State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012699	A. BUILDING: ______ B. WING ______	06/22/2018

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 The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 WAC Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 06/18/18 to 06/22/18 Examination number: 2018-349 The survey was conducted by: Surveyor #6 Surveyor #8 The Washington Fire Protection Bureau conducted the fire life safety 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 days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by 07/18/18. 4. Return the ORIGINAL REPORTS 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		

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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 Washington Administrative Code is not met as evidenced by: . ITEM #1 - Removal of trash when cleaning patient rooms Based on observation, interview, and document review, the hospital failed to ensure staff implemented policies to prevent and control infections when cleaning patient rooms. Failure to implement methods of infection control when cleaning patient rooms places patients and staff at risk of exposure to infectious organisms. Findings included: 1. Document review of the hospital's environmental services contractor's policy titled, "Discharge Room Cleaning," dated 02/13, showed that staff are to remove trash before cleaning the room. Document review of the hospital's environmental services contractor's policy titled, "Cleaning an Occupied Room (EVS)," dated 02/13, showed that staff are to remove large waste and empty container before other room cleaning tasks. 2. On 06/18/18 from 2:35 PM to 3:15 PM, the nurse manager (Staff #601) and Surveyor #6 observed a discharge cleaning of patient room 714. The housekeeper (Staff #602), disinfected the inside of a garbage bin without removing the trash that was in it. Staff #602 did not remove the	L 690		

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L 690	Continued From page 2	L 690		

trash at any time during the discharge cleaning process.

3. At the time of the observation, Surveyor #6 interviewed Staff #602 about cleaning the garbage bin while trash remained in the bin. Staff #602 stated that the trash would be emptied later in the day.

4. Surveyor #6 confirmed the findings with the nurse manager (Staff #601) at the time of the observation.

ITEM #2 - Hand hygiene before replenishing supplies

Based on observation, interview, and document review, the hospital failed to ensure staff performed hand hygiene when replenishing supplies in patient rooms.

Failure to perform hand hygiene when replenishing supplies in patient rooms places patients and staff at risk of exposure to infectious organisms.

Findings included:

1. Document review of the hospital's environmental services contractor's policy titled, "Discharge Room Cleaning," dated 02/13, showed that staff are to perform hand-hygiene prior to replenishing supplies.

2. On 06/18/18 from 2:35 PM to 3:15 PM, the nurse manager (Staff #601) and Surveyor #6 observed a discharge cleaning of patient room 714. The housekeeper (Staff #602), wore gloves while cleaning the patient bathroom. She did not remove the gloves or perform hand hygiene

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L 690	Continued From page 3 before replenishing the supply of paper towels and toilet paper. 3. At the time of the observation, Surveyor #6 confirmed the findings with Staff #601 and Staff #602.	L 690		
L1255	322-200.3D RECORDS-TREATMENT PLAN WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (d) Comprehensive treatment plan; This Washington Administrative Code is not met as evidenced by: Based on observation, interview and review of medical records, the hospital failed to ensure staff members developed and implemented individualized plans of care for 2 of 4 patient records reviewed (Patients #803 and #804). Failure to develop and maintain an updated plan of care puts the patient at risk for delayed care and/or harm due to staff being unaware of patient needs. Findings included: 1. Review of the hospital's policy titled, "Treatment Planning," Policy #1000.81, revised 5/18, showed that the interdisciplinary master treatment plan [care plan] includes psychiatric and medical problems. The attending psychiatrist will complete the psychiatric diagnosis and problem areas of the treatment plan within 24	L1255		

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L1255	Continued From page 4 hours of admission. The primary care provider will complete the the medical diagnosis and medical problem area of the treatment plan within 24 hours of admission. 2. Document review of the medical record for Patient #804, admitted 05/20/18 for bipolar depression, anxiety and suicidal ideation, showed the following: a. Nursing Progress notes dated from 06/06/18 to 06/21/18 showed patient complaints of tooth pain. b. A Psychiatric Progress note dated 06/19 showed patient report of tooth pain. c. The infection control physician's (Staff #801) consult showed that the physician reccommended Anbesol for the patient's tooth pain. d. The interdisciplinary treatment plan, completed 5/20/18, listed asthma as the only medical problem. The facility failed to include the patient's tooth pain as part of the treatment plan. 3. On 06/21/18 at 08:30 AM, Surveyor #8 reviewed the record for Patient #803, admitted 06/09/18 for psychosis and bipolar disorder. The progress notes dated from 06/09/18 to 06/14/18 showed the patient was admitted with a physical complaint of back pain. Document review of Patient #803's medical record showed that there was no evidence that the patient's back pain was included as part of the treatment plan. 4. On 6/21/18 at 10:00 AM, during an interview between Surveyor #8 and the RN risk manager (Staff #804), the RN risk manager confirmed the above findings.	L1255		

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L1305	322-200.4A RECORDS-DATE WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (a) Date; This Washington Administrative Code is not met as evidenced by: Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that all medical record entries were dated for 2 of 4 records reviewed (Patients #802, #804). Failure to develop and maintain accurately dated medical record entries risks misinterpretation of information. Findings included: 1. Review of the hospital's policy titled, "Charting Requirements," Policy #1000.87, revised 5/18, showed that the charting requirements for each chart note is to be signed, dated, and timed. 2. On 06/21/18 at 09:30 AM, Surveyor #8 reviewed the record for Patient #802, a 45 year old admitted 06/14/18 for schizoaffective disorder and symptoms of psychotic episodes. Surveyor #8 noted the following: a. The progress notes were present without a date of the professional staff's signature. b. The restraint and seclusion pages were documented without a date of the professional staff's signature. c. The consent for medical treatment was documented without a date of the professional	L1305		

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L1305	Continued From page 6 staff's signature. d. The patient rights acknowledgement was documented without a date of the professional staff's signature. 3. On 06/21/18 at 09:30 AM, Surveyor #8 reviewed the record for Patient #804, a 34 year old admitted with bipolar depression and anxiety. Surveyor #8 noted the following: a. The notice of patient rights was without a date of the professional staff's signature. b. The acknowledgement of insurance benefits was without a date of the professional staff's signature. c. The advance directives were without a date of the professional staff's signature. d. The involuntary patient rights were without a date of the professional staff's signature. e. The crisis plan was without a date of the professional staff's signature. f. The form #011 was without a date of the professional staff's signature. g. The admission completion checklist was without a date of the professional staff's signature. h. The psychosocial assessment was without a date of the professional staff's signature. i. Two psychological progress notes were found without dates of the professional staff's signatures.	L1305		

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L1305	Continued From page 7 j. Two addendum progress notes were without the dates of the professional staff's signatures. k. The initial medication consent-general psych was without a date of the professional staff's signature.	L1305		
L1310	322-200.4B RECORDS-TIME OF DAY WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (b) Time of day; This Washington Administrative Code is not met as evidenced by: . Based on record review and review of hospital policies and procedures, the hospital failed to ensure that the medical records contained timed entries for 2 of the 4 records reviewed (Patients #802, #804). Failure to develop and maintain medical record entries that are timed risks misinterpretation of information. Findings included: 1. Review of the hospital's policy titled, "Charting Requirements," Policy #1000.87, revised 5/18, showed that the charting procedure for each chart note is to be signed, dated, and timed. 2. On 06/21/18 at 09:00 AM, Surveyor #8 reviewed the record for Patient #802, a 45 year old admitted 06/14/18 for schizoaffective disorder and symptoms of psychotic episodes. Surveyor #8 noted the following:	L1310		

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L1310	Continued From page 8 a. Two Progress notes were present without the time of the professional staff's signature. b. The Initial medication consent-general psych was noted without the time of the professional staff's signature. c. The notice of patient rights was noted without the time of the professional staff's signature. d. The advance directives were noted without the time of the professional staff's signature. e. The notice of privacy practices was signed without the time of the professional staff's signature. 3. On 06/21/18 at 09:15 AM, Surveyor #8 reviewed the record for Patient #804, a 34 year old admitted with bipolar depression and anxiety. Surveyor #8 noted the following: a. The notice of patient rights was noted without the time of the professional staff's signature. b. The acknowledgement of insurance benefits was noted without the time of the professional staff's signature. c. The advance directives were noted without the time of the professional staff's signature. d. The discharge form #011 did not include the time of day. e.The admission completion list did not include the of the time of day. f. Four entries on the psychosocial assessment did not include the time of day.	L1310		

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L1310	Continued From page 9 g. Physician's progress note, identified as page 1 of 2, did not include the time of day. h. The addendum progress report did not include the time of day. i. The Initial medication consent-general psych was noted without the time of day.	L1310		
L1315	322-200.4C RECORDS-AUTHENTICATION WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (c) Authentication by the individual making the entry; This Washington Administrative Code is not met as evidenced by: Based on the medical record review and review of hospital policies and procedures, the hospital failed to ensure that the medical records contained authenticated entries for 2 of 4 records reviewed (Patient #802, #804). Failure to develop and maintain medical record entries that were authenticated risks misinterpretation of the information and potential delays in patient care. Findings included: 1. Review of the hospital's policy titled, "Charting Requirements," Policy #1000.87, revised 5/18, showed that the charting procedure for each chart note is to be signed, dated, and timed. 2. On 06/21/18 at 09:00 AM, Surveyor #8 reviewed the record for Patient #802, a 45 year	L1315		

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L1315	Continued From page 10 old admitted 06/14/18 for schizoaffective disorder and symptoms of psychotic episodes. Surveyor #8 noted the following: a. An initial medication consent was unsigned by the author. b. Patient rights form held an incomplete staff signature. c. Statement of patient belongings was without a staff signature. d. Advance directives form was unsigned. e. Two records for restraint and seclusion held incomplete staff signatures. 3. On 06/21/18 at 09:15 AM, Surveyor #8 reviewed the record for Patient #804, a 34 year old admitted with bipolar depression and anxiety. Surveyor #8 noted the following: a. The discharge form #011 was not authored. b. The admission completion list was incomplete of the signature of the author. c. Four entries on the psychosocial assessment form were without professional staff signatures as indicated. d. Physician's progress note, identified as page 1 of 2, was without professional staff signature. e. The Initial medication consent-general psych was noted without professional staff signature.	L1315		

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L1470	Continued From page 11	L1470		
L1470	322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services. The licensee shall: (1) Provide access to laboratory services to meet emergency and routine needs of patients; This Washington Administrative Code is not met as evidenced by: Based on observation and review of manufacturer information, the hospital failed to ensure laboratory testing supplies did not exceed their designated expiration date. Failure to ensure testing supplies do not exceed their expiration date places patients at risk for inadequate medical treatment due to unreliable test results. Findings included: 1. Document review of the product label for UrinCheck HealthScreen-10 Reagent Strips (used for patient urinalysis) provides space to record the date opened and includes the instruction DO NOT USE AFTER 90 DAYS OF BREAKING THE FOIL SEAL. 2. On 06/19/18 at 2:30 PM, Surveyor #6 inspected the exam room with the nurse manager (Staff #601). The observation showed that staff failed to mark the date opened on the bottle of UrinCheck HealthScreen-10 reagent test strips. 3. At the time of the observation, Surveyor #6 asked Staff #601 about the hospital's expectation for documentation of the open date on products that have a designated shelf life. Staff #601 stated that the date should have been marked on	L1470		

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L1470	Continued From page 12 the bottle.	L1470		

POC Received 07-18-18
approved 07-19-18
19 July 18
Robin Munroe

Fairfax Behavioral Health
Plan of Correction for State Licensing – Survey Dates: 06/18/2018 – 6/21/18
BHC Fairfax Hospital North (012699)

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
L 690	**322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control**	Housekeeping staff were re-trained in the process of Discharge Patient Room Cleaning, specifically to the emptying of trash receptacles and proper hand hygiene when replenishing supplies during the process of room cleaning. This training was done in-person by the Housekeeping Supervisor. Staff demonstrated competency by return demonstration and met or exceeded the 90% proficiency level required to pass. Further, housekeeping staff were retrained to the Hand Hygiene policy by the Infection Control (IC) Preventionist.	Richard Geiger, COO	7/6/18	Compliance will be monitored through direct observation, at 15 & 30 days after re-training, and the randomly daily to confirm compliance with policy. Hand hygiene monitoring is done by the IC Preventionist and reported to the IC Committee. The target for compliance is 100%. Aggregated data will be reported to Quality Council and Medical Executive Committee	<100%

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JUL 18 2018
DEPARTMENT OF HEALTH
Office of Investigation and Inspection

Progress Report received 09-20-18 approved

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
					(MEC) monthly and Governing Board quarterly.	
L1255	**322-200.3D RECORDS-TREATMENT PLAN WAC 246-322-200 Clinical Records.**	The Nurse Manager will re-educate nursing staff to the Treatment Planning policy to include medical problems on the master treatment plan with specific nursing interventions for all medical problems identified. Nursing staff will be trained in-person on 8/6/18 and 8/7/18, during mandatory meetings.	Shelly Donnelly, Nurse Manager	8/7/18	The Nurse Manager or designee will audit charts weekly with a 90% target for compliance. Aggregated data will be reported to Quality Council and Medical Executive Committee (MEC) monthly and Governing Board quarterly.	>90%
L1305	**322-200.4A RECORDS-DATE WAC 246-322-200 Clinical Records.**	The Nurse Manager will re-educate nursing staff on Fairfax policy "Charting Requirements" and the importance of including a date on all progress notes and addendum notes, seclusion and restraint paperwork, admission completion checklists, initial medical consents, and	Shelly Donnelly, Nurse Manager; Peggy Trachte, Business Office	8/7/18	Nurse Manager, DCS, and Case Management Manager will audit charts weekly with a 90% target for compliance.	>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
		Form#011 (Nursing Discharge Plan & Patient Education). Staff will be trained on 8/6/18 and 8/7/18, during mandatory, all staff meetings and sign an attestation demonstrating understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting (7/13/18) to ensure that all Psychosocial Assessments and psychological progress notes are completed with their name and licensure printed, a signature and the date and time of its completion. The Business Office Director will re-educate staff on the importance of completing the date field of the "Facility Representative Signature" and "Reason for Lack of Signature" boxes on both patient rights forms, as well as the "Fairfax Hospital Staff" field on the Consent (acknowledgement of insurance benefits) and Advance Directive forms. Training will be in-person at a weekly meeting on 7/19/18.	Director; Lamar Frizzell, Assistant Administrator; Debbie Horowski, Director of Clinical Services		Aggregated data will be reported to Quality Council and Medical Executive Committee (MEC) monthly and Governing Board quarterly. BOD will audit all admission forms weekly with a 90% target for compliance. All findings will be corrected immediately to include staff retraining.	>90%

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BHC Fairfax Hospital North (012699)

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
L1310	**322-200.4B RECORDS-TIME OF DAY WAC 246-322-200 Clinical Records.**	The Nurse Manager will re-educate nursing staff on Fairfax policy "Charting Requirements" and the importance of including a time on all progress notes and addendum notes, initial medical consents, admission completion checklists, and Form #011 (Nursing Discharge Plan & Patient Education). Staff will be trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meeting and sign attestation demonstrating understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting (7/13/18) to ensure that all Psychosocial Assessments are completed with their name and licensure printed, a signature and the date and time of its completion. Medical Staff will be re-educated by the Interim CMO and Assistant Administrator regarding requirement to time provider progress notes, at the Medical Staff Meeting on 8/2/18.	Shelly Donnelly, Nurse Manager; Peggy Trachte, Business Office Director; Lamar Frizzell, Assistant Administrator; Debbie Horowski, Director of Clinical Services	8/7/18	Nurse Manager, DCS, and Case Management Manager will audit charts weekly with a 90% target for compliance. Aggregated data will be reported to Quality Council and Medical Executive Committee (MEC) monthly and Governing Board quarterly.	>90%

Fairfax Behavioral Health
Plan of Correction for State Licensing – Survey Dates: 06/18/2018 – 6/21/18
BHC Fairfax Hospital North (012699)

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
		Business Office Director (BOD) to modify form to include a field for time of Fairfax staff signature. BOD to re-educate staff on the importance of documenting the time of staff signature on all admission forms, including Patient Rights, Advance Directives, Notice of Privacy Practices, Consent (acknowledgement of insurance benefits). In-person training will take place at the Business Office weekly staff meeting on 7/19/18.			BOD will audit all admission forms weekly with a 90% target for compliance. All findings will be corrected immediately to include staff retraining as needed.	>90%
L1315	322-200.4C RECORDS-AUTHENTICATION WAC 246-322-200 Clinical Records. (4)	The Nurse Manager will re-educate nursing staff on Fairfax policy "Charting Requirements" and the importance of authenticating all initial medical consents, statements of patient belongings, seclusion and restraint paperwork, admission completion checklists, and Form #011 (Nursing Discharge Plan & Patient Education). Staff will be trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meetings and sign attestation demonstrating	Shelly Donnelly, Nurse Manager; Peggy Trachte, Business Office Director; Lamar Frizzell, Assistant Administrator; Debbie Horowski,	8/7/18	Nurse Manager, DCS, and Case Management Manager will audit charts weekly with a 90% target for compliance. Aggregated data will be reported to Quality Council and Medical	>90%

Fairfax Behavioral Health
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		understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting (7/13/18) to ensure that all Psychosocial Assessments are completed with their name and licensure printed, a signature and the date and time of its completion. Medical Staff will be re-educated by the Interim CMO and Assistant Administrator and regarding requirement to authenticate entries, at the Medical Staff Meeting on 8/2/18. Business Office Director to re-educate staff on the importance of authenticating all admission forms with complete staff signatures. Staff will be trained in-person on 7/19/18 at our weekly staff meeting.	Director of Clinical Services		Executive Committee (MEC) monthly and Governing Board quarterly. BOD will audit all admission forms with a 90% target for compliance. All findings will be corrected immediately to include staff retraining as needed.	>90%

Fairfax Behavioral Health

Plan of Correction for State Licensing – Survey Dates: 06/18/2018 – 6/21/18

BHC Fairfax Hospital North (012699)

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
L1470	**322-220.1 LAB ACCESS** **WAC 246-322-220 Laboratory Services.**	The Nurse Manager will re-educate staff on Fairfax policy and the importance of including an expiration date when opening urinalysis strips for the first time. Staff will be trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meeting and sign an attestation demonstrating understanding and a commitment to on-going compliance. Further, staff will demonstrate competency by return demonstration and meet or exceed the 90% proficiency level required to pass.	Shelly Donnelly, Nurse Manager	8/7/18	Nurse Manager will audit expiration dates weekly with a 90% target for compliance.	>90%

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.

Progress Report
recd 20 Sept 18
appr 1 Oct 18 Robin Munroe TL

Fairfax Behavioral Health
Plan of Correction for State Licensing Progress Report – Survey Dates: 06/18/2018 – 6/21/18
BHC Fairfax Hospital North (012699)

Tag Number	Deficiency	How Corrected	Date Completed	Results
L 690	**322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control**	Housekeeping staff were re-trained in the process of Discharge Patient Room Cleaning, specifically to the emptying of trash receptacles and proper hand hygiene when replenishing supplies during the process of room cleaning. This training was done in-person by the Housekeeping Supervisor. Staff demonstrated competency by return demonstration and met or exceeded the 90% proficiency level required to pass. Further, housekeeping staff were retrained to the Hand Hygiene policy by the Infection Control (IC) Preventionist.	7/6/18	100%
L1255	**322-200.3D RECORDS-TREATMENT PLAN WAC 246-322-200 Clinical Records.**	The Nurse Manager re-educated nursing staff to the Treatment Planning policy to include medical problems on the master treatment plan with specific nursing interventions for all medical problems identified. Nursing staff were trained in-person on 8/6/18 and 8/7/18, during mandatory meetings.	8/7/18	96%
L1305	**322-200.4A RECORDS-DATE WAC 246-322-200 Clinical Records.**	The Nurse Manager re-educated nursing staff on the Fairfax policy "Charting Requirements" and the importance of including a date on all progress notes and addendum notes, seclusion and restraint paperwork, admission completion checklists, initial medical consents, and Form #011 (Nursing Discharge Plan & Patient Education). Staff were trained on 8/6/18 and 8/7/18, during mandatory, all staff meetings and signed attestations demonstrating understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting on 7/13/18 to ensure that all Psychosocial Assessments and psychological progress notes are completed with their name and licensure printed, a signature and the date and time of its completion. The Business Office Director re-educated staff on the importance of completing the date field of the "Facility Representative Signature" and	8/7/18	91% 96%

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DEPARTMENT OF HEALTH
Office of Investigation and Inspection

Tag Number	Deficiency	How Corrected	Date Completed	Results
		"Reason for Lack of Signature" boxes on both patient rights forms, as well as the "Fairfax Hospital Staff" field on the Consent (acknowledgement of insurance benefits) and Advance Directive forms. Training was in-person at a weekly meeting on 7/19/18.		
L1310	**322-200.4B RECORDS-TIME OF DAY** **WAC 246-322-200 Clinical Records.**	The Nurse Manager re-educated nursing staff on Fairfax policy "Charting Requirements" and the importance of including a time on all progress notes and addendum notes, initial medical consents, admission completion checklists, and Form #011 (Nursing Discharge Plan & Patient Education). Staff were trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meetings and signed attestations demonstrating understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting on 7/13/18 to ensure that all Psychosocial Assessments are completed with name and licensure printed, a signature, and the date and time of completion. Medical Staff were re-educated by the Interim CMO and Assistant Administrator regarding the requirement to time provider progress notes, at the Medical Staff Meeting on 8/2/18. Business Office Director (BOD) modified the form to include a field for time of Fairfax staff signature. BOD to re-educate staff on the importance of documenting the time of staff signature on all admission forms, including Patient Rights, Advance Directives, Notice of Privacy Practices, Consent (acknowledgement of insurance benefits). In-person training occurred at the Business Office weekly staff meeting on 7/19/18.	8/7/18	91% 96%
L1315	322-200.4C RECORDS-AUTHENTICATION	The Nurse Manager re-educated nursing staff on Fairfax policy "Charting Requirements" and the importance of authenticating all initial medical	8/7/18	96%

Fairfax Behavioral Health
Plan of Correction for State Licensing Progress Report – Survey Dates: 06/18/2018 – 6/21/18
BHC Fairfax Hospital North (012699)

Tag Number	Deficiency	How Corrected	Date Completed	Results
	WAC 246-322-200 Clinical Records. (4)	consents, statements of patient belongings, seclusion and restraint paperwork, admission completion checklists, and Form #011 (Nursing Discharge Plan & Patient Education). Staff were trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meetings and signed attestations demonstrating understanding and a commitment to on-going compliance. Case Management staff were re-educated in their monthly staff meeting on 7/13/18 to ensure that all Psychosocial Assessments are completed with their name and licensure printed, a signature,and the date and time of completion. Medical Staff were re-educated by the Interim CMO and Assistant Administrator regarding the requirement to authenticate entries at the Medical Staff Meeting on 8/2/18. Business Office Director re-educated staff on the importance of authenticating all admission forms with complete staff signatures. Staff were trained in-person on 7/19/18 at their weekly staff meeting.		96%
L1470	**322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services.**	The Nurse Manager re-educated staff on Fairfax policy and the importance of including an expiration date when opening urinalysis strips for the first time. Staff were trained in-person on 8/6/18 and 8/7/18, during mandatory, all staff meetings and signed attestations demonstrating understanding and a commitment to on-going compliance. Further, staff demonstrated competency by return demonstration and met or exceeded the 90% proficiency level required to pass.	8/7/18	100%

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

September 24, 2018

Darcie Johnson
Director of Quality & Risk Management
Fairfax Behavioral Health
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 licensing survey at Fairfax Behavioral Health - North on June 18 – 22, 2018. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on July 19, 2018.

Hospital staff members sent a Progress Report dated September 20, 2018 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Behavioral Health Monroe's attestation of compliance with Chapter 246-320 WAC.

The Deputy Fire Marshal conducted an on-site revisit on September 12, 2018 and verified the Fire Life Safety corrections are complete.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Robin Munroe, RS
Survey Team Leader