Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012699	A. BUILDING _____ B. WING _____	07/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE LICENSING SURVEY A state hospital survey was conducted at Fairfax Hospital North on 7/13/2016-7/14/2016 by Joyce Williams, RN, BSN; Alex Giel, REHS and PHA orientee Tyler Henning, ScM, MHS. The Washington Fire Protection Bureau conducted a fire life safety inspection on 7/13/2016. BG3111	L 000		
L 450	322-040.7 ADMIN-APPOINT STAFF WAC 246-322-040 Governing Body and Administration. The governing body shall: (7) Appoint and periodically reappoint the professional staff; This WAC is not met as evidenced by: Based on document review, the hospial failed to ensure medical staff re-appointments were completed within the specified time frame stated in the governing body bylaws. Findings: 1. The Board of Governors Bylaws part (d) subtitled, "Reappointment Procedure" stated in part, "All appointments to the Medical Staff shall be for two (2) years, . . ." 2. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a	L 450		

By signing, I understand these findings and agree to correct as noted:
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Amanda TITLE CEO (X6) DATE 8/10/16

Received: 8/15/2016 Joyce Williams, RN

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L 450	Continued From Page 1 current staff member "re-appointment" had expired on 3/22/2016.	L 450		
L 460	322-040.8B ADMIN RULES-PRIVILEGES WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (b) Delineation of privileges; This WAC is not met as evidenced by: .. Based on document review, the facility failed to assure that all members of the medical staff had current privileges. Findings: 1. The Hospital's Medical Staff Bylaws Section 7.2.4. subtitled, "Procedure" stated, "All requests for Clinical Privileges shall be evaluated and granted, modified, or denied..." 2. The Hospital's Medical Staff Bylaws Section 7.2.5 subtitled, "Term of Privileges" stated, "Clinical Privileges shall be granted for a term of not more than two(2) years." 3. The Hospital's Medical Staff Bylaws Section 7.4 titled "Temporary Privileges" stated in part: "In all cases, Temporary Privileges shall be granted for a specific period of time, not to exceed one hundred twenty (120) days. Temporary privileges shall terminate automatically at the end of the specific period without the hearing and appeal rights set forth in these Bylaws." 4. The Board of Governors Bylaws stated in part,	L 460		

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L 460	Continued From Page 2 "Article XII.3.c. Governing Board Action. The Board shall consider the recommendations of the Medical Staff so presented and appoint to the Medical Staff. . .Healthcare Professionals. . .and shall assign to them appropriate staff status as well as clinical privileges. . ." 5. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a current staff member had only temporary privileges granted in 9/28/2015. There was no documentation in the file to indicate a change from the temporary status or that privilege was granted according to procedures outlined in the Medical Staff Bylaws, the practitioner was a current member of the medical staff. THIS IS A REPEAT FINDING 6. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a current staff member had privileges granted on 3/20/14. As stated per policy above, privileges expires after 2 years.	L 460		
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect	L 690		

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L 690	Continued From Page 3 and analyze data; and (iii) Activities to prevent and control infections; This WAC is not met as evidenced by: . Based on observations and policy and procedure review the hospital failed to ensure staff members followed the hospital policy for hand hygiene. Findings: 1. The hospital policy titled "Hand Hygiene", (Policy #1600.4.4, Rev. 11/2015) states in part, "1. Employees are required to wash hands thoroughly: 1.4. After contact with potentially contaminated surfaces." 2. On 7/13/2016, Surveyor #3 observed a terminal room cleaning procedure in Room 712. A housekeeper (Staff Member #1) left the room to retrieve clean linens from the clean linen closet. The staff member removed her/his gloves and gathered linens without first performing hand hygiene. Since the staff member had been in contact with a contaminated surface, the clean linens could be contaminated.	L 690		
L 880	322-140.1i ROOM FURNISHINGS WAC 246-322-140 Patient living areas. The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow;	L 880		

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L 880	Continued From Page 4 This WAC is not met as evidenced by: Based on observation, the hospital failed to provide a safe and clean environment for its patients. Finding: On 7/13/2016 at 3:00 PM Surveyor #2 and #3 observed housekeeper (Staff Member #2) wiped down a torn mattress in patient room #711. During the process the staff member stated that the mattress would be removed, but s/he continued to make the bed, making it readily available for the next patient.	L 880		

By signing, I understand these findings and agree to correct as noted:

Fairfax Behavioral Health
Plan of Correction for State Licensing
BHC Fairfax Hospital North/Everett (012699)
Date Survey Completed: 7/14/16

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
S 023	**NFPA 101 LIFE SAFETY CODE STANDARD** Smoke barriers are provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1 1. The cross corridor fire separation doors by the staff restroom failed to close and latch.	The Lead Maintenance Technician repaired the fire separation doors to the staff restroom so that the doors now close and latch.	Facilities Director	7/14/2016	The Facilities Director will inspect all doors as part of monthly rounds. The target for compliance is 100%.	100%
L 450	**322-040.7 ADMIN-APPOINT STAFF** WAC 246-322-040 Governing Body and Administration. The governing body shall: (7) Appoint and periodically reappoint the professional staff; This WAC is not met as evidenced by: L 450 Based on document review, the hospital failed to ensure medical staff re-appointments were completed within the specified time frame stated in the governing body bylaws. 1. The Board of Governors Bylaws part (d)subtitled, "Reappointment Procedure" stated in part, "All appointments to the Medical Staff shall be for two (2) years, . . ." 2. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a current staff member "re-appointment" had expired on 3/22/2016.	The re-appointment of the identified medical staff member was approved at the Medical Executive Committee Meeting on 8/10/16. To ensure on-going compliance, the Medical Staff Coordinator updated the tracking spreadsheet on 8/1/16 to specifically track the requirement elements for re-appointments. Further, on 8/1/16, the Medical Staff Coordinator initiated a system for medical staff and the Medical Staff Coordinator to receive automated reminders starting at 3 months in advance of re-appointments to ensure timely receipt of required documentation.	Chief Medical Officer	8/10/16	The Medical Staff Coordinator will conduct at minimum biweekly audits to ensure appointments remain current. The target for compliance is 100%.	100%
L 460	**322-040.8B ADMIN RULES-PRIVILEGES**	The identified provider with temporary privileges was presented to the Medical	Chief Medical	8/10/16	The Medical Staff	100%

Tag Number	Deficiency	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	How Monitored to Prevent Recurrence & Target for Compliance	Action Level Indicating Need for Change of POC
	WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (b) Delineation of privileges; This WAC is not met as evidenced by: L 460 Based on document review, the facility failed to assure that all members of the medical staff had current privileges. Findings: 1. The Hospital's Medical Staff Bylaws Section 7.2.4. subtitled, "Procedure" stated, "All requests for Clinical Privileges shall be evaluated and granted, modified, or denied..." 2. The Hospital's Medical Staff Bylaws Section 7.2.5 subtitled, "Term of Privileges" stated, "Clinical Privileges shall be granted for a term of not more than two(2) years." 3. The Hospital's Medical Staff Bylaws Section 7.4 titled "Temporary Privileges" stated in part: "In all cases, Temporary Privileges shall be granted for a specific period of time, not to exceed one hundred twenty (120) days. Temporary privileges shall terminate automatically at the end of the specific period without the hearing and appeal rights set forth in these Bylaws." 4. The Board of Governors Bylaws stated in part, "Article XII.3.c. Governing Board Action. The Board shall consider the recommendations of the Medical Staff so presented and appoint to the Medical Staff. . .Healthcare Professionals. . .and shall assign to them appropriate staff status as well as clinical privileges. . ." 5. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a current staff member had only temporary privileges granted in 9/28/2015. There was no	Executive Committee on 8/10/16 for the granting of full privileges. The identified provider with expired privileges was presented to the Medical Executive Committee on 8/10/16 for re-privileging. The Chair of the Medical Executive Committee was re-trained on 8/9/16 regarding how to complete the Delineation of Privilege Form. On 8/1/16, the Medical Staff Coordinator expanded the tracking spreadsheet to include the tracking of provisional or temporary privileges and when privileges expire. Further, there is a checklist for the purpose of tracking items requiring for the privileging packet. On 8/1/16, the Medical Staff Coordinator also initiated a system for medical staff and the Medical Staff Coordinator to received automated reminders starting at 3 months in advance of privileges expiring to ensure timely receipt of required documentation.	Officer		Coordinator will conduct at minimum biweekly audits to ensure privileges remain current and will review the Delineation of Privileges Form after each Medical Executive Committee Meeting to ensure completeness. The target for compliance is 100%.	

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	documentation in the file to indicate a change from the temporary status or that privilege was granted according to procedures outlined in the Medical Staff Bylaws, the practitioner was a current member of the medical staff. THIS IS A REPEAT FINDING 6. On 7/14/2016, between the hours of 12:00 PM and 1:00 PM, Surveyor #2 and #3 reviewed 3 medical credentialing files for hospital medical staff members. One of three charts indicated a current staff member had privileges granted on 3/20/14. As stated per policy above, privileges expires after 2 years.					
L 690	**322-100.1A INFECT CONTROL-P&P** **WAC 246-322-100 Infection Control.** The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collectand analyze data; and (iii) Activities to prevent and control infections; This WAC is not met as evidenced by: Based on observations and policy and procedure review the hospital failed to ensure staff members followed the hospital policy for hand hygiene. Findings: 1. The hospital policy titled "Hand Hygiene", (Policy #1600.4.4, Rev. 11/2015) states in part, "1. Employees are required to wash hands thoroughly: 1.4. After contact with potentially contaminated surfaces." 2. On 7/13/2016, Surveyor #3 observed a terminal room cleaning procedure in Room 712. A housekeeper (Staff Member #1) left the room to retrieve clean linens from the clean linen closet. The staff member removed her/his gloves and gathered linens without first performing hand	Housekeeping staff were retrained via in-person training by the Nurse Manager regarding compliance with the hand hygiene policy as of 8/10/2016. On an on-going basis, the Nurse Manager will train new housekeeping staff at-hire and re-train existing housekeeping staff at a minimum annually on the hand hygiene policy and expectations.	Nurse Manager	8/10/16	The Nurse Manager will audit housekeeping staff for compliance at a minimum weekly. The target for compliance is 90%.	90%

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	hygiene. Since the staff member had been in contact with a contaminated surface, the clean linens could be contaminated.					
L 880	**322-140.1i ROOM FURNISHINGS** **WAC 246-322-140 Patient living areas.** The licensee shall: (1) Provide patient sleeping rooms with: (i) Sufficient room furnishings maintained in safe and clean condition including: (i) A bed for each patient at least thirty-six inches wide or appropriate to the special needs and size of the patient; (ii) A cleanable, firm mattress; and (iii) A cleanable or disposable pillow; Continued From Page 4 L 880 This WAC is not met as evidenced by: Based on observation, the hospital failed to provide a safe and clean environment for its patients. Finding:On 7/13/2016 at 3:00 PM Surveyor #2 and #3 observed housekeeper (Staff Member #2) wiped down a torn mattress in patient room #711. During the process the staff member stated that the mattress would be removed, but s/he continued to make the bed, making it readily available for the next patient.	A daily inspection of mattresses and pillows will be performed by Program Specialists (Mental Health Technicians) and the results documented on the "daily room check" form. These inspections will commence on 8/8/2016 and will be used to determine the integrity of the mattresses and pillows. If a mattress or pillow is compromised or not cleanable, it will immediately be removed and replaced with a new mattress or pillow. An overstock of mattresses and pillows will be available in the event a replacement is needed as of 8/31/16. The Nurse Manager will re-train the Program Specialists regarding the expectations for daily room checks and completing the audit tool individually, in-person by 8/18/16.	Nurse Manager	8/31/16	The Nurse Manager will perform weekly audits of the daily room check forms, confirm follow-up on any areas of non-compliance, and confirm an adequate inventory. The target for compliance is 100%.	90%

By submitting this Plan of Correction, the Fairfax Behavioral Health does not agree that the facts alleged are true or admit that it violated the rules. Fairfax Behavioral Health submits this Plan of Correction to document the actions it has taken to address the citations.

Fairfax Behavioral Health - BHC Fairfax Hospital North/Everett (012699)
Progress Report for State Licensing
Date Survey Completed: 7/14/16

Tag Number	How Corrected	Date Completed	Results of Monitoring
S 023	The Lead Maintenance Technician repaired the fire separation doors to the staff restroom so that the doors now close and latch.	7/14/2016	100%
L 450	The re-appointment of the identified medical staff member was approved at the Medical Executive Committee Meeting on 8/10/16. To ensure on-going compliance, the Medical Staff Coordinator updated the tracking spreadsheet on 8/1/16 to specifically track the requirement elements for re-appointments. Further, on 8/1/16, the Medical Staff Coordinator initiated a system for medical staff and the Medical Staff Coordinator to receive automated reminders starting at 3 months in advance of re-appointments to ensure timely receipt of required documentation.	8/10/16	100%
L 460	The identified provider with temporary privileges was presented to the Medical Executive Committee on 8/10/16 for the granting of full privileges. The identified provider with expired privileges was presented to the Medical Executive Committee on 8/10/16 for re-privileging. The Chair of the Medical Executive Committee was re-trained on 8/9/16 regarding how to complete the Delineation of Privilege Form. On 8/1/16, the Medical Staff Coordinator expanded the tracking spreadsheet to include the tracking of provisional or temporary privileges and when privileges expire. Further, there is a checklist for the purpose of tracking items requiring for the privileging packet. On 8/1/16, the Medical Staff Coordinator also initiated a system for medical staff and the Medical Staff Coordinator to received automated reminders starting at 3 months in advance of privileges expiring to ensure timely receipt of required documentation.	8/10/16	100%
L 690	Housekeeping staff were retrained via in-person training by the Nurse Manager regarding compliance with the hand hygiene policy as of 8/10/2016. On an on-going basis, the Nurse Manager trains new housekeeping staff at-hire and re-trains existing housekeeping staff at a minimum annually on the hand hygiene policy and expectations.	8/10/16	95%
L 880	A daily inspection of mattresses and pillows is performed by Program Specialists (Mental Health Technicians) and the results documented on the "daily room check" form. These inspections started on 8/8/2016 and are used to determine the integrity of the mattresses and pillows. Any mattresses or pillows that are compromised or not cleanable are immediately removed and replaced with a new mattress or pillow. An overstock of mattresses and pillows is available in the event a replacement is needed as of 8/31/16. The Nurse Manager trained the Program Specialists regarding the expectations for daily room checks and completing the audit tool individually, in-person effective 8/18/16.	8/31/16	90%

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received
10/14/2016
Joyce Williams

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

October 24, 2016

Ms. Darcie Johnson, MSW,CPHQ
Fairfax Behavioral Hospital-North
10200 NE 132nd Street
Kirkland, WA 98034

Dear Ms. Johnson,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Fairfax Behavioral Hospital-North (Everett) on 7/13/2016-7/14/2016. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on August 25, 2016.

Hospital staff members sent a Progress Report dated October 11, 2016 that indicates all deficiencies have been corrected. The Department of Health accepts Fairfax Behavioral Hospital's (Everett) 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,

Joyce Williams

Joyce Williams, RN, BSN
Survey Team Leader