RA 0 2130 8

COMPLAINT INVESTIGATION REPORT FORM

May 22, 1997

Facility: Washington Correction Center for Women Complaint No 002130

Address: 9601 Bujacich
Gig Harbor, WA 98335

Date Investigated: May 9,1997

Persons Contacted: [redacted] Care Mgr.
[redacted], CSU
[redacted], Safety Officer
[redacted]

Surveyed by: Kathleen Landberg, R.S.

SUMMARY OF FINDINGS

Allegation # 1: Insects are biting her.

The inmate's health record was reviewed and there was no documentation of treatment for insect bites. The record indicated treatment for anxiety and a pruritus rash in January and February of 1997. The unit had been sprayed for insects about 4-6 weeks ago. Although the inmate states she is still being bitten by "lady bug type flying insects" interviews with staff and other inmates could not validate this allegation. The inmate is in a lock-down, segregation unit, that could not be inspected at the time of this investigation. She is scheduled to stay in this unit until at least June of 1997. This inmate was incarcerated in early 1997 and has spent most of her stay in either the segregation or receiving/closed custody units.

Conclusion: This allegation could not be substantiated

Allegation # 2: Inadequate heat.

The staff were interviewed and the surveyor was in the hall way outside the inmate's cell. The temperature was comfortable at the time of the survey. Staff told the surveyor that the heat is controlled at the main heat plant and is shut off during the day when the building heats up this time of year. The inmates have adequate clothing and two blankets if they are cold.

Conclusion: This allegation could not be substantiated.

Allegation # 3: Inadequate ventilation, windows nailed shut.

This unit has central air exchange system and it is a maximum custody unit where the windows are controlled by staff The windows are closed until May 1 for better ventilation control. The ventilation in this unit is marginal, however, this is one of the older buildings on campus and capital projects have scheduled to replace all of these units during the next few years.

Conclusion: This allegation could not be substantiated.

Allegation # 4: Unclean bathing areas.

There are assigned porters to clean the shower stalls. At the time of the survey all shower stalls in use were clean. This a maximum custody unit with an average of 15 inmates and maximum capacity of 30. Only one inmate at a time takes a shower and not everyone takes a shower every day. The ratio of inmates to showers in this unit is adequate. Note: ratios are different in general housing where there is more flexibility to take showers.

Conclusion: The allegation was not substantiated.

COMPLAINT INVESTIGATION REPORT FORM RA020904

April 8, 1997

Facility: Washington Correctional Center For Women Complaint #: 001997

Address: 9601 BUJACICH Gig Harbor, WA 98335 Date Investigated: March 27, 1997

Persons Contacted: [redacted]s, Food Service Manager

Surveyed By: Kathleen Landberg, R.S.

SUMMARY OF FINDINGS:

I met with M[redacted]s and discussed the complaint. He stated that because of the high temperature of the dishwasher they at times had a residue build-up in the coffee cups. I looked at the dishwasher and clean dishes. All inspected items appeared to be clean, but the cups were stained and residue could be wiped out of them.

The concentrated instant coffee used in most DOC facilities has a tendency to stain the coffee cups. If the cups are adequately washed and sanitized, being stained is not necessarily considered to be a problem other than from an aesthetic point of view.

[redacted] has been on another assignment with DOC and during that time the policy he had implemented of bleaching out these items was not being done. He assured me that this policy would be reinstated immediately.

Mr[redacted] also showed me the monthly maintenance reports on the dishwasher that are conducted by Ecolab. These reports showed that the dishwasher was operating as designed.

The attached letter from [redacted] indicates that the facility has reinstated the procedure of destaining cups and plates.

This shoulds correct the concerns of the complaintant. The complaint was not valid.

RH 023359

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P.O. Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
December 8-9, 1997
License Number

Name of Facility
Washington Corrections Center For Women
Address
9601 Bujacich
City
Gig Harbor
Zip Code
98335
Administrator
[redacted]
Licensing or Certification Requirements Used
HS-DOC, WAC 246-215 & Multi-State Stds.

NOTE: This document contains a listing of the deficiencies cited as requiring correction. The Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
EH 230.3.a 1. Ceiling/wall vents were soiled and dusty in several areas (e.g. MSU bath areas, custodial closet G-1, L-A shower, EH 230.4.e 2. Small pipes connected to the heat units in several rooms in the mental health unit (D-6, C-2, etc.) were accessible to the inmates. EH 230.3 3. A section of mopboard was loose in G-1 / A-1. EH 090.2 4. There was no air gap/anti-siphon device at the hose connection at the shower/tub in G-1. EH 160.2.a 5. Paint was chipped and the area at the base of the shower in F-1 west was not cleanable. Also, a section of metal trim was missing at the air vent over the tub in this room.	NO POC

Surveyor signature(s):
Kathleen K. Sandberg, RS

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & Services Licensing, DOH, by X _____ declaring the extent to which this plan of correction was completed.

Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P.O. Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Survey Dates
December 8-9, 1997

Name of Facility
Washington Corrections Center For Women

City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

EH 410.1

6. The wooden step at the sink in the child care room in the education building was worn and was no longer impervious to moisture.

EH 160.2.b

7. The chipped, worn wall in the staff toilet room in the old gym is no longer cleanable.

EH 230.4.c

8. One exit light in the new recreation building was not lit and one light in CCU/Receiving was flashing..

EH 230.5.b

9. Wet mop holders in new MSU building do not allow mops to drip over the sinks.

EH 160.2.a

10. The wooden benches in the new MSU shower area are beginning to become worn and some of the surfaces are no longer impervious to moisture nor cleanable.

EH 160.2.b

11. Grout at several showers in the MSC bathrooms is moldy and/or heavily stained (e.g. L-wings A&C,K-B, J-C, etc.).

EH 230.3.e

12. The areas behind the washers and dryers in L building and MSU were soiled and dusty.

EH 230.4.e

13. One sprinkler head in L-C 325 had been painted and should be tested to see if it still operates properly.

EH 230.4

14. The mechanical handicapped door device on the exterior door of MSC dining building does not open properly.

EH 200.1

15. Linens/pillows were inappropriately stored on the floor in K-A wing closet.

Surveyor's Initials

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P.O. Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Survey Dates
December 8-9, 1997

Name of Facility
Washington Corrections Center For Women

City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

EH 230.3.b

16. Cushions on chairs in several areas, especially K day rooms, were becoming torn/worn on the corners.

EH 230.3.d

17. The floor behind the ice machine in K building was dirty.

EH 230.3.e

18. Wall surfaces by the sink and in the main hallway of the new chapel building were chipped and worn.

FS 030.1.f

19. WAC 246-215-090 There was a large section of the portable sneeze guard missing in the MSC dining room.

HS 015.3

20. HS-DOC 015 (3) The was no consistent, easily retrievable method of verifying current licensure of professional staff, especially contract staff. Records were located in several offices with varying degrees of completeness.

Surveyor's Initials _____

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P.O. Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
12/8 & 9/97

Name of Facility
Washington Correctional Center for Women

Address
9601 Bujacich

City Zip Code
Gig Harbor 98335-0017

Administrator
Alice Payne

Licensing or Certification Requirements Used
HS-DOC Minimum Stds 10/14/94

NOTE: This document contains a listing of the deficiencies cited as requiring correction. The Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

010 ADMINISTRATION OF HEALTH SERVICES
(4) Policies and procedures shall describe and define a system within each facility which: (b) encourages and supports appropriate, safe, and timely care by qualified personnel. HS 010.4.b

This requirement is not met as evidenced by:

Through review of policy and staff interview, it was learned that glucose monitors were not being tested/calibrated as per manufacturer's recommendations.

Two types of glucose monitors were noted. . One-Touch II and One-Touch Basic. Manufacturer's directions for both stated that a "glucose control solution test" and a "check strip" test be conducted.. .daily for the One-Touch II. The One-Touch Basic recommended to use the check strip daily and the glucose solution one time a week. The control solution verifies that the test strip and meter are working together properly and the correct procedure is being followed. The check strip is used to verify that the meter is working properly.

No policies were noted which outlined the glucose control solution testing of either meter as required.

Surveyor signature(s): _____

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & Services Licensing, DOH, by _____ declaring the extent to which this plan of correction was completed.

_____
Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
Facilities Survey Section
1112 S.E Quince
P.O. Box 47852
Olympia, Washington 98504-7852
STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Survey Dates
12/8 & 9/97

Name of Facility
Washington Correctional Center for Women

City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

HS 050.

050 INFECTION CONTROL (1) Policies and procedures shall provide for the development and implementation of infection control measures which are consistent with the DOC infection control program; guidance published by the DOH; rules and regulations published by the Dental Disciplinary Board; and applicable standards published by the Division of Industrial Safety and Health, Department of Labor and Industries.

This requirement is not met as evidenced by the following:

1. Through facility site review and staff interview it was learned that the storage system for glucose monitoring equipment for individual inmates had the potential for transmitting blood borne pathogens.

Individual "baggies" were stored together in a plastic box with contact between individual "baggies". It was noted that one of the bags had what appeared to be blood on the outside of the bag. Dried blood has been shown to harbor active Hepatitis B virus for several days. There is potential for the nurse handing the baggies and inmates whose baggies have touched the contaminated baggie to potentially be exposed to blood borne pathogens.

2. Collection tubes of blood in plastic bags were noted in the laboratory area. Through staff interview, it was learned that these bags are carried to a collection site in the bags. Department of Labor 29 CFR Part 1910.1030 under Methods of compliance (d)(xiii)(C) states that specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.

Surveyor's Initials _____

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
Facilities Survey Section
1112 S.E Quince
P.O. Box 47852
Olympia, Washington 98504-7852
STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Survey Dates
12/8 & 9/97

Name of Facility
Washington Correctional Center for Women

City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

Surveyor's Initials _____

022060

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

P.O. Box 47852 • Olympia, Washington 98504-7852

To: Gary Fleming, Associate Superintendent

From: Kathleen Landberg, Public Health Advisor

Re: New Construction and New Restraint Bed.

During the survey of July 3, 1997 the following concerns were noted:

EH 230.4.e

1. The water from the shower heads in the new units sprays beyond the elevated containment rims that were constructed inside each shower stall. The only floor drain in this area is within the containment area and water that splashes outside this barrier becomes hazardous with no place for drainage.

2. The shower heads are not adjustable and are mounted so close to the wall that washing hair may be very difficult.

EH 230.5.D

3. The racks mounted in the custodial closets do not allow hanging mops to drain into the mop sink. The wet mops will drip onto the floor creating a hazardoous condition.

4. The new molded restraint bed and plastic cuff restraints with washable covers correct the concerns that surveyor Judy Bishop had about the bed previously used to restrain inmates.

EH 230.4.g

5. There was a broken window in G-115-G.

If I can be of further assistance to you please contact me at 597-4335.

RA026602
19

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

Survey Dates
10/27/98
License Number

Name of Facility
Washington Corrections Center For Women
Address
9601 Bujacich
City
Gig Harbor
Zip Code
98335
Administrator
Alice Payne
Licensing or Certification Requirements Used
WAC 246-215 Food Service, HS-DOC & Multi-State Stds.

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
1. Main kitchen: WAD 246-215-080(6) Two staff (LL & JP) had expired food worker's permits. F.S. 080.6.C	1. LL complete 11/16/98 JP pomplete 11/13/98
2. WAC 246-215-~~120~~(10)(d) The broken porcelain handwash sink in the kitchen was not cleanable. F.S. 120.10.d	2. Replaced 11/5/98
3. WAC 246-215-~~150~~(5) The damaged wall surface at the tray preparation area was not cleanable. F.S. 150.~~5~~3	3. Damaged wall surface at tray area will be replaced by 12/4/98.
4. WAC 246-215-100(8)(c) The fan covers in one walk-in refrigerator were soiled and there was mold on the ceiling of the unit. F.S. 100.8.c	4. Corrected 10/29/98
5. MSC kitchen: WAC 246-215-140(1)(a) At least twice during this survey the kitchen door was open to the outside for over 5 minutes and the air blower over the door had not been activated. FS 140.1.a Also, the screen was missing from the pantry window which was pen for ventilation during the survey.	5. Instructed food service to monitor on and off switch and ensure that it is operating at all times - 10/29/98. Screen replaced - 10/28/98.

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DEC 14 1998
Facilities and Service Licensing

Surveyor Signature(s):

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH, by February 10, 1999 declaring the extent to which this plan of correction was completed.

[redacted] 12-2-98
Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

OK RH 12/23/98

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center For Women

Survey Dates
10/27/98
City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
6. WAC 246-215-120 (3)(b) The drain pipes for the dishwasher were submerged below the top of the floor drain creating a cross connection. FS - 120.3.b.i. 090.1.d	6. Corrected 10/30/98 - pipes cut to preclude cross contamination.
7. WAC 246-215-~~[illegible](c)~~ The grout at the dishwasher was moldy and loose and the area was not cleanable. ~~FS [illegible]~~ FS. 090.1.d	7. Work order submitted for repair by 12/4/98.
8. WAC 246-215-120(10)(d) The hand wash sink in the kitchen was not secured to the wall. FS 120.10.d.	8. Work order submitted for repair by 12/4/98.
9. Ceiling/wall surfaces in J-unit 101 bathroom were stained and moldy. Also, nails were beginning to come through from the sheet rock in the walls in 151 bathroom. EH ~~23~~ 160.2.a	9. Work order submitted for repair by 12/30/98
10. A three compartment sink or dishwasher has not been included in the plans for the infant area.. An appropriate method for sanitizing dishes , utensils and bottles, if necessary , must be provided. FS. 100.1.a.	10. Dishwasher will be purchased for area
11. There were shower stalls in L-unit, 324 & 351 that were moldy or had mold under the tile grout. EH. 160.7.	11. Work order to remove and replace old grout by 12/30/98
12. Health care center: The ceiling vent in the tub room was soiled. EH 230.3.a	12. Custodian will clean vent by 12/5/98
13. Several portable oxygen bottles in exam rooms, storage areas and the infirmary nurse's station were not secured to the walls. H.S. 140.2	13. Work order to secure oxygen bottles by 12/15/98
14. Note: This surveyor was unable to determine if plans for remodeling of the infirmary had been approved by DOH Construction Review Unit.	RECEIVED DEC 14 1998 Facilities and Services Licensing
15. The facility does not have a consistently followed policy / procedure for disposal of used safety razors. EH · 420	15. Draft procedures for safety razor disposal by 12/30/98

Surveyor's Initials KH

Representative's Initials [redacted]

DOH 550-005(REV. 09/97)

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center For Women

Survey Dates
10/27/98
City
Gig Harbor

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
16. Ceiling vents were soiled in Education building inmate rest room and in G-south bathroom. Also, the grout was loose at the tub G-south bath room. EH230.3.a	16. Work order submitted to clean vents and secure loose grout around tub by 12/30/98
17. Inmate laundry areas in G-unit and 256 were washing some contaminated laundry. These units do not have hot water at a minimum of 140 degrees F. Appropriate water temperatures must be provided for areas where contaminated items are washed. Also, the proposal to wash mixed batches of laundry, (more than one inmate's laundry at a time) would require the 140 degree F. temperature. EH090.6	17. Work order submitted to raise water temperature to 140 degrees by 12/5/98
18. One washing machine in G-unit was inoperable and hoses on other units were beginning to show signs of wear. EH 190.1.a.	18. Work order submitted to repair washer and check hoses in all units for possible replacement by 12/30/98
18. The Plexiglas used at the base of the shower stalls in the 256 unit were not completely sealed at the floor and inmates have complained of being splashed by shower water while using the toilet. EH 160-2.b.	19. Determine if plexiglass can be sealed closer to floor, repair if feasible by 12/30/98.
19. The location of the sanitary napkin waste containers in the 256 unit is just above the hip of a person using a toilet. This creates an infection control problem with exposure to body fluids. Also, the staff commented that the size of these containers was quite small and often the containers were filled beyond capacity in a very short time. HS050	20. Inquiring into ordering larger waste containers or ordering a second waste container and raising the level of approved containers by 1/29/99.

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Licensing

Surveyor's Initials VH
DOH 550-005(REV. 09/97)

Representative's Initials

Reviews are accepted 12/14/98 MSmith

[redacted]
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DEC 14 1998
HHRS Field Office Dept. of Health

Fax copy received at Main office, Olympia on 12/8/98

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P O Box 47852
Olympia, Washington 98504-7852

RP026601 9

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
10/27/98

Name of Facility
Washington Corrections Center for Women

License Number
Facility #004417

Address
P.O. Box 17

City
Gig Harbor, WA

Zip Code
98335

Administrator
[redacted], Superintendent

Licensing or Certification Requirements Used
Minimum Standards of Health Services Division for Operation and Maintenance of Health Services in Correctional Facilities (HS-DOC)- Major Institutions

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

INITIAL COMMENTS
DEPARTMENT OF CORRECTIONS SURVEY

This survey of the Health Services unit at the Washington Corrections Center for Women was conducted by Marieta Smith, RN MN, and Kathleen Landberg, RS.

Survey dates 10/26/98 - 10/27/98
R&A #026601

HS-DOC 010 - ADMINISTRATION OF HEALTH SERVICES

(2) There shall be written, current policies and procedures developed and implemented to address the health care needs of offenders in each facility. Policies and procedures shall be:

(a) Available to all authorized personnel in each facility.

(b) Reviewed by the health authority, medical director or other physician, and superintendent not less than every two years and revised as needed.

(3) There shall be documentation which reflects the review of applicable policies and procedures by health care staff.

HS. 010.2.a

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Facilities and Services Licensing

Surveyor Signature(s): Marieta Smith

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH, by 1/27/99 declaring the extent to which this plan of correction was completed.

[redacted] 12-7-98

Facility Representative — Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center for Women

Survey Dates
10/27/98
City
Gig Harbor, WA

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

1. Based on review of policies and procedures and inspection of the health services unit on 10/26/98, the facility failed to establish and follow policies and procedures that reflected acceptable standards of practice for storage of medications and laboratory samples.

Findings:

Three refrigerators were located within the health care unit: A small medication refrigerator in the medication room and two refrigerators, one large and one small, in the laboratory area.

In a manual entitled "Shift 1 (2200 - 0600) Responsibilities", #16 under Task Outline states that the night shift staff nurse is responsible for checking refrigerator temperatures. Two refrigerator logs, one marked "small" and the other "large", documented that the temperatures were checked every night. The logs did not designate where the small and large refrigerators were located, nor the acceptable range of temperatures. They also did not identify and track the second small refrigerator.

Failure to designate and verify high and low temperature limits in a medication refrigerator risks altering medication potency and may result in untoward effects on patients. Failure to designate and verify high and low temperature limits in laboratory refrigerators risks altering specimen properties and may result in inaccurate laboratory results.

2 Based on an inspection of the health care unit and a review of policies and procedures on 10/26/98, the facility failed to ensure that policies and procedures were developed and implemented for removing outdated supplies from health care areas.

Findings:

There was no policy and procedure that identified a system for periodic audit and removal of outdated medical supplies from patient care areas. Outdated items were found during the inspection of the examination rooms and medication room on 10/26/98:

a. Examination rooms:
   1) 7 - packets of Betadine swabsticks- Six with expiration date 9/97; one with expiration date of 12/95.

1. Correction: The temperature control log will be re-designed to reflect the monitoring of each refrigerator, the location, the acceptable range of temperature, and the signature of the inspecting nurse. The infection control nurse will design and implement a procedure and training program for the nursing staff.

Monitoring: The infection control nurse will develop a monitoring system and incorporate monitoring into next year's Continuous Quality Improvement Plan.

Responsible Person: Diane Winniford, RN3

Completion: January 1, 1999

H.S. 010.2 B a.c

2. Correction: A Medication/Supply Expiration Check Sheet will be developed by the nursing supervisor. It will identify the medications by name, the date they expire, and the signature of the nurse conducting the review. There will be a program and procedure developed explaining how the process is to occur.

Monitoring: The nurse supervisor will develop a monitoring system and incorporate monitoring into next year's Continuous Quality Improvement Plan.

Responsible Person: Patricia Wiggins, RN3

Completion: January 1, 1999

Surveyor's Initials _____

Representative's Initials DM

DOH 550-005(REV. 09/97)

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center for Women

Survey Dates
10/27/98
City
Gig Harbor, WA

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

2) 1 - Activated charcoal suspension - expiration date 12/97.
3) 3 - Dermoplast spray cans - expiration dates 6/98 and 8/98.
4) 11 - Microorganism Collection and Transport lab sample kits - expiration dates 12/97 and 3/98.
5) 1 partial 4 oz. bottle - Blinx sterile ophthalmic solution expiration date 12/97.
6.) 1 - UriProbe culture sample collection kit - expiration date 9/98.

b. Laboratory:
1) 12 - Anaerobic blood culture collection bottles - expiration date 9/98.
2) 17 - Yellow-top (ACD) blood sample collection tubes - expiration date 3/98.

c. Storage area:
1) 12 packets betadine swabsticks - expiration date 9/97.

3. Based on a review of the unit's policy and procedure manual on 10/26/98, the facility failed to ensure that the unit's policies and procedures were reviewed by the health authority, medical director or other physician, and superintendent not less than every two years.

Findings:

a. Seven of sixty-four standing orders, protocols, and procedures reviewed in the unit's Standing Orders/Nursing Protocols manual had been reviewed over two years ago. Two of sixty-four standing orders, protocols, and procedures had no signatures of approval or dates of review.

b. All of the nursing care procedures in the unit's Health Care Manual were dated April, 1993. A memo in the front of this manual stated that the procedures it contained should be reviewed by nursing staff quarterly. The health services unit currently employs 14 RN's and 3 LPN's. A signature sheet in the manual contained eleven signatures dated 1993. Six of the eleven nurses listed no longer work at WCCW.

Not reviewing and approving policies and procedures can result in implementation of inaccurate and/or otherwise unacceptable procedures and improper practice.

HS-010.2.b

3. Correction: A system for reviewing standing orders will be developed. The system should include a policy and procedural system. It will denote specific time frames, actions to take when not in compliance, and processes for review and rewrite.

Monitoring: The system will be monitored sixty days from implementation. The medical staff will be responsible for ongoing monitoring and reporting.

Responsible Persons: [redacted], MD and Patricia Wiggins, RN3

Completion: January 1, 1999

Surveyor's Initials _____
DOH 550-005(REV. 09/97)

Representative's Initials PW

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center for Women

Survey Dates
10/27/98
City
Gig Harbor, WA

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
4. Based on a review of two medical records on 10/26/98, the facility failed on two occasions to follow WCCW Field Instruction 420.250 entitled "Use of Restraints". HS 010, 2.4 Findings: The field instruction states, under Procedure, D., 5.: "An inmate kept in prolonged restraint will be continuously observed by a uniformed staff member. A health care staff member will check the restraint when initially applied on the inmate and then will make hourly checks thereafter. The check and findings will be logged in the inmate health record...(c) One limb must be released for ten (10) minutes every two (2) hours on a rotating basis." a. The medical record of patient #1, [redacted] with a borderline personality, indicates she was placed in restraints on 10/5/98 at 1505. Documentation by a nursing staff member indicates that the patient's right arm was removed from restraints at 1800 and that she was showered at her request. It is not evident from the documentation if restraint placement and circulation was checked hourly between 1505 and 1800 and when she was released from her restraints. b. The medical record of patient #2, [redacted] with a borderline personality, major depressive disorder, obesity, sleep apnea, and an atrial bigeminy arrhythmia, indicates she was placed in restraints on 10/23/98. It is unclear when she was placed in restraints. Documentation indicates that a nursing staff member checked her restraints at 0030, 0105, and 0215, and that she was released at 0310. There is no documentation evident that one limb was released for ten minutes every two hours on a rotating basis.	4. Correction: Nurses will be documenting on the Progress Notes in the TEC chart. The hourly checks and the release will be documented. Monitoring: TEC and nursing will be monitoring the process with TEC being the responsible party. The monitoring tools have already been deployed and compliance will be reported through the CQI committee. Responsible Person: [redacted]s, CMHPM and Patricia Wiggins, RN3 Completion: November 1, 1998
HS-DOC 015 PERSONNEL (3) Health care staff performing functions, tasks or duties which require state licensure, certification, or registration in the community shall comply with state law. (a) Verification of current credentials shall be on file in the personnel record of each individual performing functions requiring a license, certification or registration. (b) Within the facility personnel office, there shall be a system, with appropriate procedures, for annual verification of state licensure, certification, or registration.	Correction: Administrative staff has returned to full capacity. Documentation of a current license for professional employees is maintained in the Health Care Manager's Office. Monitoring: A sixty day review will be conducted and reported in the follow up report to the Department of Health. The Office Administrative Senior responsible for maintenance of the system will conduct monthly audits and submit reminders to employees. The system will be referred to the Continuous Quality Improvement Committee to determine if ongoing monitoring is necessary. Responsible Person: [redacted], Secretary Supervisor Completion: December 1, 1999

Surveyor's Initials _____
DOH 550-005(REV. 09/97)

Representative's Initials _____

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

Name of Facility
Washington Corrections Center for Women

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Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

Based on a review of 21 personnel records, the facility failed to verify current licensure or certification in 8 of 21 records.

HS.015.3.b.

Findings:

The following personnel files had no evidence of current licensure or certification:

1. 3 of 13 RN2 licenses
2. 1 of 2 CNA certificates
3. 1 of 2 Psychiatric Social Worker-3 licenses
4. 1 of 1 Mental Health RN2 license
5. 2 of 3 contract physician licenses

Failure to ensure that health care staff maintain current licensure and/or certification risks delivery of health care by unqualified staff members.

HS-DOC 050 - INFECTION CONTROL
(1) Policies and procedures shall provide for the development and implementation of infection control measures which are consistent with the Department of Corrections' Infection Control Program; guidance published by the Department of Health; rules and regulations published by the Dental Disciplinary Board; and applicable standards published by the Division of Industrial Safety and Health, Department of Labor and Industries.

Based on an interview with an RN3 nursing supervisor, the facility failed to ensure that policies and procedures were established and implemented that reflected current infection control standards.

Findings:

The nursing supervisor stated that, although drafts were in progress, the unit had no infection control policies and procedures in place that met OSHA standards for health care workers, such as isolation precautions (i.e. standard, droplet, airborne, and contact precautions), wound care, handwashing procedures, sharps disposal, and waste management.

Absence of such policies and procedures places health care staff at risk for exposure to communicable diseases.

Correction: The infection control nurse will insure procedures and policies are available for all staff. Additionally, monitoring systems will be developed to insure Infection Control Inspections are conducted and on-going. The possibility of an Infection Control Committee being established will be considered by the CQI committee.

Monitoring: The infection control nurse will develop a monitoring system and incorporate monitoring into next year's Continuous Quality Improvement Plan.

Responsible Person: [redacted] RN3

Completion: January 1, 1999

HS.050

Surveyor's Initials _____

Representative's Initials JL

DOH 550-005(REV. 09/97)

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
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HS-DOC 080 - PHARMACY SERVICES/MEDICATION MANAGEMENT
(5) There shall be an organized system which ensures accuracy in receiving, transcribing, and implementing orders for the administration of drugs.

Based on interviews with the nursing supervisor on 10/27/98 and review of the facility's field instruction 610.070 entitled "Medication Administration", the facility failed to ensure that a medication delivery system was in place that ensures that medications are delivered to inmates in an accurate and timely manner.

HS 080.5

Findings

1. On 10/27/98, the nursing supervisor stated that, due to the increased numbers of controlled medications being prescribed, the number of inmates required to take medications under direct supervision of nursing staff has increased from a daily average of 142.7 (from 1/98 - 5/98) to 163 (5/98 to present). These numbers do not include medication deliveries to inmates in the segregation unit nor inmates who participate in medication lines in the mental health unit. One nurse is assigned the task of administering these medications on weekends.

2. On 10/27/98, the nursing supervisor stated that the three medication lines take over two hours each to complete. Because of limited staffing, the medication nurse must close the pill line if an emergency arises that requires him/her to respond to emergencies in other parts of the facility. When this occurs, completion of medication administration is delayed. The nursing supervisor stated that the morning pill line, which begins at 6:45 AM, frequently is not finished until 11:00 AM, particularly when nurse is not available in the mental health unit. The evening pill line, which begins at 6:45 PM occasionally is not finished until 11:00 PM.

3. On 10/27/98, the nursing supervisor stated that there has been an increase in the number of incident reports for medication errors over the past seven months, from 8 in April, 1998, to 36 in October, 1998. The supervisor stated that many of these errors involved incorrect identification of inmates and were often related to staff trying to hurry through medication administration in effort to complete the medication line in a timely manner.

This finding was verbally reported out as a concern based on a "gut level" feeling. The surveyor stated she would conduct a check, in six months. Her comments in the report reflect mostly subjective comments made by the nursing supervisor.

Medications and staffing are very critical issues and the previous Health Care Manager felt the comments of the nursing supervisor did not adequately portray the situation. If there is data available to support Ms. Wiggin's comments,the surveyor should have gathered more objective data to substantiate the findings.

Correction: This response will address findings 1 thorough 4.

1. The inmate population has increased over the past two years. This will result in an increase in workload. The issue of staffing is currently under review. One additional temporary position has been identified. However, other impacting issues have come to light which need to be addressed. A new staffing model is being developed by the department. All of the variables will be addressed in the new staffing model. There is one Labor Relations Meeting yet to be held prior to a new schedule, with relief built in, being implemented. Staffing will be addressed through a work study analysis already in process through CQI.

2. The nursing supervisor referred to "limited staff". The staffing issue has been addressed above, but the assignment of staffing and the systems the staff function in will be addressed. Such tools as daily assignments and patient scheduling alternatives will be examined and implemented. The majority of the timing issues with medications can be resolved with scheduling the units appropriately. This will be a piece of the overall corrective action. Plans currently exist to take non-nursing tasks away from nurses and appropriately redistribute the workload. These issues were addressed in April, but due to administrative staff shortages, implementation was delayed until November 24, 1998.

3. Medication errors have been and are currently being tracked and are to be reported out to the CQI committee in December. The nursing supervisor has not analyzed the existing errors. Following the assessment, a plan will be devised and implemented to correct what problems do in fact exist. Control of the inmates in medication administration lines has been addressed, thus decreasing the length of time to administer

Surveyor's Initials _____
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (continuation)

Name of Facility
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Gig Harbor, WA

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

4. WCCW's field instruction 610.070 entitled "Medication Administration", which the nursing supervisor stated has recently been revised and has been sent to DOC Headquarter for approval, states as follows:

a. Under the heading "Field Instruction", D. Standard Times
   1. The following times are to be used for routine administration of medication:
      a. Once a day (QD), once in 24 hours (12:01 pm to 12 midnight - Anytime, but no sooner than 4 hours after last dose.
      b. Once every 12 hours (BID) - 8 am - 8 pm
      c. Three times a day (TID) - 8 am - 1 pm - 8 pm
      d. At bedtime (HS) - 8 pm
      e. QD PRN - Anytime, but not sooner than 4 hours after last dose. .
      f. BID PRN - 8 am - 8 pm
      g. TID PRN - 8 am - 1 pm - 8 pm
      h. QID PRN - 8 am - 1 pm - 4 pm - 8 pm

b. Under the heading "Field Instruction", F. Medication Errors
   1. A medication error can include the wrong patient, method of administration, medication, dose, time (+/- 30 minutes), omission, and numerous other errors.

c. Under the heading "Procedure":
   A. Open campus inmates at the Main Institution (MI), Minimum Security Compound (MSC), and Reception Center (RC) will receive prescribed medication or over-the-counter medication at the Health Care Unit window during scheduled general population medication times. Scheduled medication times are:

6:45 am - 7:15 am	MSC
7:30 am - 8:00 am	Main Institution
8:00 am - 9:00 am	Treatment and Evaluation Center (TEC) 8 am Monday only/ Administrative Segregation
11:45 am - 12:15 pm	MSC
12:30 pm - 1:00 pm	Main Institution
1:00 pm - 2:00 pm	TEC/Administrative Segregation
7:00 pm - 8:45	MSC
7:00 pm - 8:45 pm	MSC

medication. New lighting has been installed and new glass is scheduled to be installed, both improving visibility. Other objective issues raised by the nursing staff will be reviewed.

4. The current medication policy will be located and revised with the above plans.

Monitoring:

1. Scheduling; The state wide staffing model will be the basis for monitoring acceptable staffing levels. In the interim, the nursing supervisor will develop a system of data collection and report it through CQI.

2. Systems: The nursing supervisor will work with the nurses to develop, analyze, and report the impact of new nursing systems through the monthly report to the superintendent and the CQI process.

Responsible Person: [redacted]s, RN3

Completion: January 1, 1999

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8:30 pm - 9:30 pm TEC/Administrative Segregation (TEC 8 pm Friday, Saturday and Sunday)

WCCW is currently out of compliance with their medication administration times as defined by their field instruction. Failure to establish and maintain an accurate and timely medication administration system is a risk to inmate health and safety.

HS.085.3

HS-DOC 085 - HEALTH RECORDS SYSTEM
(3) There shall be sufficient personnel to ensure prompt completion, filing, and retrieval of health records and a system for locating individual health records for all offenders at all times.

Based on inspection of the health care unit on 10/26/98, the facility failed to ensure that sufficient personnel were provided to ensure health records were filed promptly.

Findings:

Loose filing in the medical records area included consultation reports that were four weeks old and Medication Administration records that were dated April, 1998.

Failure to file medical records promptly may result in omission of needed health care due to unavailability of information.

Correction: All filing has been completed by using limited duty staff authorized to file confidential information. This will be an ongoing program. Medical Records staff will develop a plan providing for ongoing filing by them with support *when needed.*

Monitoring: An update will be submitted in sixty days.

Responsible Person: [redacted], ART

Completion: November 15, 1998

HS.140.7.b.i

HS-DOC 140 - MAINTENANCE, HOUSEKEEPING, AND PREVENTIVE MAINTENANCE RELATED TO HEALTH CARE SERVICES
(7) Preventive maintenance and electrical safety shall include the following:
(b) A scheduled preventive maintenance program shall be established for health care equipment.

Based on inspection of the health care unit and an interview with an RN3 nursing supervisor 10/26/98, the facility failed to ensure that there was a scheduled preventive maintenance program for the unit's medical equipment.
Findings:

Correction: A regularly scheduled maintenance program will be developed. All new equipment purchased should come with a maintenance warranty.

Monitoring: Update will be provided with sixty day review.

Responsible Person: [redacted], Acting HCM, [redacted] Business Manager

Completion: January 1, 1999

Surveyor's Initials _____
DOH 550-005(REV. 09/97)

Representative's Initials DL

DEPARTMENT OF HEALTH
Facility Licensing and Certification Division
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Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
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The health care unit contained medical equipment including an electrocardiogram machine, two pulse oximeters, an incentive spirometer, two blood centrifuges, and an autoclave. The nursing supervisor stated that there was no regularly scheduled preventive maintenance program for this equipment. Absence of such preventive maintenance risks utilization of ineffective or inaccurate medical equipment for patient care.	

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1277 64

DEPARTMENT OF HEALTH
Facilities and Services Licensing
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STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
11/16/99
License Number

Name of Facility
WASHINGTON CORRECTION CENTER FOR WOMEN
Address
PO BOX 17
City
Gig Harbor
Zip Code
98335
Administrator
[redacted]
Licensing or Certification Requirements Used
WAC 246-215 Food Service , Multi-State Stds. and HS-DOC

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

The following environmental concerns were noted during this survey::

GENERAL CONCERNS:

1. The ceiling vents were heavily soiled in many areas including: clinic # 4 exam room, PI toilet rooms. 3 of 4 toilet rooms in main visiting area, clinic closet B-129, chapel inmate toilet room, H-# 320, U- # 519 & 520, warehouse toilet room and mail area of mail room, O-639, J-B & C bathrooms, K-B bathroom and custodial closet, L-A bathroom.

1. Work Order submitted for cleaning of ceiling vents by 2/11/00.

2. There were unlabeled spray bottles of assorted cleaning solutions in several areas including: infirmary laundry, MSC kitchen, C building custodial closet.

2. Spray bottle throughout the institution were checked and labeled by Janitorial Supervi CORRECTED 11/17/99

CLINIC/INFIRMARY:

3. The large oxygen tank in # 4 exam room and the small portable tank in # 1 exam room were not stored in a secure manner to prevent accidental tipping.

3. The large oxygen tanks have been removed from t institution. The attachment chain for the smal oxygen tank has been re-bolted to the wall stu by maintenance so it now secure. A memo was sen out to all staff regarding the securing of the oxygen tanks. Nurses have been assigned to specific rooms to ensure compliance for this an other compliance issues.

Surveyor Signature(s):
[signature] RS.

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH.
by 3/31/2000 declaring the extent to which this plan of correction was completed.

[redacted] 2/7/00
Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

RECEIVED
FEB 0 9 2000
Facilities and Service Licensing

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
4. Paper cups for drinking and medication as well as cans of Ensure supplement were inappropriately stored on the floor by the exit door near the medication room for both days of this survey.	4. Starting immedicately, the nurses will be required to put away all supplies by the end of the shift in which the supplies were delivered. Margo Johnson has sent out a memo to nursing staff.
5. The infirmary laundry was inappropriately stored on the floor in the infirmary laundry room. Also, re-usable plates and cups were found in this room in a single compartment sink next to laundry items.	5. A memo was sent out to all Health Services staf including the Close Obersvation Area (COA) officers to ensure laundry or cleaning cloths/ mop heads are not left on the floor in the (COA) laundry area.
6. The shower curtain in the infirmary bathroom was soiled.	6. The shower curtain in the infirmary bathroom was discarded.
MAIN CAMPUS:	
7. There were damaged/chipped wall surfaces around the toilet and sink in the chapel inmate toilet room.	7. Work Order submitted for repair by 2/11/00.
8. Ice scoops were inappropriately stored in bins/coolers in CCU and G-1.	8. CUS Isham and Sgt. Coberly have sent memo's regarding the ice scoops in G-1 to their staff to ensure proper storage.
9. The wooden seats in the shower stalls in CCU had chipped/worn surfaces that were no longer cleanable. Also, there was a hose attachment in on CCU shower that had a large build-up of soap scum and mold.	9. Work Order submitted for repair and/or replacement by 3/3/00. Work order submitted for repair and/or replacement by 3/3/00.
10. There was a significant amount of lint accumulation behind the dryers in Receiving.	10. Instructed CUS to have unit janitor to clean behind dryers on regular basis-- CORRECTED 2/03/00.
11. There were chipped, cracked and/or damaged wall surfaces in several areas including: building 5-E-9 wall, C-custodial closet, 256-B pod both custodial closets and A-pod ceiling in X-111.	11. Work Order submitted for repair by 2/18/00.

Surveyor's Initials _____
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Representative's Initials [redacted]

Name of Facility
WASHINGTON CORRECTION CENTER FOR WOMEN

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Gig Harbor

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12. The wet mops in the G-1 north custodial closet were dripping on the floor instead of into a mop sink or approved container.	12. CUS Isham and Sgt Coberly have issued directives to ensure mops are stored over mop sinks.
13. One of two sinks in the Beauty Shop did not have an approved air gap/vacuum breaker at the hose attachment.	13. Work Order submitted for repair/replacement by 2/18/00.
14. There were damaged ceiling tiles in the main kitchen.	14. Work Order submitted for repair by 2/18/00.
15. The damaged vent cover adjacent to the # 3 walk-n in the main kitchen was not cleanable.	15. Work Order sumbitted for repair by 2/18/00.
16. There was a hole approximately 5-inches by 5-inches in the exterior brick wall at the main kitchen loading dock.	16. Work Order submitted for repair by 2/18/00
MSC/CAMP:	
17. Several large piles of soiled linens were observed to being sorted on the floor in the M-large room. These items must stored in appropriate cleanable containers to limit the potential contamination of this area.	17. Six tables for folding have been purchased. Corrected on 12/15/99.
18. Two times during this survey kitchen staff were observed wrapping clean eating utensils with their bare hands. The eating surfaces were then subject to contamination.	18. Instructed Food Manger to see that inmate workers used disposable gloves when handling eating utensils. CORRECTED 2/03/00
19. There was a section of damaged/missing floor surface at the junction between the living and dining rooms in the visiting trailer.	19. Work Order submitted for repair by 2/28/00.
20. The small stools in the bathroom of the visiting trailer were chipped /worn and were no longer cleanable.	20. Work Order submitted to purchase a small stool for visit trailer by 2/28/00.

Surveyor's Initials KH

Representative's Initials [redacted]

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WASHINGTON CORRECTION CENTER FOR WOMEN

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Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
21. This surveyor and staff were not able to verify that all electrical outlets accessible to small children were of an approved safety type. Also, posted diaper changing procedures were not available in the visiting trailer.	21. Work Order submitted for approved safety outlet covers to be purchased and installed by 2/11/00 Diaper changing procedures posted on 11/18/99.
22. This surveyor and staff were not able to verify that the accessible 220-volt outlet in the library had been disconnected.	22. Electrical to check, if not being used a Lockout Device will be installed by 2/3/00.
23. There were moldy shower curtains in J-A, K-D and L-B & C.	23. All living units were instructed to change shower curtains on a regular basis- CORRECTED on 2/03/00.
24. The grout was moldy and/or damaged at several showers including: J-B, K-A tub and shower and grout was loose at the handicapped shower in L-D.	24. Work Order submitted for repair by 2/18/00.
25. There was a damaged wall with an unsealed surface in L-C # 320.	25. Work Order submitted for repair by 2/28/00.
26. There were several chairs in L day room which had torn / uncleanable surfaces.	26. Instructed CUS to have torn chairs removed from united by 2/15/00.
27. A thermometer was not available in the refrigerator in the living unit kitchen used by moms for babies.	27. Instructed CUS to submit a ESR to purchase a refrigerator thermometer for J unit Mother/ Baby wing. CORRECTED ON 2/3/00.

Surveyor's Initials _____

Representative's Initials 

STATE OF WASHINGTON
DEPARTMENT OF CORRECTIONS
WASHINGTON CORRECTIONS CENTER FOR WOMEN
P.O. BOX 17 MS:WP-04 • 9601 Bujacich Rd. N.W. • Gig Harbor, WA 98335-0017

Plan of Correction

The following is the Washington Corrections Center for Women's plan of correction for the Statement of Deficiencies for the survey that occurred on 11/16/99.

U3505:

1, 2, 3 J[redacted] Health Care Manager, will amend the procedure attachment to Field Instruction WCCW 420.250 "Use of Restraints" to clarify that nursing documentation regarding initial restraint placement and hourly restraint checks will occur on a restraint flow sheet. [redacted] will develop this flow sheet. Full implementation of the revised Field Instruction and flow sheet will occur by March 30, 2000. The flow sheet will be filed in the medical record. Monitoring will occur by nursing as part of CQI. Reporting will occur twice a year at Health Services CQI

Meeting. The Nursing CQI Plan will be amended by 3/30/00 to reflect this activity. Tracking tools are currently in place.

Note: The Department of Health Summary Statement regarding U3505 does not cite the FI/Policy correctly. The policy states that medical staff/nursing staff are to check placement and check restraints every hour while the offender is in restraints. There is no policy requirement for nurses to document when restraints are released or when they are rotated for the 10-minute release. These are custody functions. These activities are recorded on a 591 form and in the COA log.

HCM, [redacted], reviewed the charts of all offenders placed in restraints on the dates identified in the survey. The findings of the DOH Surveyors are not consistent with the charts.

1. b. Nursing Supervisor, [redacted], provided the DOH Surveyors a draft procedure titled "Inventory Control and Expiration Date Management". [redacted] has rewritten this procedure, including identification of specific HSU staff responsible for specific activities. Inventory sheets and checklists have been developed to reflect the activity and it will be done on a monthly basis. All outdated or compromised packages have been discarded. This procedure and plan will be fully implemented by February 15, 2000.

U3505 continued...

c. All expired and/or compromised items noted in the Trauma Room, Laboratory, Infirmary, and Storage Room inspections have been discarded per Diane Winniford, Nursing Supervisor. Refer to item #2b for compliance plan.

2. DOH Surveyors are interpreting Field Instruction WCCW 610.070 "Medication Administration" to include offenders who do not come to medication line as a refusal. Attendance or lack of attendance at medication line is not addressed in this Field Instruction. Medication compliance is addressed through CQI studies as evidenced by CQI Meeting Minutes, Provider Meeting Minutes, and Multidisciplinary Team Meeting Minutes. Medication Nurses review the Medication Administration Records (MARs) daily and notify providers by note or by copying the MAR. Aggregate data is collected by one LPN who organizes the compliance data and reports findings to the CQI Team, Medical Director, and the Health Care Manager.

Notice of Field Instruction Revision dated 11/24/98, signed by the Superintendent, and located in the Field Instruction manual identifies:

C. Missing Pill Line
   1. Following the closure of each pill line, medication records for inmates who failed to show for mandatory medication will be reviewed. (Mandatory medications are those which are to be taken at the designated time and cannot be missed.)
   2. Infractions for missing mandatory medications will be written per WCCW Field Instruction.

Offenders who require mandatory medications as determined by court order or Medical/Mental health Providers are placed on the medical call-out. Refusal to comply with mandatory medications constitutes cause for initiation of the Inmate Refusal Form and an infraction. The Multidisciplinary Team meets and identifies Nursing Case Managers when indicated by the team to promote medication compliance.

The Field Instruction WCCW 610.070 "Medication Administration" will be reviewed by [redacted] HCM, by March 30, 2000.

Note: In a correctional setting, medication lines do not constitute the inference that offenders are not capable of handling their own medications. Rather, medication lines constitute a security function relative to the correctional setting.

U3527:

015.3.b Standard "Personnel"

b. [redacted], Secretary Supervisor, will develop a tracking system for all Health Services staff to maintain a current list of staffs' licenses/certifications/credentials. This will be implemented by March 30, 2000.

U3527 continued...

Note: While DOH Surveyors were on site, an Office Assistant Senior (OAS) was able to verify through the Department of Licensing via telephone that all Health Services Staff have current licenses.

U3650

050.1 Standard "Infection Control"

1. a. The Nursing Supervisor provided the DOH Surveyors with a draft copy of Protocols for Application of the DOC policies regarding WCCW. The following manuals were on site in the clinic at the time of the DOH audit:
   - OSHA Bloodborne Pathogen Manual and compliance kit
   - NCCLS – Standards for Laboratories
   - Pierce County Health Department for Communicable Resource Manual
   - Guidelines for the Prevention and Treatment of TB by the Washington State Tuburculosis Program.

   The following DOC policies are located in the Policy Binders at the Nurses' Station:
   - 670.001 – Prevention and Control of Communicable, Environmental, and Infectious Diseases
   - 670.010 – Offender Immunizations/Vaccines
   - 660.450 – Infectious Waste Management
   - 670.016 – Communicable/Infectious Disease Prevention
   - 670.017 – Environmental Infectious Disease
   - 670.020 – HIV Infection and Acquired Immunodeficiency Syndrome (AIDS)
   - 670.030 – Offender Tuberculosis Program

   All of the above policies pertain to the Infection Control Program. Combined with the other manuals available, the four-hour orientation to all staff titled "Infection Control" that all new employees must attend and all staff have annual two-hour long in-service training on infection control. This provides an excellent competency-based program. Offenders coming into the institution are provided instruction regarding infection control as part of the reception program. In addition, offenders receive additional counseling/instruction as their health status and risk factors indicate.

   In addition to the DOC Policies that are available, WCCW has the following Field Instructions that complete a comprehensive Infection Control Program:
   - 660.450 – Infectious Waste Management
   - 670.001 – Prevention and Control of Communicable, Environmental, and Infectious Diseases
   - 670.010 – Inmate Immunization/Vaccination
   - 670.016 – Communicable/Infectious Disease Prevention
   - 670.017 – Environmental Infectious Disease
   - 670.020 – HIV Infection and Acquired Immunodeficiency Syndrome (AIDS)
   - 670.030 – Prevention/Control/Tracking of Tuberculosis

U3650 continued...
Plan: [redacted]N3, Infectious Disease Nurse, will complete the draft Infectious Disease manual that integrates the policies with protocols and makes the Infection Control Program at WCCW specific to the needs of the female offender population and also the staff requirements. It will also be current with national standards for a correctional setting and will provide a basis for a competency-based program for Health Care providers. Dr. Stephen Tabet, Infectious Disease Specialist, will review the manual prior to implementation. Field Instructions will be revised/eliminated as needed to implement the new protocols. DOC Policy is provided by DOC Headquarters.

Time Frames:

- Draft Infectious Disease manual was completed by [redacted] by 1/30/00.
- Dr. Stephen Tabet is currently receiving and editing the manual and will be completed by 2/15/00.
- Implementation date by [redacted] for the manual is 3/15/00.
- Competency-based program will be developed throughout the year and implemented as pieces are developed.
- Current HSU CQI will monitor Infection Control as part of its ongoing monitoring activities. CQI currently monitors this activity. Diane Winniford will report twice a year to CQI.
- [redacted], CQI Coordinator, will develop the competency-based program which will include a training video for staff, a training video for offenders, and a written pre and post test for staff.

b. (2) [redacted] developed a log to track the weekly flushing of the eyewash station for five minutes. She has assigned a RN to be responsible for this activity. Procedures have been written. Completion will occur by 2/15/00.

(3) The travel kit's eyewash has been discarded. The nurse assigned to the trauma unit will ensure compliance, please refer to U3505 2. b. A checklist has been developed. Periodic audits by [redacted], and [redacted] will monitor compliance. Monitoring activities will occur not less than twice a year.

c. (1) The Infectious Waste Spill Kit was available in the laboratory cupboard above the phlebotomy chair. The cupboard is labeled "Spill Kit". The Spill Kit is clearly visible when the door is opened.

There is no corrective action needed. We will continue to have spill kits located in the Clinic. Staff assigned to the laboratory in reference to outdated materials/restock items will utilize a checklist as part of the plan outlined above.

d. The DOH Surveyors failed to note that it is a freezer in the survey report. The freezer is for offender use; the key for the freezer is kept by the offenders. Only those offenders who are participating in the Mother Child Bonding program are eligible. There is a procedure written for this and it includes a temperature log,

U3650 continued...
which is kept inside the freezer. The offenders log the temperature of the freezer every day. The HCM has a key and keeps it locked in the Narcotics/Sharps box in the Nurses Station. Currently there are no offenders utilizing this service, so the freezer is empty and has been for several months. HSU staff are not involved in any way regarding the care, storage, or handling of breast milk. A biohazard label is on the freezer. No corrective action is needed.

e. These guidelines refer to Isolation Precautions in Hospitals. WCCW does not have a hospital.

(1) [redacted], CQI Coordinator/Nurse Educator, issued a memo to all nursing staff outlining medication administration technique. Plan: All nursing staff will carry a plastic bag for offenders to use to dispose of medication cups.

Nurses will not handle medication cups that have been handled by offenders. This is effective on 2/15/00.

(2) Plan: Nursing Staff will direct offenders to wash their hands prior to handling their multiple dose vials. A sign is now posted in the Nurses Station for Offenders/Nursing Staff. [redacted] will provide nursing staff with a directive to ensure compliance with the hand washing practice.

f., g. All outdated or compromised packages have been discarded. Please see the plan outlined in U3505 2. b.

h. Diane Winniford will develop written procedure and post it in the laboratory. Implementation of this will occur by 3/30/00. Monitoring will occur by checklist as part of the previously mentioned plan.

i. The log was present in a yellow folder next to the refrigerator. The ongoing monitoring of this activity will occur as assigned as part of the above plan.

j. Multi-dose ophthalmic solutions are the community standard in outpatient settings in eye clinics. Licensed nursing staff are professionally responsible and accountable for utilizing aseptic techniques while administering eye drops.

There is no evidence of noncompliance with acceptable standards of Aseptic Technique per DOH Audit. [redacted] issued a memo to nursing staff directing compliance with Aseptic techniques.

k. [redacted] issued a memo to Medication Nurses directing that the pill cuter will be wiped off with each use. This memo has been posted in the medication rooms. The nurses responsible for the checklist for the medication rooms will monitor compliance.

U3790

080.5 Standard "Standing Orders"

1. a. b. [redacted]ical Director; [redacted]d; Pres[redacted] [redacted] RN3; and [redacted] will develop a patient specific program for utilization of standing orders that provide evidence of patient/provider relationship. Implementation is 4/15/00.

080.5 Standard "Controlled Substance Log"

2. [redacted] reviewed the policy with nurses at the Weekly Team Meeting and issued a directive to ensure compliance with policy. Medication Nurses will comply with entering both first and last name of offenders on the log. This will be audited by an RN3 not less than four time a year to ensure compliance. Implementation will occur on 1/28/00.

RA 029132
1 029149

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
4/5/99

Name of Facility
Washingotn Corrections Center for Women

License Number
Facility #004417

Address
PO Box 17

City
Gig Harbor

Zip Code
98335

Administrator
[redacted] Superintendent

Licensing or Certification Requirements Used
Minimum Standards of Health Services Division for Operation and Maintenance of Health Services in Correctional Facilities (HS-DOC) Major Institutions

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
As a result of the complaint investigation, no defiiencies were found under Health Services Standards for Correctional Facilities - Major Institutions, relating to the allegations of this complaint.	

Surveyor Signature(s): Bliss Moore LPB

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH,
by _____ declaring the extent to which this plan of correction was completed.

_____
Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

R+A 029132 4/19/99

INVESTIGATION REPORT

Investigation #: 003553
State R & A #: 028149
Medicare R & A:

Investigated by :
Stephanie Todak, ARNP, CS

Date Report is Written:
4/7/99, 4/26/99

Report Written by:
Stephanie Todak, ARNP, CS

Date of First Contact:
4/5/99

Date(s) of Investigation:
4/5/99

Investigation Method:
On-site

Type of Facility/Name:
Department of Corrections
Washington Correction Center for Women

Address of Facility:
9601 Bujacich
Gig Harbor, WA 98335

Synopsis of Investigation:

1.01 Program Manager of Facilities and Services Licensing (FSL) received notice of death of an inmate according to the interagency agreement. The email notice was forwarded to the Investigation Unit the same date, [redacted]

1.02 IM1 died at approximately 8:36 pm at F2. Tentative cause of death is cardiac arrest. Death was unexpected, IM1 collapsed in front of unit. IM1 was resuscitated and transported. IM1 arrested two more times at the emergency room (ER). An autopsy was requested. IM1 was seen by physicians for Rheumatoid Arthritis and Hepatitis C. IM1 had hypertension, asthma, and GERD (gastric-esophageal reflux disease). IM1 was last seen by a practitioner on [redacted] and was last seen in clinic [redacted]

1.03 An article was published in a local paper titled "Inmate at corrections center dies after cardiac arrest".

1.04 The Investigator arrived at the correction facility at 9:30 am on a sunny 53 degree morning. The Investigator left at 4:00 pm and returned the next day to continue another investigation. The Investigator presented to the Correction Officers and then to the Superintendent's office to meet with S1. Later in the morning, the Investigator toured the clinic and infirmary and reviewed IM1's clinical record. The evidence does not support the allegation.

Sources of Information:

IM1's clinical record which included report of ER visit at F2 and autopsy report.

Allegations:

Allegation: Unexplained death at facility.

Narrative:

2.01 Notice of inmate death was received in FSL on 11/19/98. Death was unexpected. Tentative cause of death was cardiac arrest. IM1 had last seen practitioner on [redacted] and was seen in clinic [redacted]8 (Tab). Newspaper article (Tab) titled "...Inmate at correction center dies after cardiac arrest".

2.02 The note in the clinical record of IM1 for 11/18/98 states that IM1 was in the dining area and collapsed after a brief seizure episode. IM1 was unconscious and hardly breathing. IM1 had weak carotid pulse. CPR was initiated and IM1 was transported to F2. IM was thrashing in the ambulance during transport, so attendants were unable to obtain blood pressure. In the ER, IM1 was intubated after IM1 received versad and succinylcholine. Resuscitation efforts were continued in the ER for 1 ½ hours without success.

2.03 Urine screen was positive for lidocaine and hydroxyzine and negative for central nervous system drugs. Drug screen was positive for tricyclic antidepressants, but not in elevated amounts. Hydroxyzine was prescribed as a adjunct to Methadone and taken on a prn basis and taken X14 doses in November. The last dose was taken11/9/98. A tricyclic was not present on the medication administration record (Tab).

2.04 Atopsy documented death sequelae of right sided cardiomyopathy (arrhythmogenic right ventricular dysplasia). No other findings were pertinent.

Conclusion:

2.06 Death was not expected.. Response to the collapse of the inmate was documented in the clinical record and emergency measures were initiated. It appears that the emergent situation was handled appropriately. The evidence does not support the allegation. No evidence of a violation of Mimumum Standards of Health Services Division was found. No evidence of a violation of standards of care were found.

Other Findings:

None

INVESTIGATION REPORT

Investigation #: 003599
State R & A #: 028148
Medicare R & A:

Investigated by :
Stephanie Todak, ARNP, CS

Date Report is Written:
4/7/99

Report Written by:
Stephanie Todak, ARNP, CS

Date of First Contact:
4/5/99

Date(s) of Investigation:
4/5/99, 4/6/99, 4/14/99

Investigation Method:
On-site

Type of Facility/Name:
Department of Corrections
Washington Correction Center for Women

Address of Facility:
9601 Bujacich
Gig Harbor, WA 98335

Synopsis of Investigation:

1.01 Article in the Seattle PI on 12/8/98 titled "Medical chaos at ...prison alleged to judge". New charges have surfaced describing continued medical "chaos" at the facility almost four years after the state settled a class-action lawsuit alleging dangerously poor health care at the facility.

1.02 A discussion between the Program Manager and Intake Nurse concerning the last survey identified two problems which were addressed during the last survey. These included an allegation of a shortage of medical supplies and many items in stock are beyond the expiration date; and inmates must wait in line for medication outdoors, even in inclement weather for up to 90 minutes. These were not addressed during this investigation.

1.03 The Investigator arrived at the correction facility at 9:30 am on a sunny 53 degree morning. The Investigator presented to the Corrections Officer and then to the Superintendent's office to meet with S1. Later in the morning, the Investigator toured the clinic and infirmary, reviewed inmate clinical records, and interviewed staff. Policies, procedures and protocols and practice guidelines were reviewed. The Investigator left at 4:00 PM; returned the following day at 9:10 am to continue the investigation; and left at 4:00 PM. Due to scheduling at the facility, the investigator returned on 4/14/99 at 9:30 AM on a 50 degree sunny morning to continue this investigation. The focus of this day was the Mental Health In-patient unit (TEC). The Investigator left at 3:30 PM. The first and last visits were unannounced. The evidence does/not/partially support the allegation.

Sources of Information:

Staff interviews, review of clinical records, tour of clinic and inpatient unit, review of pertinent policies, procedures and protocols, facility practice guidelines, DOC Offender Health Plan, tour of mental health unit (TEC), and schedule of activities and staffing patterns for mental heath unit

Allegations:

Allegation #1: Orders for medications and follow-up treatment are not routinely carried out.

Narrative:

2.01 In an interview with S2 and during the tour of the clinic, S2 stated that all orders are written on the Primary Encounter Report (PER), then are sent to the Pharmacy (usually with the clinical record). The PER is divided into three equal sections on a horizontal plane. Attached to the back of the Primary Encounter Report are two NCR colored sheets (pink and yellow). The Pharmacy removes the yellow slip of all orders (even non-medications) then dispenses the ordered medication, etc. The PER is then placed in the "nursing rack" (usually in the clinical record too). An assigned Registered Nurse (RN) then transcribes the order onto the MAR (medication administration record), treatment record or other appropriate form. The RN then signs and dates the orders with a red pen. The PER goes to the Ward Clerk for input into the computer for the appropriate "call-out". This "call-out" is a listing of all inmates who are "called-out" of their assigned area to another area. The "call-out" lists those inmates scheduled for practitioner appointments, nurse/clinic appointments as well as dental, optometry, etc. The "call-out" is then posted in all pertinent areas including the clinic to notify staff and inmates. Orders for those inmates seen by a mental health practitioner are transcribed using this same system.

2.02 The Investigator chose a two week period from 11/26/98 to 12/9/98 and the last two weeks (3/22/99 to 4/5/99). The Ward Clerk was requested to pick out two dates from the first set, two dates from the second set, and then choose two dates in December. S/he was requested to pull the "call-out" and sick call log-in sheets for those dates. The Ward Clerk picked 11/26/98, 11/27/98, 12/3/98, 12/18/98 and 3/31/99. With the need for one more date and an earlier pick being the Thanksgiving holiday a date in February was requested. The Ward Clerk choose 2/4/99.

2.03 The Investigator reviewed the "call-out" lists and sick call log-in sheets. Inmates were chosen for relation to the allegations in the intake. For example, inmates scheduled for a visit related to self-mutilation, pain of specific or general nature, migraine or headache, multiple problems, annual exam, Pap or Pap results or a visit of an emergent nature were chosen. Twenty-two charts were chosen and requested from medical records. Of these twenty-two charts of inmates, 4 inmates had left the facility, the name of 1 inmate was unable to be interpreted (IM number was not present), and 1 name was inadvertently left off the list for medical records. Sixteen inmate clinical charts were subsequently reviewed. One inmate was in the infirmary. After this chart was reviewed as an acute record, it was noted that this chart was also included on the clinic list.

2.04 All except one Patient Encounter Report was signed and dated by an RN as transcribed. The orders on that Patient Encounter Report, however, were completed i.e. x-ray which was ordered had documented results of x-ray done that date. As mentioned, all other orders were documented as transcribed. Spot checks of individual orders for medications, x-rays, consults, etc. were documented as initiated or completed. Follow up clinic appointments were documented or were documented as a "no show".

Conclusion:

2.05 The evidence does not support the allegation.

Allegation #2: Routine gynecological care is not provided.

Narrative:

3.01 The newspaper article does not define "routine gynecological care as required by the 1995 settlement (Tab 1).

3.02 The Washington State Department of Corrections Offender Health Plan gives definitions, covered services, co-payment program, exclusions, and limitations and a description of the Utilization Review. Listed in the section of Covered Services I. Preventive Care, 3. Female offenders may receive a breast and pelvic exam, including PAP smear every 2 (two) years. 4. Female offenders over 40 years of age may receive mammography every 2 (two) years (Tab 2).

3.03 The clinic is staffed with three ARNPs and one physician Medical Director. The three ARNPs carry a caseload based upon living units of all of the inmates. The Medical Director carries a case load based upon acuity. Therefore the ARNP is the primary practitioner for each of the inmates based upon the living unit. In addition, the facility has contract physicians of specialists such as OB/GYN, Podiatry, Infectious Diseases, X-ray, Orthopedics, Pain Management. The facility contracts with a local facility, (A2).

3.04 S3 and the staff have developed many protocols for the nursing staff to approach such problems such as pain, diabetes mellitus, hypertension, COPD (chronic obstructive pulmonary disease). In addition, they have developed Practice Guidelines for consistent approaches by the practitioners. Some examples include Preventive Health Practice, Diabetes, Hypertension, Asthma. Planned additions include Osteoarthritis and Hepatitis C.

3.05 The facility Preventive Health Practice Guideline includes Cervical Cancer risk factors and screening recommendations (Tab 3); and Breast Cancer risk factors, and breast self-examination, breast examination by provider and mammography recommendations (Tab 4). Finally, the Practice Standards list: a breast exam every 1-2 years; pap smear-three normal yearly pap smears, then every other year in low risk women; and mammography every other year in low risk women over 40.

3.06 Current CQI subjects includes preventive care, diabetes, asthma, and kites. The CQI project for preventive care included Pap Smear and Mammograms. Every twentieth chart from a 10/14/98 list of inmates was reviewed by the practitioners. 32/692 medical records were reviewed for a sample size of 4.6% of the current population. Screening guidelines listed in the Offender Care Plan were checked on three dates. These included pap smear every two years in lower risk women; mammograms every two years in women over 40. Conclusion of data demonstrated that routine screening Pap smears and mammograms are being performed as indicated, and there has been no significant decrease in compliance compared to the July 1998 review. A peer chart review for compliance with pap smears and mammograms is planned for twice yearly.

3.07 A review of the sixteen clinical records picked as outlined in paragraphs 2.02 and 2.03 demonstrated that 9/15 inmates had a pap smear within the last calendar year. Of those who did not have a documented pap smear:

IM3 has documentation of low risk with a plan for a pap smear next year.
IM4 refused the pap smear. Documentation of last pap was 7/97.
IM5 and IM6 had a pap smear 2/98
IM7 had a pap smear 3/98
IM8 had no documentation of a pap smear. However, IM8 had a ultrasound which documented that her/his uterus was removed and no ovaries were found.

All of these dates are within the Offender Health Plan and Preventive Care Practice Standards.

3.08 A review of the sixteen clinical records picked as outlined in paragraphs 2.02 and 2.03 demonstrated that 6/15 inmates had documented mammograms or ultrasound of the breast on the record. These included IM5, IM7, IM8, IM10, IM13, IM15. Two inmates (IM5 and IM10) had diagnostic work completed due to the discovery of a breast lump. Two additional inmates (IM11 and IM12) had intake physicals which included a pelvic, pap smear, STD and breast exam and three other inmates (IM3, IM4, IM9) had an annual physical exam which included the Preventive Health Practice Guidelines.

3.09 In an interview S3 indicated that the practitioners are attempting to set up a data base of all inmates, examinations and testing. However, until the hardware/software is available, the individual practitioners are setting up a log of their group of inmates. Included is the date of the inmate's last exam and date the inmate is due for another exam. This should assist in tracking routine exams and tests.

Conclusion:

3.10 The evidence does not support the allegation.

Allegation #3: Medical conditions that can cause excruciating pain often go untreated because treatment is not considered medically necessary.

Narrative:

4.01 A review of the sixteen clinical records picked as outlined in paragraphs 2.02 and 2.03 demonstrated that practitioners included pain management as part of the prescribed treatment. Two of the visits on the indicated date (IM3 and IM15) were for severe headache/migraine. In each case medication was ordered for pain. IM3 was then seen four more times within the ensuing 8 weeks with pain management changes each visit. Another of the inmates (IM16) had an appointment with a pain specialist, S4, for management of on-going migraine/neck pain. In addition, other Primary Encounter Reports in these records were reviewed for pain management for various issues. IM 6 was seen [redacted] for headache associated with URI (upper respiratory infection); IM4 was seen for self harm action which required sutures; IM6 was seen 11/26/98 for a broken tooth; IM10 was seen [redacted] with dental pain; IM9 was seen for an ankle injury [redacted]9; and IM11 was seen for a left hand injury [redacted] In each case analgesic related to the severity or potential of pain was ordered. None of the patient records which were reviewed had a description of pain which could be attributable to kidney stones or to an unknown origin.

4.02 Health Services Unit has a Nursing Protocol for Headache (Tab 4). This protocol includes subjective observations, objective observations and assessment for nursing assessment and charting. The plan includes standing orders for headache. These include immediate referral to a provider with certain conditions, migraine headache similar to previous migraines, sinus headache and muscle tension or other headaches. In addition, the facility has a Practice Guideline for Headache for the individual practitioners (Tab 5). These guidelines provide the initial step in the management of headaches. The headaches are classified according to the International Headache Society Classification Criteria which is attached to the guideline. The guideline further outlines specific areas for medical history, examination, assessment and treatment. The review of clinical records of individuals complaining of headaches seemed to follow these guidelines without deviation. These guidelines and protocols provide parameters for consistency in the delivery of the care.

4.03 As part of an on-going assessment of pain and headaches or more specifically the Chronic Care Prevention Clinic, the facility has contracted with a pain management specialist, S4, from a local university. This physician will become part of a multi-tiered program/approach to the issue of pain management. S4 will see individual inmates for assessment and for an on-going treatment. In addition, s/he will assist to develop a multidisciplinary pain management plan to assist with approaches to inmates with on-going pain. Part of this plan will include a support group and include the approach that all pain is not necessarily bad. At this point inmates are not involved with this multidisciplinary team. However, S3 has introduced information about this multidisciplinary team to the tier representative meeting comprised of inmates. It is hoped that a volunteer will be found in this group.

Conclusion:

4.04 The evidence does not support the allegation.

Allegation #4: The psychiatric unit is grossly understaffed.

Narrative:

5.03 The newspaper article did not define "grossly understaffed" nor did the article identify the nurse who stated "it's chaos down there". TEC (Treatment and Evaluation Center) as the psychiatric unit is designated is a 25 bed unit. according to S5. 12 beds are allocated to the residential side for chronic psychiatric inmates and 10 beds allocated for acute psychiatric inmates and another area for close observation which includes 1:1 patient contact or every fifteen minute observation. Staffing for this area includes:

Night Shift (first shift) - 2 Correctional Officers (CO's)
Day Shift (second shift) - 3 Correctional Officers
1 Sergeant
1 Care Unit Supervisor
1 Registered Nurse
2 Certified Mental Health Counselor 3's (CMHC3)
Evening Shift (third shift) - 3 Correctional Officers

In addition, a CO is staffed for the COA (Close Observation Area). This area will be moved shortly to a newly remodeled area in the Infirmary. It will contain 5 areas for observation. It will be staffed by those CO's and nurses in the Infirmary.

On evenings, weekends and night shift the nurse from the clinic is scheduled to administer the routine medication, administer any other medications which an inmate may need for a prn (as needed) basis for both emergent and non-emergent needs, restraint checks, plus any other emergent or non-emergent assessment or intervention.

The CMHC3's and Care Unit Supervisor and Sergeant have variable hours to increase coverage on the evening shift. However, the staff which provide the therapeutic activities are mainly scheduled Monday through Friday during working hours. The three individuals who provide therapeutic activities are the RN and 2 CMHC3's.

5.04 The daily schedule for TEC (Tab 6) begins at 6:00 AM and ends at 10:00 PM (except Friday and Saturday the schedule ends at 11:00 PM). Some of the activities are provided or facilitated by inmates from other areas and by volunteers. These activities include Reading Program and Mural Project. The mental health staff facilitate 1-2 groups/day and provide individual therapy. If the mental health staff provide 2 hours of individual therapy a week to an individual inmate and the inmate attends **every group** which is offered (morning meeting included), the inmate will get 13.75 hours of therapeutic activities per week or **less than 2 hours** of therapeutic activities daily. The rest of the time is spent with activities of daily living, meals, medications, and leisure activities.

5.05 According to the facility's Field Instruction 630.510 "Treatment will be provided based upon a written plan:" (Tab 7A). Treatment Plan Requirements include: "<u>at a minimum</u> " a treatment plan will be completed within 72 hours of admission, 14 days after admission, 30 days

after admission, and every 60 days thereafter (Tab 7B). During an interview with S5, s/he indicated that TEC utilizes a standard Treatment Plan for those inmates admitted for self harm ideation and a q 15 minute check (Tab 8) or 1:1 suicide watch (Tab 9). These standard plans are then modified to an individual inmate.

5.06 Included within the same Field Instruction is the minimum documentation requirements for crisis, acute and residential care (Tab 7C). In addition to admission and discharge documentation, a weekly counseling contact will be documented in SOAP format, the comprehensive team evaluation will be documented and a discharge summary will be completed.

5.07 IM17 has been in the TEC unit during most of his/her incarceration in September 1998. S/he had two evaluations at other DOC facilities. Recent Treatment Plan Addendum have been completed 2/1/99. 2/16/99, 3/11/99, 3/16/99, 3/24/99 and 3/29/99. Due to behavior which is described as a "substantial history of conflict with others that put ...self and others at risk of harm", IM17 is currently housed in the Close Observation Area. S/he is given a limited time with other inmates which is based on appropriate behavior and adherence to the Treatment Plan. There are frequent notes in the Inpatient Progress Record.

5.08 IM4 was admitted to TEC on [redacted]. The initial Treatment Plan was done according to policy, the 14 day Treatment Plan was not found in the chart. The next two Treatment Plans were due 9/17/98, but not done until 9/29/98 and due 11/28/98 and not done until 12/20/98. The next Treatment Plan was done early on 2/1/99 instead of 2/19/99 and then continued. The Treatment Plan was continued on this inmate as well as seen in other records. Treatment Plans which are continued rather than revised tend to be done for staff convenience in a psychiatric facility. Patients who are not making a change in behavior precipitating a Treatment Plan revision should be evaluated for a change in approach (which requires a revision of the Treatment Plan).

5.09 IM18 was admitted to TEC [redacted] and transferred back to reception on [redacted]. Treatment Plan was not found for 72 hours despite IM18 being on 1:1 and every 15 minute checks.

5.10 IM19 was admitted to TEC [redacted] and returned to the unit [redacted]; admitted [redacted] admitted [redacted] and discharged [redacted] Only one Treatment Plan was found for these admissions and it was for the 2/1/99 admission. It was initial Treatment Plan mentioned above for self harm. Another undated plan was found addressing treatment issues such as poor anger management, lack of employment skills, needs to address abandonment issues and grief and loss. The plan was not dated.

5.11 IM20 was admitted to TEC [redacted] and discharged [redacted] Admission and subsequent Treatment Plans were not reviewed. In 1999 the Treatment Plan which was due for review [redacted] was extended until 3/13/99. No start date is documented, but the inmate signed 11/13/98. No concurrence by the inmate to the extension is documented. On 3/10/99 a note in the Inpatient Progress Record indicated that staff met with IM20 to review the new Treatment Plan. The Treatment Plan was not found in the TEC record. It was finally located in a separate Clinic Record. It does include a start date of 3/1/99 and is signed by the inmate, but not dated as signed.

5.12 Treatment Team consists of the CMHC3's, RN and CUS who formulate the Treatment Plans. Most CO's have some mental health background from prior institutional training. The Treatment and Behavior Management Plans are placed in a notebook for use by the CO's during hours which are not staffed by the mental health professionals. The CO's in turn give feedback to the mental health professionals on the behavior and compliance of inmates prior to a treatment plan and on an on-going basis according to S5.

5.13 The Treatment Team Meeting is held on Tuesday and Thursday. This includes the 2-CMHC3's, RN, psychiatrist, out-patient psychologist, director of the clinic, CUS and others as pertinent (i.e. counselor or CUS from the living unit). The log from the meetings was reviewed. Topics included requests for medication changes from staff or the inmate, transfers in and out of TEC, continued psychosis, behavior problems. During a review of progress notes, these items were not noted in the Inpatient Progress Notes.

5.14 There are many immediate plans for changes in TEC according to S7. A second RN for the unit will be added in the immediate future. A half-time recreational therapist will be added. Volunteer Services will expand coverage in TEC to include Sunday and evenings. Currently as noted in the schedule, inmates from the institution assist with a mural painting and reading at bedtime.

Conclusion:

5.15 It is difficult to state that the evidence supports the allegation. "Grossly understaffed" is quite a subjective statement. However, it is evident that the staff are not completing Treatment Plans as required in the Field Instruction. The inmates have limited therapeutic programming and pertinent information is not charted in the inmate's individual record. The population of this unit are a very difficult population which require individualized treatment planning and individualized treatment time. It is evident that additional staff will assist to meet the policies and procedures of the institution and expand the therapeutic programming of the unit.

Allegation #5: A mental health counselor had an inmate perform oral sex on multiple occasions and threaten to kill him/her if the inmate told.

Narrative:

6.01 It is not part of the pervue of this agency to determine the validity or the evidence of this allegation. S8 was interviewed as to actions taken after the allegation was brought to the attention of the administration. The staff who was accused of the action of receiving sexual favors from an inmate, was placed on home assignment immediately. The administrative staff then began an investigation. The investigation concluded credibility to the allegations by the inmate. The employee was terminated. S8 showed the Investigator a redacted termination letter.

Conclusion:

6.02 The evidence tends to support the allegation, but the evidence was not assessed by the Investigator. The facility appears to have acted appropriately.

Other Findings:

None

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

RA 029153

CM # 003599

accepted 8/9/99 Diane Todak

Survey Dates
4/14/99

Name of Facility
Washington Corrections Center for Women

License Number
Facility #004417

Address
P.O. Box 17

City
Gig Harbor

Zip Code
98335

Administrator
[redacted] Superintendent

Licensing or Certification Requirements Used
Minimum Standards of Health Services Division for Operation and Maintenance of Health Services in Correctional Facilities (HS-DOC) Major Institutions

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table

INITIAL COMMENTS
Investigation

This Investigation was done by Stephanie Todak, ARNP, CS in response to complaint # 003599 on 4/5/99, 4/6/99, and 4/14/99.

R&A#: 028148

This investigation report was reviewed by Bliss Moore, Program Manager.

HS.010.4b

HS-DOC101 - ADMINISTRATION OF HEALTH SERVICES
(4) Policies and procedures shall describe and define a system within each facility which:
(b) Encourages and supports appropriate, safe, and timely care by qualified personnel.

1. Based on review of policies and procedures and clinical records on 4/1/4/99, the facility failed to follow WCCW Field Instruction 630.510 Mental Health Services in four of five clinical records.

HS-DOC101 – PLAN OF CORRECTION
(4)(b)

1. Treatment and Evaluation Center (TEC) CUS[redacted] and CMHPM[redacted]s have implemented a tracking system to ensure compliance with Field Instruction (FI) 630.510 regarding treatment plans. The TEC RN will audit all charts and Psychologist 3, [redacted]s, will maintain a schedule of all treatment plans that are due and report monthly to Dr. Robbins and the Health Care Manager on compliance. All of the following plans of correction have a completion date of 7/15/99.

ENTERED

Surveyor Signature(s): Bliss Moore/BT

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH, by _____ declaring the extent to which this plan of correction was completed.

[redacted] 7-19-99
Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

RA 079132

DEPARTMENT OF HEALTH
Facilities and Services Licensing
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
4/5/99

Name of Facility
Washington Corrections Center for Women

License Number
Facility #004417

Address
PO Box 17

City
Gig Harbor

Zip Code
98335

Administrator
[redacted] Superintendent

Licensing or Certification Requirements Used
Minimum Standards of Health Services Division for Operation and Maintenance of Health Services in Correctional Facilities (HS-DOC) Major Institutions

NOTE: This document contains a listing of the deficiencies cited as requiring corrections. The Statement of Deficiencies is based on the Surveyor's professional knowledge and interpretation of requirements for facility licensure or certification. In the column Application's/Licensee's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time of correction.

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
As a result of the complaint investigation, no defiiencies were found under Health Services Standards for Correctional Facilities Major Institutions, relating to the allegations of this complaint.	

cpt # 003553
mailed to facility 7/1/99 by Jody

Surveyor Signature(s): Bliss Moore /jb

I understand the deficiency(s) listed and agree to correct them as outlined above by the dates indicated. I agree to send written notification to Facilities & services Licensing, DOH, by _____ declaring the extent to which this plan of correction was completed.

Facility Representative Date

The plan of correction must be returned to Department of Health within 10 (ten) days of receipt of deficiencies.

STATE DEPARTMENT OF HEALTH

AH
FORM APPROVED

OF DEFICIENCIES / N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004417	(X2) MULTIPLE CONSTRUCTION A. BUILDING_____ B. WING_____	(X3) DATE SURVEY COMPLETED 10/27/98

. OF PROVIDER OR SUPPLIER ASHINGTON CORRECTIONAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9601 BUJACICH GIG HARBOR 98335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
U 000	MEMO TAG: INITIAL COMMENTS ---------- SURVEYOR: 23KLL ---------- A full survey of this facility was conducted by kathleen Landberg, R.S. on 10/27/98. Allegation: Overheating in the kitchen. This allegation could not be substantiated during the survey of the facility. No further action required on investigation # 003379.	U 000	RA 027420 CA # 3379	

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

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

WASHINGTON STATE DEPARTMENT OF HEALTH

RT-027886

AH
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004417	A. BUILDING _____ B. WING _____	03/03/99

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CORRECTIONAL CENTER for Women	9601 BUJACICH GIG HARBOR 98335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
U 000	MEMO TAG: INITIAL COMMENTS	U 000		

Survey done 3/1/99

The facility infection Control nurse [redacted] requested an on-site visit to observe changes made in the infirmary to house mental health/suicidal patients.

The area has been divided and the utility closet for the main infirmary is housed in the new unit. There were concerns with transporting infectious materials through the nurse's station to reach this sink.

A separate utility closet was found just outside the infirmary and is actually closed than the sink in question.

There were no significant problems observed with the layout of the new unit.

Consultation

OHQ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen L Lindberg, RS	PHA 3	5/17/99

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