STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012792	A. BUILDING _____ B. WING _____	12/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS This State Hospital Licensing Survey was conducted on 12/12/2016-12/14/2016 by Lisa Mahoney MPH, PHA and Cathy Strauss, BSN, RN. The Washington Fire Protection Bureau conducted the fire life safety inspection on 12/13/2014. ASE# QJR011 RECEIVED JAN 27 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 business days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 1/16/2017. 4. Return the ORIGINAL REPORT with the required signatures.	
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing:	L 690	RECEIVED JAN 17 2017 DEPARTMENT OF HEALTH Office of Investigation and Inspection	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

R Richards CEO 1/13/17

Plan of Correction received 1-17-2017 CStrauss 1-30-17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 690	Continued From Page 1 (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: Based on observation, interview and review of hospital policies and procedures, the hospital failed to ensure staff performed hand hygiene according to hospital policies. Failure to follow infection control practices risks transmitting infections to staff and patients. Findings: 1. The hospital policy titled "Hand hygiene" (Policy #1600.4.4, revised 11/2016) read in part; " 1. Employees are required to wash hands thoroughly: 1.3- before and after each patient contact. 1.4-After contact with potentially contaminated environmental surfaces. " 2. On 12/12/2016 at 2:00 PM, Surveyor #1 observed the Medication Nurse (Staff Member #9) exit the medication room with three pills in a med cup and a bottle of hand sanitizer. The licensed nurse used the door handle with a bare hand, and walked down to the activity room where s/he addressed a patient and confirmed their identity. S/he then offered hand sanitizer to the patient who performed hand hygiene. The staff proceeded to deliver medications to the patient, but failed to perform hand hygiene prior to or after the medication administration. 3. On 12/13/2016 at 1:30 PM, Surveyor #1 observed the medication nurse (Staff Member #2) in the medication room. After performing hand hygiene the med nurse proceeded to remove a	L 690		

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L 690	Continued From Page 2 patient's medication from the Pyxis and placed into a med cup. The nurse used the door handle to exit the med room door and attempted to locate the patient. The nurse did not find the patient in the activity room, nor in the patient's room. The nurse then exited the security door to the stairwell and walked down to the first floor. The patient was located eating in the lunchroom. There was no hand sanitizer readily available.	L 690		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to perform electrical safety checks on patient-owned equipment used during the patient's hospital admission. Failure to ensure the safety of all electrical equipment used by patients in the hospital puts patients, staff, and visitors at risk from injury for electrical shock or fire. Findings: 1. The facility's contracted bio-medical engineering service policy titled "Electrical Safety Testing", (effective date: August 15, 2015) stated, "Electrical safety testing will be performed in compliance with NFPA 99 2005 and ANSI/AAMI E60601-1:2005." The scope of the policy indicated the policy affects all equipment inspected, repaired, or managed by the contractor. 2. On 12/12/2016 at 12:20 PM, Surveyor #2	L 780		

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L 780	Continued From Page 3 interviewed the Facilities Director (Staff Member #12) about safety checks on patient-owned equipment, following observation of patients' C-Pap (breathing) machines present in patient rooms. The staff member indicated there was no process for engineering staff to evaluate patient-owned items for safety prior to use in the facility.	L 780		
L1220	322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records. (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records; This RULE: is not met as evidenced by: . Based on interview and review of the medical records, the hospital failed to develop an effective process to ensure medical records were accurate, complete, and timely, as demonstrated by 7 of 11 charts reviewed (Patients #1, #2, #3, #4, #5, #6, #7). Failure to ensure medical records are accurate and complete risks medical errors, which can misdirect caregivers and / or result in patient harm. Findings: 1. Hospital policy titled "Charting Requirements" (Policy #1000.87, revised 11/2016) read in part "1, A. ...RN Nursing Assessment is initiated on	L1220		

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L1220	Continued From Page 4 admission and completed within 8 hrs. " and " 3- each note needs to be signed, dated and timed ...' 2. On 12/13/2016 at 9:00 AM, Surveyor #1 noted the following variances; a. Patient #7, was admitted 12/8/2016. The nursing assessment was unsigned, undated with no time listed, and remained incomplete as of 12/12/2016. b. Treatment plans were not present in the medical records of Patients #1, #3, #4, and #5 at the time of review. The Charge Nurse (Staff Member #3) reported "someone must have it" that "sometimes they are taken downstairs to an office." c. Restraint and seclusion (R/S) records remained incomplete for Patients #4 and #6. No face to face record was present for Patient #6. Patient response to interventions were unmarked and signatures were untimed on 12/7/2016. The checklist for R/S was incomplete for Patient's #4 and #6. d. There were two provider notations on the Psychiatric Admission Evaluation for Patient #7. One Psychiatrist (Staff Member #8) signed the document but there was no signature authentificating or identifying the second provider. Staff Member #8 reported that the second provider was an extern, and that s/he would instruct them to authenticate their entries. e. Physicians orders were unsigned for Patient #2. 3. On 12/13/2016 at 11:00 AM, Staff Member #6 acknowledged that there were not enough staff available for overseeing the medical record process and confirmed the above findings.	L1220		

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L1415	322-210.3K PROCEDURES-RESTRICTED ACCESS 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: (k) Restricting access to pharmacy stock of drugs to: (i) Legally authorized pharmacy staff; and (ii) Except for Schedule II drugs, to a registered nurse designated by the hospital when all of the following conditions are met: (A) The pharmacist is absent from the hospital; (B) Drugs are needed in an emergency, and are not available in floor supplies; and (C) The registered nurse, not the pharmacist, is accountable for the registered nurse's actions; This RULE: is not met as evidenced by: . Based on interview and review of pharmacy and medication service policies, the hospital failed to follow hospital policy for medication errors. Failure to follow policies and procedures for medication errors risks the well being of the patients, potentially resulting in patient death. Findings: 1. The hospital policy titled "Medication Variances" (Policy #1000.41; Revised 11/2016) read in part; "1.1- In the event that a medication variance occurs or is discovered, it is the responsibility of nursing staff to: 1.1.1- Ensure patient safety by monitoring patient as appropriate, 1.1.2- Notify the physician ...of the nature and severity of the variance as appropriate,	L1415		

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L1415	Continued From Page 6 1.1.3- Notify his/her immediate supervisor, and 1.1.6- Document all of the above in the patient's medical record." 2. On 12/14/2016 at 8:00 AM, Surveyor #1 reviewed the medication variance report for Patient #8. The report stated that on 8/29/2016 at 10:39 PM the patient received a second dose of an antidepressant by the medication nurse (Staff Member #9) The medication nurse reported that he/she had repeated the second dose without first checking the medication orders. 3. On 12/14/2016 at 8:00 AM, Surveyor #1 reviewed Patient #8's medical record and failed to find documentation in the chart that the nurse notified the patient's physician, and his/her supervisor regarding the medication error. There was no evidence that the patient had been monitored for a reaction to the overdose of medication. 4. On 12/14/2016 at 9:30 AM, Surveyor #1 interview with Registered Nurse Manager (RN) (Staff Member #7) confirmed there was no chart documentation of the medication error, only on the variance report. The RN was unaware of any follow up with managers or staff.	L1415		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to comply with chapters 246-215,	L1485		

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L1485	Continued From Page 7 Washington Administrative Code (WAC) for food service. Failure to remain compliant with the Washington State Retail Food Code puts patients, staff and visitors at risk from food-borne illness. Findings: All findings occurred during observation of patient breakfast service on 12/13/2016 between 8:35 and 9:00 AM and during a tour of the contracted Dietary Department on 12/13/2016 between 10:45 and 11:30 AM: 1. At 8:54 AM, Surveyor #2 observed a food service worker (Staff Member #10) as s/he completed removal of soiled dining items from the first breakfast service. Once the staff member finished this task, s/he changed gloves and began to set up for the second breakfast service. The staff member failed to do hand hygiene between glove changes. Reference: Washington State Retail Food Code, WAC 246-215-02310 (5) 2. At 11:15 AM, Surveyor #2 observed cooked turkey breast in the walk-in cooler. The Dietary Manager (Staff Member #11) indicated that cook staff had cooked the turkeys on site and cooled them for later use, using time and temperature controls. Upon review of the cooling logs, the surveyor identified 4 items(beef ribs, 12/10, turkey, 12/10, beef ribs, 12/12, potatoes, 12/13) whose internal temperature records indicated were above the maximum allowable temperature of 70 degrees Fahrenheit after 2 hours of cooling, although they were below 41 degrees Fahrenheit within 6 hours of cooling. The log contained no	L1485		

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L1485	Continued From Page 8 documentation of staff member's corrective action to reduce the temperature at the 2-hour deadline. Reference: Washington State Retail Food Code, WAC 246-215-03515 (1) (a)	L1485		

Fairfax Behavioral Health Monroe (012792)
Plan of Correction for State Licensing
12/12/2016 to 12/14/2016

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
L690	**322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control.** The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: Based on observation, interview and review of hospital policies and procedures, the hospital failed to ensure staff performed hand hygiene according to hospital policies. Failure to follow infection control practices risks transmitting infections to staff and patients.	The Infection Control Nurse provided in person re-training to all nursing staff regarding the hand hygiene policy on 1/13/17. The Nurse Manager or designee will conduct daily, random hand hygiene observations. These observations will include at least one weekly medication administration. Compliance to the hand hygiene policy will be reported to the Infection Control Nurse. The Nurse Manager will perform immediate re-training with staff who do not meet expectations for hand hygiene compliance. The Infection Control Nurse will continue to collect hand hygiene surveillance data and report results to the Infection Control Committee and Quality Council. Data reporting will include hand sanitizer usage beginning 1/13/17.	Infection Control Nurse; Pharmacy Director	1/13/17	The Nurse Manager or designee will conduct daily random hand hygiene observations, including at least one medication administration weekly, and report compliance to the Infection Control Nurse. The Pharmacist will also observe one medication administration weekly to assess compliance and report results to the Infection Control Nurse. The Nurse Manager will perform immediate re-training with staff who do not meet expectations for compliance. The target for compliance is 90%.	85%

plan of correction received 1-17-17 and approved 1-30-17 - CStrauss rn

Fairfax Behavioral Health Monroe (012792)
Plan of Correction for State Licensing
12/12/2016 to 12/14/2016

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
L780	**322-120.1 SAFE ENVIRONMENT** **WAC 246-322-120 Physical Environment.** The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This RULE: is not met as evidenced by: Based on document review and interview, the hospital failed to perform electrical safety checks on patient-owned equipment used during the patient's hospital admission. Failure to ensure the safety of all electrical equipment used by patients in the hospital puts patients, staff, and visitors at risk from injury for electrical shock or fire.	The existing process was revised effective 1/13/17 that Plant Operations will be notified by the admitting RN upon admission of a patient with patient-owned equipment, so that a safety check may be performed. Staff were re-trained to the process by the Facilities Director at the unit meeting on 1/13/17.	Facilities Director	1/13/17	Compliance to be monitored during monthly EOC Rounding. The target for compliance is 100%.	95%

Fairfax Behavioral Health Monroe (012792)
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L1220	**322-200.1A RECORDS-MANAGEMENT WAC 246-322-200 Clinical Records.** (1) The licensee shall establish and maintain an organized clinical record service, consistent with recognized principles of record management, directed, staffed, and equipped to: (a) Ensure timely, complete and accurate identification, checking, processing, indexing, filing, and retrieval of records; This RULE: is not met as evidenced by: Based on interview and review of the medical records, the hospital failed to develop an effective process to ensure medical records were accurate, complete, and timely, as demonstrated by 7 of 11 charts reviewed (Patients #1, #2, #3, #4, #5, #6, #7). Failure to ensure medical records are accurate and complete risks medical errors, which can misdirect caregivers and / or result in patient harm.	The Monroe Nurse Manager re-trained clinical staff regarding the Charting Requirements Policy, including the requirement to sign, date, and time each note. On 1/11/17, an enhanced process of utilizing deficiency slips for missing documentation was implemented. The Chief Medical Officer provided re-training via email notification to all medical staff on 12/22/16 regarding the hospital policy and Medical Staff By Law requirements related to Practitioners signing physician orders in the clinical record, authenticating records. The Chief Medical Officer reviewed the hospital policy and Medical By Law expectations related to Practitioners signing physician orders in the clinical record at the Medical Staff Meeting on 12/15/16. A chart audit is completed every night to ensure Practitioners have signed all physician orders. Physician orders not signed are flagged for physician signature the following day.	Assistant Director of Nursing; Chief Medical Officer; Manager of Case Management	1/11/17	Daily NOC shift audits identify missing documentation and generate deficiency slips for follow-up. Monthly chart audits will be conducted to ensure the accurate, timely, and complete documentation in the medical record. Target for compliance is 90%. A random weekly chart audit will be conducted by Utilization Management Staff to ensure the presence of treatment plans in patients' medical records. Target for compliance is 90%.	90%

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
L1220 (cont)		The HIM Manager completes a monthly random chart audit to include Practitioners signing physician orders. The HIM Manager forwards the names of any providers found in the monthly chart audits or other auditing mechanisms to be out of compliance with documentation requirements to the Chief Medical Officer for follow-up with that individual provider. The Chief Medical Officer oversees the monitoring of compliance with clinical records. Members of the medical staff documentation compliance are reviewed monthly in Medical Staff Committee via the established Ongoing Professional Practice Evaluation. On 1/11/17, the Manager of Case Management re-trained all Case Managers, in person, regarding the need to keep treatment plans in patients' medical records.				

Fairfax Behavioral Health Monroe (012792)
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L1415	**322-210.3K PROCEDURES-RESTRICTED ACCESS** **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: (k) Restricting access to pharmacy stock of drugs to: (i) Legally authorized pharmacy staff; and (ii) Except for Schedule II drugs, to a registered nurse designated by the hospital when all of the following conditions are met: (A) The pharmacist is absent from the hospital; (B) Drugs are needed in an emergency, and are not available in floor supplies; and (C) The registered nurse, not the pharmacist, is accountable for the registered nurse's actions; This RULE: is not met as evidenced by: Based on interview and review of pharmacy and medication service policies, the hospital failed to follow hospital policy for medication errors. Failure to follow policies and procedures for medication errors risks the well-being of the patients, potentially resulting in patient death.	The Monroe Nurse Manager re-trained nursing staff on 1/13/17 to the Medication Variance Policy.	Pharmacy Director; Assistant Director of Nursing	1/13/17	The Nurse Manager will audit all medication variances to ensure adherence to the Medication Variance Policy. Target for compliance is 90%.	85%

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L1485	**322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services.** The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This RULE: is not met as evidenced by: Based on observation and interview, the facility failed to comply with chapters 246-215, Washington Administrative Code (WAC) for food service. Failure to remain compliant with the Washington State Retail Food Code puts patients, staff and visitors at risk from food-borne illness.	All kitchen/food service workers were re-trained on the Handwashing & Personal Cleanliness Policy and the Food Safety Standards & Requirements Policy on 12/22/16 by the General Manager of Sodexo Healthcare at Evergreen Health Monroe.	COO	12/22/16	Compliance to be monitored during monthly EOC Rounding. The target for compliance is 100%.	95%

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

1/30/2017

Darcie Johnson, Director of Quality
BHC Fairfax Hospital
10200 NE 132nd Street
Kirkland, WA 98034

Dear Ms. Johnson,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Monroe BHC Fairfax Psychiatric Hospital on 12/12/2016 to 12/14/2016. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 1/30/2017.

A Progress Report is due on or before ~~4/30/2017~~ 3/15/2017 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

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

Cathy Strauss BSN, RN
Department of Health, Investigations and Inspections Office
P.O. Box 47874
Olympia, Washington 98504-7874

Please contact me if you have any questions. I may be reached at 360-236-2920. I am also available by email at Cathy.Strauss@doh.wa.gov
Sincerely,

Cathy Strauss
Survey Team Leader