State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	05/04/2023

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BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

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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 Hospital Licensing Regulations, conducted this health and safety survey. Onsite dates: 05/02/23 - 05/04/23 Examination number: 2023-106 The survey was conducted by: Surveyor #5 Surveyor #7 Surveyor #8 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell 5L2821. During the course of the survey, surveyors investigated issues related to State Complaints #2021-10993 and #2020-12405.	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 May 30,2023. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 315		

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L 315	Continued From page 1 consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Item #1 Nutritional Consult Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients at risk received a nutritional consult with a dietician for evaluation of nutritional deficiencies for 1 of 2 patients with current eating disorders documented in the medical record (Patient #509). Failure to refer a patient for a nutritional consult may lead to poor nutrition and poor health outcomes. Finding included: 1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care, 1000.0," policy number 10946282, revised 06/21, showed the following: a. A Nutritional Assessment is completed by the Registered Dietician within 72 hours of a written order by the physician with the scope to include dietary needs, preferences, and habits. 2. On 05/03/23 at 4:00 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medial record for Patient # 509 who was admitted to the Partial Hospitalization Program on 04/04/23. Documentation in the medical record showed that the patient had a current eating disorder, current self-harm, and suicidal ideation.	L 315		

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L 315	Continued From page 2 The medical record showed the following: a. On 04/06/23, a Nutritional Consult note stated that the reason for the consultation was that the patient was restricting food. b. The patient had a history of an eating disorder, unspecified anxiety, and unspecified depression. c. The Clinical Dietician documented that she had tried calling the patient and left a voicemail. Surveyor #5 found no evidence the dietician reattempted to contact the patient to complete the nutritional evaluation (a period of 28 days). 3. At the time of the review, Staff #510 verified that the medical record did not reflect any follow-up by the dietician. Item #2 Reassessment after Administration of As Needed Medications Based on document review and interview the hospital failed to ensure staff reassessed a patient going through substance use detoxification after the administration of medication for withdrawal symptoms for 1 o1 patients who required a reassessment based on protocol (Patient #505). Failure to reassess patients after the administration of as needed medication for symptoms of withdrawal places patients at risk of harm from over or under treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Use of Detoxification Protocols	L 315		

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L 315	Continued From page 3 in Inpatient Units, 1001.17," policy number 10946267, approved 06/21, showed that it is the policy of Fairfax hospital to use prescribed protocols to monitor patients who are withdrawing from opiates, benzodiazepines, and alcohol. 2. On 05/02/23 at 1:00 PM, Surveyor #5 and a Nurse Director of Quality (Staff #501), reviewed the medical record for Patient #505 who was admitted on 04/25/23 for the treatment of drug and alcohol detoxification. The patient had a history of Schizoaffective Disorder, passive suicidal ideation, obsessive compulsive disorder, anxiety, and homelessness. The review showed the following: a. On 04/25/23 at 2:00 PM, a provider order stated, "CIWA ArScale as needed. Give PRN (as needed) Librium (a benzodiazepine that is used to treat anxiety disorders and be used short-term to treat symptoms of alcohol withdrawal, or anxiety) or Ativan (a medication used to treat anxiety disorders, trouble sleeping, severe agitation, active seizures including status epilepticus, alcohol withdrawal, and chemotherapy-induced nausea and vomiting) dosage for CIWA greater than 12 and reassess within 4 hours or PRN if withdrawal is severe. Inform MD (the provider) next day if patient needed more than 150 mg." b. On 04/25/23 at 2:00 PM, a provider wrote an order for Lorazepam 1 mg every 4 hours for seizure or CIWA Score greater than 12. c. On 04/25/23 at 4:00 PM, a provider order stated, "CIWA ArScale Three times a day, give PRN (as needed) Librium or Ativan dosage for CIWA greater than 12 and reassess within 4 hours or PRN if withdrawal is severe. Inform MD	L 315		

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L 315	Continued From page 4 (the provider) next day if patient needed more than 150 mg in 24 hours." d. On 04/28/23 at 9:16 AM, staff assessed the patients CIWA score at 15. e. On 04/28/23 at 9:33 AM, staff medicated the patient with Lorazepam 1 mg. Surveyor #5 found no evidence staff reassessed the patient after 4 hours as directed by the provider orders. 3. At the time of the review, Staff #501 verified that the patient had not been reassessed after medication with the PRN Ativan. .	L 315		
L 335	322-035.1G POLICIES-EMERGENCY CARE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of policies and procedures, the hospital failed to ensure that staff followed policy for checking emergency medication supplies.	L 335		

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L 335	Continued From page 5 Failure to monitor and replace expired emergency medications could cause patient harm due to reduced efficacy of medications administered in an emergency. Findings included: 1. Document review of the hospital's policy and procedure titled, "Medication Storage Inspections," PolicyStat ID 13291708, last approved 04/23, showed the following: a. Medication storage areas include all physical spaces where medications are stored, dispensed, or administered. b. The Director of Pharmacy Services or a pharmacist works with clinical leaders to establish a process for monthly inspections of the medication storage areas throughout the organization. c. Inspections include but are not limited to emergency carts/boxes/trays. 2. On 05/02/23, Surveyor #9 and Registered Nurse (Staff #901) inspected the emergency cart on the North unit. The inspection showed four 1 milligram vials of Narcan (a medication that rapidly reverses an opioid overdose) with a manufacturer's expiration date of 04/23. 3. At the time of the observation, Staff #901 verified the expired medication, removed it from use, and called the pharmacy to replace the medication. .	L 335		

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L 375	Continued From page 6	L 375		
L 375	322-035.1o POLICIES-HOUSEKEEPING WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (o) Maintenance and housekeeping functions, including schedules; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of policies and procedures, the hospital failed to implement its policies and procedures that assure housekeepers use appropriate hand hygiene after removal of gloves. Failure to use hand hygiene may result in the spread of infections. Findings included: 1. Document review of the hospital's policy and procedure titled, "Hand Hygiene, 1600.4.4," PolicyStat ID 11999345, revised 01/23, showed the following: Use alcohol-based hand sanitizer immediately after glove removal. 2. On 05/04/23 at 9:09 AM Surveyor #8, accompanied by Assistant Administrator (Staff #803), observed housekeepers (Staff #801and Staff #802) perform a patient turnover room clean of Room #901. Both Staff #801 and Staff #802, changed gloves twice and did not wash their hands or use hand sanitizer on both opportunities. 3. On 05/04/23 at 9:30 AM Surveyor #8	L 375		

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L 375	Continued From page 7 interviewed Staff #801, Staff #802, and Staff #803 discussing hand hygiene. They acknowledged that hand hygiene was not performed after glove removal. .	L 375		
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: . Based on record review, the hospital failed to ensure that required policies and procedures were reviewed and updated annually as required. 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. Record review of the following policies showed that the hospital did not review all policies on an annual basis as required, including the following: a. Suicide Risk Assessment, PolicyStat ID 10946280, last approved 06/21. b. Sexual Aggression/Victimization Precautions, PolicyStat ID 10946235, last approved 06/21. c. Cheeking Precautions, PolicyStat ID 10946200, last approved 06/21.	L 415		

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L 415	Continued From page 8 d. Elopement Precautions, PolicyStat ID 10946092, last approved 06/21. e. Pain Assessment, Reassessment, and Management, PolicyStat ID 10946109, last approved 06/21. f. Seizure Precautions and Interventions, PolicyStat ID 10946100, last approved 06/21. g. Medically Compromised Precautions, Interventions, and Notifications, Policy Stat ID 10946206, last approved 06/21. h. Plan for Provision of Care-Scope of Services, PolicyStat ID 10946282, last approved 06/21. i. Medication Administration, PolicyStat ID 10946215, last approved 06/21. j. Medication Transcription, PolicyStat ID 10946192, last approved 06/21. k. Nursing Supplies and Equipment, PolicyStat ID 10946241, last approved 06/21. l. Patient Identification, PolicyStat ID 1094613, last approved 06/21. m. Use of Detoxification Protocols in Inpatient Units, PolicyStat ID 10946267, last approved 06/21. n. Prohibited Items, PolicyStat ID 10946137, last approved 06/21. o. Search for Contraband, PolicyStat ID 10946171, last approved 06/21.	L 415		

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L 415	Continued From page 9 p. Visitors Policy, PolicyStat ID 10946299, last approved 06/21. q. Patient Belongings and Valuables, PolicyStat 10973668, last approved 06/21. r. General Health/Emergency, PolicyStat ID 10946143, last approved 06/21. s. Nursing Care of Physical Health Emergencies, PolicyStat ID 10946145, last approved 06/21. t. Prohibited Items, PolicyStat ID 10946137, last approved 06/21. u. Patient Death/Suicide, PolicyStat ID 10946204, last approved 06/21. 2. On 05/04/23 at 11:30 AM, Surveyor #9 interviewed Director of Risk Management (Staff #902) regarding annual policy updates. Staff #902 verified that there were some policies that were not reviewed as there was a transition to PolicyStat last year. Staff #902 stated that they have a process in place to correct this. .	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: .	L 420		

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L 420	Continued From page 10 Based on interview, document review, and review of hospital policy and procedures, the hospital failed to develop and implement policies and procedure for supervision of students including verification of student documentation in the medical record. Failure to implement a system of appropriate student supervision risks patient harm from inappropriate, inconsistent, or delayed treatment of patient's needs and limits the hospital's ability to improve patient outcomes. Findings included: 1 Document review of the hospital's policy and procedure titled, "Student Interns,1" policy number 11999076, approved 11/22, showed the following: a. The facility must ensure that the internship is "for the benefit of the intern" and not the hospital. b. Interns should not perform functions which are generally the duties of compensated employees. c. Interns will be held to the same or similar performance and behavioral standards as employees. d. Criteria applies to an internship program includes: The interns' work complements, rather than displaces, the work of the paid employees while providing significant educational benefit to them. The policy does not address oversight of students by hospital staff or documentation requirements by students in the patient's medical record.	L 420		

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L 420	Continued From page 11 Document review of the hospital's policy and procedure titled, Medical Records Documentation, 1400.6," policy number 11999177, revised 06/20 showed the following: a. Treatment Staff document in Progress notes: i. Staff chart daily for patient hospitalization, and as needed when indicated. ii. All disciplines chart group notes. 2. On 05/03/23 at 2:48 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medical record for Patient #508 who was admitted to the Partial Hospitalization Program on 03/30/23. Documentation in the medical record review showed that the patient had current suicidal ideation, was assessed at high risk for suicide, had recent history of substance abuse, and a current eating disorder. Surveyor #5 reviewed 19 group note documents each containing 5 group notes that included Check in group, Check out group, Psych Ed Group, Process Group, and Skills group notes dated 04/04/23 through 04/28/23. Surveyor #5 noted group therapy notes were conducted and documented by students. Surveyor #5 noted that the "Check Out Groups" included a Suicide Severity Rating Screening assessment to determine if the patient was at risk of suicide. Surveyor #5 found no evidence that a staff provided oversight to students performing groups and documenting in the medical record. Surveyor #5 noted that staff names were assigned to groups in advance and listed on the back of the document even if the patient did not attend the group, but none of the group communication or summary of progress were signed at all. The	L 420		

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L 420	Continued From page 12 Surveyor was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/04/23: Only staff assigned to conduct and document groups. 04/05/23: Check in and Check out (which included a suicide Severity Rating Scale suicide risk screening assessment) conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/06/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/07/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster.	L 420		

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L 420	Continued From page 13 04/08/23: Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/11/23: Check in and check out (which included a suicide Severity Rating Scale suicide risk screening assessment) conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/12/23: Check in conducted/documented by a student. 04/13/23: Planned absence 04/14/23: Planned absence 04/17/23: Check in and Check out (which included a suicide Severity Rating Scale suicide risk screening assessment) conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the	L 420		

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L 420	Continued From page 14 roster. 04/18/23: Check in and Check out conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/19/23: Cheick in and Check out conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/20/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/21/23: Check in and Check out conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was	L 420		

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L 420	Continued From page 15 unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/24/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/25/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/26/26: Check in and Check out conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/24/23: Check in conducted/documented by a student. Group communication or summary for Psych Ed Group, Process Group, or Skills Group	L 420		

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L 420	Continued From page 16 or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/27/23: Group communication or summary for Psych Ed Group, Process Group, or Skills Group or the Summary of Progress for Psych Ed Group, Process Group, or Skills Group were signed. Surveyor(#5) was unable to determine who conducted the group or documented in the medical record when both staff and students were preassigned on the roster. 04/28/23: Only staff assigned to conduct and document groups. 3. On 05/03/23 at 4:00 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medial record for Patient #509 who was admitted to the Partial Hospitalization Program on 04/04/23. Documentation in the medical record showed that the patient had a current eating disorder, current self-harm, and suicidal ideation. The medical record review showed similar findings. Surveyor #5 found no evidence that a staff provided oversight to students performing groups and documenting in the medical record. Surveyor #5 was unable to determine who conducted groups or documented in the medical record when both staff and students were preassigned on the roster. 4. At the time of the review, Staff #510 verified that there was not a process for employed staff working with the students to cosign or document	L 420		

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L 420	Continued From page 17 supervision of the student documentation in the medical record. She stated she did assign a staff member and a student to groups and that was denoted on the roster on the back of the form. She stated she did conduct a chart review to ensure all aspects of the chart were complete and signed the document the following day but was not in attendance at the groups. .	L 420		
L 425	322-040.2 ADMIN-STAFF PROVISIONS WAC 246-322-040 Governing Body and Administration. The governing body shall: (2) Provide staff, facilities, equipment, supplies and services to meet the needs of patients within the purposes of the hospital; This Washington Administrative Code is not met as evidenced by: . Based on document review, observation, and interview, the hospital failed to implement a systematic process to prevent the use of patient care supplies that exceeded the manufacturer's expiration date. Failure to monitor and establish a systematic process for ensuring patient care supplies do not exceed the manufacturer's expiration date risks deteriorated or potentially contaminated supplies being available for patient care. Findings included: 1. Document review of the facility's policy titled, "Nursing Supplies and Equipment Inspection,	L 425		

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L 425	Continued From page 18 1005.2," policy number 10946241, approved 06/21, showed the following: a. Program Managers are responsible for ensuring medical supplies and equipment are not expired and stored properly. b. The purpose of the policy is to ensure that medical equipment is not expired and available when needed. c. Medical supplies and equipment may include, but are not limited to glucometer control solutions, syringes, bandages, medipore tape, pregnancy tests, stool hemoccult and urine multi-drug screen. d. Monthly, the Program Managers will monitor expiration dates of medical supplies and equipment in the nursing station medication rooms and any other areas where medical equipment and supplies are stored. e. Program Managers will discard and replace all expired and damaged supplies and equipment. 2. On 05/02/23 at 11:28 AM, Surveyor #5 and the Director of Quality (Staff #501) inspected the hospital's patient examination room. The review showed the following: a. 1 package triple antibiotic ointment with a manufacturer's expiration date of 01/23. b. 1-box Tegaderm 4X4 50/box with a manufacturer's expiration date of 04/01/23. c. 2 boxes alcohol prep pads 200/box with a manufacturer's expiration date of 04/23.	L 425		

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L 425	Continued From page 19 d. 1-4X4 gauze non adherent dressing with a manufacturer's expiration date of 04/23. e. 1-suture kit open and out of protective packaging. 3. At the time of the observation, Staff #501 verified the expiration dates and removed the equipment and supplies from use. 4. On 05/03/23 at 2:00 PM, Surveyor #5 and the Outpatient Director (Staff #503) inspected the Outpatient Partial Hospitalization Program and Intensive Outpatient Program department emergency bag. Surveyor #5 observed the following: a. 1-box fluid resistant procedural masks 25/box with a manufacturer's expiration date of 06/19. b. 1-box of Instagard Procedure Masks 50/box with a manufacturer's expiration date of 05/21. 5. At the time of the observation, Staff #503 verified the expired supplies and removed them from patient care.	L 425		
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	L 690		

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L 690	Continued From page 20 and analyze data; and (iii) Activities to prevent and control infections; This Washington Administrative Code is not met as evidenced by: . Item #1 Infection Control Data Based on document review and interview, the hospital failed to demonstrate that Infection Control data was collected and analyzed as directed by the hospital's infection control plan. Failure to implement an active and appropriate hospital surveillance program limits the hospital's ability to identify and respond to infection control concerns and puts patients, staff, and visitors at risk of harm from infections. Findings included: 1. Document review of the hospital's infection control plan titled, "Infection Control Plan 2023," no policy number, no date, showed the following: a. The mission of the Infection Prevention and Control program is to provide surveillance, prevention, and control strategies to reduce/eliminate Hospital Acquired Infections (HAI's) to the irreducible minimum. b. Facility Infection Prevention and Control Surveillance Indicators and thresholds to be measured include: i. Timely treatment (24-72 hours) will be monitored for patients diagnosed with urinary tract infections. c. The facility program will assist in providing individualized, high-quality, cost-effective care by	L 690		

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L 690	Continued From page 21 doing the following: i. Integrate all hospital components and functions into infection control prevention and control activities. ii. Monitor the appropriate use of antibiotics and other antimicrobials and minimize inappropriate antibiotic usage. iii. Collect, analyze, and report data on its antimicrobial stewardship program. iv. Take action on improvement opportunities identified in the antimicrobial stewardship program, which may include information about resistance and optimal prescribing. d. The mission of the Infection Prevention and Control program is to: i. Provide surveillance, prevention, and control strategies to reduce/eliminate Hospital Acquired Infections (HAI's) to the irreducible minimum. ii. To evaluate processes and outcomes to continuously improve quality, safety, and efficiency. e. Facility Infection Prevention and Control Surveillance Indicators and thresholds to be measured include: Hospital-acquired (nosocomial) and community acquired infections will be monitored on a monthly basis and reported to Quality/PI Council and the Infection Prevention and Control Committee on a monthly basis. 2. On 05/04/23 at 1:00 PM, Surveyor #5, an Infection Control Consultant (Staff #504), the	L 690		

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L 690	Continued From page 22 Assistant Administrator (Staff #505), and the Chief Nursing Officer (Staff #506) reviewed the hospital's Infection Control Program including Infection Control Plan, Infection Control Documents, and Infection Control Meeting Minutes via an online "Zoom" meeting. Surveyor #5 reviewed Infection Control Meeting minutes for 08/30/22, 10/25/22, 12/15/22, and 03/01/23 and the Infection Control Indicators identified in the Hospital's Infection Control Plan. The review showed the following: a. Urinary Tract Infection (UTI) with treatment to begin within 24 to72 hours: No data collection, data analysis, or process improvement activities in the meeting minutes provided. b. Appropriate antibiotic use: The minutes dated 08/30/22, 10/25/22, and 12/15/22, in the section titled, "Antibiotic Stewardship" the minutes all stated the exact same thing, "Highest HAI (Hospital Acquired Infections) continues to be skin and UTI, with Skin rising steadily. Readdress the 72-hour antibiotic review by provider, will educate, new provider team, will collect data on compliance and report to Infection Prevention Medical Director. The minutes dated 03/01/23 stated that there was no data to report as the hospital was behind in data collection from 12/22 to the current. The minutes dated 08/30/22, 10/25/22, and 12/15/22, in the section titled, "Antibiotic Review" the minutes reported hospital acquired infection rates. The minutes dated 03/01/23 stated that there was no data to report as the hospital was behind in data collection from 12/22 to the current.	L 690		

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L 690	Continued From page 23 Surveyor #5 found no data related to appropriate antibiotic use. c. Hospital Acquired Infections: Hospital Acquired Infection were reported under, "Antibiotic Review Data." The minutes dated 12/15/22 stated that Hospital-wide infections went from 11.9 in September to 9.7 in October, and 12.1 in November. Kirkland HAI went from 1.3 in September, to 1.0 in October and 1.1 in November. The minutes dated 03/01/23 state that there was no data collection or analysis from 12/22 related to staff turnover and that a staff member would have data collection caught up by the end of March meeting. No end of March Infection Control meeting minutes were provided to the surveyor. Surveyor #5 found no evidence that data collection or analysis of any caught-up data for 2023 had been reviewed by the Infection Control Committee as directed by the hospital's Infection Control Plan. 3. At the time of the review, Staff #504 verified the finding and stated that his company had recently been hired to assist the hospital with their Infection Control Program and that he was unaware that there would need to be documentation in the Infection Control minutes for all indictors identified in the Infection Control Plan. He stated that they would need to do a better job at documenting Infection Control meeting minutes and improvement activities. Item #2 Performance Improvement Based on interview and review of the hospital's infection control program, the hospital failed to	L 690		

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L 690	Continued From page 24 develop and implement performance improvement action plans when infection control goals were not being met. Failure to take actions aimed at performance improvement and failure to develop action plans when goals are not met, limits the hospital's ability to provide high quality clinical care and improve patient outcomes. Findings included: 1. Document review of the hospital's infection control plan titled, "Infection Control Plan 2023," no policy number, no date, showed the following: a. The mission of the Infection Prevention and Control program is to: i. Provide surveillance, prevention, and control strategies to reduce/eliminate Hospital Acquired Infections (HAI's) to the irreducible minimum. ii. To evaluate processes and outcomes to continuously improve quality, safety, and efficiency. b. Facility Infection Prevention and Control Surveillance Indicators and thresholds to be measured include: i. Monthly direct observation of employees will be performed to ensure compliance with hand hygiene and personal protective equipment guidelines. Percentages will be reported at least quarterly and follow-up with the manager of employee out of compliance will occur. c. The facility program will assist in providing individualized, high-quality, cost-effective care by	L 690		

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L 690	Continued From page 25 doing the following: i. Integrate all hospital components and functions info infection control prevention and control activities. ii. Monitor the appropriate use of antibiotics and other antimicrobials and minimize inappropriate antibiotic usage. 2. On 05/04/23 at 1:00 PM, Surveyor #5, an Infection Control Consultant (Staff #504), the Assistant Administrator (Staff #505), and the Chief Nursing Officer (Staff #506) reviewed the hospital's Infection Control Program including Infection Control Plan, Infection Control Documents, and Infection Control Meeting Minutes via an online "Zoom" meeting. Surveyor #5 reviewed Infection Control Meeting minutes for 08/30/22, 10/25/22, 12/15/22, and 03/01/23 and the Infection Control Indicators identified in the Hospital's Infection Control Plan. The review showed the following: Hand Hygiene: The hospital's Infection Control Plan review for 2022 showed that the hospital did not meet its hand hygiene compliance target for 2022. Document review of the minutes dated 08/30/22, 10/25/22, and 12/15/22, in the section titled, "Hand Hygiene Rounds" showed that additionally, the hospital did not meet its hand hygiene goals for 01/23, 02/23, and 03/23. The minutes dated 03/01/23 stated that there was no data to report as the hospital was behind in data collection from 12/22 to the current. The minutes dated 08/30/22, 10/25/22, and 12/15/22 showed the same documentation under "Notes/Action/Recommendation and the same documentation under the section titled, "Follow	L 690		

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L 690	Continued From page 26 up/Task assigned to." The documentation appeared to contain canned text or preprinted documentation where only the statistics entered varied. Surveyor #5 found no evidence the hospital analyzed the data, or developed or implemented performance improvement action plans in response to trended data that showed the hospital was consistently not meeting its targets established in the Infection Control Plan. 3. At the time of the review, Staff #504 verified the finding and stated that would need to do a better job at documenting Infection Control meeting minutes and improvement activities. .	L 690		
L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (e) A procedure to monitor the physical environment of the hospital for situations which may contribute to the spread of infectious diseases; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to perform a pre-construction risk assessment as required by hospital policies and procedures. Failure to implement policies or procedures	L 710		

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L 710	Continued From page 27 intended to assure a risk assessemt is preformed prior to construction or maintainence puts patients and staff at risk of harm from environmental contaminants. Findings included: 1. Record review of the hospital's policy titled "Pre-construction Risk Assessment, EC.02.06.05-2," PolicyStat ID #12647782, last approved 12/22, showed that when demolition, renovation, modification, construction, or general maintenance activities are planned, a team of qualified persons selected from Fairfax Hospital will conduct a pre-construction risk assessment (PCRA) on the impact of the work on the facility activities. 2. On 05/04/23 at 2:00 PM, Surveyor #8 toured the South Unit accompanied by assistant administrator (Staff #803). Surveyor #8 interviewed Staff #803 who stated that the South Unit was being renovated and the extent of the work was moving furniture, and painting. Patients did not occupy the unit at the time of the tour. 3. On 05/04/23 at 2:07 PM, Surveyor #5 interviewed the hospital's Infection Control Consultant (Staff #504) related to a pre-construction risk assessment (PCRA) for a current renovation project occurring on the South wing of the hospital. Staff #504 verified that a PCRA assessment had not been completed as described in the hospital's policy. 4. On 05/04/23 at 2:22 PM, Surveyor #8 toured the Central Unit accompanied by Staff #803. Surveyor #8 interviewed Staff #803 who stated that the Central Unit had been renovated and the extent of the work was moving furniture, painting,	L 710		

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L 710	Continued From page 28 and new flooring. The work was done in 2022 and considered cosmetic. The unit was not occupied by patients. 5. On 05/04/23 at 3:00 PM Surveyor #8 interviewed Staff #803 regarding the project underway in the South Unit and the work recently completed on the Central Unit. Surveyor #8 asked Staff #803 if a pre-construction risk assessment (PCRA) had been prepared for these projects. Staff #803 searched for records and a PCRA for these projects was not found.	L 710		
L 715	322-100.1E INFECT CONTROL-PROVISIONS 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: (f) Provisions for: (i) Providing consultation regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This Washington Administrative Code is not met	L 715		

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L 715	Continued From page 29 as evidenced by: . Based on observation and interview, the hospital failed to have an effective quality control process to ensure that patient care supplies available for use did not exceed their manufacturer's expiration date. Failure to ensure patient care supplies do not exceed the manufacturer's expiration date places patients at risk for inadequate medical treatment and exposure to infectious organisms. Findings included: 1. Document review of the hospital's document titled, "Attachment 1 TruMetrix Pro Glucometer", no #, no date, showed the following: a. Control testing is a 2-step process with Level 1 and 3 solutions. b. Do not use the control solution beyond the expiration date: 3 months after first opening the control solution. 2. On 05/02/23 at 12:17 PM, Surveyor #7 and a Program manager (Staff #701) toured the East Unit. Surveyor #7 and Staff #701 Observed opened TruMetrix Glucometer Low and High control solutions dated 10/28/23 in black marker. 3. At the time of the observation Staff #701 verified the control solutions were dated for greater than 5 months from the current date. .	L 715		
L 780	322-120.1 SAFE ENVIRONMENT	L 780		

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L 780	Continued From page 30 WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, 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 05/02/22 at 12:41 PM, Surveyor #7 and a Program Manager (Staff #701), toured the Central Unit. Surveyor #7 noted 2 patients on the unit, Patient #701 who was housed in room #104, and Patient #702 who was housed in room #108. 2. On 05/04/23 between 2:22 and 2:35 PM, Surveyor #8 and Surveyor #7 toured the Central Unit with Assistant Administrator (Staff#803). The tour included patient rooms #104 and #108. The observation showed the following: a. Patient room #104 was recently renovated and the door sill at the entrance was not completed. A gap was left with an uncleanable recessed area about ½-inch wide by 48-inches long. Another area had a 2-inch tear in the vinyl and 2 ft of vinyl edge not attached to the floor beneath. These provide a place for water and debris to accumulate. b. Patient room #108 also recently renovated with the door sill at the entrance not completed. A	L 780		

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L 780	Continued From page 31 recessed area about ½-inch wide by 48-inches long providing an area for accumulation of water and debris. 3. Surveyor #7 interviewed Staff #701 who stated construction on the unit had been stopped and the patient had been moved to the Central Unit to allow for the patient's COVID isolation precautions. .	L 780		
L1050	322-170.2B TREATMENT PLAN-INITIAL 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: (b) An initial treatment plan upon admission incorporating any advanced directives of the patient; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of policy and procedure, the hospital failed to ensure that staff members created an initial treatment plan for 1 of 3 patients reviewed (Patient #901). Failure to ensure the development of an initial treatment plan for behavioral and medical problem puts patients at risk for physical and mental harm, inconsistent, and delayed treatment. Findings included:	L1050		

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L1050	Continued From page 32 1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care-Scope of Services," PolicyStat ID 10946282, last approved 06/21, showed that an initial nursing treatment plan will be developed within 8 hours of admission. 2. On 05/03/23 at 11:00 AM, Surveyor #9 and Registered Nurse (Staff #901) reviewed the medical record of Patient #901 who was admitted on 04/03/23 for the treatment of Schizophrenia. The initial nursing treatment plan was signed by a Registered Nurse on 04/03/23 at 2:20 PM and the fields of problem/short term goals, specific intervention focus, treatment modality, frequency, target date, and person responsible were blank for all four pages of the document. 3. At the time of the review, Staff #901 verified that the initial nursing treatment plan was blank and stated they were not sure how that happened.	L1050		
L1055	322-170.2C EXAM & MEDICAL HISTORY 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: (c) A physical examination and medical history completed and recorded by a physician, advanced registered nurse practitioner, or physician assistant within twenty-four hours following admission, unless the patient had a physical examination	L1055		

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L1055	Continued From page 33 and medical history completed within fourteen days prior to admission, and the information is recorded in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital failed to ensure providers conducted and documented accurate history and physicals for 2 of 2 patients reviewed in the hospital's Partial Hospitalization Program (Patient #508 and #509). Failure to conduct and document an accurate history and physical risks inappropriate, inconsistent, or delayed identification and treatment of a patient's needs and may lead to poor patient outcomes. Findings included: 1. Document review of the hospital's document titled, "Medical Staff Rules and Regulations of Fairfax Hospital," no date, showed that for patients admitted to the hospitals Partial Hospital Program (PHP) a complete history and physical examination must be completed and dictated within two days of admission to a PHP program. 2. On 05/03/23 at 2:48 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medical record for Patient #508 who was admitted to the Partial Hospitalization Program on 03/30/23. Documentation in the medical record review showed that the patient had current suicidal ideation, was assessed at high risk for suicide, had recent history of substance abuse, and a current eating disorder. The review of the patient's history and physical was completed on	L1055		

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L1055	Continued From page 34 03/30/23 via a virtual format (online via a Zoom meeting). Documentation of each aspect of the physical examination showed the provider documented that she was unable to perform the exam. However, the documentation also showed that the provider completed a physical examination and that the findings were normal including: a. Respiratory: "Unable to Perform" and "Lungs clear bilaterally, full equal respiratory excursions" b. Cardiovascular: "Unable to Perform" and "Regular rate, Regular rhythm, no murmurs, no rubs, normal S1 and S2 (heart tones) no jugular vein distention, 2+ carotid, femoral and pedal pulses, no edema" c. Abdominal: "Unable to Perform" and "Normal bowel tones, abdomen non-distended, non-tender, no hepatomegaly, no splenomegaly, no masses" d. Neck: "Unable to Perform" and "Supple, full range of motion, no cervical adenopathy" e. Head/Eyes/Ears/Neck/Throat: "Unable to Perform" and "Pupils equal, round, reactive to light and accommodate to distance, extraocular movement intact, oropharynx normal" Surveyor #5 noted that the document appeared to be canned text or preprinted text with section prefilled out. 3. On 05/03/23 at 4:00 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medial record for Patient # 509 who was admitted to the Partial Hospitalization Program on 04/04/23. Documentation in the medical record	L1055		

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L1055	Continued From page 35 showed that the patient had a current eating disorder, current self-harm, and suicidal ideation. The review of the patient's history and physical was completed on 03/05/09 (questionable error in documentation as patient admitted on 04/04/23, but the patient's birthdate is 03/05/09) via a virtual format (online via a Zoom meeting). The provider documented, "Zoom Assessment." Documentation of each aspect of the physical examination showed the provider documented that she was unable to perform the exam. However, the documentation also showed that the provider completed a physical examination and that the findings were normal including: a. Respiratory: "Unable to Perform" and "Lungs clear bilaterally, full equal respiratory excursions" b. Cardiovascular: "Unable to Perform" and "Regular rate, Regular rhythm, no murmurs, no rubs, normal S1 and S2 (heart tones) no jugular vein distention, 2+ carotid, femoral and pedal pulses, no edema" c. Abdominal: "Unable to Perform" and "Normal bowel tones, abdomen non-distended, non-tender, no hepatomegaly, no splenomegaly, no masses" d. Neck: "Unable to Perform" and "Supple, full range of motion, no cervical adenopathy" e. Head/Eyes/Ears/Neck/Throat: "Unable to Perform" and "Pupils equal, round, reactive to light and accommodate to distance, extraocular movement intact, oropharynx normal" Surveyor #5 noted that the document appeared to be canned text or preprinted text with section prefilled out.	L1055		

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L1055	Continued From page 36 4. At the time of the review, Staff #510 verified that the History and Physical were completed via a Zoom call. Staff #510 verified that aspects of the physical documented could not be completed virtually. Staff #510 stated that most of the programs are online/virtual, and that the hospital is still working out the details of how a conduct a virtual program and include aspects that require an in-person assessment. .	L1055		
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: . Item #1 Master Treatment Plans Partial	L1065		

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L1065	Continued From page 37 Hospitalization Program Based on interview, record review, and review of policies and procedures, the hospital failed to develop an individualized plan for patient care for 2 of 2 patients reviewed in the (Patient #508 and #509). Failure to develop an individualized plan of care can result in inappropriate, inconsistent, or delayed treatment of a patient's needs and may lead to patient harm and lack of appropriate treatment for a medical and psychiatric condition. Findings included: 1. Document review of the hospital's policy and procedure titled, "Treatment Planning, DP.018," policy number 1309220, effective 04/23, showed the following: a. Treatment planning begins on admission and occurs at least weekly. b. As changes in the patient's condition are noted, the diagnosis may be revised; problems will be added, restated, deleted, or resolved. Interventions and actions will be modified to reflect these changes, and the objectives and goals will be appropriately updated. 2. On 05/03/23 at 2:48 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medical record for Patient #508 who was admitted to the Partial Hospitalization Program on 03/30/23. Documentation in the medical record review showed that the patient had current suicidal ideation, was assessed at high risk for suicide, had recent history of substance abuse, and a current eating disorder.	L1065		

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L1065	Continued From page 38 Surveyor #5 found no evidence that the patient's eating disorder, suicidal ideation and current risk, or substance abuse were addressed in the patient's treatment plan. 3. On 05/03/23 at 4:00 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medial record for Patient # 509 who was admitted to the Partial Hospitalization Program on 04/04/23. Documentation in the medical record showed that the patient had a current eating disorder, current self-harm, and suicidal ideation. Surveyor #5 found no evidence that the patient's eating disorder, suicidal ideation, or self-harm were addressed in the patient's treatment plan. 4. At the time of the review, Staff #510 verified the finding and stated there was an opportunity to ensure the treatment plans were more complete. Item #2 Patient Involvement in Master Treatment Planning Based on document review and interview the hospital failed to ensure that the patient was involved in the treatment plan process and that participation in treatment planning was documented in the patient medical record for 2 of 5 patients reviewed (Patient #508 and #903). Failure to include patient participation in treatment planning risks inappropriate, inconsistent, or delayed treatment of a patient's needs and may lead to poor patient outcomes. Findings included: 1. Document review of the hospital's policy and	L1065		

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L1065	Continued From page 39 procedure titled, "Treatment Planning, DP.018," policy number 1309220, effective 04/23, showed the following: a. Documentation of each treatment plan review will be included in the patient's record and include: i. Participation of the patient in treatment plan review ii. Extent of cooperation with the plan 2. Document review of the hospital's policy and procedure titled, "Interdisciplinary Patient Centered Care Planning," PolicyStat ID 11999210, last approved 12/22, showed the following: a. The social services staff member assigned to the patient will be responsible for meeting with the patient if appropriate prior to the Master Treatment Plan (MTP) meeting. b. Whenever possible, the patient and family will be included in the treatment team meeting. c. The patient/family is to sign the treatment plan to indicate their agreement with and participation in development of the plan. d. A designated staff member is responsible for discussing the treatment plan with the patient and family. e. If the patient refuses to sign or is unwilling to sign, that will be documented. 3. On 05/02/23 between 3:15 PM and 4:30 PM, Surveyor #9 and Registered Nurse (Staff #901)	L1065		

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L1065	Continued From page 40 reviewed the medical record of Patient #903 who was admitted on 04/26/23 for a psychiatric diagnosis of psychosis. Surveyor #9 observed that the interdisciplinary master treatment plan was signed by the Psychiatrist on 04/28/23 at 10:00 AM, the Registered Nurse on 05/01/23 at 09:08 AM, the Case Manager on 05/01/23 at 9:10 AM, and the Certified Therapeutic Recreation Specialist on 05/01/23 at 3:07 PM. There was no documentation of patient participation or refusal and no patient signature. 4. At the time of the review Staff #901 verified that there was no documentation related to patient involvement in the creation of the interdisciplinary master treatment plan. 5. On 05/03/23 at 2:48 PM, Surveyor #5 and the Outpatient Manager (Staff #510) reviewed the medical record for Patient #508 who was admitted to the Partial Hospitalization Program on 03/30/23. Documentation in the medical record review showed that the patient had current suicidal ideation, was assessed at high risk for suicide, had recent history of substance abuse, and a current eating disorder. The review sowed the following: a. The Interdisciplinary Master Treatment Plan dated 04/04/23: The section for the patient to sign that the plan had been presented in a way the patient understands and that the patient had an opportunity to asks questions related to the content of the treatment plan was blank. b. The Treatment Plan update dated 04/20/23: The section for the patient to sign that the plan had been presented in a way the patient understands and that the patient had an opportunity to asks questions related to the	L1065		

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L1065	Continued From page 41 content of the treatment plan contained documentation entered by an unknown staff member that stated, "Pending sent to patient via DocuSign 04/20/23". 6. At the time of the review, Surveyor #5 asked for the documents in "DocuSign." Staff #510 stated that she did not know how to get the documents from DocuSign to the patient's medical record. She stated that since Covid-19, most of the programs are online/virtual and that the hospital is still working out the details of how a virtual program works with a paper medical record. She stated that they did not have a policy related to utilization of "DocuSign" for medical record documents. .	L1065		
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 the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for safe medication administration for 1 of 3 patient records reviewed (Patient #903). Failure to follow safe medication administration	L1070		

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L1070	Continued From page 42 procedures puts patients at risk of receiving the wrong medications or unintended medication administration resulting in patient harm and/or death. Findings included: 1. Review of the hospital's policy and procedure titled, "Medication Transcription," PolicyStat ID 10946192, last approved 06/21, showed that if a nurse initiates a phone call to order/change medications, the nurse must document justification of medication change in the nursing documentation note. 2. On 05/04/23 between 9:15 AM and 10:30 AM, Surveyor #9 and Registered Nurse (Staff #901) reviewed the medication administration record of Patient #903. Patient #903 was admitted on 04/28/23 with a medical diagnosis of diabetes and a psychiatric diagnosis of psychosis. Provider medication orders were entered on 04/28/23 at 4:00 PM for insulin (a medication to treat elevated blood sugar) administration before meals using sliding scale coverage and showed the following: a. For blood sugar of 0-150 = 0 units. b. For blood sugar of 151-200 = 2 units. c. For blood sugar of 201-250 = 4 units. d. For blood sugar 251-300 = 6 units. e. For blood sugar 301-350 = 8 units. f. For blood sugar 351-400 = 10 units. g. For blood sugar >400 = call DR.	L1070		

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L1070	Continued From page 43 3. On 04/28/23 at 5:17 PM, Patient #903 had a blood sugar of 521 milligrams/deciliter, on 04/29/23 at 7:47 AM, a blood sugar of 443 milligrams/deciliter and on 04/29/23 at 8:05 PM, a blood sugar of 424 milligrams/deciliter. Surveyor #9 was unable to find evidence of documentation of a note or annotation in the medication administration record that showed the provider was notified of the patient's blood sugar. 4. At the time of the review, Staff #901 verified at the above times, there was no documentation of nurse to provider communication regarding the blood sugar value. .	L1070		
L1295	322-200.3L RECORDS-PROGRESS NOTES 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: (l) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities; This Washington Administrative Code is not met as evidenced by: . Item #1 Accurate Note Documentation Based on document review and interview, the hospital failed to ensure that staff accurately documented Adjunctive Therapy group notes and nursing progress notes related to Adjunctive Therapy in the medical record for 3 of 3 patient's	L1295		

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L1295	Continued From page 44 reviewed (Patient #505, #506, and #507). Failure to accurately document Adjunctive Therapy notes in the medical record risks patient harm from unrecognized or unmet care needs and inconsistent and unsafe care due to lack of a complete medical record. Findings included: 1. Document review of the hospital's policy and procedure titled, Medical Records Documentation, 1400.6," policy number 11999177, revised 06/20 showed the following: a. All individuals who document in the patient record should know, understand, and abide by the medical records documentation requirements. b. All disciplines chart group meetings. 2. On 05/02/23 at 1:00 PM, Surveyor #5 and a Nurse Director of Quality (Staff #501), reviewed the medical record for Patient #505 who was admitted on 04/25/23 for the treatment of drug and alcohol detoxification. The patient had a history of Schizoaffective Disorder, passive suicidal ideation, obsessive compulsive disorder, anxiety, and homelessness. Surveyor #5 reviewed 4 of 4 DBT-Process and Skills group therapy notes in the medical record dated 04/26/23, 04/27/23, 04/28/23, and 05/01/23. The review showed the following: a. On 04/26/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section for attended or not was blank. However, the section	L1295		

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L1295	Continued From page 45 for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15 AM: Psych Ed. The Joy of Perspective-The patient discussed the concept perspective. Took the quiz. Expressed gratitude." ii. "Process Group 1:15 PM: Process Group-Special Recollections. The patient shared recollection. The patient expressed what it's like to be human." iii. "Skills Group 3:45 PM: Social Wellness-Assertiveness. The patient read the handout and discussed assertiveness. Expressed gratitude." b. On 04/27/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section for attended or not was blank. However, the section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15-Psych Ed. The 6 Speres of Wellness-The patient discussed areas of life that could be worked on. Took the quiz. Expressed gratitude." ii. "Process Group 1:15 PM: Process	L1295		

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L1295	Continued From page 46	L1295		

Group-Recognizing Cultural Tunnel Vision. The patient discussed things we engage in that are psychologically unhealthy. The patient expressed what it's like to be human."

iii. "Skills Group 3:45 PM: Social Wellness-Empathy. The patient read the handout and discussed how to be empathetic. Expressed gratitude."

c. On 04/28/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did attend (Surveyor #5 was unable to tell which groups were attended or not of the 3 documented on the form). The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following:

i. "Psych Ed 11:15 AM: Psych Ed. Opportunities in a Crisis-The patient discussed areas of opportunity in a crisis and Radical Acceptance. Took the quiz. Expressed gratitude."

ii. "Process Group 1:15 PM: Process Group-Practicing Radical Acceptance. The patient discussed turning of the mind. The patient expressed what it's like to be human."

iii. "Skills Group 3:45 PM: Social Wellness-Social Wellness-Assertiveness. The patient read the handout and discussed how to be assertive and tactful at the same time. Expressed gratitude."

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L1295	Continued From page 47 d. On 05/01/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did attend (Surveyor #5 was unable to tell which groups were attended or not of the 3 documented on the form). The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15 AM-Psych Ed. Everyone Struggles and Suffers-The patient discussed feeling alone, introduced tunnel vision concept. Took the quiz. Expressed gratitude." ii. "Process Group 1:15 PM: Process Group-Boundaries Styles. The patient discussed different boundary styles and how they set them. The patient expressed what it's like to be human." iii. "Skills Group 3:45 PM: Social Wellness-Setting Good Boundaries. The patient read the handout and discussed ways to set good boundaries and be tactful at the same time. Expressed gratitude." e. Daily Nursing Progress Notes: 6 of 6 Daily Nursing Progress Notes dated 04/26/23, 04/27/23, 04/28/23, 04/29/23, 04/30/23, and 05/01/23 all stated that the patient was attending group therapy. Document review of Group Therapy Notes from 04/26/23 through 05/01/23 showed that the patient attended only 5 of 21 Adjunctive Therapy Groups. 3. At the time of the review, Surveyor #5	L1295		

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L1295	Continued From page 48 interviewed Staff #501 about why staff would document quoted material from a patient who did not attend the group and why the nurses are documenting the patient attended groups, when most groups were not attended. Staff #504 stated that she did not know why nursing was documenting "yes" to group attendance and stated that they had just become aware of a group therapist documenting all groups on one document and the hospital was working on this. 4. On 05/03/23 at 9:20 AM, Surveyor #5 and a Clinical Nurse Educator (Staff #507) reviewed the medical record for Patient #506 who was admitted on 04/28/23 for the treatment of substance use disorder, schizophrenia, psychosis, and hypokalemia. Surveyor #5 reviewed 3 of 3 DBT-Process and Skills group therapy notes in the medical record dated 04/28/23, 05/01/23, and 05/02/23. The review showed the following: a. On 04/28/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did not attend. The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15 AM: Psych Ed. Opportunities in a Crisis-The patient discussed areas of opportunity in a crisis and Radical Acceptance. Took the quiz. Expressed gratitude."	L1295		

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L1295	Continued From page 49 ii. "Process Group 1:15 PM: Process Group-Practicing Radical Acceptance. The patient discussed turning of the mind. The patient expressed what it's like to be human." iii. "Skills Group 3:45 PM: Social Wellness-Social Wellness-Assertiveness. The patient read the handout and discussed how to be assertive and tactful at the same time. Expressed gratitude." Surveyor #5 noted the notes documented for this patient (Patient #506) were exactly the same as Patient #505. Neither patient had attended the group therapy. b. On 05/01/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did not attend the groups. The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15 AM-Psych Ed. Everyone Struggles and Suffers-The patient discussed feeling alone, introduced tunnel vision concept. Took the quiz. Expressed gratitude." ii. "Process Group 1:15 PM: Process Group-Boundaries Styles. The patient discussed different boundary styles and how they set them. The patient expressed what it's like to be human." iii. "Skills Group 3:45 PM: Social Wellness-Setting Good Boundaries. The patient read the handout	L1295		

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L1295	Continued From page 50	L1295		

and discussed ways to set good boundaries and be tactful at the same time. Expressed gratitude."

Surveyor #5 noted the notes documented for this patient (Patient #506) on 04/28/23 and 05/01/23 were exactly the same as Patient #505. Neither patient had attended the group therapy.

c. On 05/02/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did not attend the groups. The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following:

i. "Psych Ed 11:15 AM-Psych Ed. Tunnel Vision-The reason for Human Suffering-The patient discussed the tunnel vision concept. Took the quiz. Expressed gratitude."

ii. "Process Group 1:15 PM: Process Group-Boundaries Styles. The patient discussed different boundary styles and how they set them. The patient expressed what it's like to be human."

iii. "Skills Group 3:45 PM: The Wise Mind-Appreciating Nature. The patient read the handout. Discussed wise mind and being in Nature. Expressed gratitude."

5. On 05/03/23 at 10:58 AM, Surveyor #5 and a Clinical Nurse Educator (Staff #507), reviewed the medical record for Patient #507 who was admitted on 05/01/23 for the opioid and alcohol

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L1295	Continued From page 51 detoxification. Surveyor #5 reviewed 1 of 1 DBT-Process and Skills group therapy notes in the medical record dated 05/02/23. The review showed the following: a. On 05/02/23, the DBT-Process and Skills group therapy note contained pre-printed documentation for 3 groups on one form (Psych Ed at 11:15 AM, Process Group at 1:15 AM, and Skills Group at 3:35 PM). The section to document attendance stated the patient did not attend the groups. The section for Alternative Programming showed that Alternative Programing was offered, and the patient refused (alternative programing is offered to patients who do not attend the regular group therapy). Typed notes on the document stated the following: i. "Psych Ed 11:15 AM-Psych Ed. Tunnel Vision-The reason for Human Suffering-The patient discussed the tunnel vision concept. Took the quiz. Expressed gratitude. 'I'm grateful for my family.'" ii. "Process Group 1:15 PM: Process Group-Boundaries Styles. The patient discussed different boundary styles and how they set them. The patient expressed what it's like to be human." iii. "Skills Group 3:45 PM: The Wise Mind-Appreciating Nature. The patient read the handout. Discussed wise mind and being in Nature. Expressed gratitude." Surveyor #5 noted the notes documented for this patient (Patient #507) on 05/02/23 were the same as Patient #506. Neither patient had attended the group therapy. 6. On 05/03/23 at 10:50 AM, Surveyor #5	L1295		

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L1295	Continued From page 52 interviewed a Social Worker (Staff #508) related to the documentation on the group therapy notes that showed quoted text made by patients documented on the forms, when the patients did not attend the groups and also refused alternate therapy. Staff #508 did not appear to understand that a staff member cannot document something a patient said or did if the patient did not say or do it. Staff #508 attempted to cross through the documentation with a pen on the DBT-Process and Skills group therapy note for Patient #506, and stated, "So, should I just get rid of this?" Item #2 Consultation Notes Based on document review and interview, the hospital failed to ensure that staff documented progress notes in the medical record for 3 of 8 patient charts reviewed (Patient #703, #704, and #705). Failure to document progress notes in the medical record risks patient harm from unrecognized or unmet care needs and inconsistent and unsafe care due to the lack of a complete medical record. Findings included: 1. Document review of the hospital's document titled, "Medical Staff Rules and Regulations of Fairfax Hospital", no #, no date, showed Consultants must make record entries, dated, and signed, whenever they see a patient. 2. On 05/02/23 at 3:29 PM, Surveyor #7 and a Program Manager (Staff #701) reviewed the medical record for Patient #703 who was involuntarily admitted on 04/21/23, the review showed the following:	L1295		

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L1295	Continued From page 53 a. On 04/24/23 at 8:55 AM, an order for a medical consultation for the complaint of constipation. b. On 04/26/23 at 10:17 AM, an order for a medical consultation to evaluate a dry cracked left foot. c. On 04/27/23 at 10:59 AM, an order for a medical consultation to evaluate constipation and for the complaint of allergies. 3. At the time of the review Staff #701 verified there were orders placed by a medical provider related to constipation, dry left foot, and allergies, but no provider progress/consult notes related to the three consult orders. 4. On 05/03/23 at 11:29 AM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #704, the review showed the following: a. On 02/08/23 at 2:46 PM, an order was placed for a medical consultation for "clarification on Ozempic (a medication to decrease blood sugar) dosage". Surveyor #7 was unable to find any progress/consult notes for the ordered consult. b. On 02/27/23 at 10:54 AM, an order was placed for a medical consultation "to assess right-hand fracture of 2nd and 3rd fingers". Surveyor #7 was unable to find any progress/consult notes for the ordered consult. c. On 03/08/23 at 7:21 AM, an order was placed for a medical consultation for "fractured 2nd and 3rd fingers- first x-ray was on 1st finger". Surveyor #7 was unable to find any progress/consult notes for the ordered consult.	L1295		

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L1295	Continued From page 54 d. On 03/25/23 at 2:00 PM, an order was placed for a medical consultation "S/P fall". Surveyor #7 was unable to find any progress/consult notes for the ordered consult. e. On 04/13/23 at 7:45 AM, an order was placed for a medical consultation "for a sore on their left foot". Surveyor #7 was unable to find any progress/consult notes for the ordered consult. 5. At the time of the review Staff #701 verified there were no progress/consult notes for the ordered consults. 6. On 05/03/23 at 3:11 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #705, the review showed the following: a. On 02/10/23 at 9:00 PM, an order was placed for a medical consult for "p/t c/o abdominal pain, diarrhea, and poor appetite." Surveyor #7 was unable to find any progress/consult notes for the ordered consult. b. On 02/25/23 at 10:00 AM, an order was placed for a medical consultation "for consistently elevated BP." Surveyor #7 was unable to find any progress/consult notes for the ordered consult. c. On 02/28/23 at 9:30 AM, an order was placed for a medical consultation "for clogged ear." Surveyor #7 was unable to find any progress/consult notes for the ordered consult. 7. At the time of the review Staff #701 verified there were no progress/consult notes for the ordered consults.	L1295		

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L1375	Continued From page 55	L1375		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Item #1 Safe medication administration. Based on observation, interview, document review, and review of the hospital's policies and procedures, the hospital failed to ensure staff members followed its policy for safe medication administration for 2 of 2 diabetic patients reviewed (Patient #704 and #708). Failure to follow safe medication administration standards risks medication errors and patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "High-Alert Medications, 41", PolicyStat #13291750, last approved 04/23 showed the following: a. Insulin is a high-alert medication. b. Independent double-check system is a strategy for safeguarding the use of high-alert medications.	L1375		

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L1375	Continued From page 56 c. An independent double-check consists of at least two qualified healthcare professionals verifying the accuracy of the drug, dose, calculation, and/or administration. An example is: Two nurses checking problem-prone medications that require preparation prior to administration (e.g. insulin). Document review of the hospital's policy and procedure titled, "Medication Administration, 1000.37", PolicyStat #10946215, last approved 06/21, showed the following: a. The HCS system documents medication as administered once they have been scanned. b. There is an hour window on either side of the administration time when the medication may be passed and considered on time. c. The medications will be scanned into HCS at the time of administration. 2. On 05/03/22 at 12.00 PM, Surveyor #7, and a Program Manager (Staff #701) reviewed the medical record for Patient #704 who was on sliding scale insulin for type 2 diabetes. The review showed the following: a. An order for sliding scale insulin before meals timed at 7:00 AM, 11:00 AM, 4:00 PM, and 9:00 PM. b. On 04/30/23 at 12:00 PM, Patient #704 received 2 units of insulin, the 2-nurse verification was documented at 2:45 PM, 2 hours and 45 minutes after administration documentation. c. On 05/01/23 at 5:38 PM, Patient #704 received 4 units of insulin, 1 hour and 38 minutes after the	L1375		

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L1375	Continued From page 57 time due. d. On 05/02/23 at 7:45 AM, Patient #704 received 2 units of insulin, the 2-nurse verification was documented at 12:19 PM, 4 hours and 34 minutes after administration documentation. e. On 05/02/23 at 11:50 AM, Patient #704 received 2 units of insulin, the 2-nurse verification was documented at 12:42 PM, 52 minutes after administration documentation. 3. At the time of the review Staff #701 verified the late medication administration and the late 2-nurse verification documentation times. 4. On 05/04/23 from 9:00 AM - 11:00 AM Surveyor #7 and Staff #701 reviewed the medical record for Patient # 708 who was diabetic and receiving sliding scale insulin. The review showed the following: a. An initial order for Novolog insulin sliding scale was placed on 01/08/23 at 7:30 AM that was discontinued on 01/08/23 at 10:19 PM. b. An order for Novolog insulin sliding scale was placed on 01/08/23 at 9:00 PM. c. Patient #708 received 4 units of insulin on 01/08/23 at 8:41 AM, Surveyor found no documentation of a 2-nurse verification. d. Patient #708 received 2 units of insulin on 01/08/23 at 8:41 AM, Surveyor found no documentation of a 2-nurse verification. e. Patient #708 received 4 units of insulin on 01/08/23 at 10:43 AM, Surveyor found no documentation of a 2-nurse verification.	L1375		

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L1375	Continued From page 58 f. Patient #708 received 6 units of insulin on 01/08/23 at 10:37 PM, Surveyor found no documentation of a 2-nurse verification. g. Patient #708 received 6 units of insulin on 01/09/23 at 7:26 AM, Surveyor found no documentation of a 2-nurse verification. h. Patient #708 received 2 units of insulin on 01/09/23 at 11:32 AM, Surveyor found no documentation of a 2-nurse verification. 5. At the time of the review Staff #701 verified the missing 2-nurse verification and added she was not sure how that happened. Staff #701 called for assistance in locating the 2-nurse documentation. After speaking with a colleague, Staff #701 stated "It is not in the chart; it should be in the Transaction Log." Item #2 PRN pain medications Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff members completed and documented reassessments after each "as needed" (PRN) medication intervention for 2 of 2 medical records reviewed for patients receiving PRN pain meds (Patient #705 and #708). Failure to assess before PRN medication administration and reassess patients after PRN medication administration risks inconsistent, inadequate, or delayed relief of symptoms. Findings included: 1. Document review of the hospital's policy and procedure titled, "Pain Assessment,	L1375		

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L1375	Continued From page 59 Reassessment and Management, 1000.22", PolicyStat #10946109, last approved 06/21, showed the following: a. It is the responsibility of all medical staff to screen all patients for the presence or absence of pain. b. All patients will undergo reassessment of pain at least once per shift while awake and after every pain control mechanism employed by patient care providers. Pain control mechanisms include, but are not limited to: i. Medications administered for the control or relief of pain. ii. Medications administered for the control or relief of anxiety. c. As part of the reassessment, the Multidisciplinary team should assess and document the pain in terms of its duration, characteristics, and intensity as well as the time of the pain, the pain rating, and any use of analgesics. Also include other pain interventions, vital signs, the effectiveness of all interventions, and any side effects or adverse reactions. 2. On 05/03/23 at 4:00 PM, Surveyor #7 and Staff #701 reviewed the medical record for Patient #705, the review showed the following: a. An order for Acetaminophen 325 mg tablet every (q) 4 hours as needed (PRN) for pain/headache. b. An order for Ibuprofen 600 mg tablet q 4 hours prn for pain/body aches.	L1375		

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L1375	Continued From page 60 c. On 02/10/23 at 3:15 PM, Patient #705 received Acetaminophen and was reassessed at 5:37 PM as tolerated. Surveyor #7 found no pre-medication assessment and no assessment for medication efficacy. d. On 02/11/23 at 11:47 PM, Patient #705 received Acetaminophen and was reassessed on 02/12/23 at 1:41 AM as tolerated. Surveyor #7 found no pre-medication assessment and no assessment for medication efficacy. e. On 02/12/23 at 11:37 PM, Patient #705 received Ibuprofen and was reassessed on 02/13/23 at 5:37 AM as tolerated. Surveyor #7 found no pre-medication assessment and no assessment for medication efficacy. f. On 02/13/23 at 4:56 PM, Patient #705 received Acetaminophen and was reassessed at 6:12 PM as effective. Surveyor #7 found no pre-medication assessment. g. On 02/19/23 at 2:55 PM, Patient #705 received Ibuprofen and was reassessed at 5:41 PM at effective. Surveyor #7 found no pre-medication assessment. h. On 02/23/23 at 8:26 AM, Patient #705 received Ibuprofen and was reassessed at 9:35 AM as effective. Surveyor #7 found no pre-medication assessment. i. On 02/24/23 at 10:46 AM, Patient #705 received Ibuprofen and was reassessed at 2:48 PM as effective. Surveyor #7 found no pre-medication assessment. j. On 02/28/23 at 9:20 AM, Patient #705 received Acetaminophen and was reassessed at 11:06 AM	L1375		

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L1375	Continued From page 61 as effective. Surveyor #7 found no pre-medication assessment. 3. At the time of the review Staff #701 verified the missing pre-medication assessments and the reassessments being documented as tolerated and effective. 4. On 05/04/23 from 9:00 AM - 11:00 AM Surveyor #7 and Staff #701 reviewed the medical record for Patient # 708 who was admitted on 01/02/23 at 8:14 PM and discharged on 01/09/23 at 2:30 PM. The review showed the following: a. An order for Acetaminophen 650 mg q4 hours PRN for pain/headache. b. An order for Ibuprofen 200 mg q6 hours PRN for pain/body aches. c. On 01/05/23 at 10:41 AM Patient #708 received Acetaminophen and was reassessed at 1:00 PM as tolerated. Surveyor #7 found no pre-medication assessment and no assessment for medication efficacy. d. On 01/05/23 at 4:35 PM Patient #708 received Acetaminophen and was reassessed at 8:52 PM, 4 hours and 17 minutes after administration as tolerated. Surveyor #7 found no pre-medication assessment and no assessment for medication efficacy. e. On 01/06/23 at 12:12 AM Patient #708 received Ibuprofen and was reassessed at 2:44 AM as effective. Surveyor #7 found no pre-medication assessment. Item #3 Medication administration outside of provider orders	L1375		

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L1375	Continued From page 62 Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff followed its policy for safe medication administration for 1 of 3 patient records reviewed (Patient #903). Failure to follow the hospital's medication administration and processes places patients at risk for medication errors and patient harm. Findings included: 1. Review of the hospital's policy and procedure titled, "Medication Transcription," PolicyStat ID 10946192, last approved 06/21, showed the following: a. Telephone orders will only be accepted when a provider is not in the building to enter his/her orders into HCS. b. The nurse will indicate a telephone order by documenting in the following manner, TORB: provider name, RN name with title. c. Nurse signs his/her name with title and includes the date and time of the order. 2. On 05/04/23 between 9:15 AM and 10:30 AM, Surveyor #9 and Registered Nurse (Staff #901) reviewed the medication administration record of Patient #903. Patient #903 was admitted on 04/28/23 with a medical diagnosis of diabetes and a psychiatric diagnosis of psychosis. Provider medication orders were entered on 04/28/23 at 4:00 PM for insulin (a medication to treat elevated blood sugar) administration before meals using sliding scale coverage. The orders had no insulin dose for blood sugar greater than 400	L1375		

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L1375	Continued From page 63 milliliters/deciliter and stated to call DR. 3. On 04/29/23 at 7:47 AM, Patient #903 had a blood sugar of 443 milligrams/deciliter. The patient received 10 units of Novolog insulin at 7:51 AM. Surveyor #9 found no evidence of an order for the medication administration. 4. On 04/29/23 at 8:11 AM, Patient #903 received 6 units of Novolog insulin. On 04/29/23 at 9:46 AM, there was a written telephone order that stated TORB-Stephanyan Order for 6 additional units Novolog now for hyperglycemia. The provider signed the order at 9:45 AM. 5. At the time of the review, Staff #901 verified the two insulin medication administrations and stated that the nurse was probably using the order for the blood sugar parameters from 351-400 for the 10 units of insulin administered. Item #4 Hand Hygiene prior to medication administration Based on observation, interview, document review, and review of the hospital's policies and procedures, the hospital failed to ensure staff members followed its policy for safe medication administration for 2 of 2 staff observed passing medication. Failure to follow safe medication administration standards risks disease transmission and patient harm. Findings included: 1. Document review of the hospital's policy titled, "Medication Administration, 1000.37" PolicyStat #10946215, last revised 06/21, showed the	L1375		

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L1375	Continued From page 64 licensed nurse will use proper hand washing techniques prior to handling medication for administration. 2. On 05/02/23 at 2:36 PM, Surveyor #7 observed a Registered Nurse (Staff #702) pass medications to 2 different patients. Staff #702 did not perform hand hygiene prior to passing the medication to either patient. 3. Surveyor #7 interviewed Staff #702 after the second medication pass, Staff #702 verified they had not performed hand hygiene, and that they thought it was ok since she had worn gloves. 4. On 05/02/023 at 2:58 PM, Surveyor #7 observed a Registered Nurse (Staff #703) pass medications to a patient. Staff #703 did not perform hand hygiene prior to passing the medication. 5. Surveyor #7 interviewed Staff #703 at the time of the medication pass, Staff #703 verified they had not performed hand hygiene and they should have. .	L1375		
L1410	322-210.3J PROCEDURES-OUTDATED 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: (j) Prohibiting the administration of outdated or deteriorated drugs, as indicated by label;	L1410		

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L1410	Continued From page 65 This Washington Administrative Code is not met as evidenced by: . Based on interview, observation, and document review, the hospital failed to develop and implement procedures for ensuring that medications do not exceed the manufacturer's expiration date. Failure to monitor and establish a systematic process for ensuring medications do not exceed the manufacturer's expiration date risks deteriorated or potentially contaminated medication being available for patient care. Findings included: 1. Document review of the hospital's policy titled, "Multi-Dose, Single-Dose and Multi-Dose Bulk Medication Containers, 19", PolicyStat #13291710, last approved 04/23, showed the following: Labeling Open Multi-Dose vials a. Opened multi-dose vials are labeled with a beyond-use date or discard date, not the date the vial is opened. b. Attached is an auxiliary label stating: "Discard unused portion after expiration date of_____". c. Label the container with the beyond-use date based on 28 days from the date the vial is opened, the manufacturer's expiration date, or the beyond-use date determined after reconstitution, whichever is shorter. 2. On 05/02/23 at 2:52 PM, Surveyor #7 and a Registered Nurse (Staff #703) observed 2 open	L1410		

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L1410	Continued From page 66 vials of Haldol in a cabinet with other multi-dose/multi-patient medications. The observation showed the following: a. An open 120ml vial of liquid Haldol had a manufacturer's expiration date of 07/31/24 and had a date of 04/30 in blue ink. b. An open 15 ml vial of liquid Haldol had a manufacturer's expiration date of 07/31/24. No date was written on the vial. 3. At the time of the observation Staff #703 stated he was not sure what the date on the 120ml vial of Haldol meant and that if he opened a vial of medication, he would put the date opened. .	L1410		
L1525	322-230.2H FOOD SERVICE-MENU PLANNING WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (h) Ensuring all menus: (i) Are written at least one week in advance; (ii) Indicate the date, day of week, month and year; (iii) Include all foods and snacks served that contribute to nutritional requirements; (iv) Provide a variety of foods; (v) Are approved in writing by the dietitian; (vi) Are posted in a location easily accessible to all patients; and (vii) Are retained for one year; This Washington Administrative Code is not met	L1525		

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L1525	Continued From page 67 as evidenced by: . Based on observation and interview, the hospital failed to post menus of daily meals in a place available to all patients. Failure to post patient menus decreases the availability, providing less time for patients to consider choices and putting patients at risk of harm from inadequate nutrition. Findings included: 1. On 05/04/23 at 2:30 PM, Surveyor #8 toured units West #1, West #2, North, and East specifically looking for the posting of menus. Assistant Administrator (Staff #803) accompanied Surveyor #8. On each unit the menu was not posted and not available for viewing throughout the day. The hospital staff kept the menu on a clipboard made available during mealtimes only. 2. On 05/04/23 at 3:00 PM following a tour of the units, Staff #803 acknowledged that menus were only available during mealtimes. .	L1525		

Rec'd 6.1.23 SHL
Approved 6.5.23

Fairfax Behavioral Health, Kirkland
Plan of Correction for
State Licensing Survey
5/2/23-5/4/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 315 Item #1	Assistant Administrator (AA) met with the Dietary manager on 5/4/23 to discuss findings from this survey related to the requirement that Inpatients and PHP patients must have a nutritional consult based on the nurses' admission screening. Nutritional consults, per hospital policy are completed within 72 hours from provider's order. Additional documentation is required when the RD is unable to complete the nutritional consult within 72 hours to include reason for noncompliance and number of attempts completed. The Dietary Manager will review the Dietary Consult Board on SharePoint daily to ensure all orders for nutritional consult have been completed within the 72 hour requirement including review of failed attempts to connect with the patient are repeated and each attempt is documented in the patients medical record.	Assistant Administrator Dietary Manager	7/3/23	The Dietary Manager will audit 30 dietary consult orders a month to include: 1. Timely completion of assessment. 2. Any attempts to complete the consult are documented in the patients record. 3. If patient was unavailable at the time of the consult, multiple attempts will be made to complete it and all attempts are documented in the patients medical record. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 315 Item #2	The CEO met with the CNO on 5/18/23 to review findings from this survey related to patient's reassessment during detox treatment. All patient's specifically those treated for substance detox require constant assessment and reassessment after medication administration for potential withdrawal symptoms.	CNO	7/3/23	The CNO/designee will review 30 administrations of medications given for withdrawal symptoms monthly to confirm : 3. Assessment of withdrawal symptoms prior to medication administration 4. Assessment of withdrawal symptoms after medication administration per guidelines.

	The CNO/designee re-educated all RN's in June 2023 on CIWA/COWS protocol to include the requirement of patient reassessment after medication administration for withdrawal symptoms per provider orders.			Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 335	Dir. of Pharmacy met with CEO on 5/26/23 to review findings from this survey and confirmed that Pharmacy would be responsible for monitoring all emergency carts for current/expired medications. The Dir. of Pharmacy/designee will perform monthly checks of all emergency carts for current/expired medications. Expired items will be disposed of immediately and replaced.	Dir. of Pharmacy	7/3/23	The Director of Pharmacy will perform monthly checks of all emergency carts in the facility to confirm: 1. All medications are within their manufacture expiration dates. 2. Any medications found to be expired are removed, disposed of and replaced immediately. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 375	The Assistant Administrator (A.A.) met with the EVS manager and all EVS staff on 5/4/23 to discuss findings from this survey and requirements of staff performing hand hygiene after the removal of gloves. The Assistant Administrator re-educated all EVS staff to the appropriate hand hygiene policy prior to donning gloves and after changing gloves. Staff signed an attestation of understanding at the conclusion of their training via sign in sheet.	Assistant Administrator EVS Manager	7/3/23	The EVS manager/designee will perform 30 observations per month of EVS staff to assess: 1. Appropriate hand hygiene is performed after the removal of gloves. All deficiencies will be corrected immediately to include staff retraining in real time. Staff with continued compliance issues may be subject to progressive disciplinary action. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 415	The Director of Risk Management (DRM) met with the CEO and other department leaders responsible for reviewing policies on 5/18/23 to discuss the finding and requirements pertaining to the annual	DRM	7/3/23	A report is printed monthly to include all current Fairfax policies to assess the status of annual reviews completed by the assigned department leader. Monitoring will include: 2. Total number of active policies due for annual review/Total number of active policies.

	review of all policies. The DRM revised the settings on PolicyStat for all Fairfax policies to have their review dates set to be completed annually during the survey. The DRM ensured all policies now have a review date of not greater than 1 year. Effective immediately, the DRM will run monthly reports for "policies due for annual review" and ensure the assigned department leader completes their department's policy reviews in a timely manner.			Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly. Policies found to be out of compliance with their annual review will be addressed by the DRM and the department leader responsible for its review. Target for compliance is 90% or greater for all current polices having been reviewed annually. Monitoring will be ongoing permanently.
L 420	The Director of Outpatient Services met with the CEO on 5/18/23 to review findings from this survey related to the requirement of student supervision. Direct supervision of student's documentation in patient's medical record as required in State requirements. Group note form was revised to include a space for Fairfax staff signature to demonstrate oversight of students or interns. Policy Student Interns, 1 was revised to include, "supervision and oversight of all students and interns will be evident on all medical record documentation as evidenced by the student/interns direct Fairfax supervisors signature accompanying any student/interns signature." PHP staff were re-educated by the Director of Outpatient Services on 5/26/23 on the requirement to sign all documentation completed by students and/or interns demonstrating oversight and supervision per policy.	Director of OPS	7/3/23	30 student and/or intern lead group notes will be reviewed every month by the Director of Outpatient Services to confirm : 1. Student led groups have the designated Fairfax supervisor's signature demonstrating oversight of the group. 2. Fairfax supervisor signature has the same date and time as the group session. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

L 425	Expired items were immediately removed on the day of discovery. The CEO met with the CNO to review findings from this survey related to expired patient care supplies on 5/18/23. The CNO met with nursing leadership to discuss the findings during survey. Nursing Leadership members reassessed all patient care supplies in all patient care areas and removed any items that have expired during the survey. The CNO/designee will monitor the expiration dates of all patient care supplies monthly. Any expired supplies will be immediately discarded and replaced.	CNO Dir of OPT/designee	7/3/23	Nursing leadership and Dir of OPT/designee will assess all patient care items for all med rooms and all exam rooms and the OPS patient care supply storage area monthly and send a report to the CNO/designee for review. Data to be reported: 1. The review of all stocked patient care supplies in all locations in the inpatient and outpatient buildings. 2. The disposal of any expired supplies Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 690 Item #1	The Director of Pharmacy met with the CEO, CNO & CMO on 5/18/23 to review findings and requirements pertaining to reporting antibiotic prescribing/use data to the Infection Control (IC) committee monthly and Pharmacy & Therapeutics Committee (P & T) quarterly. Effective immediately, the Director of Pharmacy is responsible for reporting this data to the Infection Control committee to be reviewed and analyzed monthly. Process improvement activities for measures not meeting compliance goals will be implemented by the committee. The CMO will re-educate the providers on appropriate antibiotic use and the requirement to document the review all antibiotic orders within 72 hours per hospital policy.	Dir. of Pharmacy CNO CMO	7/3/23	The Dir. of Pharmacy will monitor antibiotic use / 72 hour review for all individual providers and report this data to the CMO monthly. The CMO/designee will follow up with individual Providers not meeting compliance with target of 90% or greater. Continued non-compliance may result in progressive disciplinary action. Overall facility compliance percentages will be reported by the Dir. of Pharmacy to IC Committee and P & T monthly. Target for the facilities providers combined 72 hour antibiotic review compliance is 90% or greater. Results of monitoring will be reported to Infection Control Committee, Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

	The CNO/designee will ensure the antibiotic prescribing/72 hour review data is captured in the monthly IC Committee meeting minutes. IC minutes will reflect antibiotic prescribing data is presented and reviewed by the IC committee, action plans implemented for any measures not meeting compliance goals and the revision of the action plans that are not demonstrating improvement in stated goals.			
L 690 Item #2	The CNO met with the CEO on 5/18/23 to review findings from this survey and agreed to meet all Infection control monitoring requirements and meet all infection control goals. The CNO/designee will ensure the Infection Control (IC) committee members are informed of the 2023 infection control plan goals pertaining to hand hygiene data collection, reporting and analyzing all data required to be reported to the IC Committee monthly. Corrective action plans will be implemented for all findings from this survey specific to hand hygiene data collection. Infection Control committee minutes will reflect implementation of action plans and ongoing progress toward compliance goals.	CNO	7/3/23	The CNO/designee will review the monthly Infection Control meeting minutes to ensure: 1. hand hygiene data is collected, reported and analyzed. 2. Hand hygiene action plans are implemented or revised if compliance goals are not met and 3. that these actions are documented in the Infection Control Committee minutes. Target for hand hygiene compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 710	The CEO met with the CNO and A.A. on 5/18/23 to discuss findings from this survey related to the required pre-construction risk assessment require per hospital policy. The A.A. will inform the CNO/designee of all dates, locations, types of construction that are scheduled. The	CNO A.A.	7/3/23	The CNO/designee will ensure all construction projects have completed an ICRA's and will report monthly: 1. Number of scheduled construction activities. 2. Number of indicated/completed ICRA's. Any construction activities found not to have had an ICRA completed prior to the implementation of work by facilities

	CNO/designee and member of facilities will perform the Infection Control Risk Assessment (ICRA) together prior to the scheduled construction date. The A.A. educated all members of the facilities team on the requirements and steps of preforming a pre-construction risk assessment on 5/18/23.			staff (i.e. emergency repairs) will have one completed as soon as possible. Target for compliance is 90% or greater. Results of monitoring will be reported to Infection Control Committee, EOC, Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 715	Dir. of Pharmacy met with the CNO and CEO on 5/26/23 to review findings from this survey related to removal of expired medication supplies identified during survey. The Dir. of Pharmacy/designee will perform monthly checks of expired medications supplies. All expired items will be disposed of and replaced immediately. New orange expirations stickers were provided to all units and instructions on the proper labeling of glucometer solution was posted on all units during survey. The CNO/designee provided re-education June 2023 to nursing staff to include proper labeling of glucometer solution and strips using the orange tags, each tag will be labeled with exp dates of solution/strips upon opening.	Dir of Pharmacy CNO	7/3/23	The Director of Pharmacy will perform monthly checks of all open glucometer solutions and glucometer strips in the facility to ensure: 1. All open glucometer solutions and strip containers have appropriate expiration dates documented on them. 2. Any glucometer solution or strip containers found to be expired are removed, disposed of and replaced immediately. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months
L 780	All issues identified during survey were corrected on 5/17/23. The CEO met with the A.A on 5/18/23 to review findings from this survey related to lack of cleanliness identified during this survey The CNO/designee will perform monthly IC rounds and the A.A./designee will perform monthly EOC rounds in all patient areas to	A.A. CNO	7/3/23	The A.A/designee will report the following: 1. Number of damaged furniture items or dirty surface areas discovered on EOC rounds per month. 2. Number of work orders placed for damaged furniture or uncleanable surfaces per month. 3. Any work orders that have not been addressed in a timely manner or repeat findings on monthly assessments. The CNO/designee will report the following:

	assess for damaged surfaces, damaged furniture or dirty surfaces. Work orders will be implemented for any damaged surface or furniture in need of repair as they are discovered.			1. Number of damaged furniture items or uncleanable surface areas discovered on IC rounds per month. 2. Number of items that were also listed the previous month (repeat findings) Target for compliance is 90% or greater. Results of monitoring will be reported to Infection Control Committee , Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1050	The CEO met with the CNO on 5/18/23 to review findings from this survey related to the completion of the initial nursing care plan upon admission. The CNO/designee provided re-education to all RN's June 2023 on Policy, "Plan for Provision of Care-Scope of Services" with an emphasis on the section on initial nursing treatment plan completion.	CNO	7/3/23	The CNO will audit 30 medical records a month to ensure: 1. The initial nursing treatment plan is completed within 8 hours of admission 2. If unable to complete or if there are blanks on the treatment plan the reason is documented. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1055	The CEO met with the CMO on 5/18/23 to discuss findings from this survey related to completion and documentation of history and physicals. The CMO re-educated all providers on 6/18/23 on the requirement to ensure documentation for all physical exams is accurate, to review documentation prior to filing it in the patients medical record and not to utilize pre-filled templates.	CMO	7/3/23	The CMO/designee will review 30 charts a month from the OPT program to ensure: 1. H & P's are completed and accurate 2. H & P's done over Zoom or virtually do not contain elements that would require an in person visit. 3. H & P's are not pre-filled or contain pre=printed text. Target for compliance is 90% or greater. Results of monitoring will be reported to QC & MEC monthly, GB quarterly until compliance goals have been sustained for a minimum of 3 consecutive months.
L 1065 Item #1	The CEO met with the Director . of OPS on 5/18/23 to review the findings from this	Director of OPS	7/3/23	30 charts per month will be audited for PHP/OPS patients treatment plans to ensure:

	survey related to individualized treatment plans for patients participating in the PHP treatment program. The Director of OPS met with staff on 5/26/23 to discuss findings and documentation requirements. Effective immediately, staff will ensure all patients have individualized treatment plans initiated according to hospital policy to include all current diagnosis listed on the patients Psych eval and H & P. The staff will ensure all problems/diagnosis listed on the master treatment plan have individual treatment plans initiated for each active diagnosis with interventions and short/long term goals per hospital policy.			1. All current diagnosis listed in the patients Psych Eval and H & P is captured in the patients Master treatment plan. 2. Individualized treatment plans are initiated for each active diagnosis with interventions and short/long term goals per hospital policy. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1065 Item #2	The CEO met with the Director of OPS on 5/18/23 to review findings from survey related to review of treatment plan with the patients and required documentation. Dir of OPS met with staff on 5/26/23 to discuss findings and documentation requirements related to patient's involvement in their treatment. Effective immediately, staff will ensure all patients have their treatment plans reviewed over Zoom, if they are virtually attending, and document the review, participation in treatment planning and approval of the plan with the patient in the MR.	Director of Outpatient Services	7/3/23	The Director of OPS will review 30 PHP patients records per month to ensure: 1. Documentation on the treatment plan demonstrates the treatment plan was reviewed with the patient virtually as evidenced by staffs signature on the treatment plan specifically noting the date and time of the review with the patient and their level of participation in planning. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1070	The CEO met with the CNO on 5/18/23 to review findings from this survey related to safe medication administration. The CNO/designee provided education to nursing staff June 2023 regarding safe medication administration and notification of critical lab values to the providers per	CNO	7/3/23	Total # of critical results/total # proper notifications. CNO/Designee will review critical lab values logs weekly to ensure: 1. Proper and timely notification of a critical lab value to Provider is noted in the critical lab values log. 2. Documentation of provider notification of a critical lab value is also evident in the patients medical record.

	hospital policy. CNO/Designee will review critical lab values logs weekly to ensure proper timely notification and documentation of results to the provider.			Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1295 Item #1	The group therapists met with the COO/Interim DCS on 5/16/23 to discuss findings from this survey and requirements for group documentation. . The COO/Interim DCS re-educated the group therapists on documentation requirements for all groups to include: 1.documenting one group per note, 2.no sections of group notes are left blank, 3.each patient's note is individualized and accurately reflects the patients attendance/participation in the group 4. do not contain "canned" statements. The CNO re-educated the nursing staff including Registered Nurses and MHTs on (insert date) to the requirements to accurately document each patient's group attendance on their daily progress note.	COO/Interim DCS CNO	7/3/23	The COO/Interim DCS and/or designee will review 30 group notes per month to ensure: 5. One group is documented per note. 6. No sections are left blank on the group note. 7. Documentation is individualized and does not contain "canned" statements. 8. Documentation demonstrated the patients attendance/participation in the group. The CNO will review 30 nursing progress notes a month and compare them to the rounding sheets to ensure: 2. Nursing documentation accurately reflects the patients group attendance. Target for compliance is on the above measures is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals are achieved and sustained for a minimum of 3 consecutive months.
L 1295 Item #2	CMO met with the CEO to review findings from this survey related to the completion of medical consults in patient's records. The CMO re-educated the providers on requirement to complete consults as ordered and to ensure consults not completed have documentation in the patient's medical record to explain why the consult was not completed.	CMO	7/3/23	The CMO/designee will audit 30 charts a month that have medical consults ordered to ensure: 1. The ordered medical consult has corresponding documentation from the medical provider in the patients medical record. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

L 1375 Item #1	The CEO met with the Dir. of Pharmacy and the CNO on 5/18/23 to review findings from this survey related to the proper and safe medication administration. The CNO provided education to all LPN/RN's June 2023 pertaining to high-risk medication administration and 2 RN verification documentation requirements in HCS. Nursing staff were reminded that the times entered for 2 RN verification must be prior to the administration of drug.	CNO	7/3/23	The CNO/designee will review the documentation of 30 administration of medications requiring 2 RN verification to ensure: 1. The 2 RN verification was completed. 2. The time stamp of the 2 RN verification was prior to the administration of the medication. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1375 Item #2	The CEO met with the CNO 5/18/23 to review findings from this survey related to nursing's assessment of pain prior to medicating patients and post pain medication administration. . The CNO provided re-training to nursing staff June 2023 regarding the requirement to document the assessment and reassessment of pain levels pre and post medication administration.	CNO	7/3/23	The CNO/designee will audit 30 patient records a month to ensure: 1. Patients who receive pain medication have a pain level assessment documented in their medical record prior to the administration of pain medication. 2. Patients who receive pain medication have a pain level re-assessment documented in their medical record after the administration of the medication. 3. All deficiencies will be corrected immediately to include staff retraining as needed. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1375 Item #3	The CEO met with the CNO 5/18/23 to review findings from this survey related to confirming current provider's orders prior to medication administration. The CNO provided training to nursing staff June 2023 regarding ensuring medication orders, emphasizing insulin orders, are	CNO	7/3/23	The CNO will review 30 medical records of patients who have received insulin to ensure: 1. The patient had an order for the medication that was administered. 2. All deficiencies will be corrected immediately to include staff retraining as needed. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive

	documented in the paper medical record as well as HCS.			Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1375 Item #4	The CEO met with the CNO 5/18/23 to review findings from this survey related to proper hand hygiene by nursing staff prior to medication administration. Nursing staff were re-trained by the CNO June 2023 on Fairfax's requirements for medication administration which includes; proper hand hygiene between administering medications to patients and/or prior to medication administration. Staff signed an attestation of understanding at the conclusion of their training.	CNO	7/3/23	CNO/designee will observe 30 medication passes a month to ensure: 1. Staff perform hand hygiene prior to medication pass. 2. All deficiencies will be corrected immediately to include staff retraining as needed. Target for compliance is 90% or greater. Results of monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.
L 1410	Dir. of Pharmacy met with the CNO and CEO on 5/26/23 to review findings from this survey related to removal of expired medication supplies identified during survey. The Dir. of Pharmacy/designee will perform monthly checks of expired medications/ supplies. All expired items will be disposed of and replaced immediately. New orange expirations stickers were provided to all units and instructions on the proper labeling was posted on all units during survey. The CNO/designee provided re-education June 2023 to nursing staff to include proper labeling of multi-dose medications using the orange tags, each tag will be labeled with exp dates upon opening.	Director of Pharmacy CNO	7/3/23	Pharmacy will monitor all open multi-dose vials in all medication rooms monthly to ensure: 1. Multi-dose vials that have been opened have the correct expiration date written on the vial. 2. Multi-does medication vials with no expiration date or incorrect expiration dates will be discarded. Target for compliance is 90% or greater. Results of monitoring will be reported to QC & MEC monthly, GB and P&T quarterly until compliance goals have been sustained for a minimum of 3 consecutive months.

L 1525	On 5/4/23 the Assistant Administrator (AA) placed current menus on all units. On 5/4/23 the AA met with the Dietary manager to discuss this finding and the hospital requirement to post weekly menus on each unit. The Dietary Manager will ensure all patient care areas have the current menu posted in an area that is available to all patients. Dietary staff were re-educated by the Dietary Manager on 5/25/23 regarding the requirement to post menus in a place available to all patients. The CNO/designee informed all nursing staff in June 2023 that staff will no longer keep menus on clipboards. Dietary staff will ensure menus are posted in areas that patients have access to them.	A.A. Dietary Manager	7/3/23	The Dietary manager will assess each patient care area monthly to ensure: 1. Current menus are posted and accessible to patients at all times. Target for compliance is 90% or greater. Results of overall compliance monitoring will be reported to Quality Council and Medical Executive Committee monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months.

Print: Christopher West, CEO Signature: Date: 7/30/23

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

August 15, 2023

Janet Huff, RN
10200 NE 132nd St
Kirkland, WA 98034

Dear Ms. Huff,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Fairfax Kirkland Behavioral Health Hospital on 05/02/23 to 05/04/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 06/05/23.

Hospital staff members sent a Progress Report dated 08/03/23 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Kirkland 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

Samantha Roe, MSN, RNC-OB
Survey Team Leader