State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC), 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation. On site dates: 12/13/22, 12/14/22, 12/16/22, and 12/29/22 Case number: 2020-11715 Intake number: 103736 This investigation was conducted by Investigator #15 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: * The regulation number and/or the tag number; * HOW the deficiency will be corrected; * WHO is responsible for making the correction; * WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and * WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on 01/26/23. 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter.	
L1105	322-170.3C NURSING SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (c) Nursing services, including: (i) A psychiatric nurse, employed full time, responsible for	L1105		

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L1105	Continued From page 1 directing nursing services twenty-four hours per day; and (ii) One or more registered nurses on duty within the hospital at all times to supervise nursing care; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that staff provide patients with the appropriate medical care during their hospitalization, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1512). Failure to provide patients with appropriate and timely medical care can result in inconsistent or delayed treatment of patient needs and may lead to patient harm or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Seizure Precautions," policy number PC.SP.101, last revised 09/21, showed the following: a. Seizures are to be treated as a medical emergency. b. Patients at risk for seizures include patients detoxing from alcohol or drugs, patients with head trauma, and patients with seizure disorders. c. Procedures for Nursing Care: i. Preictal Phase (Before Seizure) - Make sure home medications, particularly seizure medications have been verified and ordered for	L1105		

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L1105	Continued From page 2 the patient. ii. Tonic-Clonic Phase (During a Seizure) - Time the seizure, turn patient to left side, protect the patient from injury, stay with the patient, assess, and document. iii. Postictal Phase (After the Seizure) Registered Nurse (RN) care includes: Take vital signs and neuro-checks as ordered. Check for injuries. Provide safe area to rest, dim lights. Stay with patient, as needed. Call Attending Physician to notify of seizure activity. Obtain order for patient to be evaluated by Medical Physician status post seizure activity for recommendations. Perform a neurological examination, noting pupil size and reactivity, level of consciousness, responsiveness to stimuli, and respiratory status. Repeat the evaluation every 15-30 minutes until the condition stabilizes. Avoid excessive environmental stimuli during the postictal phase. Assess and document. Document review of the hospital's policy and procedure titled, "Assessment and Reassessment," no policy number, last revised 05/22, showed the following: a. Reassessments are conducted by all disciplines as indicated, with documentation provided through a variety of formats, including but not limited to progress notes, nursing reassessment forms, and medical staff dictation. b. Reassessments are completed by the RN pm	L1105		

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L1105	Continued From page 3 day and evening shifts and documented in the nursing reassessment form. c. Each patient is reassessed as necessary, based on the patient's plan of care, or change in their condition. If needed, the nurse may obtain a blank progress note to document additional information. Document review of the hospital's policy and procedure titled, "Non-Formulary Drug Procurement," policy number PHR-121, last reviewed 09/21, showed the following: a. When a non-formulary (NF) medication order is received by the Pharmacy Department, the medication will be evaluated to determine if a suitable alternative drug listed on the Automatic Substitution List is available. b. If an alternative medication is not on the Automatic Substitution List, the Pharmacist may contact the prescriber with a formulary alternative. c. When an automatic substitution or home medication supply is not readily available, the prescription may be procured from a local vendor pharmacy. If a prescription requires procurement from a local vendor pharmacy, it will first be arranged through the Pharmacy Department. Arrangements for the prescription delivery to the facility will be completed via courier service or hospital staff member. d. When the NF cannot be obtained by a medication on the Automatic Substitution List or the patient home supply of the medication, the Non-Formulary Drug form will be completed by the patient care unit and sent to the Pharmacy	L1105		

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L1105	Continued From page 4 Department. The Pharmacist will seek approval from the Medical Director and/or Chief Operating Officer. Once approval is obtained, the Pharmacist will obtain the smallest day supply of the Non-Formulary medication from an outpatient vendor pharmacy and order the smallest package size available from the wholesaler. e. The Pharmacist will make every attempt to resolve the NF drug form before the end of their shift, especially if the drug order is of urgent nature. The Pharmacist will notify the patient care unit of the anticipated delivery of the NF drug. f. If the drug order is carried over to the next day, procurement must be resolved as quickly as possible. Patient #1506 2. Patient #1506, a 39-year-old female, was voluntarily admitted on 06/29/20 for Alcohol Use Disorder, Major Depressive Disorder (MDD), and Seizure Disorder. On the Psychiatric Evaluation dated 06/29/20, the psychiatric provider documented that the Patient had a long history of Epilepsy, for which she was prescribed phenobarbital (most commonly used anti-seizure medication). Patient #1506 was allergic to Keppra (another prescription medication to treat seizures). a. On the History and Physical Evaluation dated 06/29/20, the medical provider documented that the plan of care to treat the Patient's Seizure Disorder was to resume her phenobarbital 32.4 mg. by mouth every 12 hours. b. On the Medication Administration Records (MAR) dated 06/29/20 and 06/30/20, nursing staff	L1105		

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L1105	Continued From page 5 documented that the Patient's seizure medication, phenobarbital was not available from the pharmacy and that the pharmacy was notified. Review of the medical record found that staff failed to notify the medical provider that the medication was not available. c. On the Medical Progress Note dated 06/30/20, the medical provider documented that at 10:13 AM, Patient #1506 had one episode of seizure activity that lasted about 2 minutes. The provider reported that the vitals machine could not pick up the Patient's blood pressure, her oxygen saturation had dropped to 88% (normal oxygen saturation is between 95% and 100%, levels below 95% are considered abnormal and the brain may be affected). The medical provider was unable to find a carotid or radial pulse and cardiopulmonary resuscitation (CPR) was initiated. On the 5th compression the Patient regained consciousness. The Patient was administered oral Ativan and staff was instructed to continue to monitor the Patient every 30 minutes. d. On the Medical Progress Note dated 06/30/20 at 11:27 AM, the medical provider documented that the Patient had one event of seizure activity and would resume the Patient's phenobarbital 32.4 mg by mouth every 12 hours. The provider did not document that this medication was not available in the hospital's formulary or that the Patient had not received her regularly scheduled dose since her admission on 06/29/20. e. On the Nursing Reassessment Note dated 06/30/20, the RN documented that Patient #1506 was sitting in the dining room and had a seizure lasting 2-3 minutes. The Patient hit her head on the table and was helped to the floor. The RN	L1105		

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L1105	Continued From page 6 documented that the medical provider was on site. The RN documented that the Patient was given Ativan and initiated neuro-checks. The RN noted that they had called the pharmacy earlier that day and the Patient's phenobarbital was arriving tomorrow (07/01/20). f. Review of the medical records found that nursing staff had failed to document the time that the seizure started, results of vital signs and neuro-checks, the plan of care for the Patient after the seizure, or if a staff member would be staying with the Patient for increased observations. g. On the Nursing Reassessment Note dated 06/30/20 at 11:00 PM, the RN documented that Patient #1506 was sleeping in her room, and then got up for dinner at 4:15 PM. While sitting in the dining room the Patient had a second seizure lasting 90 seconds. When the Patient regained consciousness, she was confused and unsure of her location. The RN documented that the Patient was given an intramuscular injection of Ativan and assisted to her room to lay down. The medical provider was notified of the seizure activity and the nurse was advised to "monitor the patient for seizure activity and call back if the patient has further seizures." Nursing staff failed to document an assessment of the Patient after the seizure, results of vital signs and neuro-checks, or if a staff member would be staying with the Patient for increased observations. h. At 6:00 PM, the RN documented that the Patient was assessed per the Alcohol Withdrawal Protocol (CIWA) and administered oral Ativan and Phenergan for withdrawal symptoms.	L1105		

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L1105	Continued From page 7 i. At 7:00 PM, the RN documented that Patient #1506 had a third seizure that lasted 2 minutes. The medical provider was notified, and the Patient was transported to the hospital for medical care at 7:50 PM. j. The Investigator's review of the medical record found that staff failed to ensure that the seizure medications for Patient #1506's Seizure Disorder were ordered, expedited, and administered to prevent withdrawal symptoms, such as convulsions, delirium, seizures, and auditory/visual hallucinations. k. The Investigator's review of the medical record found that nursing staff failed to consistently document the time and duration of the seizures, results of vital signs and neuro-checks (to be performed until the patient stabilizes), assessments, and provider notifications and orders during the Postictal Phase (after the seizure). Review of the Nursing Assessments and Re-assessments found that nursing staff failed to document if a staff member stayed with the patient to monitor their condition until stabilized. Patient #1512 3. Patient #1512, a 24-year-old transgender female to male, was voluntarily admitted on 06/25/20 for Suicidal Ideation with a Plan. Patient #1512 has a psychiatric diagnosis of Bipolar Disorder and a medical diagnosis of Seizure Disorder. a. On the History and Physical Evaluation dated 06/25/20, the medical provider documented that the Patient reported that they experienced frequent seizure activity. The most recent seizure attack was two days prior. However, the Plan of	L1105		

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L1105	Continued From page 8 Care for Patient #1512 failed to include their seizure disorder or recommendations for treatments and interventions. b. Review of the Medical Progress Notes, dated 06/26/20 through 06/28/20 the medical providers failed to list the Patient's Seizure Disorder diagnosis under the Plan of Care review. The medical providers failed to document any interventions, including medications, or the patient's status of incidents of seizure activity. c. On the Nursing Reassessment Note dated 06/26/20, the nursing staff documented that at 1:55 PM while standing near the nurse's station, the Patient experienced a seizure. The RN recorded the Patient's vital signs, the Patient was taken to his room, and an intramuscular injection of Ativan was administered. The RN notified the provider of the event. The nursing staff failed to document the duration of the seizure or the Postictal Phase vitals and neuro-checks. d. On the Psychiatric Progress Note dated 06/28/20, the psychiatric provider documented that the Patient had a history of seizures and was placed on Seizure Precautions and observations every 5 minutes. The provider documented that the Patient reported a seizure and aura, appearing irritable. The provider recommended that staff continue to monitor the Patient every 5 minutes. e. On the Nursing Reassessment Note dated 06/28/20, the RN documented that the Patient reported that they "had an aura for a seizure" and was screaming but no one came to help, "it made me cry." The RN documented that the Patient was assessed for seizure episodes, but the RN did not document the findings of the assessment.	L1105		

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L1105	Continued From page 9 The RN failed to document provider notification of the incident. f. On the Nursing Reassessment Note dated 06/29/20, the RN documented that at 10:55 AM, Patient #1512 was standing near the nursing station when another patient grabbed them and threw them to the ground. Patient #1512 began convulsing, experiencing a seizure. The seizure episode lasted 6 minutes. The Patient regained consciousness and was administered an intramuscular injection of Ativan. Staff took the Patient to his room and placed his mattress on the floor for safety. Nursing staff notified the medical provider of the seizure incident. Patient #1512 complained of neck pain due to hitting his head during the seizure. The medical provider evaluated the Patient and wrote an order to send the Patient to the hospital for medical care. Nursing staff failed to document the Patient's level of consciousness (LOC) on the neuro-checks performed at 11:10 AM, 11:25 AM, and 1140 AM. g. The Investigator's review of the medical record found that staff failed to ensure that the there was a medical plan of care for the Patient's seizure disorder, to help ensure patient safety and prevent exacerbations of seizures during admission. h. The Investigator's review of the medical record found that nursing staff failed to consistently document the time and duration of the seizures, results of vital signs and neuro-checks (to be performed until the patient stabilizes), assessments, and provider notifications and orders during the Postictal Phase (after the seizure).	L1105		

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L1105	Continued From page 10 4. On 12/16/22 at 10:50 AM, during an interview with Investigator #1, the Chief Nursing Officer (CNO) (Staff #1505) verified that for patients that need a non-formulary medication (Patient #1501), the pharmacy department notifies the unit that the medication is not in their formulary. Usually they can expedite the request, getting the medication the same day. Staff #1505 stated that she was unsure if there was a substitute medication for the phenobarbital prescribed for Patient #1501. The CNO verified that the medical records reviewed contained incomplete and inconsistent documentation of the seizure events. Staff #1505 was not able to speak to the specifics of the protocols and documentation requirements for patients experiencing seizures and would need to refer to the policy for accuracy. The clinical educator has incorporated training and competencies that meet the policy requirements, including seizure protocols.	L1105		

POC rec'd 03.01.23
POC approved 03.03.23
Mary Drew MSN, RN
Nurse Investigator DOH

Cascade Behavioral Hospital

Plan of Correction for
State Follow-Up Revisit Investigation
Exit 12/29/22
(Case #2020-11715)

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L000	Initial Comments Submission of this plan of correction is not an admission by the hospital that the citations are true or that the hospital violated the law. Immediately following receipt of the statement of deficiencies on 1/16/23, Hospital Leadership and members of the Governing Board reviewed the findings identified by the surveyors in the statement of deficiencies and began formulating a plan of correction.	CEO	Completion date:	
L 1105 322-170.3C NURSING SERVICES WAC 246-322-170 Patient Care Services	**Item #1** Nursing staff failed to consistently document the time and duration of the seizures, results of vital signs and neuro-check The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Director of Quality reviewed the "Seizure Precautions" (PC.SP.101) policy and "Assessment and Re-Assessment" policy and determined that the policies meet regulatory requirements. The CNO/Clinical Educator will distribute refresher materials electronically and/or during staff huddles provide education on the Seizure Precautions policy to existing nursing staff with a signed acknowledgment of receiving training. Education will be incorporated into New Hire Orientation for new nursing staff and will be provided in a refresher at the annual skills fair. Training consists of a refresher on Seizure Precautions policy, the requirements for conducting an assessment/ reassessment following seizure activity, documenting new problems identified by the patient or the nurse during the assessment including incorporation of the newly identified problem in the patient's individual treatment plan. Development of Seizure checklist and/or packet will be done. This tool shall be incorporated into the Seizure	CNO/Pharmacy/ Quality Dir.	02/28/2023	**Monitoring Process** The CNO and/or designee will report all incidents of seizures to Risk and/or Quality. Quality director or designee will add incident reports involving seizures to current chart audit list for compliance. The audit of patient charts are to assure compliance and completion of the chart elements. The audits will review elements to include: • The completion of reassessments by the Registered Nurse; ensuring all active problems identified in the patient's individual treatment plan are accurately addressed. • That a reassessment is done for each patient as necessary based on the patient's change in condition. • For documentation in the nursing re-assessment and/or progress note of newly

	Precautions policy training along with copies accessible electronically at all open unit nursing stations. The checklist and packet will provide a progress note template containing but not limited to the following: Start Time (approx.), Stop Time, account of Tonic-Clonic Phase, Vitals, Seizure assessment, Physician notified (orders/recommendations), Neurological evaluation containing pupil size and reactivity, level of consciousness and continued monitoring status.			identified medical problems, and provider notification of newly identified problems. • That the treatment plan has a new problem sheet with specific interventions and the problem is added to the active problem list, for any new problems identified during the re-assessment of patients. • The medical problem sheets are updated at a minimum of weekly to record progress being made toward meeting goals, new interventions if any, and any areas that have been resolved or new problems identified. • Any deviation from provider orders has justification and notification documented of provider and other necessary parties e.g. pharmacy. • Audits of charts resulting from incidents will be audited to the check list/packet and policy associated.
	Item# 2 Nursing staff failed to document if a staff member stayed with the patient to monitor their condition until stabilized. The CNO/Clinical Educator will distribute refresher materials electronically and/or during staff huddles provide education on the Seizure Precautions policy to existing nursing staff with a signed acknowledgment of receiving training. Education will be incorporated into New Hire Orientation for new nursing staff and will be provided in a refresher at the annual skills fair. Training consists of a refresher on Seizure Precautions policy, the requirements for conducting an assessment/ reassessment following seizure activity, documenting new problems identified by the patient or the nurse during the assessment including incorporation of the newly identified problem in the patient's individual treatment plan. Development of Seizure checklist and/or packet will be done. This tool shall be incorporated into the Seizure Precautions policy training along with copies accessible electronically at all open unit nursing stations. The checklist and packet will provide a progress note template containing but not limited to the following: Start Time (approx.), Stop Time, account of Tonic-Clonic Phase, Vitals, Seizure assessment, Physician notified (orders/recommendations), Neurological evaluation containing pupil size and reactivity, level of consciousness and continued monitoring status.			**Target for Compliance** The target goal for education and training of nursing and medical staff on the Seizure Precautions policy and initiation of a problem sheet for seizures utilizing the Neurological Disorder problem sheet template is 100%. The target goal for the audit as described above is 90% compliance. Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council. **Monitoring Process** The Pharmacist or designee will review non-formulary log monthly with Quality Director or designee auditing for documentation:

	Item#3 Staff failed to ensure that there was a medical plan of care for the Patient's seizure disorder, to help ensure patient safety and prevent exacerbations of seizures during admission The CMO, CNO/Clinical Educator and Director of Quality reviewed "Interdisciplinary Treatment Plan Medical Problem Sheet" and determined that the sheet meets the facility's policy and needs. The CMO, CNO/Clinical Educator will provide reeducation to providers and nursing staff on initiation of a problem sheet for seizures once treatment is initiated utilizing the Neurological Disorder problem sheet template. Patient's history of seizures will be included in the Interdisciplinary Treatment Plan. **Item# 4** Failure to ensure that seizure medications for seizure disorder were ordered, expedited and administered to prevent withdrawal symptoms The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), and Pharmacist reviewed the "NON-FORMULARY DRUG PROCUREMENT" (PHR-121) policy and determined that the policies meet regulatory requirements. The Pharmacy Department will provide reeducation to pharmacy staff and Nursing staff on "NON-FORMULARY DRUG PROCUREMENT" (PHR-121) policy and its procedures. The training/ reeducation will be performed by classroom presentations and small groups to cover 100% of working nursing and pharmacy staff. Pharmacy Department will contact the nursing station and/ or provider as necessary regarding non-formulary medication without suitable alternative on the Automatic Substitution List. Nursing staff will document conversations with pharmacy and providers regarding non-formulary orders and follow-up as needed to ensure resolution obtained. The Pharmacist or designee will log and review non-formulary request with resolutions. Non-formulary request requiring clarification and/or provider approval will be documented and followed up on appropriately.			◦ date and time nursing and/or provider contacted ◦ recommendation/ resolution per provider ◦ fulfillment of order ◦ nursing documentation of contact with provider and pharmacy if necessary and follow up communication **Target for Compliance** The target goal for education and training of pharmacy staff and nursing staff on "NON-FORMULARY DRUG PROCUREMENT" (PHR-121) policy and its procedures is 100%. The target goal for the audit as described above is 90% compliance. Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council.

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

June 2, 2023

Shaun Fenton
Chief Executive Officer
Cascade Behavioral Hospital
12844 Military Road South
Tukwila, WA 98168

Re: Complaint #103736/Case #2020-11715

Dear Mr. Fenton,

Investigators conducted a state hospital complaint investigation at Cascade Behavioral Hospital on 12/13/22, 12/14/22, and 12/29/22. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 03/03/23.

Hospital staff members sent a Progress Report dated 05/12/23 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Hospital's attestation that it will correct all deficiencies cited at Chapter 246-322 WAC.

We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Mary New

Mary New, MSN, RN
Nurse Investigator