State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013260	A. BUILDING: 02 B. WING ______	09/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This report is the result of an unannounced Fire and Life Safety state survey conducted at the Inland Northwest Behavioral Health on September 27, 2022 by a team of representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) health survey teams. The facility has a total of 100 beds and at the time of this survey the census was 71. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a II construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Deputy State Fire Marshal Kimberly Bloor PO Box 42642 Olympia, WA 98501	S 000		
S 300	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3	S 300		

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

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S 300	Continued From page 1 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based upon observations, documentation review, and staff interviews on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to maintain their facility in accordance with NFPA 101 (2012) 18.3. This could lead to the rapid spread of smoke and fire throughout the facility and expose patients, staff, and visitors to these fire dangers. The findings include: The room 1128 had electrical and IT equipment and had a large penetration above the door into the conference room. The facility could not produce plans to determine if the wall was rated. The EVS closets on the 2nd and 3rd floor were missing 1/2 of right wall, leaving only 1 sheet of sheetrock. The facility will produce plans to determine if the walls need additional sheetrock. The above was discussed and acknowledged by the facility staff.	S 300		

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S 362	Continued From page 2	S 362		
S 362	NFPA 101 Corridors Construction of Walls Corridors - Construction of Walls 2012 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.2 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to maintain corridors construction as capable of resisting smoke. This could result in toxic products of combustion getting into the room or into the exit corridor in the event of a fire which would endanger the patients, staff and/or visitors within the smoke compartment. The findings include: All patient wings had a pharmacy pass through that is approximately 2x4 feet. The facility could not provide documentation that the windows were fire rated. The above was discussed and acknowledged by the facility staff.	S 362		

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S 374	Continued From page 3	S 374		
S 374	NFPA 101 Subdivision of Building Spaces Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1-3/4 inch thick solid bonded core wood. Required clear widths are provided per 18.3.7.6(4) and (5). Nonrated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal-sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels, or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.6, 18.3.7.7, 18.3.7.8 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to properly maintain fire/smoke barriers doors within the facility as capable of resisting the passage of smoke. This could result in the products of combustion traveling from one smoke compartment to another which would endanger the patients, staff, and/or visitors within the	S 374		

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S 374	Continued From page 4 facility. The findings include: The doors by room 3421 did not close. The above was discussed and acknowledged by the facility staff.	S 374		
S 711	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately	S 711		

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S 711	Continued From page 5 1300 to 1630 hours the facility has failed to maintain a written plan for the protection of all patients, staff and visitors and for their evacuation in the event of an emergency. At a minimum a written care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarms to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire The findings include: The fire response plan did not include an emergency call to 911. The above was discussed and acknowledged by the facility staff.	S 711		
S 918	NFPA 101 Electrical Systems Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator.	S 918		

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S 918	Continued From page 6 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to maintain and test the emergency generator in accordance with NFPA 110. This could result in a failure of the emergency power system which would leave the facility without egress and task lighting in the event of a power failure which would endanger the patients, staff, and/or visitors within the facility. The findings include: October 2021 and March-July 2022 monthly generator runs did not include a start and stop time to determine the how long the runs were for. The above was discussed and acknowledged by the facility staff.	S 918		
S 920	NFPA 101 Electrical Equipment Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for	S 920		

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S 920	Continued From page 7 non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility failed to restrict the use of extension cords and non-approved power strips in their facility. This could endanger patients, staff, and visitors in the facility due to the increased fire risk. The findings include: 2203 has a refrigerator, microwave and water cooler in power-strip. 2205 has a refrigerator in power-strip.	S 920		

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S 920	Continued From page 8 2104 extension cord in use for a refrigerator. The above was discussed and acknowledged by the facility staff.	S 920		
S 923	NFPA 101 Gas Equipment Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must	S 923		

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S 923	Continued From page 9 be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to maintain construction of oxygen storage areas as being smoke and fire resistant. This could result in the products of combustion traveling from the hazardous area into the exit corridor in the event of a fire which could endanger patients, first-responders, staff, and/or visitors. The findings include:	S 923		

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S 923	Continued From page 10 The oxygen storage room had cardboard within 5 feet of the cylinders, including touching the cylinders. The above was discussed and acknowledged by the facility staff.	S 923		
S 926	NFPA 101 Gas Equipment Qualifications and Training Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview on September 27, 2022 between approximately 1300 to 1630 hours the facility has failed to provide documentation of personnel concerned with the application, maintenance, and handling of medical gases and cylinders that are trained on the risk and provide continuing education. Failure to provide training and continuing education on the safe handling and use of gases and cylinders could place patients, visitors, and staff at risk of oxygen malfunctions.	S 926		

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S 926	Continued From page 11 The findings include: The facility could not produce evidence of staff training on the risk and use of compressed gas cylinders. The above was discussed and acknowledged by the facility staff.	S 926		

Inland Northwest Behavioral Health

Plan of Correction
Received 10/24/22
approved 10/25/22 - Health
FM POC approved 11/8/22
[signature] 10/25/22

Plan of Correction for
State Licensing Hospital Survey
09/21/2022-9/23/2022 & 9/27/2022

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L345	**323-035.1i POLICIES-PHARMACY** The CEO, the CNO, the Director of PI and the Director of Pharmacy met to review the Automated Drug Distribution Device Policy and no changes were needed to this policy. The Pharmacy staff and Nursing staff were retrained to the Automated Drug Distribution Device Policy to confirm compliance with controlled substances needing to be in a locked cabinet and needing to be counted every 12 hours. Training was initiated by the Director of Pharmacy and the CNO and completed by 11/1/2022.	Director of Pharmacy Chief Nursing Officer	11/26/2022	100% of controlled substance count logs will be monitored to confirm compliance with counting the controlled substances every 12 hours. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L375	**322-035.1o POLICIES-HOUSEKEEPING** The CEO, the Director of PI, and the Director of Plant Operations met to review the Discharge Cleaning of Patient Rooms Policy, no revisions needed at this time. The Housekeeping staff were retrained to the Discharge Cleaning of Patient Rooms Policy specific to locking the cart during the room cleaning. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	Director of Plant Operations	11/26/2022	The Director of Plant Operations will monitor 100% of the housekeeping carts for being locked while cleaning. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%

L390	**322.-035.1R POLICIES-PATIENT TRANSFER** The CEO, the Director of PI and the CNO met to review the current Emergency Services and Patient Transfer Policy, no revisions needed at this time. The Nursing staff were retrained to the Emergency Services and Patient Transfer Policy specific to the patient receiving an explanation of risks and benefits and the patient consenting to transfer. Training was initiated by the Chief Nursing Officer and completed on 11/1/2022.	Chief Nursing Officer	11/26/2022	The Chief Nursing Officer will monitor 100% of medical send outs for having an explanation of risks and benefits and for a consent to transfer. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L425	**322-040.2 ADMIN-STAFF PROVISIONS** The CEO, the CNO, the Director of PI and the Director of Clinical Services met to review the current Format and Content of the Record Policy and the Active and Individualized Treatment Policy, no revisions needed at this time. The Clinical Service staff and Nursing staff were retrained to the Format and Content of the Record Policy specific to the patient attending 4 hours of programming a day including 2 hours by a licensed therapy/social services staff, 1 hour of Activity Therapy, 1 Psychoeducation group held by licensed hospital staff such as trained registered Nurses. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022. The Providers, Clinical Service staff and Nursing staff were retrained to the Active and Individualized Treatment Policy specific to active treatment services must be provided 7 days a week and supervised and evaluated by a physician who is the leader of the treatment team. Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022.	Director of Clinical Services Chief Nursing Officer	11/26/2022	The Director of Clinical Services and the Chief Nursing Officer will monitor 100% of group notes for providing 7 days a week of active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%

	To address the active programming on the weekends the Director of Clinical Services has moved a MSW schedule to cover on Sundays. She has hired a MSW that will be working on Saturdays. This MSW starts orientation on 10/31. There is also a MSW Student that is working on weekends too. She hired a new Activity Therapist to work on Sundays. A Recreational Specialist under the director of the Recreational Therapist will be working on Saturdays. We contracted with a Yoga Instructor to provide Yoga on the weekends. We still have one MSW and one RT per diem positions posted.			
L805	**322-120.6A WATER-BACKFLOW** The CEO, the Director of PI and the Director of Plant Operations met to review the Follett Symphony Plus ice machine manufacturer's instructions for use. The Maintenance Technician and the Director of Plant Operations fixed the slope of the drain lines immediately. The Maintenance Technician was retrained to the ice machine manufacturer's instructions specific to the drain lines should be sloped ¼ inch per foot. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	Director of Plant Operations	11/26/2022	The Director of Plant Operations will monitor 100% of the ice machine drain lines to slope ¼ inch per foot. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%
L1065	**322-170.2E TREATMENT PLAN-COMPREHENSIVE** The CEO, the CNO, The Medical Director, the Director of PI and the Director of Clinical Services met to review the Treatment Planning Policy, no revisions needed at this time. The Providers, Clinical Services staff and the Nursing staff were all retrained on the Treatment Planning Policy specific to addressing any acute, chronic/stable, and/or deferred/referred medical problems on the Master Treatment Plan.	Medical Director Director of Clinical Services Chief Nursing Officer	11/26/2022	The Director of Clinical Services and the Chief Nursing Office will monitor 100% of the Treatment Plans for compliance with addressing medical problems and updating treatment plans when there is a change of status. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly.

	Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022. The Providers, Clinical Services staff and the Nursing staff were all retrained on the Treatment Planning Policy specific to updating the Master Treatment Plan when a change in the patient's status occurs. Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022.			Target compliance is >/= 90%
L1265	**322-200.3F RECORDS-OBSERVATIONS** The CEO, Medical Director, the CNO and the Director of PI met to review the Medical Staff Rules and Regulations, no revisions needed at this time. All Providers were retrained to the Medical Staff Rules and Regulations specific to needing to document medical consultations and this documentation must include reason for consult, medical evaluation and results of the evaluation, treatment rendered, response to treatment, outcome of treatment, response to medication and the must be dated, timed, and signed whenever they see a patient. Providers not present at this training were individually retrained by the Medical Director and provided a copy of the MS Rules and Regulations for their review. Training was initiated by the Medical Director and Director of PI and completed on 11/1/2022.	Medical Director Director of PI	11/26/2022	The Medical Director and Director of PI will Monitor 100% of the medical consult orders for compliance of charting progress notes regarding the consult. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%
L1295	**322-200.3L RECORDS-PROGRESS NOTES** The CEO, the CNO, the Director of PI, and the Director of Clinical Services met to review the Documentation Standards Policy and the Format and Content of the Record Policy, no revisions needed at this time. The Clinical Services staff and Nursing staff were retrained to the Documentation Standards Policy specific to the part that	Director of Clinical Services Chief Nursing Officer	11/26/2022	The Director of Clinical Services and the Chief Nursing Officer will monitor 100% of the Group Progress Notes for being filed timely and for including four hours of programming a day. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained.

	services are to be charted immediately or within 8 hours following completion. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and competed on 11/1/2022. The Clinical Services staff and Nursing staff were retrained to the Format and Content of the Record Policy specific to that the content of the medical record shall include but not be limited to Therapy progress notes that consist of four hours of programming a day, two hours conducted by a licensed therapy/social services staff, one Activity Therapy recreation group and one psychoeducation group help by a licensed staff member such as a registered nurse. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and was completed on 11/1/2022.			Aggregated data will be reported to the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance is >/= 90%

APPROVED
By Kimberly Bloor at 12:48 pm, Nov 08, 2022

Inland Northwest Behavioral Health
Plan of Correction for
State Licensing Hospital Survey
09/27/2022

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
S300	**NFPA 101 PROTECTION-OTHER** The Regional Facilities Manager and the Director of Plant Operations met to review the facilities life safety drawing that show room 1128 walls is not fire rated. The Director of Plant Operations will repair Room 1128 with smoke blankets, and this will be completed by 11/1/2022. Any future work will be inspected by the Director of Plant Operations for compliance. The Regional Facilities Manager and the Director of Plant Operations met to review the facility life safety drawings. The facility life safety drawings indicate the EVS closets are part of a smoke partition and do not require fire rated wall specifications. We are requesting review of the life safety drawings attached.	Director of Plant Operations	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with life safety codes regarding fire rated walls. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.
S362	**NFPA 101 CORRIDORS-CONSTRUCTION OF WALLS** The Regional Facilities Manager and the Director of Plant Operations met to review the facilities life safety drawings that show that the medication windows do not require fire rated windows. The facility life safety drawings indicate the medication pass windows are part of a smoke partition and do not require fire rated windows. We are requesting review of the life safety drawings attached.	Director of Plant Operations	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with life safety codes regarding smoke partitions. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.
S 374	**NFPA 101 Subdivision of Building Spaces-Smoke Barrier Doors** The Director of Plant Operations immediately fixed the door. The Director of Plant Operations was retrained on how to properly maintain fire/smoke barrier doors with the facility as	Director of Plant Operations	11/1/2022	100% of the smoke barriers doors will be monitored to confirm compliance with closing appropriately and becoming a smoke barrier door.

	capable of resisting the passage of smoke. Training was initiated by the Regional Facilities Manager and completed on 10/18/2022.			Monitoring will be ongoing for 4 months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100%
S 711	**NFPA 101 Evacuation and Relocation Plan** The CEO, the CNO, the Director of Plant Operations and the Director of PI met to review the Fire Response Plan. The Fire Response Plan was updated to include an emergency call to 911. The updated Fire Response Plan was reviewed and approved by the MEC on 10/26/2022. The updated Fire Response Plan was reviewed and approved by the GB on 10/27/2022. All Hospital staff were retrained to the Fire Response Plan specific to needing to place the emergency call to 911. Training was initiated by the Director of Plant Operations and was completed on 11/1/2022.	Director of Plant Operations	11/1/2022	100% of Fire Drills will be monitored to confirm compliance with placing the emergency call to 911. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. Aggregated data will be reported to Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance 100%
S918	**NFPA 101 ELECTRICAL SYSTEMS-ESSENTIAL ELECTRIC SYSTEMS** The CEO, the Regional Facilities Manager, the Director of Plant Operations, and the Director of PI met to review the findings. The Director of Plant Operations was retrained on maintaining and testing the emergency generators in accordance with NFPA 110 specific to including the generator run start and stop times. Training was initiated by the Regional Facilities Manager and was completed on 10/18/2022.	Regional Facilities Manager Director of Plant Operations	11/1/2022	100% of emergency generator testing will be monitored to confirm compliance with start and stop time documentation. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.
S920	**NFPA 101 ELECTRICAL EQUIPMENT-POWER CORDS AND EXTENSION CORDS** The CEO, the Regional Facilities Manager, the Director of Plant Operations, and the Director of PI met to review the findings.	Director of Plant Operations	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with not having any extension cords in the hospital and for the use of power cords.

	The Director of Plant Operations was retrained on the restriction of use of extension cords and non-approved power strips in the Hospital. Training was initiated by the Regional Facilities Manager and was completed on 10/18/2022.			Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.
S923	**NFPA 101 GAS EQUIPMENT-CYLINDER AND CONTAINER STORAGE** The CEO, the Regional Facilities Manager, the Director of Plant Operations, and the Director of PI met to review the findings. The Director of Plant Operations was retrained on maintaining construction of oxygen storage areas as being smoke and fire resistant specific to not having cardboard within 5 feet of the cylinders. Training was initiated by the Regional Facilities Manager and completed on 10/18/2022.	Director Of Plant Operations	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with the storage of oxygen. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.
S926	**NFPA 101 GAS EQUIPMENT-QUALIFICATION AND TRAINING** The CEO, the CNO, the Director of Plant Operations, and the Director of PI met to review the findings. All Hospital staff were trained on the risk and use of compressed gas cylinders. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	Director of Plant Operations	11/1/2022	100% of the Hospital staff employee files will be monitored to confirm compliance with training on the risk and use of compressed gas cylinders. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee, the MEC monthly and to the Governing Board quarterly. Target for compliance is 100%.

Progress Report received 12/23/22 approved 1/18/23 [signature] 1/18/23

Inland Northwest Behavioral Health
Progress Report for State Licensing Hospital Survey
09/21/2022 – 9/23/2022 & 9/27/2022

Tag Number	How Corrected	Date Completed	Results of Monitoring
L345 **323-035.1i** **POLICIES-PHARMACY**	The Pharmacy staff and Nursing staff were retrained to the Automated Drug Distribution Device Policy to confirm compliance with controlled substances needing to be in a locked cabinet and needing to be counted every 12 hours. Training was initiated by the Director of Pharmacy and the CNO and completed by 11/1/2022.	11/26/2022	100% of controlled substance count logs will be monitored to confirm compliance with counting the controlled substances every 12 hours. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. **November:** 92% **December:** 100% **January:** **February:**
L375 **322-035.1o** **POLICIES-HOUSEKEEPING**	The Housekeeping staff were retrained to the Discharge Cleaning of Patient Rooms Policy specific to locking the cart during the room cleaning. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	11/26/2022	The Director of Plant Operations will monitor 100% of the housekeeping carts for being locked while cleaning. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. **November:** 95% **December:** 100% **January:** **February:**
L390 **322-035.1R** **POLICIES-PATIENT TRANSFER**	The Nursing staff were retrained to the Emergency Services and Patient Transfer Policy specific to the patient receiving an explanation of risks and benefits and the patient consenting to transfer.	11/26/2022	The Chief Nursing Officer will monitor 100% of medical send outs for having an explanation of risks and benefits and for a consent to transfer. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed.

	Training was initiated by the Chief Nursing Officer and completed on 11/1/2022.		**November:** 85%- A new Medical Send Out Checklist was made and implemented on 11/28/2022. **December:** 100% **January:** **February:**
L425 **322-040.2** **ADMIN- STAFF PROVISIONS**	The Clinical Service staff and Nursing staff were retrained to the Format and Content of the Record Policy specific to the patient attending 4 hours of programming a day including 2 hours by a licensed therapy/social services staff, 1 hour of Activity Therapy, 1 Psychoeducation group held by licensed hospital staff such as trained registered Nurses. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022. The Providers, Clinical Service staff and Nursing staff were retrained to the Active and Individualized Treatment Policy specific to active treatment services must be provided 7 days a week and supervised and evaluated by a physician who is the leader of the treatment team. Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022. To address the active programming on the weekends the Director of Clinical Services has moved a MSW schedule to cover on Sundays. She has hired a MSW that will be working on Saturdays. This MSW starts orientation on 10/31. There is also a MSW Student that is working on weekends too. She hired a new Activity Therapist to work on Sundays. A Recreational Specialist under the director of the Recreational Therapist will be working on Saturdays. We contracted with a Yoga Instructor to provide Yoga on the weekends. We still have	11/26/2022	The Director of Clinical Services and the Chief Nursing Officer will monitor 100% of group notes for providing 7 days a week of active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. **November:** 75%- Staff that were not holding Groups were reeducated and held accountable for providing Groups. The Director of Clinical Services hired two MSW's that started on 10/31/2022. The Director of Clinical Services added a Nursing Group to each unit each day and that new Programming Scheduled was implemented on 11/28/2022. **December**: 90%- Charge Nurses hired for each unit and started on 12/12/2022. The Charge Nurses were educated by the Director of Clinical Services on Nursing Groups and Group Documentation. This occurred on 12/16/2022. **January:** **February:**

	one MSW and one RT per diem positions posted.		
L805 **322-120.6A WATER-BACKFLOW**	The Maintenance Technician and the Director of Plant Operations fixed the slope of the drain lines immediately. The Maintenance Technician was retrained to the ice machine manufacturer's instructions specific to the drain lines should be sloped ¼ inch per foot. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	11/26/2022	The Director of Plant Operations will monitor 100% of the ice machine drain lines to slope ¼ inch per foot. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. **November:** 100% **December:** 100% **January:** **February:**
L1065 **322-170.2E TREATMENT PLAN-COMPREHENSIVE**	The Providers, Clinical Services staff and the Nursing staff were all retrained on the Treatment Planning Policy specific to addressing any acute, chronic/stable, and/or deferred/referred medical problems on the Master Treatment Plan. Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022. The Providers, Clinical Services staff and the Nursing staff were all retrained on the Treatment Planning Policy specific to updating the Master Treatment Plan when a change in the patient's status occurs. Training was initiated by the Medical Director, Director of Clinical Services and the Chief Nursing Officer and completed on 11/1/2022.	11/26/2022	The Director of Clinical Services and the Chief Nursing Office will monitor 100% of the Treatment Plans for compliance with addressing medical problems and updating treatment plans when there is a change of status. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. **November:** 80%- The Providers, Clinical Services staff, and Nursing staff were all reeducated by the Director of PI. The Director of PI attended Treatment Plan meetings daily for 2 weeks. This was completed by 11/30/2022. **December:** 92%- Charge Nurses were hired for each unit and started on 12/12/2022. The Charge Nurses were educated on the Treatment Planning Process by the Director of PI on 12/21/2022. **January:** **February:**
L1265 **322-200.3F RECORDS-OBSERVATIONS**	All Providers were retrained to the Medical Staff Rules and Regulations specific to needing to document medical consultations and this documentation must include reason for consult, medical evaluation and results of the evaluation, treatment rendered, response to treatment,	11/26/2022	The Medical Director and Director of PI will Monitor 100% of the medical consult orders for compliance of charting progress notes regarding the consult. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained.

	outcome of treatment, response to medication and the must be dated, timed, and signed whenever they see a patient. Providers not present at this training were individually retrained by the Medical Director and provided a copy of the MS Rules and Regulations for their review. Training was initiated by the Medical Director and Director of PI and completed on 11/1/2022.		**November:** 80%- The Medical Director met with all Medical Providers including weekend staff and reeducated them on the Medical Consult process and the new template to use. This was completed on 11/30/2022. **December:** 93% **January:** **February:**
L1295 **322-200.3L RECORDS-PROGRESS NOTES**	The Clinical Services staff and Nursing staff were retrained to the Documentation Standards Policy specific to the part that services are to be charted immediately or within 8 hours following completion. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and competed on 11/1/2022. The Clinical Services staff and Nursing staff were retrained to the Format and Content of the Record Policy specific to that the content of the medical record shall include but not be limited to Therapy progress notes that consist of four hours of programming a day, two hours conducted by a licensed therapy/social services staff, one Activity Therapy recreation group and one psychoeducation group help by a licensed staff member such as a registered nurse. Training was initiated by the Director of Clinical Services and the Chief Nursing Officer and was completed on 11/1/2022.	11/26/2022	The Director of Clinical Services and the Chief Nursing Officer will monitor 100% of the Group Progress Notes for being filed timely and for including four hours of programming a day. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. **November:** 75%- Staff that were not holding Groups were reeducated and held accountable for providing Groups. The Director of Clinical Services hired two MSW's that started on 10/31/2022. The Director of Clinical Services added a Nursing Group to each unit each day and that new Programming Scheduled was implemented on 11/28/2022. **December:** 90%- Charge Nurses hired for each unit and started on 12/12/2022. The Charge Nurses were educated by the Director of Clinical Services on Nursing Groups and Group Documentation. This occurred on 12/16/2022. **January:** **February:**

Inland Northwest Behavioral Health
Progress Report for State Licensing Hospital Survey
09/27/2022

Tag Number	How Corrected	Date Completed	Results of Monitoring
S300 **NFPA 101 PROTECTION-OTHER**	The Regional Facilities Manager and the Director of Plant Operations met to review the facilities life safety drawing that show room 1128 walls is not fire rated. The Director of Plant Operations will repair Room 1128 with smoke blankets, and this will be completed by 11/1/2022. Any future work will be inspected by the Director of Plant Operations for compliance. The Regional Facilities Manager and the Director of Plant Operations met to review the facility life safety drawings. The facility life safety drawings indicate the EVS closets are part of a smoke partition and do not require fire rated wall specifications. We are requesting review of the life safety drawings attached.	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with life safety codes regarding fire rated walls. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 100% **December:** 100% **January** **February:**
S362 **NFPA 101 CORRIDORS-CONSTRUCTION OF WALLS**	The Regional Facilities Manager and the Director of Plant Operations met to review the facilities life safety drawings that show that the medication windows do not require fire rated windows. The facility life safety drawings indicate the medication pass windows are part of a smoke partition and do not require fire rated windows. We are requesting review of the life safety drawings attached.	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with life safety codes regarding smoke partitions. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 100% **December:** 100% **January:** **February:**

S374 **NFPA 101 SUBDIVISION OF BUILDING SPACES-SMOKE BARRIER DOORS**	The Director of Plant Operations immediately fixed the door. The Director of Plant Operations was retrained on how to properly maintain fire/smoke barrier doors with the facility as capable of resisting the passage of smoke. Training was initiated by the Regional Facilities Manager and completed on 10/18/2022.	11/1/2022	100% of the smoke barriers doors will be monitored to confirm compliance with closing appropriately and becoming a smoke barrier door. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. **November:** 100% **December:** 100% **January:** **February:**
S711 **NFPA 101 EVACUATION AND RELOCATION PLAN**	The CEO, the CNO, the Director of Plant Operations and the Director of PI met to review the Fire Response Plan. The Fire Response Plan was updated to include an emergency call to 911. The updated Fire Response Plan was reviewed and approved by the MEC on 10/26/2022. The updated Fire Response Plan was reviewed and approved by the GB on 10/27/2022. All Hospital staff were retrained to the Fire Response Plan specific to needing to place the emergency call to 911. Training was initiated by the Director of Plant Operations and was completed on 11/1/2022.	11/1/2022	100% of Fire Drills will be monitored to confirm compliance with placing the emergency call to 911. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. All deficiencies will be corrected immediately to include staff retraining as needed. **November:** 100% **December:** 100% **January:** **February:**
S918 **NFPA 101 ELECTRICAL SYSTEMS-ESSENTIAL ELECTRIC SYSTEMS**	The Director of Plant Operations was retrained on maintaining and testing the emergency generators in accordance with NFPA 110 specific to including the generator run start and stop times. Training was initiated by the Regional Facilities Manager and was completed on 10/18/2022.	11/1/2022	100% of emergency generator testing will be monitored to confirm compliance with start and stop time documentation. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 100% **December:** 100% **January:** **February:**

S920 **NFPA 101 GAS EQUIPMENT-CYLINDER AND CONTAINER STORAGE**	The Director of Plant Operations was retrained on maintaining construction of oxygen storage areas as being smoke and fire resistant specific to not having cardboard within 5 feet of the cylinders. Training was initiated by the Regional Facilities Manager and completed on 10/18/2022.	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with not having any extension cords in the hospital and for the use of power cords. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 100% **December:** 100% **January:** **February:**
S923 **NFPA 101 GAS EQUIPMENT-CYLINDER AND CONTAINER STORAGE**	The Director of Plant Operations was retrained on maintaining construction of oxygen storage areas as being smoke and fire resistant specific to not having cardboard within 5 feet of the cylinders. Training was initiated by the Regional Facilities Manager and completed on 10/18/2022.	11/1/2022	100% of monthly environmental rounds will be monitored to confirm compliance with the storage of oxygen. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 100% **December:** 100% **January:** **February:**
S926 **NFPA 101 GAS EQUIPMENT-QUALIFICATION AND TRAINING**	All Hospital staff were trained on the risk and use of compressed gas cylinders. Training was initiated by the Director of Plant Operations and completed on 11/1/2022.	11/1/2022	100% of the Hospital staff employee files will be monitored to confirm compliance with training on the risk and use of compressed gas cylinders. Monitoring will be ongoing for 4 months until compliance is achieved and sustained. **November:** 85%- More staff meetings held to get all Hospital Staff educated and this was completed by 11/30/2022. **December:** 100% **January:** **February:**