being utilized to flag those individuals with inactive BLS and will notify HR to pull those staff from patient care duties. Director of HR will conduct monthly audits of 100% of staff to ensure software is flagging appropriately. Findings will be reported on a quarterly basis to Quality Committee.	Director of Human Resources	9/20/2019
RCW 71.05 & 71.34	L595	Hospital failed to provide staff training on least restrictive alternatives, including restraints and seclusion for 6 medical staff members	All identified defecient medical staff members scheduled to receive Handle with Care training to ensure least restricitve alternative education requirements are met. Protocol established to provide this training to all new medical staff members. Monthly audits of 100% provider staff to evaluate compliance instituted and to be reported to Quality Committee on a Quarterly basis.	Director of Human Resources	9/26/2019
WAC 246-322-050	L615	Hospital failed to implement policies designed to protect patients from TB for 2 of 10 personnel files reviewed. Files showed no documentation of TB Screening	Staff identified are now in compliance with TB Screening regulations. Infection Control Officer has scheduled monthly audits to ensure 100% of staff are in compliance of TB screening Regulations. Findings are reported to Infection Control Committee on quarterly basis.	Infection Control Officer	9/7/2019

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Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-100	L690	Hospital failed to ensure that staff members performed specific precautions to prevent transmission of infection. Meds administerd to 3 patients without performing Hand hygeine prior to or after giving meds to patients. LPN had personal drink in the medication room, policy indicates food & drink are prohibited.	Specific staff member observed received immediate education regarding lack of hand-hygiene and other activities increasing risk of infection transmission. All nursing staff has been retrained on hand hygiene methods, importance, and standards as well as related policies regarding personal food and drinks in patient care areas with elevated risk for contamination or transmission. Hand hygiene monitoring to be performed by a variety of nursing staff (in addition to the Infection Control Officer) and with increased frequency per assigned schedule for the next 30 days to support improved, department-wide integration of hand hygiene practices during medication administration. Findings to be reported quarterly to Infection Control Committee.	Infection Control Officer	9/20/2019
WAC 246-322-120	L780	3- East consult room had several holes on walls and ceiling. No work orders present	The holes were patched and repaired. Re-education has been provided to all staff on entering maintenace requests, including wall penetrations, into the work order system. Environment of Care Rounds, conducted by a multidisciplinary group and the Director of Plant Operations, are scheduled on a monthly basis to assist in identifying wall penetrations. Findings are reported monthly to Environment of Care Committee.	Director of Plant Operations	9/10/2019
WAC 246-322-120	L805	In nourishment room on 2- east and 3-east, drain line from a Follett Symphony series ice machine was connected directly to the plumbing underneath the hand sink. Manufacturer instructions indicate that an air break should be provided to prevent backflow	Air Gaps were installed on all ice machines (4) within the facility. Environment of Care Rounds, conducted by a multidisciplinary group and the Director of Plant Operations, are scheduled on a monthly basis to ensure air gaps are in proper working condition. Findings are reported monthly to Environment of Care Committee.	Director of Plant Operations	9/11/2019

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Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-120	L810	Hospital failed to ensure hot water temperatture does not exceed 120 degrees Farenheit. Handwashing sink in kitchen area, water temp was assessed at 131.7 degrees Farenheit	Mixing valve for handwashing sink was adjusted to ensure water temperature was below 120 degrees Farenheit. Environment of Care Rounds, conducted by a multidisciplinary group and the Director of Plant Operations, are scheduled on a monthly basis to ensure water temperature remains under 120 Degrees F. Findings are reported monthly to Environment of Care Committee.	Director of Plant Operations	9/11/2019
WAC 246-322-170	L1040	Review of policy indicates hospital failed to ensure that staff members notified the receiving facility, gave a provider to provider report regarding the condition of patients being transferred for emergency treatment in 5 of 6 transfers. Elements missing included - order for transport, documentation of provider to provider conversation, record of mode of transport, post ER assessment on return	All open charts have been reviewed to ensure presence of all required elements of documentation for those transferred out of facility for emergency treatment. All Emergency Treatment related policies, forms, tools have been reviewed and modified as necessary for inclusion of verbiage, triggers and spaces for required elements of documentation related to this form of medical send-out. All nursing staff received training via IN-service meeting on new Medical Send Out forms and tools, Medical Send Out policy, Required elements for documentation including: Order for transport, Mode of transport, and Post ER assessment upon return. Chief Medical Officer has provided re-education to provider staff in morning meeting on medial send out policy, required elements for order of transport and provider to provider documentation. New protocol established in which all medical send-outs to be reviewed by Nurse Manager as well as an interdisciplinary team each month with a return to routine and random audits as scheduled upon consistent complete documentation for these incidents. Findings are reported to Quality Committee on quarterly basis.	Chief Nursing Officer Chief Medical Officer Nurse Manager	9/25/2019

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Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-170	L1065	Treatment Plan: Review of policy indicates that hospital failed to ensure that staff developed an initial treatment plan that included a chronic medical condition that required active treatment for 2 patients. Document review of the initial treatment plan and master treatment plan for both patients did not identify the diagnosis of IDDM or treatment goals related to diagnosis	New Treatment Plan templates have been developed to promote improved ease and consistency of both initial treatment plan development and treatment plan updates for chronic conditions that require active treatment. All nursing staff have been re-educated through small group training on INBH Treatment Plan related policies, processes and forms. Chief Medical Officer has re-educated all provider staff on Treatment Plan policy and required elements concerning identifying, documenting and treating medical conditions and chronic conditions that require treatment. New protocol established requiring all treatment plans to be reviewed routinely by night nurses for inclusion of actively treated conditions. New protocol established which assigns the Nurse Manager and Nurse Educator to perform weekly audits of 100% patient charts for inclusion of all medical conditions being actively treated to assure ongoing compliance over the next 4 months. Audit results to be presented by Chief Nursing Officer at Quality Committee on a monthly basis.	Chief Nursing Officer Chief Medical Officer Nurse Manager Nurse Educator	9/25/2019

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Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-180	L1145	Based on review of policy and procedure and record review, the hospital failed to modify the patient's plan of care after placing patients in restraints in 4 out of 5 reviews. The hospital failed to ensure that staff followed policy in regards to informing the patient the reason for restraint/seclusion and the criteria for release in 2 of 5 records reviewed. Hospital failed to ensure staff documented notification of a provider and obtaining an order within one hour of seclusion/restraint in 4 of 5 records reviewed.	All open charts have been reviewed to ensure presence of all required elements of documentation for patients placed in restraints/seclusion. All Restraint and Seclusion related policies, forms, tools have been reviewed to ensure inclusion of verbiage, triggers and spaces for required elements of documentation related to seclusion/restraint. All nursing staff received 1:1 or small group training/re-training on: updated Restraint and Seclusion forms and tools, the Seclusion and Restraint policy, required elements for documentation including: documented notification of a provider and obtaining provider order within 1 hour of seclusion. All incidents of seclusion and restraint to be reviewed ongoing by Nurse Manager as well as an interdisciplinary team each month. Findings to be reported to Quality Committe.	Chief Nursing Officer Mursing Manager	9/25/2019

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Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
WAC 246-322-180	L1150	Based on policy and record review, the hospital failed to ensure that a licensed provider wrote an order for restrictive intervention for 2 of 7 episodes reviewed. This includes signatures from the provider and nurse.	All open charts reviewed to ensure the presence presence of a provider order for each incident of restrictive intervention. Restraint and Seclusion policies, forms, and tools have been reviewed reviewed to ensure inclusion of verbiage, triggers and spaces for a provider order for each restrictive incident. All nursing staff received group training/re-training on: responsibility of nurse to ensure the licensed provider writes an order for each restrictive intervention and requirement for obtaining provider order within 1 hour of seclusion. Chief Medical Officer has provided re-education to provider staff in morning meeting regardning Seclusion/Restraint Policy and requirement of ensuring signed order is present in the medical record for every episode of restraint and seclusion. New protocol instituted requiring 100% of incidents of restrictive intervention to be reviewed ongoing by Nurse Manager as well as an interdisciplinary team each month. Findings are reported to Quality Commitee on quarterly basis.	Chief Nursing Officer Chief Medical Officer Nursing Manager	9/25/2019
WAC 246-322-200	L1285	Based on record review, the hospital failed to ensure that permanent records documented when staff tested blood glucose levels and administered insulin coverage with sliding scale insulin for 2 patients diagnosed with insulin dependent diabetes mellitus	Required documentation has been added to the HCS data output into Medical Records. Patients that undergo blood glucose testing and are administerd insulin coverage with sliding scale insulin will now have the required documentation present in their medical chart. Next Level of care providers now have acces to this documentation on dischage. Medical Record will audit 100% of charts over the next month to ensure required documentation is outputted by HCS into the paper medical record. Findings are reported to Quality Committee in 4th Quarter.	HIM Manager	9/20/2019

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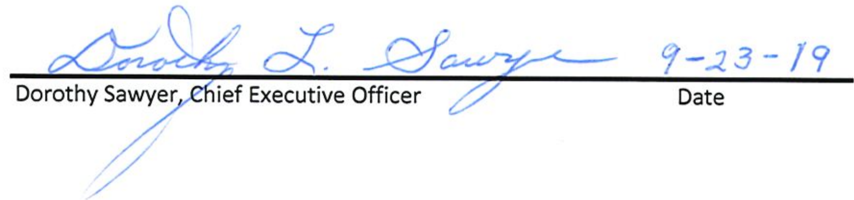
Regulation	Tag #	Citation	How has Deficiency been corrected & Monitoring Plan	Responsible Individual(s)	Estimated Date of Correction
NFPA 101 HVAC	S521	Based on documentation review, the facility has failed to ensure dampers in the facility were inspected within 12 months after installation and at least every 4 years in accordance with NFPA 90A	"Dampers West" provided inspection on all fire and smoke dampers and provided validating documentation. The next inspection has been scheduled for 03/01/2025 as required by NFPA guidelines. Damper Inspection documentation has been scheduled to be reviewed by the Environment of Care Committee upon completion.	Director of Plant Operations	9/11/2019



Dorothy Sawyer, Chief Executive Officer Date

APPROVED
By Kimberly Bloor at 12:49 pm, Sep 24, 2019

Inland Northwest Behavioral Health
Plan of Correction for DOH Visit 11/14/19

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Dorothy Sawyer, Chief Executive Officer   Date

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

September 24, 2019

Mr. Gran Shinwar, MHA, Dir. of Quality
Inland NW Behavioral Health
104 W. 5th St.
Spokane, WA 99204

Dear Mr. Shinwar,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Inland NW Behavioral Health on 09/03/19 to 09/05/19. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on September 24, 2019.

A Progress Report is due on or before December 4, 2019 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please mail this progress report to me at the following address:

Alex Giel, HSC
Department of Health, Investigations and Inspections Office
16201 E Indiana Ave. Ste. 1500
Spokane, Washington 99216-2835

Please contact me if you have any questions. I may be reached at 509-329-2212. I am also available by email at alex.giel@doh.wa.gov

Sincerely,

Alex Giel, HSC
Survey Team Leader