State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

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L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC), 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. On-site dates: 11/07/23-11/09/23 Off-site dates: 11/13/23-11/16/23, 11/20/23 Case number: 2022-13674 Intake number: 126948 There were violations found pertinent to this complaint.	L 000	POC text 1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on 12/31/23. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following	L 355		

Christopher West, CEO

12/14/23

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L 355	Continued From page 1 written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: . Based on interviews, record review, document review, and review of policies and procedures, the hospital failed to implement policies and procedures for staff actions in the event of incidents potentially harmful to the patient for 1 of 9 patients reviewed (Patient #1). Failure to follow policies and procedures regarding staff actions in the event of potentially harmful incidents risks patient safety and mental wellbeing. Findings included: 1. Review of hospital policies and procedures showed the following: a. The policy titled, "Incident Reporting: Occurrence Reporting System," policy number PI-002, #14430311, last approved 11/23, addressed incident reporting and the role of Risk Management. The policy showed that it was intended to ensure identification of serious injuries, conduct timely peer reviews, intervene to reduce occurrences, and ensure prompt	L 355		

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L 355	Continued From page 2 reporting. An occurrence is defined as an incident that is not consistent with the routine care of a patient and/or the desired operations of the facility. The results of the occurrence must have caused or have the potential to cause unexpected physical or mental impairment. The policy described the procedure to be followed: any staff member who discovers or is involved in an event or occurrence is to complete the electronic incident report form. The Director of Risk Management (DRM) has the primary responsibility for administrative functions around the incident reporting system. The staff member most closely associated with the event documents the following in the medical record: the facts of the event, the clinical condition of the patient, and the persons notified. The Nursing Supervisor (NS) or House Charge (HC) gathers information and sends the completed incident report to the DRM. The NS or the HC is responsible for ensuring intervention and appropriate actions are taken to protect the patient. b. The policy titled, "Patient Observation Policy," 1000.5, policy number #13426428, last approved 06/23, showed that staff is required to monitor hallways and patient care areas to ensure patients are not entering other patients' rooms or other restricted areas without supervision. c. The policy titled, "Sexual Aggression/Victimization Precautions, 1000.80," policy number #13426424, last approved 06/23, showed that the policy was designed to provide a plan for the prevention of sexual behaviors by identifying early warning signs, monitoring the patient suspected of having a potential for sexual aggression or victimization, and implementing interventions to minimize risks. Categories of	L 355		

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L 355	Continued From page 3 relevant events include boundary violations evidenced by sexually provocative language or taking actions that invade another person's privacy. Nursing staff assess risk factors and place the patient on the appropriate precautions. Changes to levels of precautions are communicated through staff and across shifts, and a sexually inappropriate behavior treatment plan is initiated. Unit staff observe patients for sexually acting out behaviors, including boundary violations. Staff should always maintain awareness of the patient's location, document signs of concern, separate patients at risk, and pay attention to isolated areas on the unit during rounds. Interventions can include scheduling a specific shower time with appropriate supervision. The DRM is to be notified within 24 hours of an incident. Sexual Victimization Precautions (SVP) or Sexual Aggression Precautions (SAP) are ordered accordingly, and a treatment plan addendum is added addressing the SVP or SAP precautions. d. The policy titled, "Suspected or Confirmed Cases of Patient Sexual Activity, 1000.30," policy number #13426447, last approved 06/23, showed that the staff member who first learns of suspected activity between patients will immediately separate the patients, report the incident to the charge nurse, attending physician, house supervisor, and program manager, and complete an incident report. e. The policy titled, "Patient Complaints and Grievances, PI-004," policy number #14430313, last approved 11/23, showed that any patient complaint involving an allegation of abuse, injury, or neglect is automatically considered a formal grievance. The allegation is then to be reported and investigated; a resolution is to be completed	L 355		

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L 355	Continued From page 4 within 7 days of receipt. 2. Review of the document titled, "Suspected In-house Abuse/Neglect/Sexual Activity Response Checklist," last revised in 07/19, showed that staff are required to follow the checklist after any allegation. Checklist tasks included documenting the incident in the medical record, filing an incident report, and completing the investigation, including follow-up activities. 3. On 11/07/23 at 2:30 PM, an interview with a Registered Nurse (RN) (Staff #1) showed that staff will redirect any patient trying to go into another patient's room, and that any incident where a patient enters another's room is an incident requiring an incident report. The RN stated that, in the event of an incident or allegation, they will try to verify the report by gathering more information, talking with the alleged victim, reporting the incident to the doctor and supervisors, doing an Incident Report, placing the alleged perpetrator on SAP, and considering SVP for the alleged victim depending on that patient's history. She stated that an incident report would be completed even if the alleged perpetrator is scheduled to be discharged the same day. 4. On 11/8/23 at 2:05 PM, an interview with a Mental Health Technician (MHT) (Staff #3) showed that when a staff member sees a patient enter a peer's room, they will immediately attempt to remove the patient from the room. Staff #3 stated that they will complete a progress note, notify the provider and HC, and file an incident report. Staff #3 stated that they will follow the same process for all patients, even if they are scheduled to be discharged the same day. Staff #3 stated that when a patient enters another	L 355		

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L 355	Continued From page 5 patient's room, staff will report the event to the charge nurse and file an incident report. 5. Record review of Patient #1's medical record showed that Patient #1 was a 24-year old female involuntarily admitted for suicidal ideation on 11/02/22. On 11/03/22, nursing note documentation showed that Patient #1 complained to an MHT that a male peer entered her room while she was showering and asked if he could join her in the shower. The MHT documented that he informed Patient #1 that the peer was scheduled to discharge later that day. There was no documentation showing that the incident was reported to the primary nurse, the charge nurse, or the attending physician as required by hospital policy. On 11/04/22, Case Manager (CM) documentation showed that Patient #1's mother called the CM to report the shower incident. Documentation showed that the CM discussed the incident with the MHTs and the charge nurse and recommended that the group therapist check in with the patient. The investigator found no further documentation regarding the incident, including the patient's clinical condition or provider notification, as required by hospital policy. 6. On 11/09/23 at 12:30 PM, an interview with a Program Manager (Staff #5) showed that staff should file an incident report any time a patient enters a peer's room, even if it was unwitnessed by staff. When asked about the incident with Patient #1, Staff #5 stated that staff should have written a progress note that included notification of the doctor, charge nurse, and HC, completed an incident report of the event, and reported the incident to the Director of Risk Management.	L 355		

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L 355	Continued From page 6 7. Record review of 6 male patients discharged between 11/03/22 and 11/07/22 showed no documentation of allegations of a potential boundary violation with Patient #1, and none of the patients were placed on SAP after the alleged incident on 11/03/23. 8. On 11/09/23 at 9:55 AM, the investigator reviewed Incident Reports with the Director of Risk Management (Staff #6). During the review, Staff #6 was unable to locate any incident reports involving Patient #1 and alleged boundary violations. Staff #6 stated nursing staff should have completed an incident report and confirmed the investigator's findings that the hospital did not follow its process for reporting and investigating incidents of alleged boundary violations.	L 355		

POC received 01/02/24
revision received 01/09/24
approved 02/05/24

PRINTED: 12/21/2023
FORM APPROVED

State of Washington

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

Christopher West, CEO 1/2/24

Revision Approved by Christopher West, CEO _____ Date: 1/9/24

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L 355	Continued From page 2 reporting. An occurrence is defined as an incident that is not consistent with the routine care of a patient and/or the desired operations of the facility. The results of the occurrence must have caused or have the potential to cause unexpected physical or mental impairment. The policy described the procedure to be followed: any staff member who discovers or is involved in an event or occurrence is to complete the electronic incident report form. The Director of Risk Management (DRM) has the primary responsibility for administrative functions around the incident reporting system. The staff member most closely associated with the event documents the following in the medical record: the facts of the event, the clinical condition of the patient, and the persons notified. The Nursing Supervisor (NS) or House Charge (HC) gathers information and sends the completed incident report to the DRM. The NS or the HC is responsible for ensuring intervention and appropriate actions are taken to protect the patient. b. The policy titled, "Patient Observation Policy," 1000.5, policy number #13426428, last approved 06/23, showed that staff is required to monitor hallways and patient care areas to ensure patients are not entering other patients' rooms or other restricted areas without supervision. c. The policy titled, "Sexual Aggression/Victimization Precautions, 1000.80," policy number #13426424, last approved 06/23, showed that the policy was designed to provide a plan for the prevention of sexual behaviors by identifying early warning signs, monitoring the patient suspected of having a potential for sexual aggression or victimization, and implementing interventions to minimize risks. Categories of	L 355	The Director of Clinical Services re-educated all Case Management staff on the requirements of abuse/ neglect reporting and documentation requirements utilizing Fairfax policies: 1. Incident Reporting: Occurrence Reporting System 2. Patient Complaints and Grievances 3. Case Management and Abuse Assessment and Reporting. Re-training included, but was not limited to: 1. Reporting all allegations of abuse/neglect received by the patient or family member to the Director of Clinical Services and Patient Advocate immediately, as they are considered an automatic grievance. 2. Documenting allegations of abuse/neglect in the patient's medical record to include the notification of appropriate members of the patients care team of the allegation. 3. If Case Management staff receives the initial allegation of abuse or neglect, they are responsible for entering the incident report into Midas. 4. Case Managers must document all contact with outside parties, to include discussions with family members, in the patients medical record per Fairfax policy "Case Management, 1000.83" as the "Hand Off" document currently in use is not part of the medical record. 5. Ensuring that any documented recommendation that a Case Manager makes in a patient's medical record for another member of the Clinical Services team to follow up or "check in" with a patient is completed and documentation is present in that patients chart. Training by DCS/designee occurred via staff meetings and small groups. Understanding of training was verified by sign-in sheet. The Director of Risk Management met with the Patient Advocate on 12/28/23 to ensure the hospitals policies pertaining to the reporting, investigating and response expectations of patient abuse/neglect allegations is understood and is being followed to include: The Patient Advocate will investigate complaints/ grievances and issue a formal response to the patient within 7 days. Patient Advocate investigations are not part of the patients medical record and are maintained with the advocate. The Patient Advocate will report requested data to identified members of Leadership as outlined in this Plan of Correction.	2/4/24

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L 355	Continued From page 4 within 7 days of receipt. 2. Review of the document titled, "Suspected In-house Abuse/Neglect/Sexual Activity Response Checklist," last revised in 07/19, showed that staff are required to follow the checklist after any allegation. Checklist tasks included documenting the incident in the medical record, filing an incident report, and completing the investigation, including follow-up activities. 3. On 11/07/23 at 2:30 PM, an interview with a Registered Nurse (RN) (Staff #1) showed that staff will redirect any patient trying to go into another patient's room, and that any incident where a patient enters another's room is an incident requiring an incident report. The RN stated that, in the event of an incident or allegation, they will try to verify the report by gathering more information, talking with the alleged victim, reporting the incident to the doctor and supervisors, doing an Incident Report, placing the alleged perpetrator on SAP, and considering SVP for the alleged victim depending on that patient's history. She stated that an incident report would be completed even if the alleged perpetrator is scheduled to be discharged the same day. 4. On 11/8/23 at 2:05 PM, an interview with a Mental Health Technician (MHT) (Staff #3) showed that when a staff member sees a patient enter a peer's room, they will immediately attempt to remove the patient from the room. Staff #3 stated that they will complete a progress note, notify the provider and HC, and file an incident report. Staff #3 stated that they will follow the same process for all patients, even if they are scheduled to be discharged the same day. Staff #3 stated that when a patient enters another	L 355	for all identified patients to ensure: 1. Case Management documentation shows the Patient Advocate was notified if allegation of abuse or neglect was initially reported to the patients Case Manager. 2. Case Manager has entered an incident report, if the initial report of abuse/neglect is received by Case Management staff. 3. The patients medical record includes Case Management documentation pertaining to any allegations of abuse or neglect allegations initially received by the patients Case Manager and the notification of the patients care team including the patients Provider. 4. Any allegation of patient abuse/neglect documented on the Case Managers "hand-off" document has corresponding note from Case Manager regarding the allegation in the patients medical record. 5. Documented recommendations by Case Management for other Clinical Services team members to follow up with a patient have a corresponding note from that team member. Patient Advocate will monitor all reported allegations of patient abuse/neglect monthly to ensure: 1. Documentation of a response to the patient is completed within 7 days. Target for compliance for all the above monitoring is 90% or greater. Results of monitoring will be reported to the Quality Council and Medical Executive Committees monthly and to the Governing Board quarterly until compliance goals have been achieved and sustained for a minimum of 3 consecutive months. **When Correction is Completed: 2/4/24**	2/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000102	A. BUILDING: _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BHC FAIRFAX HOSPITAL	10200 NE 132ND ST KIRKLAND, WA 98034

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L 355	Continued From page 5 patient's room, staff will report the event to the charge nurse and file an incident report. 5. Record review of Patient #1's medical record showed that Patient #1 was a 24-year old female involuntarily admitted for suicidal ideation on 11/02/22. On 11/03/22, nursing note documentation showed that Patient #1 complained to an MHT that a male peer entered her room while she was showering and asked if he could join her in the shower. The MHT documented that he informed Patient #1 that the peer was scheduled to discharge later that day. There was no documentation showing that the incident was reported to the primary nurse, the charge nurse, or the attending physician as required by hospital policy. On 11/04/22, Case Manager (CM) documentation showed that Patient #1's mother called the CM to report the shower incident. Documentation showed that the CM discussed the incident with the MHTs and the charge nurse and recommended that the group therapist check in with the patient. The investigator found no further documentation regarding the incident, including the patient's clinical condition or provider notification, as required by hospital policy. 6. On 11/09/23 at 12:30 PM, an interview with a Program Manager (Staff #5) showed that staff should file an incident report any time a patient enters a peer's room, even if it was unwitnessed by staff. When asked about the incident with Patient #1, Staff #5 stated that staff shouldhave written a progress note that included notification of the doctor, charge nurse, and HC, completed an incident report of the event, and reported the incident to the Director of Risk Management.	L 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 355	Continued From page 6 7. Record review of 6 male patients discharged between 11/03/22 and 11/07/22 showed no documentation of allegations of a potential boundary violation with Patient #1, and none of the patients were placed on SAP after the alleged incident on 11/03/23. 8. On 11/09/23 at 9:55 AM, the investigator reviewed Incident Reports with the Director of Risk Management (Staff #6). During the review, Staff #6 was unable to locate any incident reports involving Patient #1 and alleged boundary violations. Staff #6 stated nursing staff should have completed an incident report and confirmed the investigator's findings that the hospital did not follow its process for reporting and investigating incidents of alleged boundary violations.	L 355		

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

02/20/24

Alexandra Hughes
Fairfax Behavioral Health, Kirkland
10200 NE 132nd Street
Kirkland, WA 98034

Re: Complaint 2022-13674

Dear Ms Hughes:

I conducted a state hospital licensing complaint investigation at Fairfax Behavioral Health onsite 11/07/23-11/09/23 and off-site: 11/13/23-11/16/23 and 11/20/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 02/05/24.

Hospital staff members sent a Progress Report dated 02/14/24 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Behavioral Health's attestation that it has corrected all deficiencies cited under WAC 246-322.

We sincerely appreciate you and your staff's cooperation and hard work during the investigation process.

Sincerely,

Mary D'Avanzo, MN/BSN/RN
Nurse Investigator