R# 027756

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HHRS Field Office
Dept. of Health

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

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
4/16/99
License Number
Facility #004414

Name of Facility
Washington Corrections Center
Address
P.O. Box 900
City
Shelton, WA
Zip Code
98584
Administrator
[redacted]
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; Multi-State Standards for Auditing Prison Facilities in Washington, Idaho, and Oregon, 1989.

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 Washington Corrections Center was conducted by Marieta Smith, RN MN.

Survey dates 4/5/99, 4/14/99 - 4/14/99.
R&A #027756

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

1. Based on review of the WCC health services field instruction and policy and procedure manuals and interviews with the Associate Superintendent, the Health Care Manager, and the RN3 Nursing Supervisor on 4/14/99, the facility failed to

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 July 16, 1999 declaring the extent to which this plan of correction was completed.

[redacted]
Facility Representative

5-26-99
Date

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

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Approved 6/1/99 Marieta RN

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

provide written, current policies and procedures to direct health services staff in the performance of blood glucose monitoring and application and monitoring of patients in restraints.

Findings:

a. The procedure in the Nursing Procedures Manual for performing glucose testing was inaccurate for the type of monitors currently in use. The procedure in the manual was for a One-Touch ® monitor, and the facility was currently using Advantage Accucheck ® monitors.

b There was no procedure in the Nursing Procedures Manual for performing quality control testing of the blood glucose monitors.

c. The Associate Superintendent and RN3 Nursing Supervisor stated that inmates were occasionally placed in restraints in the facility's Intensive Management Unit. She stated that nursing staff were responsible for checking for proper application of restraints and to check for adequate circulation on an hourly basis.

The facility policy manuals contained DOC policies and Division Directives regarding the use of restraints for inmates, but the facility's field instruction manual and nursing procedure manual did not contain procedures which directed WCC health care staff regarding how restraints are authorized for medical and/or psychiatric reasons, and monitoring parameters and interventions required for inmates in restraints. The Associate Superintendent, the Health Care Manager, and the RN3 confirmed that there was no field instruction or nursing procedures for restraints.

2. Based on review of the WCC health services field instruction and policy and procedure manuals and interviews with the the RN3 Nursing Supervisor and administrative clerical staff on 4/14/99, the facility failed to ensure that unit policies and procedures were reviewed by the health authority, medical director or physician, and superintendent every two years and revised as needed.

a.
A procedure for performing glucose testing with Advantage Accu-chek monitors is being drafted by the Chief of Nursing. It will be in place by June 15, 1999. The Health Care Manager (HCM) will monitor to ensure this occurs.

b.
The Nursing Procedures Manual has been updated and contains a procedure for performing quality control testing of the Advantage Accu-chek monitors. The new procedure was put in place on April 17, 1999. The Chief of Nursing will monitor continued compliance by reviewing the Procedures Manual each January to ensure it contains up to date procedures.

c.
A field instruction regarding authorization, monitoring and intervention with restraints is being drafted by the Infirmary Operations Manager. It will be completed by June 8 and then sent through the sign-off process. The HCM will monitor.

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DOH 550-005(REV. 09/97)

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

Findings:

a. An audit of WCC's field instruction manual revealed that thirty-one (31) of sixty (60) of the 600 series Offender Health Care field instructions had not been reviewed during last two years.

b. An audit of the health services unit's Nursing Procedures Manual revealed that fifteen (15) of thirty (30) nursing procedures had not been reviewed during the last two years. Eight (8) of these thirty (30) procedures had no date of issue or review.

Failure to provide and periodically review policies and procedures can result in implementation of inaccurate and/or otherwise unacceptable procedures and improper practice.

a.
Drafts of 23 of the 31 Health Care Field Instructions not reviewed in the last two years have been completed and are being processed for final sign off. The remaining 7 will be completed by June 15. The HCM will monitor to ensure that occurs and will audit the Field Instructions each January for compliance/review/revision for the coming year.

b.
The 15 Nursing Procedures that have not been reviewed in the last two years will be reviewed and updated by June 15. The Nursing Chief will coordinate this and the HCM will monitor for compliance.

HS DOC-015 - PERSONNEL

(4) All supervisory staff, as well as those staff performing custody function, shall be trained in first aid and cardiopulmonary resuscitation and there shall be documentation that such training is current.

Based on an audit of training records of WCC health services staff members and interviews with a training unit clerical support staff member on 4/14/99 and interview with the RN3 Nursing Supervisor and WCC's RN2 First Aid instructor on 4/15/99, the facility failed to ensure that all health services staff members were currently trained in first aid and CPR.

Findings:

An audit of training records of health services staff members revealed that twenty-six (26) of seventy (70) employees were not currently certified in cardiopulmonary resuscitation. Interviews with the nursing supervisor and first aid instructor confirmed that these employees were not currently certified. THIS IS A REPEAT DEFICIENCY FROM 6/18/98.

First Aid/CPR training has been scheduled for June 8 and June 15. Those staff who have not received this training in the last two years will be trained. The HCM will monitor. The number of staff to be trained is somewhat less than 26 as the training records were incorrect. They have now been updated.

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Name of Facility
Washington Corrections Center

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4/16/99
City
Shelton, WA

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

HS DOC-025 EMERGENCY SERVICES

(1) There shall be written policies and procedures, developed in coordination with the health authority, which provide for emergency and trauma care.

Based on review of the facility's field instruction manual and an interview with an administrative clerical support staff member on 4/14/99, the facility failed to ensure that field instruction 620.200 Inmate Deaths was revised by 8/14/98, as indicated in the facility's Plan of Correction for a deficiency cited during the last Department of Health survey (6/18/98).

Findings:

1. On 6/18/99, the facility was cited for discontinuation of CPR by custody staff prior to the arrival of medical staff when an inmate was found with no pulse on respiration on 6/10/98. WCC's plan of correction included correcting discrepancies between two field instructions: 610.020 First Response to a Life-Threatening Emergency, and 620.200 Inmate Deaths. The plan of correction stated "WCC 620.200, Inmate Deaths, and WCC 610.200 will be revised by August 14, 1998."

1. Drafts of WCC 620.020 and WCC 620.200 have been completed and are being processed for sign off. The HCM will monitor.

2. Review of field instruction 620.200 indicated that it was effective on 9/28/95. There was no indication that the field instruction had been reviewed since that time. Clerical support staff confirmed that it had apparently not been reviewed or revised since that time. THIS IS A REPEAT DEFICIENCY FROM 6/18/99.

2. As stated above, a draft of WCC 620.200 has been completed.

HS DOC-035 - INFIRMARY SERVICES

(9) There shall be policies and procedures for the use of restraints within the health services area.

Based on review of the WCC health services field instruction and policy and procedure manuals and interviews with the Associate Superintendent, the Health Care Manager, and the RN3 Nursing Supervisor on 4/14/99, and with a staff psychologist on 4/15/99, the facility failed to provide policies and procedures for the use of restraints within the health services area.

Draft policies regarding the use of restraints will be completed by June 15 as follows on next page of this report.

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

Findings:

1. The RN3 Nursing Supervisor stated that inmates were occasionally placed in restraints in the mental health unit's facility's Close Observation Unit. She stated that nursing staff were responsible for checking for proper application of these restraints and to check for adequate circulation on an hourly basis.

2. The facility policy manuals contained DOC policies and Division Directives regarding the use of restraints for inmates, but the facility's field instruction manual and nursing procedure manual did not contain procedures which directed WCC health care staff regarding how restraints are authorized for medical and/or psychiatric reasons, and monitoring parameters and interventions required for inmates in restraints. The Associate Superintendent, the Health Care Manager, the staff psychologist, and the RN3 confirmed that there was no field instruction or nursing procedures for restraints.

Failure to provide and periodically review policies and procedures can result in implementation of inaccurate and/or otherwise unacceptable procedures and improper practice.

1. A Nursing Procedure will be completed by June 15. The Chief of Nursing is responsible. The HCM will monitor.

2. A draft Field Instruction will be completed by June 8 by the Infirmary Operations Manager. The HCM will monitor.

HS 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;...

Based on an audit of training records of WCC health services staff members and interviews with a training unit clerical support staff member on 4/14/99 and an interview with the RN3 Nursing Supervisor on 4/15/99, the facility failed to ensure that all health services staff members had annual HIV/AIDS training as required by DOC policy.

Findings:

1. DOC policy 670.020 "HIV Infection and Acquired Immunodeficiency Syndrome (AIDS), page 3 of 8, I. A.,

1. The institution has included HIV/AIDS training in new employee orientation for at least the last five years. It was part of the annual in-service training for at least the last four years and will be part of the new series beginning in July. All Infirmary supervisors are being required to monitor attendance in the future.

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

states: "Training on HIV/AIDS for correctional staff members will be provided consistent with DOC Policy 890.600, Bloodborne Pathogens Employee Protection, in the course of the orientation of all new correctional staff members and annually thereafter.

2. An audit of training records of health services staff members revealed that nine (9) of sixty-six (66) employees had not had HIV/AIDS training within the past year. An interview with the nursing supervisor confirmed that these employees lacked documentation confirming this annual training.

2. The nine Infirmary employees who failed to attend the annual in-service training this year will be trained by the Infection Control Nurses by June 15. The HCM will monitor.

HS-DOC 070 - STERILIZATION AND SUPPLY
(2) Sterilizers and autoclaves shall be of the proper type with necessary capacity and maintained in a safe and satisfactory condition. Regular biological testing shall be recorded.

(3) There shall be written procedures for the cleaning, disinfection, and sterilization of supplies, equipment, utensils, and solutions.

Based on interviews with the RN3 Nursing supervisor, the medical technologist, and a dental technician on 4/15/99, the facility failed to establish and follow policies and procedures for sterilization of supplies, equipment, utensils, and solutions that reflected acceptable standards of practice for infection control.

Findings:

1. The WCC outpatient clinic had an autoclave unit for sterilization of supplies and equipment. There were no written procedures for biological growth medium testing to ensure the autoclave was reaching temperatures high enough to kill all microorganisms and spores. The RN3 nursing supervisor confirmed that there was no written procedure biological growth testing.

   Laboratory records indicated that biological growth testing of the clinic autoclave had not been performed since June, 1998.

1. Written procedures for biological growth medium testing for the Infirmary autoclave were put in the Nursing Procedures manual on May 24, 1999. The Chief of Nursing will monitor complian

2. The WCC dental clinic had two autoclaves for sterilization of dental supplies and equipment. The dental technician stated there were no written procedures for the cleaning, disinfection, and sterilization of supplies, equipment, utensils,

2. Written procedures for use of dental autoclave were put in the Dental Procedures manual on May 24, 1999. Also included were written procedures for the cleaning, disinfection, and (cont.)

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STATEMENT OF DEFICIENCIES
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Washington Corrections Center

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4/16/99
City
Shelton, WA

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and solutions. Although the laboratory had documentation of regular biological growth medium testing of the dental autoclaves, there was no written procedure to direct staff how to perform these tests. Absence of such procedures could result in improper sterilization of medical items and transmission of communicable diseases	(cont). sterilization of supplies, equipment, utensils and solutions for the Dental Department. The Dentist 2 will monitor compliance.

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Facilities and Services Licensing
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Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION

Survey Dates
4/5/99
License Number

Name of Facility
Washington Corrections Center
Address
PO Box 900
Administrator
[redacted]

City
Shelton
Zip Code
98584
Licensing or Certification Requirements Used
WAC 246-215 Food Service, HS-Doc and 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
GENERAL: . E-unit hallway vents, B-building custodial closet and men's nd women's visitor's toilet rooms were heavily soiled. .. The partitions between the fixtures in the gym toilet room /ere rusty and were no longer impervious to moisture. . The large fan in the Activity area behind the gym was soiled nd there was an uncovered vent hole in the inmate toilet room eiling in this area. The damaged wall surface in the utility closet in the mental ealth wing was not cleanable. . There was an unfinished/uncleanable board over the mop sink t the chapel. There was a loose ceiling vent in B-building custodial closet 13.	See Attached

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. Except Items #8 42 by 31 August 99 declaring the extent to which this plan of correction was completed.

Facility Representative — Date: 7-12-99

follow 12/31/99 and P.L.

POC OK KH 7/23/99

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

C99.DOC

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Facilities and Services
Licensing

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

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

ne of Facility
ashington Corrections Center

Survey Dates
4/5/99
City
Shelton

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

MU:

. There were significant water leaks in the custodial closets ehind several shower stalls (e.g.D-110, E-110,etc.). There was lso considerable mold growth on the ceilings and walls in these reas.

. The floor areas outside the D-110 and E-110 shower stalls vere soiled.

0. The exit light in the main hallway to IMU was not operable.

1. IMU staff were inappropriately distributing bulk antacids in pen paper cups to the inmates upon request. Over-the-counter ıedications must be in individual/prepackaged containers.

ITCHEN:

2. The damaged wall area by the steam kettle in the staff itchen was not cleanable. Also, the chipped, rust metal frames ver the windows at the pot and pan sink were moldy and ncleanable.

3. Anti-siphon devices/vacuum breakers were not available at ıe hose bibs under the sink in the vegetable room and adjacent) the garbage can washer. Also, the hose attachment on the andwash sink in the barbershop did not have a vacuum breaker.

4. Several plastic cutting boards in the vegetable preparation oom were scored and were no longer cleanable.

5. Ceiling and walls in several of the walk-n refrigeration units ere moldy (i.e. meat, bread , bakery, egg and # 4 coolers). lso, the walls in # 11 cooler were chipped and the ceiling was ıoldy.

6. The fan cover in # 10 walk-in was dusty.

rveyor's Initials KH
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Facilities and Services
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Facility Licensing and Certification Division
P O Box 47852
Olympia, Washington 98504-7852

STATEMENT OF DEFICIENCIES
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me of Facility
ashington Corrections Center

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4/5/99
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Shelton

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

.7. There were several damaged wall surfaces that were no onger cleanable (i.e. wall by door to bakery walk-in, wall areas n meat and vegetable preparation rooms, etc.). There were also ıncleanable surfaces in the bakery where wall and floor tiles vere damaged.

:8. There were damaged moldy walls in the dishwashing areas. Mold was also growing on the walls above the mop sink off the lining room.

19. The damaged floor surface near the tray line in one dining oom was not cleanable.

R-UNITS:

20. Temperature logs were not available for review for efrigerators in the R-unit serving kitchens. Also, a thermometers vere not available in R-1 and 3 refrigerators.

21. The ceiling was moldy in the custodial closet in R-1-F and ents were dusty in R-1-D & H, R-2-B&H, custodial closets.

22. The shower ceiling were beginning to chip in several units. The most noticeable was in unit R-1-A.

23. There was a large amount of standing water on the floor in # 235 mechanical room.

24. Staff commented to this surveyor that there was not a sufficient number of hot water hoses to adequately clean many of the areas.

25. There were holes around the vent in R-2-C custodial closet.

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:6. Clean blankets were inappropriately stored on the floor in he R-2 first floor closet.

:7. The refrigerator in R-3 was soiled. Also, the frame/edge of he refrigerator was damaged and was not cleanable

:7.One kitchen window in R-3 was not screened.

:9. The chase way behind the R-3 officer's station was very lusty. This dust often blew back into the office areas when the loor was opened .

:0. There was an uncovered light in the R-gym area.

31. The air system filters in R-5 were very dusty.

2. Stairs to the basement in R-5 were dirty.

3. There was no ramp to the shower in C-D.

4. The screens in the walls between the hallway and day rooms 1 R-4 were very dirty. There was no way to open this area and lean the space between the screens.

5. The rusty partitions in the toilet areas in R-4 A/B and G/H /ere not cleanable.

6. There was a cracked window and a rusty window sill in R-4 √B shower room.

7. The grout at the shower area in R-4 G/H was chipped and iese areas were not cleanable.

TRAINING CENTER:

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

STATEMENT OF DEFICIENCIES
AND
PLAN OF CORRECTION (continuation)

ne of Facility
ashington Corrections Center

Survey Dates
4/5/99
City
Shelton

Statement of Deficiencies with Reference Citation Number	Applicant's/Licensee's Plan of Correction with Time Table
8. There was standing water on the floor in the basement in Cedar and a faucet by the boiler was leaking. Pipes were also leaking in Evergreen basement.	
9. The wall area by the hot pot in the Evergreen day room was damaged and was not cleanable.	
0. There were clothing items as well as lint and dirt behind the clothes dryers in Pine.	
1. The bench in the shower and the board where towels were hung in Pine showers C/D & G/H were worn and were no longer impervious to moisture.	
2. The grout at the Pine mops sink in C/D was moldy.	
NFIRMARY:	
3. Walls were chipped and were not sealed where old hooks had been removed in custodial closet # 58. Also, mop hooks had not been installed in this area.	
ISITING UNITS:	
4. Reusable dishes in the visiting units were not washed in a dishwasher or by an acceptable three-compartment sink method.	
5. Cleaning supplies/toxic chemicals were found inappropriately ore under kitchen and bathroom sinks.	
6. There was a broken towel rack in # 2 bathroom.	
7. The portable fans in both units were dusty.	

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Facilities and Services
Licensing

ACTION PLAN

RECEIVED
AUG 2 0 1999
Facilities and Services
Licensing

TO: Jim Blodgett, Superintendent

FROM: Ginny Lynch, HCM

DATE: July 1, 1999

FOR: DOH INSPECTION

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
1a.	E unit hallway vents were heavily soiled.	Porters will be instructed to clean vents on a routine basis.	E-Building Officer	July 31, 1999	Unit Sergeant and Officer will ensure compliance.
1b.	B-Building custodial closet and men's and women's visitor's toilet rooms were heavily soiled.	The B-Building closet and visitor toilets have been cleaned. Inmate porters' work is now being checked.	B-Building Officer	Completed	B-Building Officer will inspect areas daily.
2.	The partitions between the fixtures in the gym toilet room were rusty and were no longer impervious to moisture.	Remove rust and repaint.	Painter Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
3a.	The large fan in the Activity area behind the gym was soil.	The large fan will be cleaned and a cleaning schedule established.	Recreation Leader	Within the next 30 days	Recreation Leader will check the fan for compliance.
3b.	There was an uncovered vent hole in the inmate toilet room ceiling in the Activity area behind the gym.	Repair holes in ceiling.	Plant Mechanic Supervisors	July 30, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
5.	The damage wall surface in the utility closet in the mental health wing was not cleanable.	Repair damaged wall.	Construction Supervisor	August 20, 1999	Plant Manager 1 to ensure compliance.
6.	There was an unfinished/ uncleanable board over the mop sink in the chapel.	Sand and seal board.	Painter Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
7.	There was a loose ceiling vent in B-building custodial closet #13.	Repair vent.	Construction Supervisor	No loose vent was found.	Plant Manager 1 to ensure compliance.
8.	There were significant water leaks in the custodial closets behind several shower stalls (e.g., D-110, E-110, etc.). There was also considerable mold growth on the ceilings and walls in these areas. (IMU)	Repair leaks. Clean and paint. RECEIVED AUG 2 0 1999 Facilities and Services Licensing	Maintenance Project Supervisor	South end – August 18, 1999 North end – September 17, 1999	Plant Manager 1 to ensure compliance.
9.	The floor areas outside the D-110 and E-110 shower stalls are soiled. (IMU)	Work orders submitted on July 7, 1999, for repair.	Maintenance/Unit Lt.	July 30, 1999	Weekly inspection by Unit Lieutenant.
10.	The exit light in the main hallway to IMU was not operable.	Repair light.	Electrician Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
11.	IMU staff were inappropriately distributing bulk antacids in open paper cups to the inmates upon request. Over-the-counter medications must be individual/prepackaged containers.	Warehouse has new vendor for antacids. New orders will be individually prepackaged containers.	N/A	N/A	N/A
12a.	The damaged wall area by the steam kettle in the staff kitchen was not cleanable.	Repair walls.	Construction Supervisor	August 20, 1999	Plant Manager 1 to ensure compliance.
12b.	the chipped, rust metal frames over the windows at the pot and pan sink were moldy and uncleanable.	Clean and remove rust. Paint.	Painter Supervisor	August 13, 1999	Plant Manager 1 to ensure compliance.
13.	Anti-siphon devices/ vacuum breakers were not available at the hose bibs under the sink in the vegetable room and adjacent in the garbage can washer. Also, the hose attachment on the handwash sink in the barbershop did not have a vacuum breaker.	Install vacuum breakers as required. RECEIVED AUG 2 0 1999 Facilities and Services Licensing	Plumber Supervisor	August 31, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
14.	Several plastic cutting boards in the vegetable preparation room were scored and were no longer cleanable.	17 new cutting boards have been placed on order to replace unserviceable boards.	Food Manager	August 16	Food Manager 1 will ensure new boards are used upon arrival.
15.	Ceiling and walls in several of the walk-in refrigeration units were moldy (i.e., meat, bread, bakery, egg and #4 coolers). Also, the walls in the #11 cooler were chipped and the ceiling was moldy.	Ceiling in large walk-in refrigerator has been washed and repainted. Bakery #2 and #4 coolers are scheduled for painting.	Area Supervisors	August 6	Food Manager 1 will ensure painting has been completed.
16.	The fan cover in #10 walk-in was dusty.	The fan cover in #10 has been cleaned. Also, it is now on the schedule for weekly cleaning.	Kitchen A/C Cooks	Completed	Food Manager 1 will monitor on-going compliance.
17.	There were several damaged wall surfaces that were no longer cleanable (i.e., wall by door to bakery walk-in, wall areas and meat and vegetable preparation rooms, etc.). There were also uncleanable surfaces in the bakery where wall and floor tiles were damaged.	Repair walls in kitchen area. Repair wall and floor tiles. RECEIVED AUG 2 6 1999 Facilities and Services Licensing	Construction Supervisor	August 20, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
18.	There were damaged moldy walls in the dishwashing areas. Mold was also growing on the walls above the mop sink off the dining room.	Walls in both dish-washing rooms are cleaned daily. Mop sink (dining room) has been cleaned.	Unit Officer	Completed	Food Manager 1 will monitor on-going compliance.
19.	The damaged floor surface near the tray line in one dining room was not cleanable.	Repair floor.	Construction Supervisor	August 20, 1999	Plant Manager 1 to ensure compliance.
20.	Temperature logs were not available for review for refrigerators in the R-unit serving kitchens. Also, thermometers were not available in R-1 and 3 refrigerators.	Temperature logs have been put in place and thermometers placed on order.	Area Supervisors RECEIVED AUG 2 0 1999 Facilities and Service Licensing	August 6	Food Manager 1 will monitor on-going compliance.
21.	The ceiling was moldy in the custodial closet in R-1-F and vents were dusty in R-1 D & H, R-2 B & H, custodial closets.	Mold has been removed and vents cleaned. Unit Sergeants are now supervising the porters' work.	Unit Sergeants	Completed	R-Unit Lieutenant will monitor on-going compliance.
22.	The shower ceilings were beginning to chip in several units. One most noticeable was in unit R-1 A.	Repaint ceilings.	Painter Supervisor	Completed July 9, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
23.	There was a large amount of standing water on the floor in #5 mechanical room. (R-units)	Repair leak as required.	Plumber Supervisor	August 30, 1999	Plant Manager 1 to ensure compliance.
24.	R-Unit staff commented to this surveyor that there was not a sufficient number of hot water hoses to adequately clean many of the areas.	The Sergeant will assess need for additional water hoses. More will be ordered if needed.	Unit Sergeants	Assessment done in one week.	R-Unit Lieutenant will monitor on-going compliance.
25.	There were holes around the vent in R-2 C custodial closet.	Repair holes in closet.	Maintenance Project Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
26.	Clean blankets were inappropriately stored on the floor in the R-2 first floor closet.	Blankets are now off the floor and on shelves. Porters have been retrained.	Unit Sergeants	Completed	R-Unit Lieutenant will monitor on-going compliance.
27.	The refrigerator in R-3 was soiled. Also, the frame/edge of the refrigerator was damaged and was not cleanable.	Refrigerator has been cleaned. Maintenance will assess whether or not the frame can be repaired. If it cannot, new fridge will be ordered.	Unit Sergeants RECEIVED AUG 2 6 1999 Facilities and Services Licensing	Cleaning completed. Assessment of repair will be done by July 20.	R-Unit Lieutenant will monitor on-going compliance.
28.	One kitchen window in R-3 was not screened.	Screen windows.	Plant Mechanical Supervisor	September 30, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
29.	The chase way behind the R-3 officer's station was very dusty. This dust often blew back into the office areas when the door was opened.	The chase way has been cleaned and porters have been instructed to clean it regularly.	Unit Sergeants	Completed	R-Unit Lieutenant will monitor on-going compliance.
30.	There was an uncovered light in the R-gym area.	Repair light.	Electrician Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
31.	The air system filters in R-5 were very dusty.	Change filters.	Steamfitter/ Heating Supervisor	July 16, 1999	Plant Manager 1 to ensure compliance.
32.	Stairs to the basement in R-5 were dirty.	The stairs have been cleaned and porters have been instructed to clean them regularly.	Unit Sergeants	Completed	R-Unit Lieutenant will monitor on-going compliance.
33.	There was no ramp to the shower in R-5 C/D.	Install Ramp	Plant Mechanic Supervisors	Completed April 29, 1999	Plant Manager 1 to ensure compliance.
34.	The screens in the walls between the hallway and day rooms in R-4 were very dirty. There was no way to open this area and clean the space between the screens.	1. Have maintenance cut opening. 2. Remove old grill. 3. Repair with different type screen which can be cleaned.	Unit Sergeants RECEIVED AUG 2 6 1999 Facilities and Service Licensing	August 31	R-Unit Lieutenant will monitor to ensure maintenance follows through.
35.	The rusty partitions in the toilet areas in R-4 A/B and G/H are not cleanable.	Clean and repaint.	Painter Supervisor	Completed May 14, 1999	Plant Manager 1 to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
36.	There was a cracked window and a rusty window sill in R-4 A/B shower room.	Replace window and paint sills.	Painter Supervisor	Completed June 30, 1999	Plant Manager 1 to ensure compliance.
37.	The grout at the shower area in R-4 G/H was chipped and these areas were not cleanable.	Regrout showers.	Carpenter Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
38.	There was standing water on the floor in the basement in Cedar and a faucet by the boiler was leaking. Pipes were also leaking in Evergreen basement.	Repair water leak.	Plumber Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
39.	The wall area by the hot pot in the Evergreen day room was damaged and was not cleanable.	Repair wall.	Construction Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
40.	There were clothing items as well as lint and dirt behind the clothes dryers in Pine.	Area is being cleaned daily.	Unit Sergeant	Completed	Correctional Unit Supervisor and Sergeant will inspect to ensure compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
41.	The bench in the shower and the board where towels were hung in Pine showers C/D and G/H were worn and were no longer impervious to moisture.	Seal boards as required.	Painter Supervisor	August 18, 1999	Plant Manager 1 to ensure compliance.
42.	The grout at the Pine mops sink in C/D was moldy.	Replace group. Cut vent in doors.	Maintenance Department	December 31, 1999	Correctional Unit Supervisor will do inspection and follow-up on work orders.
43.	Walls were chipped and were not sealed where old hooks had been removed in custodial closet #58. Also, mop hooks had not been installed in this area.	Repair walls and seal.	Painter Supervisor	August 18, 1999	Plant Manager 1 to ensure compliance.
44.	Reusable dishes in the visiting units were not washed in a dishwasher or by an acceptable three-compartment sink method.	We will begin using paper plates.	Recreation Supervisor	Within the next 30 days	Recreation Supervisor will ensure compliance.
45.	Cleaning supplies/toxic chemicals were found inappropriately stored under kitchen and bathroom sinks.	Locks will be put on the doors under kitchen sink to secure supplies and toxic chemicals.	Maintenance	Within the next 30 days.	Maintenance will monitor for compliance.

TASK #	DEFICIENCY	TASKS (Steps to be taken to implement assignment)	RESPONSIBILITY (Person(s) responsible for each task)	TIME FRAME (Time planned to accomplish task)	Monitors (Steps to ensure compliance)
46.	There was a broken towel rack in #2 visiting unit bathroom.	Replace towel rack.	Plumber Supervisor	July 30, 1999	Plant Manager 1 to ensure compliance.
47.	The portable fans in both Visiting Units were dusty.	Clean portable fans and a cleaning schedule established.	Recreation Supervisor	Within the next 30 days.	Recreation Leader will monitor for compliance.

WASHINGTON STATE DEPARTMENT OF HEALTH RA 027482 & 027527

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FORM APPROVED

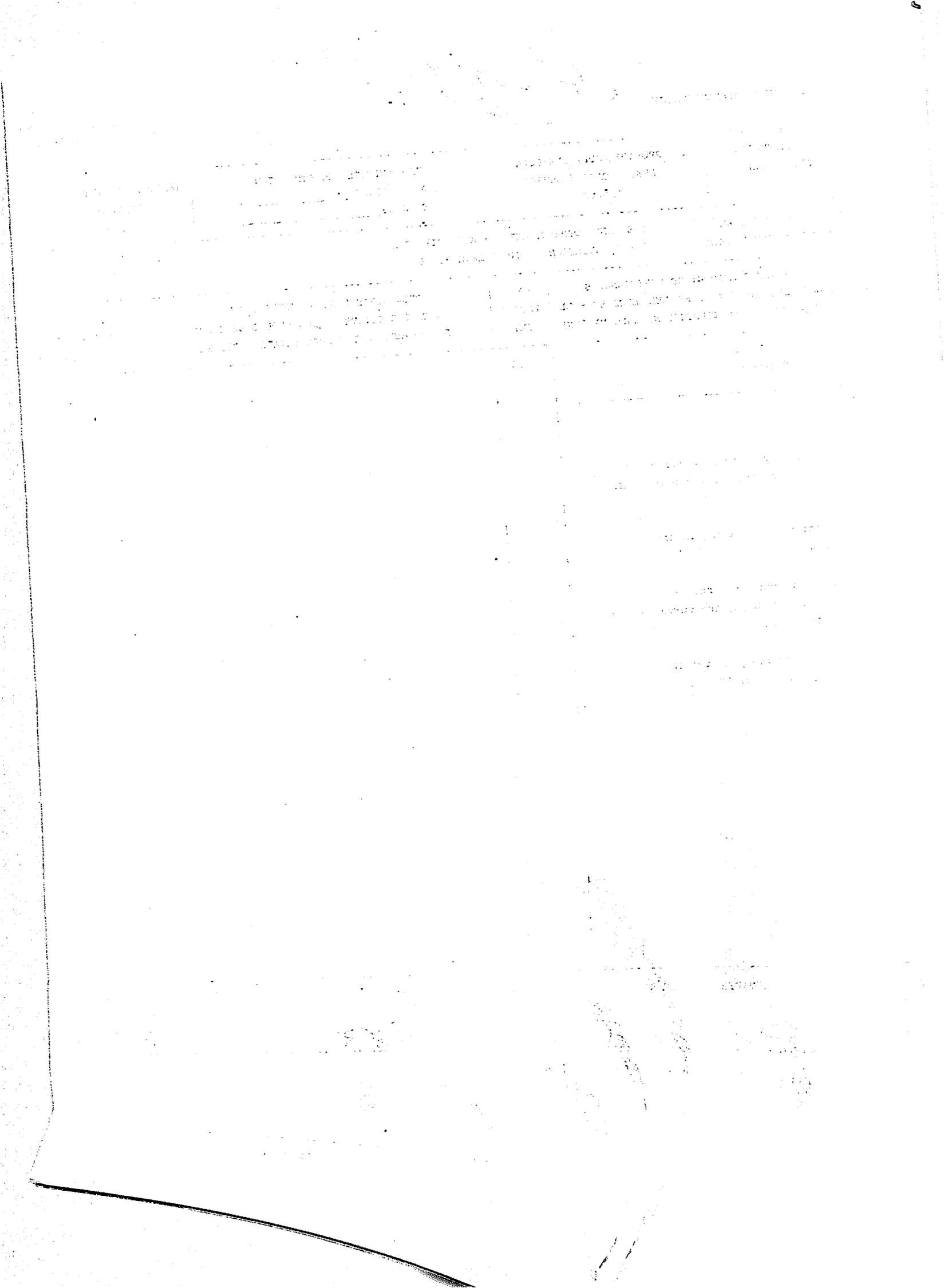
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/15/99

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WASHINGTON CORRECTIONAL CENTER	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 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathleen L Landberg R.S.	OHA3	2/5/99

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



INVESTIGATION REPORT

Investigation #: 003533 and 003507
State R & A #: [redacted], see survey R&A # 027694
Medicare R & A:

Investigated by :	Kathleen L. Landberg, R.S.		
Type of Facility/Name:	Washington Corrections Center	**Date Report is Written:**	05/17/99
Address of Facility:	Shelton, Wa	**Date of First Contact:**	04/05/99
		Date(s) of Investigation:	04/05/99
		Investigation Method:	On-site survey
Persons Contacted: Name:	Food Service Manager Staff on duty in IMU unit.		

Synopsis of Investigation: Food was monitored in kitchen as hot trays were prepared for lunch meal. Then on 04/07/99 the lunch trays were observed as served to IMU inmates.

Sources of Information: On-site observation by surveyor.

Allegations:

Allegation: # 1 Food not hot when served.

 # 2 Staff do not wash hand or wear gloves.

Narrative: The hot food is served into thermo/insulated divided trays with matching insulated covers. The trays are delivered to the IMU , separated for special diets and served directly to the inmates.

This surveyor did not observe at time lag of more than 5 - 10 minutes before food was served to the cells and food check the day of the survey was warm at time of delivery.

The custody officers during this survey were observed to put on disposable latex gloves before serving the food. This surveyor has visited these units several times in the last few years and has always observed staff putting on gloves before coming into direct contact with inmates or food served to the inmates. Gloves are carried in their pockets as well as located in several places throughout the IMU area.

Conclusion: Allegation # 1 and 2 could not be substantiated.

Attachments: None

Note : Investigations # 003507 and 003533 both were concerning the same two issues mentioned above.