STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012699	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/05/2015

RECEIVED
SEP 04 2015
DEPARTMENT OF HEALTH
Office of Investigation and Inspection

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL NORTH	**916 PACIFIC AVE FI 7 EVERETT, WA 98201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY This state psychiatric hospital licensing survey was conducted at Fairfax Hospital North on 08/04/2015 - 08/5/2015 by Alex Giel, REHS, and Lisa Sassi RN, MN. The Washington Fire Protection Bureau conducted the fire life safety inspection on 08/04/2015. ASE Shell # AIY011	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 due on September 3, 2015. 4. Return the ORIGINAL REPORT with the required signatures on the first page to: Alex Giel, REHS Public Health Advisor 3 Office of Investigations and Inspections P.O. Box 47874 Olympia, WA 98504-7874	

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
[signature]	CEO	9.3.15

Plan of Correction Rec 8/28/15 POC Approved 9/21/15 A Giel 9/21/15

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L 690	Continued From Page 1	L 690		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This RULE: is not met as evidenced by: . Based on observation and review of policy and procedures, the facility failed to ensure implementation of activities designed to prevent and control infections. Item #1 Hand Hygiene-During Medication Administration Findings: 1. In review of facility policy titled, "Medication Administration" (Revised 8/2014) on page 2 under item 4.b.ii. it stated, "The licensed nursing staff will use proper hand washing techniques prior to handling medication for administration". Information about hand hygiene related to medication administration was not included in the facility policy titled, "Hand Hygiene" (Revised 3/2014). 2. On 8/4/2015 at 1:00 PM Surveyor #2 observed a nurse (Staff Member #1) administer medications to Patient #1 - #3. The system for medication administration included patients coming to a designated window at the medication room to receive medication from the nurse. The nurse	L 690		

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L 690	Continued From Page 2 obtained medications from the electronic cabinet for administration to each patient (one at a time). The medication nurse did not perform hand hygiene after administering 2 oral medications to Patient #1, including after handling and disposing the patient's water cup. Then s/he proceeded to administer 2 oral medications to Patient #2 and subsequently discarded that patient's water cup. Then the nurse proceeded to administer medications to Patient #3 which included a hydrogen peroxide oral rinse after which the patient subsequently spit the rinse solution into a paper cup and returned it to the nurse. At that point, the nurse was prompted to perform hand hygiene by the Chief Nursing Officer (Staff Member #2). Item #2- Hand Hygiene - After Glove Removal Reference: CDC Protocol for Hand Hygiene and Glove use observation (Rev. 11/1/2012) Stated, "glove use does not preclude the need for hand hygiene after removing gloves." Findings: 1. In review of facility policy titled, "Hand Hygiene" (Rev 06/2014) in procedure 1.4... "Employees are required to wash hands thoroughly: After contact with potentially contaminated environmental surfaces." In part 3; "Employees may use a waterless hand washing products supplied by the employer." There is no reference regarding glove use except under policy number 1600.7.11 titled, "Terminal Disinfection of Patient Rooms" section 12 stated, "wash hands according to CDC guidelines."	L 690		

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L 690	Continued From Page 3 Reference: CDC Protocol for Hand Hygiene and Glove use observation (Rev. 11/1/2012) Stated, "glove use does not preclude the need for hand hygiene after removing gloves." 2. On 8/5/2015 at 1:30 PM during a daily clean of patient's room, room number 714, Surveyor #1 observed a housekeeper (Staff Member #8) not doing hand hygiene between glove changes on 3 separate occasions. Item #3 - Cleaning Patient Care Equipment-Glucometer Findings: Reference: CDC Centers for Disease Control and Prevention: Infection Prevention during Blood Glucose Monitoring and Insulin Administration (Rev date 2/6/2013) page 6 under Blood Glucose Meters Stated in part: "If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be used". Reference: In review of the One Touch Ultra Mini User Guide (Rev date: 07/2009) on page 20 it provided a section on "Caring for your system." it stated in part, "To Clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter". 1. On 8/5/2015 at 11:30 AM Surveyor #1 interviewed a licensed practical nurse (Staff Member #1) on the process of disinfecting the glucometer. S/he stated that s/he would use bleach wipes. Surveyor observed the bleach wipe container which was labeled with a marker "used	L 690		

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L 690	Continued From Page 4 for glucometer". After review of the manufacturer's instructions for use, it was determined that the manufacturer's instructions did not provide information how to disinfect the glucometer and therefore did not meet the CDC guidelines. Item #4: Cleaning Patient Care Equipment-Pill Splitter 1. In review of the hospital's policy and procedure titled, "Cleaning Agents Selection" (Revised 10/2014) on page 2 of 3 it stated, the "cleaner-disinfectant" agent to be used on the "Pill splitter/crusher" was "Alcohol" and it was to be used "after each use". 2. On 8/4/2015 at 1:30 PM Surveyor #2 interviewed the medication nurse (Staff Member #1) about how s/he cleaned pill splitters after s/he used it to split a pain medication (oxycodone) for Patient #4. S/he stated that s/he cleaned the pill splitter with soap and water. Item #5 Exam Table Cleaning Findings: 1. In review of the hospital's policy and procedure titled, "Cleaning Agents Selection" (Revised 10/2014) on page 2 and 3 the policy identified that "cleaner-disinfectant" agents to be used on many types of patient care items. However, it did not specify how exam tables (located in treatment rooms) were to be cleaned. That room type was used by health care providers to perform physical examinations and minor procedures. 2. On 8/4/2015 at 10:30 AM Surveyor #2 entered the facility's treatment room. There was crumpled exam paper in place on the exam table (as per	L 690		

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L 690	Continued From Page 5 use after patient care). 3. At that time Surveyor #2 interviewed the Nurse Manager (Staff Member #3) about the condition of the room. When asked if s/he knew who used the room and for what type of patient care, s/he stated that there was no system for her to ascertain that information. When asked about a cleaning procedure for the room, s/he referenced a signage posted in the room that asked staff to "dispose of ...used exam table liner in lined trash bin" and to wipe all surfaces with "Sani-wipes or Bleach wipes". (The facility did not have a cleaning product called "Sani-wipes"). In a follow-up interview at 11:30 AM with a nurse practitioners (Staff Member #4) s/he stated that s/he had placed the sign there to request that all staff clean the room when done using it. She stated that s/he used "Sani-Hands" (not "Sani-wipes") to clean the exam table. At that point, the surveyor indicated that "Sani-Hands" (65.9% alcohol) was indicated for cleaning hands (rather than the patient care environment).	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 RULE: is not met as evidenced by:	L 710		

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L 710	Continued From Page 6 Based on observation and review of manufacturer's instructions for use the hospital staff failed to use the appropriate disinfection when wiping down high touch surfaces. References: Manufacturer's Label: "PDI Sani Hands instant Hand Sanitizing Wipes" intended use if for hand washing to decrease bacteria on the skin. Hand sanitizing wipes are designed for hand use only. Finding: On 08/04/2015 at 1:15 PM Surveyor #1 observed a RN (Staff Member #6) wiping several patient's rooms door handles with "Sani Hands", a product that is used for hands only.	L 710		
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	L1065		

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L1065	Continued From Page 7 persons designated in the plan; This RULE: is not met as evidenced by: . Based on record review, the facility failed to demonstrate that the status of treatment plan goals were finalized by designated members of the treatment team prior to discharge. Findings: 1. In review of facility document titled "Treatment Planning" (Revised May 26, 2014), it included 10 pages of steps to be taken by multidisciplinary treatment members in the development and revision of the patient treatment plan. However, the document did not specifically direct staff to document the goal outcome per the treatment plan standard format. This finding was confirmed by the Chief Nursing Officer (Staff Member #2) and s/he acknowledged an expectation of completion of the treatment plan goal documentation. 2. In review of the following medical records it was noted that documentation about treatment goal status was left blank: a. Patient #5 was 19 years old, admitted on 1/19/2015 and discharged on 1/24/2015 for treatment of bipolar disorder with psychosis. The team identified a total of 4 goals and 8 interventions on the treatment plan. The sections titled "Date Goal Met" were left blank by designated care providers. b. Patient #6 was a 66 years old patient, admitted on 2/6/2015 and discharged on 2/18/2015 for treatment of bipolar disorder. The patient had 2 care plans and the final care plan identified 3 goals and 7 interventions. All sections titled "Date	L1065		

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L1065	Continued From Page 8 Goal Met" of all treatment plans were left blank by designated care providers. c. Patient #7 was 27 years old, admitted on 3/14/2015 and discharged on 3/31/2015 for treatment of psychosis. The patient had 3 treatment plans and the final one identified 4 goals and 9 interventions. All sections titled "Date Goal Met" of all treatment plans were left blank by designated care providers. d. Patient #8 was 31 years old, admitted on 3/15/2015 and discharged on 4/3/2015 for treatment of schizoaffective disorder. The patient had 4 treatment plans and the final one identified 4 goals and 7 interventions. All sections titled "Date Goal Met" of all treatment plans were left blank by designated care providers. e. Patient #9 was 47 years old, admitted on 3/20/2015 and discharged on 4/15/2015 for treatment of schizoaffective disorder. The patient had 3 treatment plans and the final one had 4 goals and 7 interventions. All sections titled "Date Goal Met" of all treatment plans were left blank by designated care providers. f. Patient #10 was 55 years old and admitted on 4/27/2015 and discharged on 5/6/2015 for treatment of bipolar disorder. The patient had 1 treatment plan with 7 interventions. All sections titled "Date Goal Met" of the treatment plan were left blank by designated care providers.	L1065		

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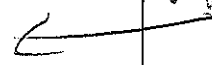
Fairfax Behavioral Health - Everett
Plan of Correction for State Licensing Survey (August 4-5. 2015)

Tag Number	WAC	Responsible Individual(s)	Date of Correction Completed (or will be completed)	How Corrected	How Monitored to Prevent Recurrence	Results of Monitoring: Compliance Level
L 690	322-100.1A INFECT CONTROL-P&P	Infection Control Nurse; Primary Care Lead Physician	9/15/2015	The "Medication Administration" Policy was updated to address proper hand hygiene prior to and after medication administration. The "Hand Hygiene" Policy was updated to address medication administration. All Sani-Hands product was removed and replaced with PDI 70% alcohol wipes by 8/24/15. The "Cleaning Agent Selection" Policy was updated to reflect to specify how to clean exam tables. Glucometers were replaced with devices that can be cleaned with bleach wipes by 8/28/15. On 9/2/15, the Infection Control Nurse trained all direct care staff to the aforementioned policies including the need for hand hygiene after removing gloves, proper cleaning of pill splitters, and proper cleaning of exam tables. By 9/4/15, the Infection Control Nurse trained the housekeeping staff on proper hand hygiene between glove changes. On 9/2/15, the Infection Control Nurse trained the nursing staff regarding proper glucometer cleaning and associated cleaning products. Updated policies will be approved at Quality Council on 9/15/15.	The Infection Control Nurse does weekly audits to observe all direct care staff to ensure the use of proper hand hygiene and to ensure that appropriate cleaning agents are being used throughout the hospital, based on the device and manufacturer's recommendations. The Infection Control Nurse monitors the ordering supply list and ensures the hospital only orders approved products. New patient care items and disinfecting products will be reviewed and approved by the Infection Control Committee quarterly. All patient care items and disinfecting products will be reviewed by Infection Control Committee annually. Nurse Managers are to monitor units weekly to ensure the correct product is being used.	90%

L 710	322-100.1D INFECT CONTROL-PHYS ENVIRON	Infection Control Nurse; Primary Care Lead Physician	9/15/2015	All Sani-Hands products were removed and replaced with PDI 70% alcohol wipes by 8/24/15. The "Cleaning Agent Selection" Policy was updated to include "High Touch Surfaces" and the new cleaning agent. On 9/2/15, the Infection Control Nurse trained all direct care staff to the aforementioned policy. The updated policy will be approved at Quality Council on 9/15/15.	The Infection Control Nurse does weekly audits to ensure that appropriate cleaning agents are being used throughout the hospital. The Infection Control Nurse monitors the ordering supply list and ensures the hospital only orders approved products. New patient care items and disinfecting products will be reviewed and approved by the Infection Control Committee quarterly. All patient care items and disinfecting products will be reviewed by Infection Control Committee annually. The Nurse Manager is to monitor units weekly to ensure the correct product is being used.	90%
L1065	322-170.2E TREATMENT PLAN-COMPREHENS	COO; Manager of Case Management Services	8/28/2015	Training on Treatment Plans for Case Managers was completed on 8/28/15. Training was provided by the Lead Case Manager in a mandatory staff meeting regarding treatment planning. During this training, the requirement to document the status of treatment goals was re-enforced.	Treatment Plans are audited by the Manager of Case Management Services for compliance with the requirement that the status of treatment plan goals is completed by discharge. This audit is done by random sample of at least 25% of patients, on a monthly basis. Results will be reported monthly to Quality Council.	90%
S 160	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services; Providence Pacific Facilities Staff and Otis Elevator Company	9/4/2015	Documentation shows evidence that the Firefighters service test is completed on a quarterly basis. The testing frequency deficiency is noted and will be increased to a frequency of monthly tests. This test is currently completed and documented by an Elevator Service company (Otis). This test will be reviewed by the Facilities Leadership for completion by In-house engineering staff or amending the test to the elevator service contract responsibilities.	Fire Recall Testing was added to our CMMS on a monthly frequency and recorded with the Elevators MCP documentation. Documentation of tests completed is reported to the Environment of Care Committee. Providence now provides the Fairfax Director of Support Services evidence of above documentation on a monthly basis.	100%
S 012	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services	8/21/2015	The hole was re-sealed on 8/21/15. The damage was caused during the survey inspection when a ceiling tile was removed for the Fire Marshall. Facilities staff were re-trained on 8/21/15 regarding proper removal of ceiling tiles to prevent damage.	Ceiling tiles are now randomly inspected on a semi-annual basis to ensure integrity. Immediately following any work necessitating the removal of ceiling tiles, the Director of Support Services conducts an inspection and immediately corrects any damage.	100%



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L1065	322-170.2E TREATMENT PLAN-COMPREHENS	COO; Manager of Case Management Services	8/28/2015	Training on Treatment Plans for Case Managers was completed on 8/28/15. Training was provided by the Lead Case Manager in a mandatory staff meeting regarding treatment planning. During this training, the requirement to document the status of treatment goals was re-enforced.	Treatment Plans are audited by the Manager of Case Management Services for compliance with the requirement that the status of treatment plan goals is completed by discharge. This audit is done by random sample of at least 25% of patients, on a monthly basis. Results will be reported monthly to Quality Council.	90%
S 160	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services; Providence Pacific Facilities Staff and Otis Elevator Company	9/4/2015	Documentation shows evidence that the Firefighters service test is completed on a quarterly basis. The testing frequency deficiency is noted and will be increased to a frequency of monthly tests. This test is currently completed and documented by an Elevator Service company (Otis). This test will be reviewed by the Facilities Leadership for completion by In-house engineering staff or amending the test to the elevator service contract responsibilities.	Fire Recall Testing was added to our CMMS on a monthly frequency and recorded with the Elevators MCP documentation. Documentation of tests completed is reported to the Environment of Care Committee. Providence now provides the Fairfax Director of Support Services evidence of above documentation on a monthly basis.	100%
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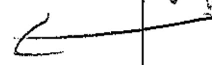

S 050	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services	8/28/2015	Fire drills are conducted once per shift per quarter and are documented. Providence located the appropriate documentation and provided it to the Fairfax Director of Support Services as of 8/28/15.	Providence now provides the Fairfax Director of Support Services evidence of documentation quarterly of the fire drills conducted once per shift per quarter. The Director of Support Services monitors the documentation for compliance.	100%
S 052	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services; Providence Pacific Facilities Staff and Convergent Technologies Fire Device Testing Vendor; Tyco/Simplex Technologies. Fire Panel Service/OEM Sonnitrol Alarm Services	9/4/2015	Past practice of scheduling 25% of total devices in the building tested each quarter has been replaced with an annual test that captures 100% of Fire Device Inventory within the building. This testing model improves inventory reporting and enables quick discovery of "missed" devices or areas. The Pacific Campus Building to include 7th Floor was conducted by 8/28/15. The Fire Panel serving the Pacific building displayed a trouble (UPS battery current) indication for Node 2 , which does not serve the 7th Floor where Fairfax Everett is located. This was observed during building tour. Node 2 was reset and the panel cleared with no other displayed troubles. Fire Panel Service was called for operation verification and identified no issues.	Annual Fire Device Testing Documentation is reviewed by Facilities Leadership for accuracy and completeness. Documentation will be reported to PRMCE Environment of Care Committee on a Monthly basis. Results are now reported to the Fairfax Director of Support Services on a monthly basis to ensure compliance. The Fire Panel is monitored 24/7 locally and by offsite notification services. Identified issues are resolved immediately by Providence Facilities staff members.	100%
S 056	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services	9/3/2015	A sprinkler was added to Medical Director's office closet on 9/3/15.	The Director of Support Services ensures compliance with the adequate fire sprinkler protection standards at the monthly environment of care rounds.	100%

S 062	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services; Providence Pacific Facilities Staff and Burns Fire Systems	8/28/2015	Documentation review of Fire Sprinkler Vendor indicates that this test of inspecting internal condition of the sprinkler pipe is incorporated in the annual inspection, which was completed on 6/4/2015. Documentation was provided by Providence to the Fairfax Director of Support Services on 8/28/15. Documentation of Quarterly Fire Sprinkler testing is available and shows evidence of completion on 2/16/2015- 1st Qtr. and on 6/1/2015 -2nd Qtr. Documentation was provided by Providence to the Fairfax Director of Support Services on 8/28/15.	The internal pipe inspection test to the documentation form. All Life Safety and Fire Safety documentation is reported to the Environment of Care Committee on Monthly basis. Providence now provides documentation of internal pipe testing and quarterly fire sprinkler inspections on at least a quarterly basis (or as indicated with the other required time increments).	100%
S 074	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services	8/4/2015	An inspection was conducted to ensure the identification of all hanging fabrics not rated as flame resistant were identified, and these identified hanging fabrics were removed on 8/4/15. All Everett staff were re-trained by 8/28/15 by the Nurse Manager in both staff meetings and individual training formats.	The Nurse Manager or designee now assesses compliance with this standard on daily rounds. Any identified fabrics, etc. not meet the flame resistant standards are removed immediately and responsible staff re-trained immediately or as soon a possible.	90%
S 144	NFPA 101 LIFE SAFETY CODE STANDARD	Fairfax Director of Support Services; Providence Pacific Facilities Staff and Pacific Power	8/28/2015	The Annual Load test for the Pacific Building was completed on 7/24/2015 and is compliant with the annual schedule. Documentation of the generator tests are completed on custom forms to capture all regulatory information often requested. It takes 2-3 weeks to receive the formal testing forms after the load test is completed. Effective 8/28/15, Interim Generator Testing documentation from the testing technicians is now readily available until formal documentation is received.	Providence now provides the Fairfax Director of Support Services evidence of documentation on the annual load test. The Director of Support Services monitors the documentation for compliance.	100%

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.

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

September 23, 2015

Darcie Johnson
Fairfax Behavioral Health
10200 NE 132nd St
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 Fairfax North Hospital on 8/4/2015 -8/6/2015. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on

A Progress Report is due on or before 11/6/2015 when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

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

Alex Giel
Department of Health, Investigations and Inspections Office
PO Box 47874
Olympia, Washington, 98504

Please contact me if you have any questions. I may be reached at 360-236-2982. I am also available by email at alex.giel@doh.wa.gov

Sincerely,

Alex Giel, REHS
Survey Team Leader