State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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
L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. On site dates: 10/06/21 - 10/08/21 Offsite dates: 10/14/21 Examination number: 2021-847 The survey was conducted by: Surveyor #5 Surveyor #17 The Washington Fire Protection Bureau conducted the fire life safety inspection (See Shell # K5GN21). During the course of the survey, surveyors assessed issues related to complaint #2021-11377.	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 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by November 5, 2021. 4. Return the REPORT electronically with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing	L 315		

State of Washington

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L 315	Continued From page 1 or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Item #1 Active Therapy Based on document review and interview, the hospital failed to ensure that active treatment measures were provided or demonstrated attempts to engage patients in alternative active treatment measures when they chose not to attend groups as directed by hospital policy for 2 of 2 patients reviewed (Patient #502 and #503). Failure to provide active treatment at a sufficient level and intensity results in affected patients being hospitalized without all active treatment interventions for recovery, thereby delaying their improvement. Findings included: 1. Document review of the hospital's policy and procedure titled," Plan for Provision of Care-Scope of Services," policy number 100.12, reviewed 08/11/21, showed the following: a. Each unit provides distinctive programing to allow treatment to be tailored to the level of functioning and degree of illness present. b. Programming includes group therapy, psycho-educational groups, and expressive and recreational therapies. c. Treatment consists of multiple avenues of therapy, provided by many disciplines. These various therapies are based upon the plans and	L 315		

State of Washington

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L 315	Continued From page 2 interventions documented in the individualized treatment plan and include individual treatment, group therapy, supportive family therapy, and milieu therapy. d. Group Therapies conducted daily, and the daily schedule includes a variety of activities based recreational or occupational therapy groups as well as other psychoeducational or milieu-based groups. Document review of the hospital's policy and procedure titled, "Individual Supportive Therapy and Education," policy number 400.04, reviewed 12/01/20, showed the following: a. A Social Worker (SW) or Licensed Professional (LP) will provide psychoeducation to individuals at the hospital. b. The SW and the Physician will determine the extent of the need for individual supportive therapy. c. The SW/LP will document all contacts with the patient in the patient's medical record including the psych-social assessment, education provided, supportive therapy interventions, patient response, and plan for the next session. Document review of the hospital's policy and procedure titled," Alternative Programing," policy number 400.11, reviewed 12/01/20, showed the following: a. The hospital supports a model of active treatment for all patients and the primary treatment is group therapy provided by a variety of disciplines to include social services, activity groups, and nursing.	L 315		

State of Washington

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L 315	Continued From page 3 b. An individualized treatment plan is developed for each patient that directs the specific focus of these groups for the patient as well as other treatment interventions. c. At times, due to a patient's psychiatric or medical condition, group interventions are not appropriate for the patient to realize active services and alternative therapeutic interventions must be identified, planned, and implemented for that patient. d. The patient's treatment team, led by the attending physician, is responsible for recognizing the need for alternative treatment interventions, development of an appropriate treatment plan, implementation of the plan, and documentation for the individual interventions. e. Each therapist, social worker, activity therapist, Registered Nurse or Mental Health Technician assigned to conduct educational or therapeutic groups is responsible for documenting the group in each patient's medical record. f. In the event that a patient misses an individual group intervention, the staff member responsible for providing the group will seek out the patient and provide individual therapy. The staff member will chart the intervention, including what was discussed or the educational/activity provided, the patient's response to the intervention, and the patient's progress toward meeting treatment goals. g. If a patient continues to refuse group or is unable to attend group for greater that 24 hours, the Unit Program Director or Charge Nurse will be responsible for calling an ad hoc meeting of the	L 315		

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L 315	Continued From page 4 treatment team to revise the patient's current treatment plan or develop a new plan with interventions more appropriately done on an individual basis rather that a group intervention. g. Staff assigned to perform individual interventions with the patient will document these interventions in the medical record under the progress note section, including date/time of the interventions, the modality and the focus of the intervention, the patient's response to the intervention and progress toward treatment goals. 2. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, depression, Post-Traumatic Stress Disorder, and anxiety. Document review including review of the active therapy attendance records from 09/09/21 through 10/06/21 (28 days) showed the following: a. The Treatment Plan Problem Sheet dated 09/17/21, showed that the patient's short-term goal included attending group programming to improve coping skills daily. The patient will attend psychoeducation group daily, group therapy with the social worker daily, and activity therapy groups twice daily (total of 4 groups). b. Surveyor #5 found no evidence that the patient attended a process group or received alternate treatment for 15 of 28 days. c. Surveyor #5 found no evidence that the patient attended a recreational group or received alternate treatment for 7 of 28 days.	L 315		

State of Washington

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L 315	Continued From page 5 d. Surveyor #5 found no evidence that the patient attended an activity group or received alternate treatment for 13 of 28 days. e. Surveyor #5 found no evidence that the patient attended morning communication group or received alternate treatment for 7 of 28 days. f. Surveyor #5 found no evidence that the patient attended evening communication group or received alternate treatment for 10 of 28 days. g. Staff documented on the Master Treatment Plan Update Worksheets for 09/16/21, 09/20/21, 09/23/21, 09/27/21, and 10/04/21, that the patient was attending 3 or more groups a day. Surveyor #5 found no evidence that the patient attended 3 or more groups daily for 12 of 28 days and no evidence the patient attended all 4 groups directed by the treatment plan for 17 of 28 days. h. On 09/16/21, the Master Treatment Plan Update Worksheet showed a box check "Yes" that the patient was placed on "Specialized Programming" and a written note stated, "off 1:1 for 2 hours now placed back on 1:1." Surveyor # 5 found no evidence of alternative therapeutic interventions identified, planned, and implemented as directed by hospital policy. i. On 09/21/21, the Master Treatment Plan Update Worksheet showed a problem of "Suicidal," added to the problem list. In the section titled, "Progress toward Goal," staff documents," placed on alternative programming." Surveyor #5 found no evidence of alternative therapeutic interventions identified, planned, and implemented as directed by hospital policy.	L 315		

State of Washington

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L 315	Continued From page 6 3. At the time of the review, Staff #501 stated that the hospital offered an opening communication group in the morning and a closing communication group in the evening, daily process groups, and activity therapy/recreational therapy twice daily. Staff #501 verified the finding and stated that staff should be documenting group attendances and alternate therapy. 4. On 10/07/21 at 10:45 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #503 who was admitted as an involuntary patient for an attempted suicide on 09/11/21. The patient's history included Post Traumatic Stress Disorder, Borderline Personality Disorder, and Oppositional Defiance Disorder. Document review including review of the active therapy attendance records from 09/12/21 through 10/01/21 (20 days) showed the following: a. The Treatment Plan Problem Sheet dated 09/15/21, showed that the patient's short-term goal included attending group programming to improve coping skills daily. The patient will attend psychoeducation group daily, group therapy with the social worker daily, and activity therapy groups twice daily (total of 4 groups). b. Surveyor #5 found no evidence that the patient attended a process group or received alternate treatment for 8 of 20 days. c. Surveyor #5 found no evidence that the patient attended a recreational group or received alternate treatment for 6 of 20 days. d. Surveyor #5 found no evidence that the patient attended an activity group or received alternate treatment for 7 of 20 days.	L 315		

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L 315	Continued From page 7 e. Surveyor #5 found no evidence that the patient attended morning communication group or received alternate treatment for 4 of 20 days. f. Surveyor #5 found no evidence that the patient attended evening communication group or received alternate treatment for 4 of 20 days. g. Staff documented on the Master Treatment Plan Update Worksheets for 09/16/21, 09/22/21 and 09/29/21 that the patient was attending 3 or more groups a day. Surveyor #5 found no evidence that the patient attended 3 or more groups daily for 6 of 20 days and no evidence the patient attended all 4 groups directed by the treatment plan for 8 of 20 days. h. On 09/16/21, the Master Treatment Plan Update Worksheet shows a box check "Yes" that the patient was placed on "Specialized Programming" and a written note stated, "1:1 programming." Surveyor # 5 found no evidence of alternative therapeutic interventions identified, planned, and implemented as directed by hospital policy. 5. Staff #501 verified the finding and stated that staff should be documenting group attendances and alternate therapy. Item #2 Monitoring of Patients on Enhanced Precautions Based on interview, observation, and document review the hospital failed to develop and implement a system to ensure staff were notified of and provided appropriate monitoring for patients who had been placed on enhanced monitoring precautions for 3 of 3 patients (Patient	L 315		

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L 315	Continued From page 8 #507, #508 and #509). Failure to properly communicate patients' risk of self-harm, harm to other patients or harm to unit staff members, posed a threat to the health and safety of all patients and staff, which could result in serious injury and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Aggression and Sexual Victimization: Prevention and Response and Notification Plan," policy number 500.05F, reviewed 01/18/21, showed the following: a. Staff are to observe patients for specific behaviors/precursors to sexually acting out including boundary violations, sexual aggression, and sexual victim. b. Maintain an awareness of the patient location at all times c. Communicate and document signs of concern d. Conduct observation rounds as ordered Document review of the hospital's policy and procedure titled, "Suicide Precautions," policy number 500305, reviewed 07/16/21, showed the following: a. The physician will reevaluate the Suicide Precaution order daily to determine continued need. The physician order for discontinuance of Suicide Precautions is initiated when the patient is assessed to be no longer at risk b. Patients on Suicide Precautions will be	L 315		

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L 315	Continued From page 9 identified by an "S" written on the unit census boards. The Suicide Prevention box will be check on the Observation sheet. c. Staff will closely monitor the patient on the unit d. When conducting rounds, staff shall observe the patient directly. 2. On 10/06/21, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) observed staff provide patient rounding observations for patients on enhanced precautions, reviewed rounding documentation, and interviewed staff related to monitoring of patients on enhanced precautions. Surveyor #5 observed the following: a. From 9:52 AM until 10:02 AM, Surveyor #5 interviewed a Mental Health Technician (MHT) (Staff #504) and observed Staff #504 perform patient rounding observations. During interview with Surveyor #5, Staff #504 stated that she was monitoring Patient #507, #508, and #509 for enhanced suicide precautions. b. At 10:45 AM, Surveyor #5 interviewed a Registered Nurse (Staff #505) about patients on enhanced monitoring and reviewed enhanced precaution orders for Patient #501, #507, #508, and #509. The provider order review showed that Patient #508 was on Suicide Precautions. Patient #507 and #509 were not on Suicide Precautions. Patient #501 and #509 were on Sexual Aggression Precautions. c. From 10:48 AM until 11:08 AM, Surveyor #5 interviewed an MHT (Staff #506) and observed Staff #506 perform patient rounding observations. Staff #506 stated that she was monitoring Patient	L 315		

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L 315	Continued From page 10 #508 and #509 for enhanced suicide precautions and Patient #509 for Sexual Aggression Precautions. Surveyor #5 asked Staff #506 if there were any other patients on Sexual Aggression Precautions. Staff #506 stated "no." At this time, Surveyor #5 specifically asked if Patient #501 was on Sexual Aggression Precautions. Surveyor #5 and Staff #506 reviewed the observation record for Patient #501. The review showed that the patient should have been receiving enhanced monitoring for sexual aggression. d. At this time, Staff #506 also stated that Patient #510 should be on sexual aggression precautions related to his behavior, but she didn't know if he was. e. At 10:50 AM, Surveyor #5 and Staff #505 reviewed the orders for Patient #510. The review showed the patient was only on "cheeking" precautions. 3. At the time of the findings, Staff #501 verified the hospital did not have an effective process in place to ensure that staff provided the appropriate enhanced monitoring for the appropriate patient. Item #3 Implementation of Enhanced Precautions and Observational Monitoring Based on interview and document review the hospital failed to implement a system to ensure patients were placed on appropriate observational monitoring and enhanced precautions for 2 of 3 patients reviewed (Patient #501 and #502). Failure to implement enhanced precautions in a timely manner puts patients at risks of an unsafe therapeutic environment, psychological harm, and	L 315		

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L 315	Continued From page 11 serious injury or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Suicide Precautions," policy number 500.05C3, reviewed 07/16/21, showed that suicide precautions are used for patients at risk for suicide and/or self-destructive behavior, which requires intensive support, close observation, frequent re-assessment, and indicated protective measures to ensure the emotional and physical welfare of patients at all times. All suicide threats, gestures, and attempts are considered serious and are to be responded to immediately. Staff observe patients on Suicide precautions with an increased level of vigilance. Document review of the hospital's policy and procedure titled, "Sexual Aggression and Sexual Victimization Prevention and Response and Notification Plan," policy number 500.05F, reviewed 01/18/21, showed that the provision of a safe, therapeutic environment of care includes the prevention of patient to patient sexual incidents as well as any verbal or physical threats of sexual incident. The policy provides a plan for identification of early warning signs and Monitoring the patient with suspected potential for sexual aggression/victimization and implementing intervention steps to minimize the risk of sexual behaviors. Patients assessed for risk factors for Sexual aggression/victimization are placed on Sexually Acting Out (SAO)-Aggression or SAO-Victimization precautions. Document review of the hospital's policy and procedure titled, "Fall Risk Assessment and Care," policy number 500.16, reviewed 11/18/20, showed the following:	L 315		

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L 315	Continued From page 12 a. When a patient falls while hospitalized staff will: i. Initiate Fall Precautions (implement all interventions as for a patient placed on Fall Precautions upon Admission). ii. Document the fall in the patient's medical record. iii. Initiate Post Fall and Fall Risk Individual Treatment Plans and inventions as appropriate. 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted on 10/04/21 for the treatment of Schizophrenia. The medical record showed that patient had a history of a broken hip with complications resulting in pain and alteration in mobility and the patient utilized a shopping cart to assist with mobility prior to admission to the hospital. The review showed the following: a. On 10/04/21 at 22:30 PM, the Registered Nurse Admission Assessment showed the patients Fall Risk as low. Review of the assessment showed that the nurse failed to include all diagnosis including substance use, ambulation assistive devices (wheelchair/walker) and mental status in the assessment. b. On 10/05/21 at 1:15 AM, the Daily Nursing Flow Sheet showed that the patient was using a walker for ambulation related to an unsteady gait related to a history of a hip fracture. The patient was unable to use the walker and the hospital	L 315		

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L 315	Continued From page 13 then provided the patient with a wheelchair. c. Surveyor #5 found no evidence the patient was placed on Fall Precautions. 3. During interview with Surveyor #5, Staff #501 verified the finding and stated that the walker the hospital provided was too small, so the hospital provided the patient with a wheelchair to assist with mobility. 4. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, depression, Post-Traumatic Stress Disorder, and anxiety. The review showed the following: a. On 09/11/21, the patient pulled the steri-strips off a wound from a prior self-harm event and pulled the wound edges apart approximately 2.5 inches long by .5 inch wide. The patient was not placed on self-harm precautions until 09/13/21. b. On 09/14/21 the patient fell and hit her head. The patient had additional fall episodes on 09/20/21 and 09/21/21. The patient was not placed on fall precautions until 09/21/21. c. On 09/19/21 the patient had inappropriate behaviors with a peer. Surveyor #5 found no evidence the patient was placed on Sexual Aggression Precautions. 5. At the time of the review, Staff #501 verified that precautions had not been implemented timely.	L 315		

State of Washington

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L 315	Continued From page 14	L 315		
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to ensure that patients' rights were protected by failure to provide informed consent detailing the risks, benefits, and alternatives for prescribed psychotropic medications, as demonstrated by 3 of 5 records reviewed (Patient #501, #502 and #503). Failure to ensure that patients receive informed consent for prescribed psychotropic medications, including scheduled and PRN (as needed) medications violates the patient's rights to receive details of the risks, benefits, and alternatives for all psychotropic medications prior to administration. Findings included: 1. Document review of the hospital's policy titled, "Medication-Involuntary Use of Antipsychotics for	L 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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L 320	Continued From page 15 Involuntary Patients," Policy Number 500.04, date issued 10/01/18, showed that prior to the administration of antipsychotic medications, an attempt will be made to obtain informed consent. Document review of the hospital's policy and procedure titled, "Patient's Rights and Responsibilities," Policy Number 100.11, issue date 10/01/28, showed that involuntary patients have the right to refuse psychiatric medications, except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber, make an informed decision regarding the use of anti-psychotic medication, and have the right to not consent to the administration of anti-psychotic medications beyond the hearing conducted pursuant to RCW 71.05.320 (2). Document review of the hospital's preprinted consent form titled, "Inland Behavioral Health Specific Authorization for Psychotropic Medications," dated 02/19, showed that Risperidone (an antipsychotic medication), Thorazine (an antipsychotic medication), Abilify (an antipsychotic medication), Lorazepam (an anxiolytic medication), Zyprexa (an antipsychotic medication), Seroquel (an antipsychotic medication), Ambien (a hypnotic medication), Lamictal (a mood stabilizer), Prozac (an antidepressant medications), Trazodone (an antidepressant/antianxiety medication), Vistaril (an antihistamine medication), Cymbalta (an anti-depressant medication), Adderall XR (Central Nervous System Stimulant used for the treatment of Attention-Deficit/hyperactivity disorder) were medications requiring informed consent. 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff	L 320		

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L 320	Continued From page 16 #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted as an involuntary patient for danger to self and a danger to others on 10/04/21. The patient had a history of Schizophrenia and was not taking any medications. The record review showed that the provider ordered Risperidone, Thorazine, Lorazepam, Zyprexa, Seroquel, and Ambien. Surveyor #5 found no informed consent documents or attempt to obtain informed consent in the medical record. 3. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, depression, Post-Traumatic Stress Disorder, and anxiety. The Psychiatric Evaluation completed on 09/09/21 at 7:54 AM, showed that the patient consented to continue taking her current home medications which included Trazodone, Prozac, Lamictal, and Vistaril. Additional provider orders included Thorazine, Lorazepam, Zyprexa, and Ambien. Surveyor #5 found no informed consent documents or attempt to obtain informed consent in the medical record. 4. At the time of the findings, Staff #501 verified that the records for Patient #501 and #502 did not contain evidence of informed consent or an attempt to obtain informed consent. Staff #501 stated that she would contact the patient's providers to determine if the consent was with the providers or in the provider's office. Staff #501 stated that the medical record should have contained a consent for the administration of	L 320		

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L 320	Continued From page 17 Psychotropic medications or at minimum an attempt to obtain consent should have been documented. 5. On 10/07/21 at 10:45 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #503 who was admitted as an involuntary patient for an attempted suicide on 09/11/21. The patient's history included Post Traumatic Stress Disorder, Borderline Personality Disorder, and Oppositional Defiance Disorder. The Psychiatric Evaluation completed on 09/12/21 at 9:00 AM, showed that the patient would continue home medications. The Medical History and Physical 09/12/21 at 11:12 AM showed the home medications included Trazadone, Abilify, Cymbalta, and Atarax (Vistaril). Additional provider orders after admission included Ativan, Adderall XR, Zyprexa, and Ambien. Surveyor #5 found no informed consent documents or attempt to obtain informed consent in the medical record. 6. On 10/08/21 at 9:00 AM, Staff #501 verified that she was unable to obtain evidence that the Providers had obtained informed consent for Psychotropic medication administration for Patient #501, #502, and #503.	L 320		
L 370	322-035.1N POLICIES-PATIENT WORK WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (n) Allowing patients to work on the premises,	L 370		

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L 370	Continued From page 18 according to WAC 246-322-180; This Washington Administrative Code is not met as evidenced by: . Based on interview and review of the hospital's policies and procedures, the hospital failed to establish an approved written policy and procedure addressing patients working at the facility as part of their treatment plan. Failure to have an approved written policy and procedure risks staff confusion and delay in addressing a patient's request to work on the premises. Findings included: 1. Record review showed that the hospital did not have a policy or procedure in place for allowing patients to work according to WAC 246-322-180. 2. On 10/08/21 at 10:26 AM, Surveyor #17 interviewed the Infection Preventionist (Staff #1707) about the hospital's policy for allowing patients to work as part of their treatment plan. Staff #1707 stated that the hospital did not have a policy on patient work.	L 370		
L 380	322-035.1P POLICIES-EQUIP MAINTENANCE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (p) Cleaning, inspecting, repairing and calibrating electrical, biomedical and therapeutic equipment, and documenting actions;	L 380		

State of Washington

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L 380	Continued From page 19 This Washington Administrative Code is not met as evidenced by: Based on document review and interview, the hospital staff failed to ensure that routine preventative maintenance of ice machines was documented in the hospital asset management system. Failure to conduct and document preventative maintenance of ice machines at required intervals risks unclean or inoperable ice machines that could lead to infeciton or dealys in care. Findings included: 1. Record review of the work order for the ice machines showed that preventative maintenance occurs at bi-annual cycle. 2. Record review of the preventative maintenance work orders for Follet ice machines K42052, K42320, K42053, K42050 showed that the preventative maintenance was due on 04/21/21. The work orders were not marked as completed until 10/07/21, which occurred during the survey. 3. On 10/08/21 at 10:00 AM, Surveyor #17 interviewed the Facilities Manager (Staff #1701) about the ice machine maintenance. Staff #1701 confirmed that the most recent preventative maintenance records for the four ice machines had not been completed in the work order system as required. Staff #1701 showed the surveyor a purchase order for cleaning equipment dated 08/10/21. Staff #1701 stated that these items were used to perform the maintenance.	L 380		

State of Washington

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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L 560	Continued From page 20	L 560		
L 560	322-050.6D TRAINING-INFECT CONTROL WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (d) Infection control; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that staff completed annual infection control training for 2 of 10 staff reviewed (Staff #1702 and #1703). Failure to ensure staff complete ongoing infection control training places patients and staff at risk of transmission of infection. Findings included: 1. Record review of the syllabus for the training course titled, "Rapid Regulatory - Non-Clinical, 2020," showed that infection control training was a part of the training course. 2. On 10/07/21 at 1:30 PM, Surveyor #17 conducted a personnel file review with Director of Human Resources (Staff #1704) and a human resources generalist (Staff #1705) for ten staff. The file review showed that a housekeeper (Staff #1702) and a cook (Staff #1704) did not have annual infection control training in their file. 3. During the review, Surveyor #17 interviewed Staff #1704 about ongoing infection control training. Staff #1704 stated that all staff take annual trainings for infection control, amongst other topics, via the Rapid Regulatory training. Staff #1704 confirmed the missing annual training	L 560		

State of Washington

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L 560	Continued From page 21 for Staff #1702 and #1703.	L 560		
L 575	322-050.6G ORIENTATION-PATIENT RIGHTS WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (g) Patient rights according to chapters 71.05 RCW and 71.34 RCW and patient abuse; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that staff completed annual patient rights training for 2 of 10 staff reviewed (Staff #1702 and #1703). Failure to ensure staff complete ongoing patient rights training places patients at risk of unsafe care and violation of their rights. Findings included: 1. Record review of the syllabus for the training course titled, "Rapid Regulatory - Non-Clinical, 2020," showed that patient rights training was a part of the training course. 2. On 10/07/21 at 1:30 PM, Surveyor #17 conducted a personnel file review with Director of Human Resources (Staff #1704) and a human resources generalist (Staff #1705) for ten staff. The file review showed that a housekeeper (Staff #1702) and a cook (Staff #1704) did not have annual patient rights training in their file. 3. During the review, Surveyor #17 interviewed Staff #1704 about ongoing patient rights training.	L 575		

State of Washington

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L 575	Continued From page 22 Staff #1704 stated that all staff take annual trainings for patient rights, amongst other topics, via the Rapid Regulatory training. Staff #1704 confirmed the missing annual training for Staff #1702 and #1703.	L 575		
L 615	322-050.9A TB-MANTOUX TEST WAC 246-322-050 Staff. The licensee shall: (9) In addition to following WISHA requirements, protect patients from tuberculosis by requiring each staff person to have upon employment or starting service, and each year thereafter during the individual's association with the hospital: (a) A tuberculin skin test by the Mantoux method, unless the staff person: (i) Documents a previous positive Mantoux skin test, which is ten or more millimeters of induration read at forty-eight to seventy-two hours; (ii) Documents meeting the requirements of this subsection within the six months preceding the date of employment; or (iii) Provides a written waiver from the department or authorized local health department stating the Mantoux skin test presents a hazard to the staff person's health; This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that staff received baseline screening and testing for tuberculosis for 1 of 10 personnel files reviewed (Staff #1706). Failure to screen and test staff prior to their start	L 615		

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L 615	Continued From page 23 of work risks patient and staff exposure to tuberculosis infection. Findings included: 1. Record review of the hospital's policy titled, "Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan," Policy #300.04, reviewed 10/01/18, showed that staff will receive a purified protein deriviative (PPD) test for TB or chest x-ray depending on test results or prior history of TB vaccination or testing within the first two weeks of hire. The infection previontion and control nurse will document these results. 2. Record review of personnel files for 10 staff showed that a mental health technician (Staff #1706) had no documented employee health records, including tuberculosis screening or testing prior to hire. 3. On 10/07/21 at 1:30 PM, Surveyor #17 reviewed personnel files. At the conclusion of the review, the surveyor interviewed the Infection Preventionist (Staff #1707) about the employee health records for Staff #1706. The Infection Preventionist stated that she could not find documentation for Staff #1706 and confirmed it was missing at the time of review.	L 615		
L 715	322-100.1E INFECT CONTROL-PROVISIONS 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: (f) Provisions for: (i) Providing consultation regarding patient care practices,	L 715		

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L 715	Continued From page 24 equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to have an effective quality control process to ensure that patient care supplies available for use did not exceed their manufacturer's expiration date. Failure to ensure patient care supplies do not exceed manufacturer's expiration date places patients at risk for inadequate medical treatment and exposure to infectious organisms. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nursing Supplies and Equipment Inspection," policy number 500.10C, reviewed 10/01/18, showed that monthly the Nurse Managers will monitor for expiration dates of medical supplies and equipment in the nursing unit and in the medication rooms. The Nurse	L 715		

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L 715	Continued From page 25 Managers will discard and replace all expired/damaged supplies and equipment. 2. On 10/06/21 at 10:02 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) inspected a supply cupboard and a supply cart located on 2 East. Surveyor #5 observed the following: a. McKesson Electrode tabs (4 packages) with a manufacturer's expiration date of 02/16/20-4 packages. b. Hydrogen Peroxide (1 bottle) with a manufacturer's expiration date of 11/20. c. Hydrogen Peroxide (1 bottle) with a manufacturer's expiration date of 06/21. d. Size 7 Sterile latex gloves (7 packages) with a manufacturer's expiration date of 01/31/21. e. Size 6 Sterile latex gloves (4 packages) with a manufacturer's expiration date of 04/30/21. 3. At the time of the observation, Staff #501 verified the finding and removed the expired supplies.	L 715		
L 825	322-120.8B HOUSEKEEPING CLOSETS WAC 246-322-120 Physical Environment. The licensee shall: (8) Provide housekeeping and service facilities on each floor, including: (b) Housekeeping closets: (i) Equipped with shelving; (ii) Ventilated to the out-of-doors; and (iii) Kept locked;	L 825		

State of Washington

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L 825	Continued From page 26 This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to ensure housekeeping closets were equipped with shelving. Failure to equip housekeeping closets with shelving limits the ability of housekeeping staff to store products safely and make them readily available for use when needed. Findings included: 1. On 10/07/21 at 3:45 PM, Surveyor #17 and the Facilities Manager (Staff #1701) inspected the janitorial closets on the second and third floor. Each floor has a central janitorial closet that serves two patient care units. The inspection showed that the two closets were not equipped with shelving. 2. At the time of observation, Surveyor #17 interviewed Staff # 1701 who confirmed that neither closet was equipped with shelving.	L 825		
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	L1065		

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L1065	Continued From page 27 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 persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Item #1 Comprehensive Master Treatment Plan Based on interview and record review, the hospital failed to ensure that staff members developed an Individualized Comprehensive Treatment Plan for all patients that included behavioral and medical problems, as demonstrated by 3 of 3 charts reviewed (Patient #501, #502, and #503). Failure to ensure the development of a Comprehensive Treatment Plan for behavioral and medical problems puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospitals policy and procedure titled, "Treatment Planning," policy number 400.09, reviewed 12/01/20, showed the following: a. The Master Treatment Plan (MTP) is completed within 72 hours of admission following the nursing assessment, initial psychiatric assessment, medical history and physical, and	L1065		

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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1065	Continued From page 28 psychosocial assessments. b. The treatment team will meet after all assessments have been completed to review all aspects of care and completed the initial MTP. c. The History and Physical as well as the Nursing Assessment will guide the psychiatric provider in identifying medical problems to be included on the MTP medical problem list d. Identified problems are to match the clinical impressions of the patient and their specific care plan goals. e. A Medical Treatment Plan will be initiated for any acute/chronic actively treated medical issues identified. f. Chronic but stable medical conditions requiring no active treatment can be deferred. These require a reason for deferral. g. The Mater Treatment Plan, Individual Treatment Plans, or the Treatment Plan Update may be revised at any time by the team when new information is obtained justifying addition or revision. For example, following seclusion or restraint, new onset symptoms, or other change in status or programing h. Revisions can be documented through the addition of a new problem on the MTP and completion of an associated Individual Treatment Plan. 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the	L1065		

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1065	Continued From page 29 plan of care for Patient #501 who was admitted as an involuntary patient for danger to self and a danger to others on 10/04/21. The patient had a history of Schizophrenia with methamphetamine use disorder and was non-compliant with medications management. The medical record showed the following: a. The patient had a history of a broken hip with complications resulting in pain and alteration in mobility and the patient utilized a shopping cart to assist with mobility prior to admission to the hospital. b. The Medical History and Physical Exam completed on 10/05/21 at 9:55 AM, showed the following medical problems: i. Chronic right hip pain since an accident in 2016, that the patient reported using a shopping cart to ambulate, and that the patient reported that he needed a wheelchair to get around, ii. Hip pain with straightening out the right knee when he lays back, iii. Acute Cystitis and was taking an oral antibiotic, iv. Diarrhea, v. A Medical/Psychiatric History of Asthma, Sleep Apnea, Irregular heartbeat, Schizophrenia and amphetamine abuse, and socially and sexually inappropriate behaviors. c. The Psychiatric Evaluation (undated and untimed) showed that the patient had Hepatitis C and nicotine dependence. The admitting diagnosis was listed as Schizoaffective disorder-bipolar sub-type most recent episode	L1065		

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L1065	Continued From page 30 mania, methamphetamine use disorder severe, nonadherence with treatment plan, rule out cluster B personality disorders, and nicotine use disorder severe. d. On 10/05/21 at 2:00 PM, a Nursing Order showed "wheelchair related to hip pain." e. On 10/05/21 at 2:00 PM a provider ordered sexual aggression precautions. Surveyor #5 reviewed the MTP completed by the treatment team on 10/05/21. Surveyor #5 found no evidence a Psychiatric Problem/s was identified and documented on the MTP. Surveyor #5 found no evidence that Acute Medical Problems including acute cystitis, pain, diarrhea, asthma, alteration in mobility including the use of assistive devices, nicotine dependence, or sexually acting out behaviors were identified and documented on the MTP. 3. At the time of the review, Staff #501 confirmed the findings and stated that staff should have listed all active and chronic problems on the MTP. 4. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal gestures and self-injurious ideation. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. The medical record review showed the following: a. On 09/09/21, the Medical History and Physical showed that the patient had attempted suicide by drug overdose, had superficial lacerations on the left temporal head area and the left forearm and	L1065		

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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1065	Continued From page 31 antibiotic ointment and dressing changes were ordered, and the patient had Hypomagnesemia (low blood magnesium) not replaced. b. On 09/09/21 at 7:54 AM, the Psychiatric Evaluation showed that the patient was admitted for suicidal ideation and attempt by cutting her arm. The patient had a history of physical and sexual abuse. Her admitting diagnosis was major Depressive Disorder, Generalized Anxiety Disorder and Chronic Post-Traumatic Stress Disorder. c. Surveyor #5 reviewed the patient's Interdisciplinary Master Treatment Plan (MTP) dated 09/10/21. Surveyor #5 found no evidence that any Psychiatric Problems, Acute Medical Problems, or Chronic/Stable Medical Problems were identified and documented on the patient's MTP. 5. At the time of the review, Staff #501 confirmed the findings and stated that staff should have listed all active and chronic problems on the MTP. 6. On 10/07/21 at 10:45 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #503 who was admitted as an involuntary patient for an attempted suicide on 09/11/21. The patient's history included Post-Traumatic Stress Disorder, Borderline Personality Disorder, and Oppositional Defiance Disorder. The record review showed the following: a. The Medical History and Physical completed 09/12/21 at 11:12 AM, showed the following: i. Acute medical problems including blunt head injury, difficulty ambulating, abrasions to	L1065		

State of Washington

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1065	Continued From page 32 forehead, arms, knees and abdomen, and chronic patellar subluxation (kneecap moves towards the outside of the body when it slides out of place). ii. A History of multiple suicide attempts and a history of violence and aggression. b. The Psychiatric Evaluation completed on 09/12/21 (untimed), showed the following: i. Adolescent Transgender Male to Female with hormone therapy admitted after an attempted suicide by purposefully crashing a motor vehicle. ii. Multiple abrasion and abrasions and lacerations to the head and knee with stitches to the left knee. iii. The admitting psychiatric diagnosis was Borderline Personality Disorder, Post-Traumatic Stress Disorder, and Oppositional Defiance Disorder. v. History of multiple suicide attempts. c. The Registered Nurse Admission Assessment completed on 09/11/21 at 6:00 PM, showed the patient had pain of 6/10 in the forehead, right knee, bilateral arms, and abdomen and sustained a head injury on 09/08/21. Surveyor #5 reviewed the MTP completed by the treatment team on 09/15/21. Surveyor #5 found no evidence a Psychiatric Problem/s was identified and documented on the MTP. Surveyor #5 found no evidence that Acute/Chronic Medical Problems including wound/alteration in skin integrity, pain, suicide/self-harm, or altered mobility were identified and documented on the	L1065		

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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

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L1065	Continued From page 33 Master Treatment Plan. 7. At the time of the review, Staff #501 confirmed the findings and stated that staff should have listed all active and chronic problems on the MTP. Item #2 Treatment Plan Interventions/Individual Treatment Plan (ITP) Based on interview and record review, the hospital failed to implement a system to ensure that interventions for psychological and medical problems were developed and documented for each problem identified on the Master Treatment Plan and Treatment Plan Updates for 3 of 3 patients reviewed (#501, #502, and #503). Failure to identify and implement individualized treatment interventions puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospitals policy and procedure titled, "Treatment Planning," policy number 400.09, reviewed 12/01/20, showed the following: a. Each psychiatric problem will be identified by a number and link to a problem specific Individual Treatment Plan (ITP) for example Suicidal Ideation ITP. b. Each medical problem will be identified by a letter and link to a specific medical ITP for example Diabetes ITP. c. An identified need for alternative programming	L1065		

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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L1065	Continued From page 34 can be identified at this time and an individual treatment plan completed specifying what the alternative plan is and what measurable goal are identified to track patient progress. d. Each ITP will include measurable short and long-term goals, specific interventions planned to include treatment modality, frequency and duration, team member responsible for follow-up, target dates, and to the degree possible, the patient "voice." 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted as an involuntary patient for danger to self and a danger to others on 10/04/21. The patient had a history of Schizophrenia with methamphetamine use disorder and was non-compliant with medications management. The medical record showed the following: a. The patient had a history of a broken hip with complications resulting in pain and alteration in mobility and the patient utilized a shopping cart to assist with mobility prior to admission to the hospital. b. The Medical History and Physical Exam completed on 10/05/21 at 9:55 AM, showed the following medical problems: i. Chronic right hip pain since an accident in 2016, that the patient reported using a shopping cart to ambulate, and that the patient reported that he needed a wheelchair to get around, ii. Hip pain with straightening out the right knee	L1065		

State of Washington

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L1065	Continued From page 35 when he lays back, iii. Acute Cystitis and was taking an oral antibiotic, iv. Diarrhea, v. A Medical/Psychiatric History of Asthma, Sleep Apnea, Irregular heartbeat, Schizophrenia and amphetamine abuse, and socially inappropriate behaviors. c. The Psychiatric Evaluation (undated and untimed) showed that the patient had Hepatitis C and nicotine dependence. The admitting diagnosis was listed as Schizoaffective disorder-bipolar sub-type most recent episode mania, methamphetamine use disorder severe, nonadherence with treatment plan, rule out cluster B personality disorders, and nicotine use disorder severe. d. On 10/05/21 at 2:00 PM, a Nursing Order showed "wheelchair related to hip pain." e. On 10/05/21 at 2:00 PM a provider ordered sexual aggression precautions. f. On 01/05/21 at 8:00 AM, a provider ordered a dietary consult. A nutritional Assessment dated 10/04/21, showed protein calorie malnutrition and a 35-pound weight loss. On 10/06/21 at 1:00 PM, a provider order showed a Special Diet of large portions for severe protein-calorie malnutrition/hypercatalolism. Surveyor #5 found no evidence that ITP's were developed and implemented for psychiatric and medical problems identified through patient assessments including acute cystitis, pain, diarrhea, asthma, alteration in mobility including	L1065		

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L1065	Continued From page 36 the use of assistive devices, nicotine dependence, nutritional deficiency with weight loss, or sexually acting out behaviors. 3. At the time of the review, Staff #501 stated that the hospital had preprinted ITP's that could be individualized, and that staff should have used the documents. 4. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal gestures and self-injurious ideation. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. The medical record review showed the following: a. On 09/09/21, the Medical History and Physical showed that the patient had attempted suicide by drug overdose, had superficial lacerations on the left temporal head area and the left forearm and antibiotic ointment and dressing changes were ordered, and the patient had Hypomagnesemia (low blood magnesium) not replaced. b. On 09/09/21 at 7:54 AM, the Psychiatric Evaluation showed that the patient was admitted for suicidal ideation and attempt by cutting her arm. The patient had a history of physical and sexual abuse. Her admitting diagnosis was major Depressive Disorder, Generalized Anxiety Disorder and Chronic Post-Traumatic Stress Disorder. c. Surveyor #5 found no evidence that ITP's were develop and implemented for psychiatric and medical problems identified through patient assessments including wounds,	L1065		

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L1065	Continued From page 37 hypomagnesemia, sexual victimization. d. During the patient's hospitalization, additional problems including self -harm, suicide attempt, inappropriate sexual behavior, additional wounds, restraint/seclusion, alternative programming, and multiple falls occurred. Surveyor #5 found no evidence the hospital developed and implemented ITP's. 5. At the time of the review, Staff #501 stated that the staff should have utilized the Individual Treatment Plan documents. 6. On 10/07/21 at 10:45 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #503 who was admitted as an involuntary patient for an attempted suicide on 09/11/21. The patient's history included Post-Traumatic Stress Disorder, Borderline Personality Disorder, and Oppositional Defiance Disorder. The record review showed the following: a. The Medical History and Physical completed 09/12/21 at 11:12 AM, showed the following: i. Acute medical problems including blunt head injury, difficulty ambulating, abrasions to forehead, arms, knees and abdomen, and chronic patellar subluxation (kneecap moves towards the outside of the body when it slides out of place). ii. A History of multiple suicide attempts and a history of violence and aggression. b. The Psychiatric Evaluation completed on 09/12/21 (untimed), showed the following:	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1065	Continued From page 38 i. Adolescent Transgender Male to Female with hormone therapy admitted after an attempted suicide by purposefully crashing a motor vehicle. ii. Multiple abrasion and abrasions and lacerations to the head and knee with stitches to the left knee. iii. The admitting psychiatric diagnosis was Borderline Personality Disorder, Post-Traumatic Stress Disorder, and Oppositional Defiance Disorder. v. History of multiple suicide attempts. c. The Registered Nurse Admission Assessment completed on 09/11/21 at 6:00 PM, showed the patient had pain of 6/10 in the forehead, right knee, bilateral arms, and abdomen and sustained a head injury on 09/08/21. d. Surveyor #5 found no evidence that ITP's were developed and implemented for psychiatric and medical problems identified through patient assessments including wound/alteration in skin integrity, pain, suicide/self-harm, or altered mobility. e. During the patient's hospitalization, additional problems including suicide attempt/self-harm, alternative programming, bully behaviors with peers, and purging occurred. Surveyor #5 found no evidence the hospital developed and implemented ITP's. 7. At the time of the review, Staff #501 verified the finding and stated that the staff should have utilized the Individual Treatment Plan documents. Item #3 Treatment Plan Updates	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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
L1065	Continued From page 39 Based on interview and record review, the hospital failed to ensure that staff members kept current a nursing care plan for each patient that reflected the patient 's current goals and the nursing care to be provided to meet the patient's needs, as demonstrated by 3 of 3 patients reviewed (Patient #501, #502, and #503). Failure to ensure that treatment plans are kept current puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospitals policy and procedure titled, "Treatment Planning," policy number 400.09, reviewed 12/01/20, showed the following: a. The Master Treatment Plan (MTP) is update at least once a week or sooner If warranted by clinical changes in condition or other factors including new onset of medical issues, alternative programming etc. b. A Treatment Plan Update (TPU) will be completed at least every seven days from the completion of the MTP. c. Progress toward short-term goals is noted for each problem. d. A change in status of a problem will be noted on the Master Problem List, with a date change noted. This may include discontinuing a goal that was achieved or extending further a goal date. e. For each new active problem, the team initiates a new Individual Treatment Plan (ITP). Alternative	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1065	Continued From page 40 programming needs not already identified on the MTP can be added at any time and the alternative plan documented in the individual treatment plan specifying measurable goals in order to track patient progress. f. Each ITP will be reviewed to see if revisions in goals or interventions are indicated. g. If it is identified that a patient is unable or unwilling to engage in traditional programming the treatment team must update the plan to include an alternative plan to engage the patient in meaningful activities that address the patient's specific goals. 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted as an involuntary patient for danger to self and a danger to others on 10/04/21. The patient had a history of Schizophrenia with methamphetamine use disorder and was non-compliant with medications management. The medical record showed the following: a. On 01/05/21 at 8:00 AM, a provider ordered a dietary consult. A Nutritional Assessment dated 10/04/21 at 12:27 PM, showed that the patient has severe protein-caloric malnutrition related to chronic inadequate oral nutrient intake and methamphetamine abuse. The patient had a 35-pound unintentional weight loss in less than 6 months and visual appraisal showed muscle loss and fat wasting visible at the temples, triceps, under eyes, and interosseous muscle. The plan for the patient was a high protein diet, and extra portions and snacks. On 10/06/21 at 1:00 PM, a	L1065		

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L1065	Continued From page 41 provider order showed a Special Diet of large portions for severe protein-calorie malnutrition/hypercatalolism. Surveyor #5 found no evidence a Treatment Plan Update was completed, the MTP was updated, or that an Individual Treatment Plans was initiated to address the nutritional deficiencies. Surveyor #5 found no evidence that staff were monitoring the patient's dietary intake. 3. At the time of the review, Staff #501 confirmed the finding and stated that the Treatment Plans should be updated when there are new problems identified and that dietary intake as well as a utensil count should have been conducted with every meal. 4. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal gestures and self-injurious ideation. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. The medical record review showed the following: a. On 09/11/21, the patient committed self-harm by patient pulling the steri-strips off a wound from a prior self-harm event and pulling the wound edges apart approximately 2.5 inches long by .5 inch wide. b. On 09/13/21, 09/15/21, 09/16/21, 09/20/21, 09/22/21, and 09/23/21 the patient was placed in restraints/seclusion. c. On 09/14/21, the patient fell and hit her head.	L1065		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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
L1065	Continued From page 42 d. On 09/16/21, the patient was placed on Alternative Programing. e. On 09/19/21, the patient had inappropriate behavior of a sexual nature with a peer. f. On 09/20/21, the patient was found on the ground with superficial lacerations to the anterior neck. g. On 09/21/21, the patient fell. h. On 09/26/21, the patient attempted suicide by strangulation and was sent to an acute care hospital for evaluation. Surveyor #5 reviewed the Master Treatment Plan Update Worksheets for 09/16/21, 09/20/21, 09/23/21, 09/27/21, and 10/04/21. The review showed that on 09/20/21 a Problem of "Suicidal placed on Alternative Programing" was listed on the Update Worksheet. The Problem List update/revision sections of the Update Worksheets for 09/16/21, 09/23/21, 09/27/21, and 10/04/21 were blank. Surveyor #5 found no evidence that the hospital updated/revised the patients treatment plan to reflect the patient 's current goals and the nursing care related to the falls, restraint, suicide attempt, self-harm, inappropriate sexual behavior, new wounds, or falls. No problems were added to the Master Treatment Plan. 5. At the time of the finding, Staff #501 verified the findings and stated that the Treatment Plan should be updated at least weekly and that the new problems should also be added to the Master Treatment Plan. 6. On 10/07/21 at 10:45 AM, Surveyor #5 and the	L1065		

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1065	Continued From page 43 Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #503 who was admitted as an involuntary patient for an attempted suicide on 09/11/21. The patient's history included Post-Traumatic Stress Disorder, Borderline Personality Disorder, and Oppositional Defiance Disorder. The record review showed the following: a. On 09/16/21 the patient attempted suicide by strangulation and was placed on Alternative Programming related to the 1:1 status for suicide attempt. b. On 10/04/21 the patient was found purging. c. On 10/05/21 the patient was placed on Alternative Programing for Bullying peers. Surveyor #5 reviewed the Master Treatment Plan Update worksheet dated 10/05/21. The Update Worksheets did not identify or address the purging or bullying behavior that resulted in Alternative Programing. 7. At the time of the finding, Staff #501 stated that staff should have updated the worksheet to reflect current care ordered.	L1065		
L1120	322-170.3F OT SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (f) Occupational therapy services coordinated and supervised by	L1120		

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L1120	Continued From page 44 an occupational therapist with experience working with psychiatric patients, responsible for integrating occupational therapy functions into the patient's comprehensive treatment plan; This Washington Administrative Code is not met as evidenced by: . . Based on interview and document review, the facility failed to ensure that Occupational Therapy services were integrated into patient's comprehensive treatment plans. Failure to ensure that Occupational Therapy Services are integrated into patient's comprehensive treatment plans places hospital patients at risk for receiving incomplete comprehensive treatment. Findings included: 1. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted on 10/04/21 for the treatment of Schizophrenia. The medical record showed that patient had a history of a broken hip with complications resulting in pain and alteration in mobility and the patient utilized a shopping cart to assist with mobility. The patient reported that he needed a wheelchair to get around. The patient reported hip pain with straightening out the right knee when he lays back. 2. At the time of the record review, during discussion with Surveyor #501 about how the	L1120		

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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1120	Continued From page 45 hospital assesses patients mobility, ability to perform Activities of Daily Living (ADLs), and use and fit of assistive devices, Staff #501 stated that the walker provided to the patient did not work as it was too short for the patient, so the hospital provided the patient a wheelchair for mobility. She stated that the hospital provided Occupational Therapy and Physical Therapy services on referral from the provider. Surveyor #5 found no evidence of referral. 3. On 10/08/21 at 8:30 AM, the Chief Executive Officer (Staff #508) stated that the hospital provided Physical and Recreational Therapy Services, but that the hospital did not employ an Occupational Therapist. He stated he would follow up to see if Occupational Therapy was available via a contracted service. 4. On 10/08/21 at 11:00 AM, Staff #501 stated that the hospital did not have an Occupational Therapist and that she did not know that this was a requirement. 5. On 10/14/21, Surveyor #5 received an Email communication from Staff #501 stating that the hospital did have a contract for Occupational and Physical Therapy Services with INHS. 6. Surveyor #5 found no evidence that the hospital had a process in place to ensure Occupational Therapy Services were integrated into patient comprehensive treatment plan development and patient care processes.	L1120		
L1140	322-180.1B ASSAULTIVE INCIDENTS	L1140		

State of Washington

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L1140	Continued From page 46 WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (b) Staff shall document all assaultive incidents in the clinical record and review each incident with the appropriate supervisor; This Washington Administrative Code is not met as evidenced by: Based on interview and document review the hospital failed to capture and document each episode of restraint in the patient' s medical record for 2 of 9 episodes of restraint reviewed (Patient #502 and #505). Failure to authorize use, monitor and evaluate patients during restraint/seclusion, and document patient response to restraint/seclusion episodes risks harm, injury and death. Findings included: 1. Document review of the hospital's policy titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," policy number 1300.22, reviewed 09/21, showed the use of restraint/seclusion will be thoroughly documented in the patient's medical record and includes the following: a. That the patient and/or family were informed of the hospital's policy on the use of restraint/seclusion and consent for notification. b. The initial assessment of the patient related to	L1140		

State of Washington

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L1140	Continued From page 47 restraint/seclusion use. c. Documentation of each episode of restraint/seclusion including: i. the circumstances that led to the use of restraint/seclusion, ii. specific behaviors, iii. detailed description of events leading up to the event, iv. consideration or failure of non-physical interventions, v. rational for the use of restraint/seclusion, vi. notification of the patient's family, when appropriate, vii. written orders for use-including each order for discontinuation, viii. behavioral criteria for discontinuation of restraint/seclusion, ix. informing the patient of behavioral criteria for discontinuation, x. check of appropriate restraint application, xi. the initial in-person and subsequent evaluations of the patient, xii. 15-minute assessments of the patient's status, xiii. continuous monitoring of the patient and the care provided,	L1140		

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L1140	Continued From page 48 xiv. debriefing of the patient with the staff, xv. any injuries sustained, and the treatment received for these injuries, xvi. time of initiation and termination of the restraint/seclusion, xvii. treatment plan review/revision following the episode of restraint/.seclusion including treatment interventions to prevent further use. 2. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. The review showed the following: a. On 09/20/21 at 4:50 PM, a Progress Note stated that staff placed the patient in a physical hold and administered intramuscular medication including 1mg of Ativan (an anxiolytic medication) and 10 mg of Zyprexa (an antipsychotic medication). 3. Surveyor #5 found no evidence in the medical record of a provider order, evaluation, monitoring, or documentation as described in the hospital's policy. 4. At the time of the finding, Staff #501 verified that the medical record did not contain required documentation. Staff #501 was unable to locate the missing documentation.	L1140		

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L1140	Continued From page 49 5. On 10/07/21 at 4:10 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the discharge medical record for Patient #505 who was admitted on 05/25/21 for the treatment of Suicidal Ideation, Anxiety, Bipolar Disorder, Post-Traumatic Stress Disorder, and Depression. The patient had a history of suicide attempts by strangulation, cutting and over-dose and aggressive behavior with behavioral outbursts. On 06/07/21, a provider order showed the patient was placed in restraint for violent and destructive behaviors including assaulting a Registered Nurse and attempting to punch a Mental Health Technician. Surveyor #5 found no restraint documentation in the medical record. 6. At the time of the finding, Staff #507 verified the finding and stated he would look to see if there was any documentation with the auditors. At 5:00 PM, Staff #507 stated he was unable to locate any documentation.	L1140		
L1145	322-180.1C RESTRAINT OBSERVATIONS WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical record;	L1145		

State of Washington

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L1145	Continued From page 50 This Washington Administrative Code is not met as evidenced by: . Item #1 Failure to Follow Policy Regarding Restraint Documentation Based on record review and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's restraint policy and procedure for monitoring patients for 2 of 3 records reviewed (Patient #502 and #504). Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. Findings included: 1. Document review of the hospital's policy titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," policy number 1300.22, reviewed 09/21, showed the following: a. Any patient placed in mechanical restraint will have a staff member within arm's length of the patient to provide immediate response should the patient experience any physical distress. b. The patient will be assessed every 15 minutes while in restraint/seclusion. The assessment includes signs of any injury associated with the use of restraint/seclusion, circulation and skin integrity, mental status, level of distress and agitation, readiness for discontinuation of the restraint/seclusion. c. Range of motion and release of limbs will be done minimally every 1 hour.	L1145		

State of Washington

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L1145	Continued From page 51 d. Fluids and opportunity for toileting shall be offered every 2 hours. e. Vital signs shall be taken upon initiation and as clinically indicated, but at least every 2 hours. Document review of the hospital's restraint flow sheet titled, "Inland Northwest Behavioral Hospital Seclusion/Restraint/Chemical 15-minute Flow Sheet," no date, showed the following: a. For patients in Chemical Restraints staff are to monitor vital signs, neuro status and perform safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours or as directed by the physician. b. Documentation is to occur every 15 minutes or more frequently as appropriate to the patients physical, emotional, and safety needs. c. Nutrition and hydration, circulation, hygiene and elimination, respiratory status, patient condition, behavior and response, and staff interventions are to be evaluated at least every 15 minutes. 2. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. Documentation in the patient's medical record showed the patient was in restraint/seclusion on 09/13/21, 09/15/21, 09/16/21, 09/20/21, 09/22/21, and 09/26/21.	L1145		

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L1145	Continued From page 52 a. On 09/13/21, the patient was placed in physical, 4-point mechanical, and chemical restraint. Surveyor #5 found no evidence that staff monitored and documented the patient's vital signs, neuro status, and safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours as directed by hospital policy for patient receiving chemical restraint. b. On 09/15/21, the patient was placed in physical, 4-point mechanical, and chemical restraint. Surveyor #5 found no evidence that staff monitored and documented the patient's vital signs, neuro status, and safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours as directed by hospital policy for patient receiving chemical restraint. Surveyor #5 found no evidence staff evaluated and documented nutrition and hydration, circulation, hygiene and elimination, respiratory status, patient condition, behavior and response, and staff interventions at least every 15 minutes as directed by hospital policy. c. On 09/16/21, the patient was placed in physical and chemical restraints. Surveyor #5 found no evidence that staff monitored and documented the patient's vital signs, neuro status, and safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours as directed by hospital policy for patient receiving chemical restraint. Additionally, 1 of 2 evaluation documentation entries were undated and untimed. d. On 09/20/21, Surveyor #5 found no documentation for the episode of restraint. e. On 09/22/21, the patient was placed in	L1145		

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1145	Continued From page 53 restraint. The record review showed the following conflicting documentation: i. On 09/22/21 at 4:09 PM, a provider ordered physical and mechanical restraint, and seclusion. ii. On 09/22/21, an untimed Seclusion and Restraint Note showed the patient received chemical, physical, and mechanical restraint, and seclusion. iii. On 09/22/21, a Seclusion/Restraint/Chemical 15-Minute Flow sheet showed that the patient was placed in a physical hold at 4:04 PM, 4-point-mehanical restraint at 4:04 PM, and received chemical restraint at 6:15 PM, and the restraint was removed at 6:11 PM. iv. On 09/22/21 at 8:16 PM, the Post Intervention Nursing Summary showed the patient was physically restrained and in seclusion. v. On 09/23/21 (unable to decipher time documented), the Face to Face Evaluation showed the patient calmed after an Intra-Muscular injection was delivered. Surveyor #5 was unable to determine the type/s of restraint the patient was place in. Documentation on the every 15-minute Flow Sheet contained only 2 entries, one at 4:22 PM and one at 5:11 PM. Both entries contained only the patient vital signs. Surveyor #5 found no evidence that staff monitored and documented the patient's vital signs, neuro status, and safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours as directed by hospital policy for patient receiving chemical restraint. Surveyor #5 found no evidence staff evaluated and documented	L1145		

State of Washington

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L1145	Continued From page 54 nutrition and hydration, circulation, hygiene and elimination, respiratory status, patient condition, behavior and response, and staff interventions at least every 15 minutes as directed by hospital policy. 3. At the time of the review, Staff #501 verified the findings and stated that the hospital was working on restraint process improvement initiative. 4. On 10/07/21 at 3:30 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the discharge medical record for Patient #504 who was admitted on 06/08/21 for the treatment of Acute Psychosis and Schizophrenia. Documentation in the medical record showed on 06/10/21 the patient physically attacked staff and was placed in Physical and Chemical restraints. The review showed the following: a. Surveyor #5 found no evidence that staff monitored and documented the patient's vital signs, neuro status, and safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours as directed by hospital policy for patient receiving chemical restraint. b. 4 of 4 evaluation documentation entries were incomplete and did not contain all evaluation criteria as directed by hospital policy. c. 2 of 4 evaluation documentation entries were undated and untimed. 5. At the time of the finding, Staff #507 verified the incomplete entries and the undated and untimed entries into the medical record.	L1145		

State of Washington

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L1145	Continued From page 55 Item #2 Updating the Treatment Plan Based on interview and document review, the hospital failed to modify the patients' plan of care after placing patients in restraints/seclusion for 3 of 3 patient records reviewed (Patient #502, #504, and #505). Failure to modify care plans when patients are in restraints/seclusion, placed patients at risk of harm by not meeting physical and emotional needs. Findings included: 1. Document review of the hospital's policy titled, "Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion," policy number 1300.22, reviewed 09/21, showed the following: a. When the patient has presented behavior that is dangerous to themselves or others so that restraint/seclusion were indicated, a review and modification of the treatment plan is indicated. b. The Registered Nurse will review and update the treatment plan within 8 hours. c. The updated treatment plan will reflect the identification of the problem, goals to prevent further instances of restraint/seclusion, interventions to define alternative approaches. d. Responsibility of each intervention assigned. e. Review of the plan with the patient. 2. On 10/06/21 at 2:45 PM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) reviewed the medical record for Patient	L1145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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INLAND NORTHWEST BEHAVIORAL HEALTH	104 W 5TH AVE SPOKANE, WA 99204

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L1145	Continued From page 56 #502 who was admitted on 09/08/21 as an involuntary patient due to suicidal and self-injurious ideation and behavior. The patient had a history of suicide attempts, Depression, Post-Traumatic Stress Disorder, and Anxiety. Documentation in the patient's medical record showed the patient was in restraint/seclusion on 09/13/21, 09/15/21, 09/16/21, 09/20/21, 09/22/21, and 09/26/21. Surveyor #5 found no evidence for 6 of 6 restraint episodes that the patient's treatment plan was reviewed or modified reflecting the dangerous behaviors that indicated restraint/seclusion and subsequent restraint episodes. 3. At the time of the finding, Staff #501 verified the finding and stated that Staff should have updated the Treatment Plan. 4. On 10/07/21 at 3:30 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the discharge medical record for Patient #504 who was admitted on 06/08/21 for the treatment of Acute Psychosis and Schizophrenia. Documentation in the medical record showed on 06/10/21 the patient was in Physical and Chemical restraints. Surveyor #5 found no evidence that the patients Treatment Plan was updated to reflect the episode of restraint. 5. On 10/07/21 at 4:10 PM, Surveyor #5 and the Chief Nursing Officer (Staff #507) reviewed the discharge medical record for Patient #505 who was admitted on 05/25/21 for the treatment of Suicidal Ideation, Anxiety, Bipolar Disorder, Post-Traumatic Stress Disorder, and Depression. The patient had a history of suicide attempts by strangulation, cutting and over-dose and aggressive behavior with behavioral outbursts.	L1145		

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	013250	A. BUILDING: _____ B. WING _____	10/14/2021

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L1145	Continued From page 57 Documentation in the medical record showed the patient as placed in restraint on 06/01/21 and 06/07/21. Surveyor #5 found no evidence that the patient's Treatment Plan was updated to reflect the episode of restraint on 06/07/21. 6. At the time of the findings, Staff #507 verified the findings and stated he would look to see if there was any documentation with the auditors.	L1145		
L1265	322-200.3F RECORDS-OBSERVATIONS 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: (f) Significant observations and events in the patient's clinical treatment; This Washington Administrative Code is not met as evidenced by: Based on interview and document review the hospital failed to ensure staff monitored and documented patient dietary intake as directed by hospital policy for all patients located on the 2 East Unit (#501, #506, #507, #508, #509, #510, #511, #513, #514, #515, #516, #517, #518, #519, #520, #521, #522, #523, #524, #525, #526, #527, #528, #529, #530, #531, #532, and #533). Failure to monitor and document dietary intake risks failure to ensure that patients receive the appropriate nutrition that could lead to unanticipated patient outcomes, harm, and death.	L1265		

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L1265	Continued From page 58 Findings included: 1. Document review of the hospital's policy and procedure titled, "Monitoring and Recording Food Intake," policy number 500.25, reviewed 10/01/28, showed the following: a. Program staff are responsible for monitoring and recording patient's food intake after each meal as identified and prescribed by the treatment plan. b. Program staff will record food intake on the "Daily Assessment Progress Note (DAP)" in the form of percentage of meal eaten and general observations including, subjective reports of appetite change, patient requires prompts to eat, request extra portions, accepts offered snacks. c. Staff are to alert the physician if meal intake is less than adequate to meet nutritional needs and/or there is a significant change in the patient's appetite. 2. On 10/06/21 at 11:20 AM, Surveyor #5, the Director of Quality and Infection Control (Staff #501) and a Registered Nurse (Staff #502) reviewed the medical record and discussed the plan of care for Patient #501 who was admitted as an involuntary patient for danger to self and a danger to others on 10/04/21. The record review showed the following: a. On 01/05/21 at 8:00 AM, a provider ordered a dietary consult. b. A Nutritional Assessment dated 10/04/21, showed the patient suffered from protein calorie malnutrition and a 35-pound weight loss in less than 6 months. The dietician ordered high protein	L1265		

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L1265	Continued From page 59 snacks every morning, evening and at bedtime and large protein portions (1.5X) for each meal. c. On 10/06/21 at 1:00 PM, a provider order showed a Special Diet of large portions for severe protein-calorie malnutrition/hypercatalolism. Surveyor #5 was unable to locate any information in the medical record related to the patient's meal intake or compliance with meal intake. 3. At this time, Staff #501 located a binder that contained 20 documents titled "Patient Meal and Utensil Tracking Form." Staff #501 stated that the binder contained individual forms for staff to document meal intake and utensil tracking for each patient on the unit. 4. Document review showed that the binder contained forms for 3 patients no longer on the Unit (Patient #530, #531, #532) and did not contain any forms for 8 current patients (#508, #509, #524, #525, #526, #527, #528, and #529) . Of the 17 forms for current patients (#501, #506, #507, #510, #511, #513, #514, #515, #516, #517, #518, #519, #520, #521, #522, #523, and #533), 7 contained one day of dietary intake entry for 09/25/21 (#507, #510, #511, #513, #514, #515, and #516). Surveyor #5 found no other documentation of dietary intake for those patients in September or October. The form for Patient #501 was blank. 5. On 10/08/21 at 11:00 AM, Staff #501 stated that the 2 other inpatient units were documenting intake, but that the staff on 2 East stated to her that they were told to no longer document intake and utensil counts. She stated that they should be documenting the intakes and utensil counts.	L1265		

State of Washington

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L1265	Continued From page 60	L1265		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c) Administering drugs; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and review of hospital documents, the hospital failed to ensure nursing staff positively identified a patient prior to medication administration for 2 of 3 medication administrations observed (Patients #506 and #507). Failure to follow safe medication administration standards can lead to administration errors - wrong patient, wrong dose, wrong time, or additional dose resulting in patient harm or death. Findings included: 1. Document review of the hospital's policy and procedure titled, Medication Administration," policy number 28, reviewed 05/13/18, showed that staff must positively identify the patient before administering a medication. Staff must check the patient's identification with 2 hospital approved identifiers (i.e. date of birth, name band, or photograph) and ask the patient (when possible) to state his/her name.	L1375		

State of Washington

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L1375	Continued From page 61 2. On 10/06/21 at 9:00 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) inspected the medication room on 2 East and observed medication administration. Surveyor #5 observed a Licensed Practical Nurse (Staff #503) administer medications to ambulatory patients presenting to the medication room window. Surveyor #5 observed Staff #503 call the patients by their name and ask them their birthdate. 3. At this time, during interview with Surveyor #5 about the hospital's policy and procedure for patient identification, Staff #503 stated that the hospital policy was to ask their birthdate and verify their armband. She stated that patients usually removed their armband and that she could identify the patients as the patients had been admitted for a while. She stated if she was not familiar with the patient, she would have them state their name. 4. On 10/06/21 at 9:10 AM, Staff #501 verified that Staff #503 had not utilized 2 patient identifiers prior to medication administration. She stated the hospital utilized name and date of birth. Surveyor #5 and Staff #501 reviewed the patient photograph list hanging near the medication window and noted that many of patients were not recognizable in their photo related to photo quality, size, and patient non-cooperation with being photographed.	L1375		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1)	L1485		

State of Washington

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L1485	Continued From page 62 Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to follow food safety standards places patients at risk from food borne illness. Findings included: Item #1 - Cooling 1. On 10/06/21 from 10:30 AM to 12:30 PM, Surveyor #17 inspected the hospital kitchen. The surveyor observed a container of freshly made applesauce cooling in the walk-in refrigerator. The observation showed the sauce was stored covered in a container that was 6 to 8 inches in depth. No cooling log documenting the time and temperature for cooling the item was available. 2. During the observation, Surveyor #17 interviewed the Dietary Manager (Staff #1708) about cooling practices at the facility. Staff #1708 confirmed that there was no cooling log for the product. Staff #1708 also confirmed that the product should not be covered while cooling. Reference: Washington State Retail Food Code, WAC 246-215-03515 Item #2 - Time without Temperature as a Public Health Control. 1. Record review of the hospital policy titled,	L1485		

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L1485	Continued From page 63 "Meal Trays for the Communities," Policy # 900.11, reviewed 10/30/18, did not show that the hospital had established a process for timing food trays when delivered to the unit as a means for time as a public health control. 2. On 10/06/21 at 9:00 AM, Surveyor #1 and the Facilities Manager (Staff #1701) inspected the nourishment room on unit 3 East. The Surveyor observed unmarked food trays resting on the counter. During the observation, the Surveyor asked Staff #1701 about the process for delivery of food trays to the unit. Staff #1701 stated that the hospital had identified that dietary staff were not putting times on food deliveries to the unit when the hospital conducted an internal audit. 3. On 10/06/21 at 9:18 AM, Surveyor #5 and the Director of Quality and Infection Control (Staff #501) inspected the patient kitchen area located on 2 East. Surveyor #5 observed 3 patient trays containing breakfast type foods sitting on the sink and counter. The trays were undated and untimed. 4. At the time of observation, Surveyor #5 and Staff #501 asked the Registered Nurse (Staff #505) when the trays had arrived and if they were for a patient or to be discarded. Staff #505 stated that the trays were for patients who were sleeping during breakfast time, and that the trays had been sitting there about 20-30 minutes. At the time of the finding, Staff #501 verified that the trays were not dated or timed. 5. On 10/06/21 from 10:30 AM to 12:30 PM, Surveyor #17 conducted an inspection of the kitchen. During the inspection, the Surveyor interviewed the Dietary Manager (Staff #1708) about the process of tray delivery. Staff #1708	L1485		

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L1485	Continued From page 64 stated that she was new to the hospital and was not sure of the process. 6. On 10/06/21 at 12:15 PM, Surveyor #17 observed meal service for the patients, which included preparations for trays to the unit. A Dietary Aide (Staff #1709) preparing the containers for delivery wrote the date and time of preparation on the container rather than the time the item would be beyond use for time as a public health control. 7. At the time of the observation, Surveyor #17 interviewed Staff #1709 about the process for food delivery. Staff #1709 stated that she routinely writes the time of preparation on the containers. Staff #1709 stated that it is up to the clinical staff to manage the food once it is delivered to the unit and ensure that it is disposed of when needed. Reference: Washington State Retail Food Code, WAC 246-215-03530	L1485		

State of Washington

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S 000	INITIAL COMMENTS This report is the result of an unannounced fire and life safety State-licensure survey conducted at Inland Northwest Behavioral Health in Spokane, Washington on 10/7/2021 by a representative of the Washington State Patrol, Fire Protection Bureau (WSP/FPB). The survey was conducted in concert with the Washington State Department of Health survey team. During the physical tour of the facility I was accompanied by the Director of Plant Ops who witnessed any deficiency noted during this survey. The facility is licensed for 100 beds and at the time of this survey the census was 60. The New section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a three story structure of Type II (1-1-1) hour construction constructed in 2018 with exits to grade and is protected by a Type 13 sprinkler system and an automatic/manual fire alarm system with corridor smoke detection. The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: David Rogers Deputy State Fire Marshal 32863 The surveyor was from: Washington State Patrol Office of the State Fire Marshal Fire Protection Bureau	S 000		

State of Washington

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S 000	Continued From page 1 PO Box 19130 Spokane WA 99219-9130 Telephone: (509) 954-2746 DSFM D.A. Rogers	S 000		
S 211	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based upon observations and staff interviews on 10/07/2021 during the physical tour of the facility between approximately 0900 and 1130 hours the facility has failed to maintain the means of egress as being readily available for full instant use in the event of fire. This could cause an inability or delay in the evacuation of staff in the event of an emergency which would endanger patients, staff and/or visitors. The findings include: -There were multiple freestanding chairs and combustible storage items in cardboard boxes in	S 211	S211 NFPA 101 Means of Egress-General " The Director of Plant Operations was retrained by the Corporate Facilities Manager to the NFPA 101 means of egress sections for new health care occupancies: Sections 18.1.3.6 to 18.1.3.9, 18.2, 18.4.3.3, 18.4.3.4, A18.2.2 to A 18.2.5.7.3.2 (C). " Chairs and storage items were relocated out of the exit corridors and monitoring will be added to monthly EOC rounds going forward to call for a correction if it does happen again.	11/18/21

State of Washington

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S 211	Continued From page 2 the first floor Outpatient exit corridor and the SE-Storage exit corridor. -1 (the north gate) of 2 exit gates to the public way from the East Courtyard failed to unlatch and open when tested due to inoperative hardware. The above was discussed and acknowledged by the Director of Plant Ops who said they were unaware the chairs and stored items were not allowed to be in the corridors and that the north gate was inoperative. 2012 NFPA 101-18.2.1, 7.1.10.1	S 211	" The North gate deadbolt in the East Courtyard was removed and replaced with a new deadbolt and tested for proper function. Director of Plant Operations 11/18/2021 11/18/2021 Monthly EOC rounds will have a line added to specifically check exit corridors for obstructions and will be checked monthly (ongoing). Work orders will be created for any deficiencies and corrected going forward. A quarterly, recurring work order will be added to verify that the courtyard doors are lubricated and functioning properly (ongoing). 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 325	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	S 325		11/18/21

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 325	Continued From page 3 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: *Corridor is at least 6 feet wide. *Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols. *Dispensers shall have a minimum of 4 foot horizontal spacing. *Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. *Storage in a single smoke compartment greater than five gallons complies with NFPA 30. *Dispensers are not installed within one inch of an ignition source. *Dispensers over carpeted floors are in sprinklered smoke compartments. *ABHR does not exceed 95 percent alcohol. *Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11). *ABHR is protected against inappropriate access. 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and	S 325		

State of Washington

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S 325	Continued From page 4 485 This STANDARD is not met as evidenced by: Based upon observations and staff interviews on 10/07/2021 during the physical tour of the campus between approximately 0900 and 1130 hours, the facility has failed to properly install alcohol based hand rub dispensers. Dispensers installed improperly could result in alcohol hand rub coming in contact with an electrical source resulting in a fire causing potential endanger to patients, staff and/or visitors within the facility. The findings include: -There was an ethyl-ABHR-dispenser installed over an electrical light switch in the 3E Nurses Station. -There was an ethyl-ABHR-dispenser installed over an electrical outlet in the third floor Chart Room. -There was an ethyl-ABHR-dispenser installed over an electrical light switch in the 2E and 2W Nurses' stations. The above was discussed and acknowledged by the Director of Plant Ops who said the dispensers had not been previously observed to be above the outlets and switches. 2012 NFPA 101-18.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	S 325	S325 NFPA 101 Alcohol Bases Hand Rub Dispenser (ABHR) " Alcohol based hand rub dispensers were removed from above electrical sources and relocated to safe locations to eliminate the safety risk. " All EOC members were informed on what would cause such a deficiency in the October EOC Meeting (Nov. 2nd) to ensure we are properly inspecting during EOC rounds. " EVS Staff and the Engineer were retrained on the proper placement of alcohol bases hand rub dispensers on 11/5/2021. Director of Plant Operations 11/18/2021 Monthly EOC rounds will continue to monitor for improperly located alcohol hand sanitizer dispensers. With proper inspecting methods this will result in creating work orders for any deficiencies and corrected going forward. 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%	

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013250	A. BUILDING: 02 - NEW B. WING _____	10/07/2021

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 345	Continued From page 5	S 345		
S 345	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: Based on record review and staff interview on 10/07/2021 between approximately 1130 to 1230 hours, the facility has failed to conduct required testing of the fire alarm system which could result in failure of the system to operate properly which could result in a delay in the detection of system failure or in the detection of fire conditions and occupant notification, endangering patients, staff and/or visitors within the facility. The findings include: The facility failed to provide documentation indicating smoke detector sensitivity testing had been conducted within one year of installation (approximate install date of 7-2018). The above was discussed and acknowledged by the Director of Plant Ops who said he is unsure if the testing was conducted as that was prior to his employment at the facility. NFPA 101 (2012 ed) 18.1.1.1.1, 18.3.4.1, 9.6.1.3,	S 345	S 345 NFPA 101 Fire Alarm System-Testing and Maintenance The sensitivity testing (EC 02.03.05 EP3) was performed on 10/22/2018, as well as annual each year since. Due to a misunderstanding of the request, the Director of Plant Operations was unable to provide the information during the inspection. The sensitivity test was on site in the Director of Plant Operations office during the inspection and has been tested annually each year since. The sensitivity test will continue to be completed. Director of Plant Operations 11/18/2021 The Director of Plant Operations will be more focused on the details of each request going forward to ensure proper reports are provided during an inspection. Monitoring will be ongoing for 4 months until compliance is achieved and sustained.	11/18/21

State of Washington

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	013250	A. BUILDING: 02 - NEW B. WING _____	10/07/2021

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

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S 345	Continued From page 6 2.1, NFPA 72 (2010 ed) 1.1.1, 14.4.4.3.1	S 345	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 712	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This STANDARD is not met as evidenced by: Based upon record review and staff interviews on 10/07/2021 during document review between approximately 1130 and 1230 hours the facility has failed to conduct all fire drills as required by NFPA 101. This could potentially result in the staff and facility being unaware of an inoperative fire alarm system as well as resulting in a failure of staff to train in a life-like fire situation which could then result in staff not responding in a coordinated manner in the event of an actual fire or other emergency, endangering patients, staff, and/or visitors.	S 712	S 712 NFPA 101 Fire Drills The 3rd quarter night shift fire drill was performed on 10/8/2021. The drill was performed late (as per the fire drill matrix) and to ensure drills are not performed late again the Engineer will be scheduled to perform any drills if the Director of Plant Operations is not available. The Director of Plant Ops trained the Engineer on how to perform Fire Drills by 11/5/2021. Director of Plant Operations	11/18/21

State of Washington

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	013250	A. BUILDING: 02 - NEW B. WING _____	10/07/2021

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

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S 712	Continued From page 7 The findings include: -The facility could not provide documentation indicating a night shift fire drill for 3rd quarter of 2021 (July-Sept) had been conducted. The above was discussed and acknowledged by the Director of Plant Ops who said the drill was not conducted as they did not have enough available staff managers to conduct and observe the drill. 2012 NFPA 101-18.7.1.4 through 18.7.1.7	S 712	11/18/2021 The Engineer will be trained to perform a fire drill alone by the Director of Plant Operations Additionally he will be in charge of the next two drills in 2021 (with DPO to help) to ensure he is prepared to perform a drill without assistance going forward. 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%	

Inland Northwest Behavioral Health

Plan of Correction for
State Licensing Hospital Survey
10/06/21-10/14/21

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L315	**322-035.1C POLICIES TREATMENT** The CEO, the Director of PI and the Director of Clinical Services met to review the Plan for Provision of Care Policy and the Individual Supportive Therapy and Education Policy and no changes were needed to this policy. The Alternative Programming Policy was reviewed and revised to reflect the Therapist is responsible for meeting individually with patients that do not attend group. The revised Alternative Programming Policy was reviewed and approved by the Governing Board on November 12th. The Clinical Service Staff and Nursing staff responsible for groups were retrained to the revised Alternative Programming Policy to confirm compliance with documentation of active treatment. Staff were also retrained on the Plan for Provision of Care Policy and the Individual Supportive Therapy Policy as well. Training was initiated by the Director of Clinical Services and the CNO and completed by November 25th, 2021. Item #2: The CEO, the Director of PI, the Risk Manager and the CNO met to review the Suicide Precautions Policy, Sexual Aggression and Sexual Victimization Prevention and Response and Notification Plan policy and no changes were needed to these policies. All licensed Nursing Staff and MHT's were retrained to: • Maintain awareness of patient at all times • Communicate and document signs of concern • Conduct observation rounds ordered	Director of Clinical Services Chief Nursing Officer Chief Nursing Officer	12/13/2021	100% of records of patients not attending Groups will be monitored to confirm compliance with documentation of alternative active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of patients not attending Groups will continue monthly. 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% Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly.

POC Approved: 12/14/21

	• Observe patients for specific behaviors to sexually acting out, including boundary violations, sexual aggression and sexual victim. • The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk. • Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of precautions are changed and/or discontinued. • Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team. Item #3 The CEO, the Director of PI, the Risk Manager and the CNO met to review the Suicide Precautions Policy, Sexual Aggression and Sexual Victimization Prevention and Response and Notification Plan policy and the Fall Risk Assessment and Care Policy and no changes were needed to these policies. All licensed Nursing Staff and MHT's were retrained to: • The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk. • Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of precautions are changed and/or discontinued. • During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered. • Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team all patient precautions. • The Fall Risk Assessment with a focus on key interventions for patients on Fall Precautions,	Chief Nursing Officer		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% Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly. 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%

	documentation of Fall Risk in the individual Treatment Plan with appropriate interventions. • Communication with the Treatment Team on all patients on Fall Precautions. • Additional training was provided on Active Precautions orders that are printed out each day at 0700. The House Supervisor is responsible for providing a copy of the order sheet to each Lead Nurse each day on each unit. • Lead Nurse is responsible for auditing all Observation sheets for each patient on their unit to confirm compliance. • Confirming that each individual level of observation and precautions is addressed on admit and daily when conditions warrant it. • Ensuring patient's safety by increasing the level of observation on patient's when conditions warrant it. • The RN <u>may increase</u> the level of observation if the patient's condition changes. The physician will be notified as soon as possible of the change in condition. • If a change to status is needed to 1:1, as identified by the RN, then the RN will notify the House Supervisor. Increases to 1:1 status may be initiated by the House Supervisor, but requires Provider's order • Reasons that the RN may increase the level of observation include but are not limited to: o Actively suicidal o Aggression/Agitation o Sexual Aggression/misconduct o Homicidal o Combative o Disorganization or Confused to the degree that they place themselves at risk or harm o Threatening harm to self and others o Intrusive behavior, does not respond to redirection o Failure to maintain safety at precious level of observation			

	• Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions).			
L320	**322.035.1D POLICIES PATIENT RIGHTS** The CEO, the Medical Director, the Director of PI, the Director of Pharmacy and the CNO met to review the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient's Rights and Responsibilities Policy, no revisions needed at this time. The Medical Director met with the Providers to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy specific to obtaining written consent prior to administering medications. The Providers are responsible for reviewing the risk and benefits of medications with each patient and obtaining written consent. The CNO met with all licensed Nursing staff to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy. Focus of this training included confirmation of a written consent prior to medication administration. The process will go as followed: • Psychotropic Consent form was added to Admit packet for Providers • Provider meets with patient and gets consent form signed • Provider then goes into HCS and adds order stating Consent received for each Psychotropic medication that they reviewed with the patient. • The Med Room Nurse will check the Consent tab in HCS before giving any Psychotropic medications to make sure that consent was obtained. • Consent form will be given to Med Room Nurse to file in patients chart	Medical Director Director of Pharmacy Chief Nursing Officer	12/13/2021	The Medical Director and Director of Pharmacy will Monitor 100% of the INBH Specific Authorization for Psychotropic Medications Consent Form monthly to confirm compliance with Policy. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Psychotropic Consents will continue. 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%

L370	**322.035.1N POLICIES PATIENT WORK** The CEO, the Director of PI and the CNO met to review the current Patient Employment Policy that was issued October 1st, 2018. Patient Employment Policy was reviewed with no revisions required. The Hospital Leadership Team was reeducated to the Patient Employment Policy by November 12th.	Director of Quality	12/13/2021	The Director of PI and the Leadership Team will be reviewing and updating Hospital Policies annually. All revised and updated policies will be reported to MEC and Governing Board quarterly. Target compliance is 100%
L380	**322.035.1P POLICIES EQUIPMENT MAINTENANCE** The CEO, the Director of PI and the Director of Plant Ops met to review survey findings related to the lack of documentation of maintenance of the ice machines. The Director of Plant Ops implemented a process that includes a vendor responsible for maintaining the ice machines quarterly. Documentation will be kept in the DPO's office. Ice Machine cleaning will be performed by November 15th. An inspection sticker will be put on the side of the ice machine to verify last date cleaned.	Director of Plant Ops	12/13/2021	Monitoring process includes the Director of Plant Ops responsible for maintaining all documentation specific to the cleaning of ice machines. Environmental of Care rounds will be completely monthly to confirm compliance with revised process. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%
L560	**322.050.6D TRAINING INFECTION CONTROL** The CEO, the Director of PI and the Director of Human Resources met to review finding from the survey and discuss corrective actions. The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Infection Control. Staff with incomplete required trainings to Infection Control will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	Director of Human Resources	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Infection Control Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%

L575	**322.050.6G ORIENTATION PATIENT RIGHTS** The CEO, the Director of PI and the Director of Human Resources met to review finding from the survey and discuss corrective actions. The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Patient Rights. Staff with incomplete required trainings to Patient Rights will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	Director of Human Resources	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Patient Rights Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100%
L615	**322.050.9A TB-MANTOUX TEST** The CEO, the Director of PI, the Infection Control Nurse and the Clinical Educator met to review the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy, no revisions needed at this time. The Divisional Director of Clinical Services-Nursing reeducated the Infection Control Nurse and the Clinical Educator on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of this training included the need for TB screening and testing and/or chest x-ray or TB Vaccination proof within the first two weeks of hire. Any staff that are missing their TB Assessment/Test will be completed immediately.	Infection Control Nurse Clinical Educator	12/13/2021	The Infection Control Nurse will Monitor 100% of the Employee Health Files weekly. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 100% of Employee Health Files will continue Quarterly and reported to the Infection Control Committee. Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%.
L715	**322.100.1E INFECTION CONTROL PROVISIONS** The CEO, the Director of PI, the Infection Control Nurse and the CNO met to review the findings from the survey and discuss corrective actions. The CEO directed the Infection Control Nurse to review 100% of supplies and equipment to confirm compliance with not having any expired/damaged supplies and/or equipment. All expired/damaged supplies and/or equipment will be discarded immediately.	Infection Control Nurse	12/13/2021	The Infection Control Nurse will complete Environment of Care rounds monthly to all Exam rooms, Med Rooms and Lab room to confirm compliance with disposal of all expired items. Monitoring will be ongoing Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%.

L825	**322.120.8B HOUSEKEEPING CLOSETS** The CEO, the Director of PI and the Director of Plant Ops met to review the findings from the survey and discuss corrective actions. The CEO directed the Director of Plant Ops to order the shelves for the closets and install them as soon as possible.	Director of Plant Ops	12/13/2021	The Director of Plant Ops will monitor appropriate use of shelf space and further need for additional shelving in closets. Findings will be corrected immediately. Target compliance is 100%
L1065	**322.170.2E TREATMENT PLAN COMPREHENSION** The CEO, the Director of PI, the Medical Director, the Director of Clinical Services, the RD and the CNO met to review the Treatment Planning Policy, no revisions needed at this time. The Director of Clinical Services reeducated all Providers, Clinical Services staff, and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to develop an Individualized Comprehensive Master Treatment Plan for all patients that includes behavioral and medical problems. Item #2: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that interventions for psychological and medical problems are developed and documented for each problem identified on the Master Treatment Plan and the Treatment Plan Updated.	Director of Clinical Services Director of Clinical Services	12/13/2021	100% of Treatment Plans will be monitored weekly to confirm compliance with the Comprehensive Treatment Plan including Behavioral and Medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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% 100% of Treatment Plans will be monitored weekly to confirm compliance with the Treatment Plan containing interventions for Behavioral and Medical problems. The interventions need to be developed and documented and identified on the Master Treatment Plan and the Treatment Plan Updates. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed.

	Item #3: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that any change of status, change of precaution and/or medical concerns noted that a Treatment Plan Update needs to be done with interventions addressing that specific concern.	Director of Clinical Services		Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% 100% of Treatment Plans will be monitored weekly to confirm compliance with a Treatment Plan Update being done on any patient that has a change of status, change of precautions and/or medical concerns and will contain interventions addressing that specific concern. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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%
L1120	**322.170.3F OT SERVICES** The CEO, the Director of PI, the Medical Director, the Director of Clinical Services, the RD, and the CNO met to review the Treatment Planning Policy, no revisions needed at this time. The Director of Clinical Services reeducated all Providers, Clinical Services staff, the RD and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to integrate any services ordered by the Provider into the comprehensive treatment plan and patient care processes. The process is as follows: • The Provider will enter an order for the patients needing OT Assessment into HCS. • The Social Worker will call INHS and schedule the OT Assessment.	Director of Clinical Services	12/13/2021	100% of Treatment Plans will be monitored weekly to confirm compliance with addressing any patient that has an OT Evaluation ordered and the OT recommendations will be incorporated into the Treatment Plan. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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%

	• OT Assessment will be put in the patient's chart under the Assessment Tab • Treatment Plan will be updated to reflect the OT Assessment			
L1140	**322-180.1B ASSAULTIVE INCIDENTS** The CEO, the Director of PI, the Medical Director, the Risk Manager and the CNO met to review the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy, no revisions needed at this time. The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • That the patient and/or family was informed of Hospital Policy on the use of restraint/seclusion and consent for notification. • The initial assessment of the patient related to restraint and seclusion use • Documentation of each episode of seclusion/restraint including specific behaviors, detailed description of the events leading up to event, failure of interventions, notification of patient's family, written orders for use, behavioral criteria for discontinuation of seclusion/restraint, informing patient of behavioral criteria for discontinuation, check for appropriate restraint application, face to face assessment and continuous monitoring of patient and care provided, and debriefing of patient	Chief Nursing Officer	12/13/2021	100% review of Hospital Report, Incident Reports and Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting to capture all Seclusion/Restraint incidents. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%
L1145	**322.180.1C RESTRAINT OBSERVATIONS** The CEO, the Director of PI, the Medical Director, the Risk Manager and the CNO met to review the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy, no revisions needed at this time. The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included:	Chief Nursing Officer	12/13/2021	100% review of Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%

	• A staff member will be within arm's length of the patient to provide immediate response should the patient experience any physical distress • The patient will be assessed every 15 minutes will in seclusion/restraint. This assessment includes, circulation, skin integrity, mental status, level of distress/agitation and readiness for discontinuation of seclusion/restraint. • Range of motion and release of limbs will be done minimally every 1 hour • Fluids and toileting will be offered every 2 hours • Vital signs will be taken upon initiation and as clinically indicated, but at least every 2 hours • For Chemical Restraints staff are to monitor vital signs, neuro status and perform safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours or as directed by the Provider. Item #2 The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • When a patient ends up in seclusion/restraint a review and modification of the treatment plan is indicated. • The RN will review and update the Treatment Plan within 8 hours • The updated Treatment Plan will reflect the identification of the problem, goals to further prevent instances of seclusion/restraint, interventions to define alternative approaches with responsibility of interventions assigned • Review of the updated plan with the patient			100% review of Treatment Plans within 24 hours of incident. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%
L1265	**322.200.3F RECORDS OBSERVATIONS** The CEO, the Director of PI, the Medical Director, the RD and the CNO met to review the Monitoring and Recording Food Intake Policy, no revisions needed at this time.		12/13/2021	100% review of the Patient Meal and Utensil Tracking Forms for Intake percentage 100% review of the Nursing Flowsheets for Intake percentage and general observations.

	The CNO reeducated all Nursing and MHT staff on the Monitoring and Recording Food Intake Policy. Focus of this training included: • Program staff are responsible for monitoring and recording patients food intake after each meal • Program staff will record food intake on the Nursing Flowsheet in the form of percentage of meal eaten and general observations including not eating requiring prompts to eat, requests for extra portions and accepted snacks. • Program staff will alert the Provider if meal intake is less than adequate to meet nutritional needs	Chief Nursing Officer		Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Patient Meal Intake and Nursing Flowsheets will continue monthly. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L1375	**322.210.3C PROCEDURES-ADMINISTER MEDS** The CEO, the Director of PI, the Medical Director, and the CNO met to review the Medication Administration Policy, no revisions needed at this time. The CNO reeducated all licensed Nursing staff on the Medication Administrations Policy. Focus of this training included that staff must check the patient's identification with 2 Hospital approved identifiers (i.e. date of birth, name band, or photograph) and ask the patient to state his/her name.	Chief Nursing Officer	12/13/2021	30 med passes will be audited each month Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of med passes will continue. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%
L1485	**322.230.1 FOOD SERVICES REGS** The CEO, the Director of PI, the Director of Plant Ops and the Dietary Manager met to review the findings of survey and discuss corrective actions. The Director of Plant Ops and Dietary Manager reviewed the current Leftover Food Policy and they revised and updated the Policy to reflect the proper procedure for cooling food items. The DPO and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Leftover Food Policy. Focus of this training included the need for a Cooling Log to document the time and temperature for cooling items when using a pan greater than 2 inches in depth.	Director of Plant Ops	12/13/2021	100% review of the Leftover food cooling will be done weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%

	Item #2: The CEO, the Director of PI, the Director of Plant Ops and the Dietary Manager met to review the Meal Trays for the Communities Policy and they revised and updated the policy to reflect the procedure for timing/dating food trays when delivered to the unit as a means for public health control. The Director of Plant Ops and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Meal Trays for the Communities Policy. Focus of this training included the new process for timing and dating food trays when they are being delivered to the unit. The time will need to be the time that the item would be beyond use for time as a public health control.	Director of Plant Ops Dietary Manager		100% review of the meal trays brought to the communities weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100%

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

December 14, 2021

Rlynn Wickel
CEO
Inland Northwest Behavioral Health
104 W 5th Avenue
Spokane, WA 99204

Dear Mr. Wickel:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Inland Northwest Behavioral Health from October 6-14, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on December 14, 2021.

A Progress Report is due on or before January 12, 2022 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 sign and return the original reports and Plans of Correction to me at the electronically at tyler.henning@doh.wa.gov.

Please contact me if you have any questions. I may be reached at 360-236-2918. I am also available by email at tyler.henning@doh.wa.gov.

Sincerely,
Tyler Henning
Tyler Henning, ScM, MHS
Survey Team Leader

APPROVED
By Kimberly Bloor at 1:53 pm, Nov 08, 2021

Inland Northwest Behavioral Health
Plan of Correction for
State Licensing Hospital Survey
10/06/21-10/14/21

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
S211	**NFPA 101 Means of Egress-General** • The Director of Plant Operations was retrained by the Corporate Facilities Manager to the NFPA 101 means of egress sections for new health care occupancies: Sections 18.1.3.6 to 18.1.3.9, 18.2, 18.4.3.3, 18.4.3.4, A18.2.2 to A 18.2.5.7.3.2 (C). • Chairs and storage items were relocated out of the exit corridors and monitoring will be added to monthly EOC rounds going forward to call for a correction if it does happen again. • The North gate deadbolt in the East Courtyard was removed and replaced with a new deadbolt and tested for proper function.	Director of Plant Operations	11/18/2021 11/18/2021	Monthly EOC rounds will have a line added to specifically check exit corridors for obstructions and will be checked monthly (ongoing). Work orders will be created for any deficiencies and corrected going forward. A quarterly, recurring work order will be added to verify that the courtyard doors are lubricated and functioning properly (ongoing). 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%
S325	**NFPA 101 Alcohol Bases Hand Rub Dispenser (ABHR)** • Alcohol based hand rub dispensers were removed from above electrical sources and relocated to safe locations to eliminate the safety risk. • All EOC members were informed on what would cause such a deficiency in the October EOC Meeting (Nov. 2nd) to ensure we are properly inspecting during EOC rounds. • EVS Staff and the Engineer were retrained on the proper placement of alcohol bases hand rub dispensers on 11/5/2021.	Director of Plant Operations	11/18/2021	Monthly EOC rounds will continue to monitor for improperly located alcohol hand sanitizer dispensers. With proper inspecting methods this will result in creating work orders for any deficiencies and corrected going forward. 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 345	**NFPA 101 Fire Alarm System- Testing and Maintenance** The sensitivity testing (EC 02.03.05 EP3) was performed on 10/22/2018, as well as annual each year since. Due to a misunderstanding of the request, the Director of Plant Operations was unable to provide the information during the inspection. The sensitivity test was on site in the Director of Plant Operations office during the inspection and has been tested annually each year since. The sensitivity test will continue to be completed.	Director of Plant Operations	11/18/2021	The Director of Plant Operations will be more focused on the details of each request going forward to ensure proper reports are provided during an inspection. 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 712	**NFPA 101 Fire Drills** The 3rd quarter night shift fire drill was performed on 10/8/2021. The drill was performed late (as per the fire drill matrix) and to ensure drills are not performed late again the Engineer will be scheduled to perform any drills if the Director of Plant Operations is not available. The Director of Plant Ops trained the Engineer on how to perform Fire Drills by 11/5/2021.	Director of Plant Operations	11/18/2021	The Engineer will be trained to perform a fire drill alone by the Director of Plant Operations Additionally he will be in charge of the next two drills in 2021 (with DPO to help) to ensure he is prepared to perform a drill without assistance going forward. 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%

Inland Northwest Behavioral Health
Progress Report for State Licensing Hospital Survey 10/06/21-10/14/21

Tag Number	How Corrected	Date Completed	Results of Monitoring
# L315 – 322-035.1C POLICIES TREATMENT	**Item #1:** The Clinical Service Staff and Nursing staff responsible for groups were retrained to the revised Alternative Programming Policy to confirm compliance with documentation of active treatment. Staff were also retrained on the Plan for Provision of Care Policy and the Individual Supportive Therapy Policy as well. Training was initiated by the Director of Clinical Services and the CNO and completed by November 25th, 2021.	12/13/2021	**Item #1:** 100% of records of patients not attending Groups will be monitored to confirm compliance with documentation of alternative active treatment. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of patients not attending Groups will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed **November**: 60%- Re-education done by DSC and assigned a Group Facilitator. Daily spot checks to be done by DSC. **December:** 87%*- Director of Quality met with Social Workers and Recreational Therapists and re-educated them on Policy and Procedure on 12/21/2021. **January** so far: 99%
	Item #2: All licensed Nursing Staff and MHT's were retrained to: • Maintain awareness of patient at all times • Communicate and document signs of concern • Conduct observation rounds ordered • Observe patients for specific behaviors to sexually acting out, including boundary violations, sexual aggression and sexual victim. • The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk. • Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of	12/13/2021	**Item #2:** Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed. **November**: 89%*- Re-education done to Providers to communicate when discontinuing Precautions. Lead Nurse is running a precaution report 3 times/day to make sure all information is correct. **December:** 91% **January** so far: 95%

Progress Repor Rec. 1/11/22 Apprvd. 1/12/22 1/21/22

	precautions are changed and/or discontinued. • Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team.		
	Item #3: All licensed Nursing Staff and MHT's were retrained to: • The Physician reevaluates Suicide Precautions daily and will discontinue Suicide Precautions and will assess and discontinue Precautions when patient is no longer at risk. • Lead Nurse is responsible for communicating with the Med Nurse and MHT's when levels of precautions are changed and/or discontinued. • During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered. • Lead Nurse is responsible for updating the Assignment sheet, the 24 Hour Nurse Report and the individual patient Observation Form and communicate with the Team all patient precautions. • The Fall Risk Assessment with a focus on key interventions for - patients on Fall Precautions, documentation of Fall Risk in the individual Treatment Plan with appropriate interventions. • Communication with the Treatment Team on all patients on Fall Precautions. • Additional training was provided on Active Precautions orders that are printed out each day at 0700. The House Supervisor is responsible for	12/13/2021	**Item #3:** Monitoring of all Nursing Assignment Sheets, Observation Sheets and HCS Precaution Orders to confirm compliance with documentation of patient precautions and observation levels. During morning report with Providers, all patients along with their Precautions will be reviewed to make sure no new Precautions need to be ordered. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Assignment Sheets, Observation Sheets and HCS Precaution Orders will continue monthly. All deficiencies will be corrected immediately to include staff retraining as needed. **November**: 89%*- Re-education done to Providers to communicate when discontinuing Precautions. Lead Nurse is running a precaution report 3 times/day to make sure all information is correct. **December:** 91% **January** so far: 95%

providing a copy of the order sheet to each Lead Nurse each day on each unit.

- Lead Nurse is responsible for auditing all Observation sheets for each patient on their unit to confirm compliance.
- Confirming that each individual level of observation and precautions is addressed on admit and daily when conditions warrant it.
- Ensuring patient's safety by increasing the level of observation on patient's when conditions warrant it.
- The RN may increase the level of observation if the patient's condition changes. The physician will be notified as soon as possible of the change in condition.
- If a change to status is needed to 1:1, as identified by the RN, then the RN will notify the House Supervisor. Increases to 1:1 status may be initiated by the House Supervisor, but requires Provider's order
- Reasons that the RN may increase the level of observation include but are not limited to:
    - Actively suicidal
    - Aggression/Agitation
    - Sexual Aggression/misconduct
    - Homicidal
    - Combative
    - Disorganization or Confused to the degree that they place themselves at risk or harm
    - Threatening harm to self and others
    - Intrusive behavior, does not respond to redirection
    - Failure to maintain safety at precious level of observation

	• Staff will be vigilant for potential risk factors identified for specific patients (levels of precautions).		
# L320 – **322.035.1D- POLICIES PATIENT RIGHTS**	The Medical Director met with the Providers to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy specific to obtaining written consent prior to administering medications. The Providers are responsible for reviewing the risk and benefits of medications with each patient and obtaining written consent. The CNO met with all licensed Nursing staff to reeducate on the Medication-Involuntary Use of Antipsychotics for Involuntary Patients Policy and the Patient Rights and Responsibilities Policy. Focus of this training included confirmation of a written consent prior to medication administration. The process will go as followed: • Psychotropic Consent form was added to Admit packet for Providers • Provider meets with patient and gets consent form signed • Provider then goes into HCS and adds order stating Consent received for each Psychotropic medication that they reviewed with the patient. • The Med Room Nurse will check the Consent tab in HCS before giving any Psychotropic medications to make sure that consent was obtained.	12/13/2021	The Medical Director and Director of Pharmacy will Monitor 100% of the INBH Specific Authorization for Psychotropic Medications Consent Form monthly to confirm compliance with Policy. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Psychotropic Consents will continue. All deficiencies will be corrected immediately to include staff retraining as needed. **November**: 78%*- Re-education done to Providers and Med nurses on process. Changed our process to make it easier on the Med Nurses to upload the form into HCS. **December:** 88%*- One Provider is delinquent in doing the Consent form. This Provider was re-educated. **January** so far: 100%

	• Consent form will be given to Med Room Nurse to file in patients chart		
# L370- **322.035.1N-POLICIES PATIENT WORK**	The CEO, the Director of PI and the CNO met to review the current Patient Employment Policy that was issued October 1st, 2018. Patient Employment Policy was reviewed with no revisions required. The Hospital Leadership Team was reeducated to the Patient Employment Policy by November 12th.	12/13/2021	The Director of PI and the Leadership Team will be reviewing and updating Hospital Policies annually. All revised and updated policies will be reported to MEC and Governing Board quarterly. Target compliance is 100% **November**: 100% **December:** 100%
# L380- **322.035.1P-POLICIES EQUIPMENT MAINTENANCE**	The CEO, the Director of PI and the Director of Plant Ops met to review survey findings related to the lack of documentation of maintenance of the ice machines. The Director of Plant Ops implemented a process that includes a vendor responsible for maintaining the ice machines quarterly. Documentation will be kept in the DPO's office. Ice Machine cleaning will be performed by November 15th. An inspection sticker will be put on the side of the ice machine to verify last date cleaned.	12/13/2021	Monitoring process includes the Director of Plant Ops responsible for maintaining all documentation specific to the cleaning of ice machines. Environmental of Care rounds will be completely monthly to confirm compliance with revised process. Aggregated data will be reported to the EOC, Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% **November**: 100% **December:** 100%
# L560- **322.050.6D-TRAINING INFECTION CONTROL**	The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Infection Control. Staff with incomplete required trainings to Infection Control will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Infection Control Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% **November**: 88%*- Each Director was given their list of employees that were non-compliant and each employee came in to do their education. **December:** 95%

# L575-**322.050.6G-ORIENTATION PATIENT RIGHTS**	The CEO directed the Director of Human Resources to review 100% of employee files to confirm compliance with all required training specific to Patient Rights. Staff with incomplete required trainings to Patient Rights will be notified. All required trainings will be completed by November 25th, 2021. Staff that have not completed required trainings will not be scheduled to work until required trainings are completed.	12/13/2021	Monitoring process includes the Director of Human Resources will download all required trainings completed by staff and notify the Department Directors weekly of any staff that are not compliant with Patient Rights Training. The Department Directors are responsible for all required trainings to be completed by their staff. All deficiencies will be corrected immediately. Aggregated data will be reported to the Quality Committee and MEC monthly and to the Governing Body quarterly. Target compliance is 100% **November**: 88%*- Each Director was given their list of employees that were non-compliant and each employee came in to do their education. **December:** 95%
# L615-**322.050.9A-TB-MANTOUX TEST**	The Divisional Director of Clinical Services-Nursing reeducated the Infection Control Nurse and the Clinical Educator on the Tuberculosis (TB) Screening and Airborne Pathogen Exposure Plan Policy. Focus of this training included the need for TB screening and testing and/or chest x-ray or TB Vaccination proof within the first two weeks of hire. Any staff that are missing their TB Assessment/Test will be completed immediately.	12/13/2021	The Infection Control Nurse will Monitor 100% of the Employee Health Files weekly. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 100% of Employee Health Files will continue Quarterly and reported to the Infection Control Committee. Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%. **November**: 90%*- Employees notified that needed a TB test and/or X-ray. **December:** 95%
# L715-**322.100.1E-INFECTION CONTROL PROVISIONS**	The CEO directed the Infection Control Nurse to review 100% of supplies and equipment to confirm compliance with not having any expired/damaged supplies and/or equipment. All expired/damaged supplies and/or equipment will be discarded immediately.	12/13/2021	The Infection Control Nurse will complete Environment of Care rounds monthly to all Exam rooms, Med Rooms and Lab room to confirm compliance with disposal of all expired items. Monitoring will be ongoing Aggregated data will be reported to the Infection Control Committee, the Quality Committee, and the MEC monthly and to the Governing Board quarterly. Target for compliance 100%. **November**: 95% **December:** 100%

# L825- **322.120.8B-** **HOUSEKEEPING CLOSETS**	The CEO directed the Director of Plant Ops to order the shelves for the closets and install them as soon as possible.	12/13/2021	The Director of Plant Ops will monitor appropriate use of shelf space and further need for additional shelving in closets. Findings will be corrected immediately. Target compliance is 100% **November**: 100% **December:** 100%
# L1065- **322.170.2E-** **TREATMENT PLAN COMPREHENSION**	**Item #1:** The Director of Clinical Services reeducated all Providers, Clinical Services staff, and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to develop an Individualized Comprehensive Master Treatment Plan for all patients that includes behavioral and medical problems.	12/13/2021	**Item #1:** 100% of Treatment Plans will be monitored weekly to confirm compliance with the Comprehensive Treatment Plan including Behavioral and Medical problems. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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% **November**: 75%*- Re-education done to Providers and Nursing regarding addressing all Medical problems. **December:** 90%
	Item #2: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment Planning Policy. Focus of this training included the need to ensure that interventions for psychological and medical problems are developed and documented for each problem identified on the Master Treatment Plan and the Treatment Plan Updated.	12/13/2021	**Item #2:** 100% of Treatment Plans will be monitored weekly to confirm compliance with the Treatment Plan containing interventions for Behavioral and Medical problems. The interventions need to be developed and documented and identified on the Master Treatment Plan and the Treatment Plan Updates. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. All deficiencies will be corrected immediately to include staff retraining as needed. **November**: 75%*- Re-education done to Providers, Social Workers and Nurses on the need to have interventions listed on the Updates **December:** 90%
	Item #3: The Director of Clinical Services reeducated all Providers, Clinical Services staff, and the Nursing staff on the Treatment	12/13/2021	**Item #3:** 100% of Treatment Plans will be monitored weekly to confirm compliance with a Treatment Plan Update being done on any patient that has a change of status, change of precautions and/or medical

	Planning Policy. Focus of this training included the need to ensure that any change of status, change of precaution and/or medical concerns noted that a Treatment Plan Update needs to be done with interventions addressing that specific concern.		concerns and will contain interventions addressing that specific concern. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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% **November**: 75%*- Re-education done to Providers, Social Workers and Nursing on needing to address any changes with patients and address that specific concern in Treatment Plan meeting. **December:** 90%
# L1120- **322.170.3F- OT SERVICES**	The Director of Clinical Services reeducated all Providers, Clinical Services staff, the RD and Nursing staff on the Treatment Planning Policy. Focus of this training included the need to integrate any services ordered by the Provider into the comprehensive treatment plan and patient care processes. The process is as follows: • The Provider will enter an order for the patients needing OT Assessment into HCS. • The Social Worker will call INHS and schedule the OT Assessment. • OT Assessment will be put in the patient's chart under the Assessment Tab Treatment Plan will be updated to reflect the OT Assessment	12/13/2021	100% of Treatment Plans will be monitored weekly to confirm compliance with addressing any patient that has an OT Evaluation ordered and the OT recommendations will be incorporated into the Treatment Plan. Monitoring will be ongoing for 4 months until compliance of 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Treatment Plans will continue. 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% **November**: 85%*- Re-education done to Providers, Social Workers and Nursing to address on Treatment Plans any patient being referred for PT/OT Evaluations. **December:** 100%
# L1140- **322.180.1B- ASSAULTIVE INCIDENTS**	The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • That the patient and/or family was informed of Hospital Policy on the use of restraint/seclusion and consent for notification. • The initial assessment of the patient related to restraint and seclusion use	12/13/2021	100% review of Hospital Report, Incident Reports and Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting to capture all Seclusion/Restraint incidents. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% **November**: 87%*- Nursing Staff reeducated on doing the Staff Debriefing form. **December:** 100%

	Documentation of each episode of seclusion/restraint including specific behaviors, detailed description of the events leading up to event, failure of interventions, notification of patient's family, written orders for use, behavioral criteria for discontinuation of seclusion/restraint, informing patient of behavioral criteria for discontinuation, check for appropriate restraint application, face to face assessment and continuous monitoring of patient and care provided, and debriefing of patient		
# L1145- **322.180.1C-RESTRAINT OBSERVATIONS**	**Item #1:** The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • A staff member will be within arm's length of the patient to provide immediate response should the patient experience any physical distress • The patient will be assessed every 15 minutes will in seclusion/restraint. This assessment includes, circulation, skin integrity, mental status, level of distress/agitation and readiness for discontinuation of seclusion/restraint. • Range of motion and release of limbs will be done minimally every 1 hour • Fluids and toileting will be offered every 2 hours • Vital signs will be taken upon initiation and as clinically indicated, but at least every 2 hours • For Chemical Restraints staff are to monitor vital signs, neuro status and perform safety checks every 15 minutes for 1 hour, every 30 minutes for 1 hour and then every 1 hour for 4 hours or as directed by the Provider	12/13/2021	**Item #1:** 100% review of Seclusion/Restraint Packets within 24 hours of incident during the Flash Meeting. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% **November**: 100% **December:** 100%

	Item #2: The CNO reeducated all Nursing staff on the Proper Use and Monitoring of Physical/Chemical Restraints and Seclusion Policy and the Seclusion/Restraint Packet. Focus of this training included: • When a patient ends up in seclusion/restraint a review and modification of the treatment plan is indicated. • The RN will review and update the Treatment Plan within 8 hours • The updated Treatment Plan will reflect the identification of the problem, goals to further prevent instances of seclusion/restraint, interventions to define alternative approaches with responsibility of interventions assigned • Review of the updated plan with the patient	12/13/2021	**Item #2:** 100% review of Treatment Plans within 24 hours of incident. Monitoring will be ongoing All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% **November**: 85%*- Re-education done to Nurses on the need to address the incident in the Treatment Plan meeting. **December:** 100%
# L1265- **322.200.3F-RECORDS OBSERVATIONS**	The CNO reeducated all Nursing and MHT staff on the Monitoring and Recording Food Intake Policy. Focus of this training included: • Program staff are responsible for monitoring and recording patients food intake after each meal • Program staff will record food intake on the Nursing Flowsheet in the form of percentage of meal eaten and general observations including not eating requiring prompts to eat, requests for extra portions and accepted snacks. Program staff will alert the Provider if meal intake is less than adequate to meet nutritional needs	12/13/2021	100% review of the Patient Meal and Utensil Tracking Forms for Intake percentage 100% review of the Nursing Flowsheets for Intake percentage and general observations. Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of Patient Meal Intake and Nursing Flowsheets will continue monthly. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90% **November**: 75%*- Re-education done to Nurses and MHT's. CNO made new form that made the charting easier and we started that form on 12/13/2021. **December:** 94%
# L1375- **322.210.3C-PROCEDURES-ADMINISTER MEDS**	The CNO reeducated all licensed Nursing staff on the Medication Administrations Policy. Focus of this training included that staff must check the patient's identification with 2 Hospital approved identifiers (i.e. date of birth, name band, or photograph) and ask the patient to state his/her name.	12/13/2021	30 med passes will be audited each month Monitoring will be ongoing for 4 months until 90% or greater is achieved and sustained. Ongoing monitoring of 50% of med passes will continue. All deficiencies will be followed up by the CNO and/or designee. Aggregated data will be reported to Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance >/= 90%

			November: 91% **December:** 93%
# L1485-**322.230.1-FOOD SERVICES**	**Item #1:** The Director of Plant Ops and Dietary Manager reviewed the current Leftover Food Policy and they revised and updated the Policy to reflect the proper procedure for cooling food items. The DPO and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Leftover Food Policy. Focus of this training included the need for a Cooling Log to document the time and temperature for cooling items when using a pan greater than 2 inches in depth.	12/13/2021	**Item #1:** 100% review of the Leftover food cooling will be done weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% **November**: 91% **December:** 95%
	Item #2: The CEO, the Director of PI, the Director of Plant Ops and the Dietary Manager met to review the Meal Trays for the Communities Policy and they revised and updated the policy to reflect the procedure for timing/dating food trays when delivered to the unit as a means for public health control. The Director of Plant Ops and Dietary Manager reeducated all Dietary Kitchen staff on the newly revised Meal Trays for the Communities Policy. Focus of this training included the new process for timing and dating food trays when they are being delivered to the unit. The time will need to be the time that the item would be beyond use for time as a public health control.	12/13/2021	**Item #2:**100% review of the meal trays brought to the communities weekly to confirm compliance. Monitoring will be ongoing All deficiencies will be followed up by the DPO and/or designee. Aggregated data will be reported to the Environment of Care Committee, the Quality Committee and MEC monthly and to the Governing Board quarterly. Target for compliance 100% **November**: 92% **December:** 95%

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

October 26, 2021

Rlynn Wickel
CEO
Inland Northwest Behavioral Health
104 W 5th Avenue
Spokane, WA 99204

Dear Mr. Wickel:

This letter contains information regarding the recent survey of Inland Northwest Behavioral Health by the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau. Your state licensing survey was completed on 10/14/2021.

During the survey, deficient practice was found in the areas listed on the attached Statements of Deficiencies (CMS 2567). A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 calendar days after you receive this letter. All corrections for **Fire Life Safety** issues must be completed within **35 days** of the survey exit date (11/18/21). All corrections for the **Health survey** must be completed within **60 days** of the survey exit date (12/13/21).

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;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring procedure including time frame, number of planned observations and the target for compliance.

A sample Plan of Correction has been enclosed for reference. You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return the original reports and Plans of Correction to me at the electronically at tyler.henning@doh.wa.gov.

If more than 35 days for Fire Life Safety corrections is required and/or more than 60 days for Health corrections is required, the hospital must request an **extension/waiver**. The extension/waiver request must include: the facility name; Medicare provider number and/or State license number, date of inspection; citation number; description of deficiency; description of circumstances that will not allow you to meet current deadlines; revised date of when you expect to correct the deficiency; timetable of events leading to correction (i.e. new equipment receive date, new equipment install date etc.); and steps you will take to mitigate risk to patients while the deficiency is being corrected.

Requests for extensions/waivers must be submitted to the undersigned.

Please contact me if there are questions regarding the survey process, deficiencies cited, or completion of the Plans of Correction. I may be reached at 360-236-2918. I am also available by email at tyler.henning@doh.wa.gov.

I want to extend another "thank you" to you and to everyone that assisted us during the survey.

Sincerely,

Tyler Henning

Tyler Henning, ScM, MHS
Survey Team Leader

Enclosures: DOH Statement of Deficiencies
WSP Fire Inspection Report
Sample Plan of Correction

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

January 12, 2022

Rlynn Wickel
CEO
Inland Northwest Behavioral Health
104 W 5th Avenue
Spokane, WA 99204

Dear Mr. Wickel:

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Inland Northwest Behavioral Health from October 6-14, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on December 14, 2021.

Hospital staff members sent a Progress Report dated January 11, 2022 that indicates all deficiencies have been corrected. The Department of Health accepts Inland Northwest Behavioral Health's attestation to be in compliance with Chapter 246-320 WAC.

If there were fire life safety deficiencies identified in your report, the Deputy Fire Marshal will perform an on-site revisit after the correction date to verify those corrections.

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,

Tyler Henning

Tyler Henning, ScM, MHS
Survey Team Leader