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 02/02/2023

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: 01/13/23, 01/17/23, 01/30/23, and 02/02/23 Case number: 2022-15740 Intake number: 127738 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 03/16/23. 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter.	
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including	L 320		

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

COO 8/22/2023

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L 320	Continued From page 1 posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Item #1 - Safe Environment of Care Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff implemented interventions to maintain a safe environment, providing patient's sexual safety by maintaining separation between patients who are alleged to have engaged in sexual behavior, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1502). Failure to provide for patient's sexual safety and a safe environment for care increases the risk of recurrence of sexual activity and/or assault, and violates the patient's right to be free of sexual harassment, abuse, or assault. Reference RCW 71.05.217 Rights-Posting of Rights (1) (g) To have the right to individualized care and adequate treatment; Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. Separate any patients who are alleged to have engaged in sexual behavior or who have been	L 320		

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L 320	Continued From page 2 identified as at increased risk to engage in such behavior. b. Upon report or discovery of an allegation of sexual familiarity between clients, immediately separate the patients to maintain safety. 2. Review of the hospital's incident reports, and investigation summary revealed that on 12/24/22 at approximately 9:00 AM, an Activity Therapist (Staff #1506) entered the room of Patient #1501, a 38-year-old male, who was admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder and found Patient #1502 laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. Patient #1502, a 49-year-old female, was admitted involuntarily for grave disability on 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). 3. The patients were physically separated, and staff escorted Patient #1502 back to her room. 4. On 12/24/22 at 3:00 PM, Staff #1506 documented briefly about the earlier incident on the Activity Therapy Group Progress Note for Patient #1501 and Patient #1502. As per hospital policy, Staff #1506 did not identify the other patient in the client's medical record but instead used "male" and "female" identifiers. The Group Progress Notes were placed in the Patient's medical records later that day. Staff #1506 failed to notify the House Supervisor of the incident. 5. On 12/24/22 at 5:00 PM, the House Supervisor (Staff #1512) contacted nursing staff on 3 North unit and relayed a telephone order from the Chief	L 320		

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L 320	Continued From page 3 Executive Officer (CEO) (Staff #1510) who was the Administrator on Call (AOC) for the day, to move Patient #1501 from 2 West (where the sexual assault occurred) to 3 North. 6. On 01/13/23 at 4:20 PM, during an interview with Investigator #15, the Chief Executive Officer (Staff #1510) stated that staff failed to notify the house supervisor, or hospital leadership of the incident that took place on 12/24/22. Staff #1506 stated that the order to move Patient #1501 to 3 North had nothing to do with the sexual assault earlier that day; he was not yet aware of the incident. Staff #1506 stated that it was an administrative move, which was typical. The CEO stated that they had seen a lot of male admissions and they were trying to open a potential female bed on 2 West. 7. On the Nursing Reassessment Progress Note dated 12/24/22 at 5:20 PM, nursing staff from 3 North documented that Patient #1501 was transferred to the unit per supervisor request. 8. On 12/27/22 at 5:40 PM, the public defender for Patient #1502 contacted the hospital's Court Evaluator (Staff #1522) and reported the discovery of the Activity Therapy Group Progress Note in Patient #1502's medical record that detailed the sexual assault incident that occurred on 12/24/22. The public defender requested additional information and asked if an incident report was initiated, an investigation performed, and was police involved. The public defender also requested the identity of the male peer. Staff #1522 was unable to provide that information. After communication from Patient #1502's public defender, Staff #1522 notified the leadership team, and the investigation process was initiated.	L 320		

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L 320	Continued From page 4 9. On 12/27/22 at 6:50 PM, the psychiatric provider (Staff #1519) wrote an order to transfer Patient #1502 to 3 North and place her on Sexual Victimization Precautions (SXV). At the time the order was written, the provider was unaware of the identity of the male peer, or that Patient #1501 had already been transferred to 3 North on 12/24/22. 10. On the Nursing Reassessment Progress Note dated 12/27/22 at 11:00 PM, nursing staff from 3 North documented that Patient #1502 was transferred from 2 West at 7:20 PM. Nursing staff failed to document the reason for the transfer or the change in precautions, adding the SXV precautions. 11. The transfer of Patient #1502 on 12/27/22 at 7:20 PM, placed both patients involved in the sexual assault incident on 12/24/22 (Patient #1501 and Patient #1502) on the same unit. 12. On 12/28/22, the hospital identified Patient #1501 as the male peer involved in the incident of sexual assault of 12/24/22. On 12/28/22 at 10:15 AM, the psychiatric provider wrote and order transferring Patient #1501 back to 2 West. The provider failed to document a reason (indication) for the transfer. 13. On the Nursing Reassessment Progress Note dated 12/28/22, nursing staff documented that Patient #1501 was transferred to 2 West at 11:12 AM. 14. The Investigator's review of the medical records found that after the incident of sexual assault on 12/24/22, hospital staff inadvertently transferred the alleged perpetrator (Patient #1501) to the same unit as the alleged victim	L 320		

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L 320	Continued From page 5 (Patient #1501). Both patients were located on 3 North from 12/28/22 at 7:20 PM to 12/29/22 at 11:12 AM. During this time period, there were no additional precautions or observations implemented to ensure environmental sexual safety. 15. On 01/13/23 at 4:20 PM, during an interview with Investigator #15 the Chief Executive Officer (Staff #1510) verified that based on the initial missing notification of the incident that took place on 12/24/22, the two patients involved (Patient #1501 and #1502) were accidently transferred to the same unit for a short period of time. Staff #1510 stated that staff involved in the failure to report the incident were disciplined accordingly for not following the hospital's policy. Item #2 - Right to Interpreter and Translator Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that patients with limited English proficiency and language barriers are provided access to interpreters and translators, as demonstrated by 1 of 1 record reviewed (Patient #1502). Failure to provide patients with limited English proficiency an interpreter or translator limits the patient's ability to communicate and receive information regarding patient rights, consent for treatment, and their medical conditions and treatment, places the patient at risk for barriers to care, inappropriate or inadequate care, or violation of their patient rights. Findings included:	L 320		

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L 320	Continued From page 6 1. Document review of the hospital's policy and procedure titled, "Communication with Persons with Limited English Proficiency," policy number PC.CLEP.101, last reviewed 08/21, showed the following: a. The policy of Cascade is to ensure meaningful communication with Limited English Proficiency (LEP) patients and their authorized representatives involving their medical conditions and treatment. b. This policy also provides for communication of information contained in vital documents, including but not limited to, waiver of rights, consent to treatment forms, and financial and insurance benefits forms. c. The hospital will promptly identify the language and communication needs of the LEP person to determine the preferred language. d. Intake staff will insure that any patient with known interpreter needs have a minimum of 3 days scheduled with an interpreter or language service to begin on the 1st day of admission to Cascade. e. The Director of Social Services is responsible for ensuring that Social Services staff continues ongoing scheduling needs for interpreter services throughout the remainder of the patient's stay at Cascade. f. Some LEP patients may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP patient will not be used as interpreters unless specifically requested by the individual and after the LEP patient has understood that an offer of	L 320		

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L 320	Continued From page 7 an interpreter at no charge has been made by the facility. g. Providing notice to LEP persons - The hospital will inform LEP persons of the availability of language assistance free of charge, by providing written notice in languages the LEP person will understand. Patient #1502 2. Patient #1502, a 49-year-old female, was admitted involuntarily for grave disability on 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). Review of the medical record showed the following: a. On the Intake Assessment dated 11/21/22, staff documented that Patient #1502 was currently living with family (including her sister and their parents). The family reported that the Patient's mental health had been decompensating over the years and that the Patient had been off medication since 2019. b. Intake staff documented that the Patient did have barriers to communication and spoke Cantonese and English, however would require a qualified interpreter. The patient was advised that a Cantonese interpreter would assist with communication when obtaining the initial history and physical assessment, the psychiatric assessment, explanation of diagnosis, obtaining informed consent/permission to treat, and patient education, including medication education and written materials. c. On the Initial Nursing Assessment dated 11/21/22, nursing staff documented that Patient	L 320		

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L 320	Continued From page 8 #1502's preferred language was Cantonese. The nurse also documented that the Patient would require a Cantonese interpreter. d. The Investigator's review of the medical record found that intake staff failed to ensure that Patient #1502 had a minimum 3 days scheduled with an interpreter or language service to begin on the 1st day of admission to Cascade, as directed by hospital policy. Additionally, staff failed to document an attempt to obtain language services and the reason the interpreter was not obtained. e. Review of the medical records found that social services staff failed to document obtaining a Cantonese interpreter for Patient #1502, or efforts to schedule ongoing interpreter services throughout the remainder of the patient's stay. f. The Investigator found conflicting accounts of the Patient's need for a Cantonese interpreter. On the Initial Psychiatric Evaluation dated 11/22.22, the provider documented that while the Patient was in the Emergency Department prior to admission at Cascade, the medical hospital reported that Patient #1502 was able to speak English and preferred to respond that way. However, while at the medical hospital, a Cantonese interpreter was obtained for the Patient. g. During Patient #1502's admission, 8 of 9 psychiatric progress notes (between 12/19/22 to 12/28/22) documented that the Patient was mute or responded with nonsensical language. h. The review of Patient #1502's medical record review found that staff failed to document an attempt to obtain an interpreter, as identified during intake and admission, or document the	L 320		

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L 320	Continued From page 9 reason that an interpreter was not obtained for Patient #1502. 3. On 01/17/23 at 1:00 PM, during an interview with Investigator #15, the Mental Health Technician (MHT) (Staff #1514) stated that Patient #1502 didn't talk a lot. The MHT stated that the Patient was often confused, but reported that she thought that the Patient understood English. 4. On 01/17/23 at 1:15 PM, during an interview with Investigator #15, a Registered Nurse (RN) (Staff #1515) reported that Patient #1502 was mostly catatonic. The RN stated that Patient #1502 seemed to be getting better and coming out of her room more often, but she was still very confused. Staff #1515 was not sure why an interpreter was not obtained for the Patient during her admission. 5. On 02/24/23 at 12:15 PM, during an interview with Investigator #15, Patient #1502's caretaker stated that when the Patient was admitted she was psychotic, confused, and speaking very little. The caretaker reported that often the Patient would call her to request an explanation of care that the hospital was providing or to request items that she needed, with the intention that the caretaker would contact the hospital and communicate her request. The caretaker stated that Patient #1502 should require a Cantonese interpreter during her hospital stay. Patient #1502's caretaker reported that she did not believe that the hospital offered the Patient interpreter services. .	L 320		

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L 325	Continued From page 10	L 325		
L 325	322-035.1E POLICIES-ABUSE PROTECTION WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (e) Protecting against abuse and neglect and reporting suspected incidents according to the provisions of chapters 71.05, 71.34, 74.34 and 26.44 RCW; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that the local police department was notified of an incident of nonconsensual sexual misconduct/sexual intercourse between two patients. Failure to report an incident to the local police department may put patients and staff at further risk for harm and create barriers or a delay in the implementation of preventative safety measures. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Safety Precautions," policy number PC.SSP.101, last reviewed 08/21, showed the following: a. Sexual Violence: Sexual activity that happens where consent is not obtained or freely given. It occurs when a person is forced, coerced or manipulated into sexual activity. Includes	L 325		

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L 325	Continued From page 11 unwanted touching, sexual harassment, and sexual acts. b. Sexual Activity: Any activity of a sexual nature (including touching, intercourse, oral sex) that occurs between people. c. Sexual Assault: Any behavior of a sexual nature that is unwanted, making the victim feel uncomfortable or afraid. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients," policy number PC.SAAP.120, last reviewed 08/22, showed that when sexual activity between patients does occur some circumstances require administration to report the allegation to other authorities. Administration will determine if any outside authorities/law enforcement are to be notified. The Risk Manager will assist in notifying the police. Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed the following: a. The Risk Management Program provides a systematic, multidisciplinary approach to managing and reporting incidents of injury, damages, and loss. b. An "incident" is an unanticipated event which was not consistent with the standard of care that results in, or nearly causes, a negative impact on a patient(s) receiving care at the facility. Any harm caused can be temporary, long-term, or permanent, and range in severity from "no obvious or significant injury up to death."	L 325		

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L 325	Continued From page 12 c. Incidents of Sexual Allegations include: i. Patient to Patient Sexual Intercourse - Any allegation of sexual intercourse/contact between patients. d. Severity Classifications include: i. Level I Tragic - Incidents which are considered sentinel or considered tragic in nature. For example: Sexual intercourse with penetration. ii. Level II Serious - Major injury or impairment in which the patient's function is altered requiring outside medical intervention. For example: Sexual misconduct with oral, sexual, or digital penetration. e. In the event that law enforcement is involved, the facility Risk Manager or Designee must notify the Chief Compliance Officer and Chief Risk Office. 2. Review of the hospital's incident reports, and investigation summary revealed that on 12/24/22 an Activities Therapist (AT) (Staff #1506) was going throughout the unit to each room to encourage the patients to attend her 9:15 AM group activity. The AT knocked on the closed door of Patient #1501, a 38-year-old male, who was admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder. When the staff member entered the room, Patient #1501 looked at the AT and placed his finger to his lips, symbolizing the request to "shhh - be quiet." In Patient #1501's room, the AT also found Patient #1502, a 49-year-old female, who was admitted involuntarily for grave disability on	L 325		

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L 325	Continued From page 13 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). The AT observed that Patient #1502 was laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. 3. On the Activity Therapy Group Progress Note dated 12/24/22 at 3:00 PM, the AT documented that while reminding the patients of the upcoming 9:15 AM group, Patient #1501 was found on top of a female patient (Patient #1502) in his room, on his bed where "it appeared like they were having sexual intercourse." Staff #1506 requested assistance from a Mental Health Technician (MHT) (Staff #1514) who separated the patients and told the patients to stop. Staff #1514 escorted Patient #1502 back to her room. 4. On 01/13/23 at 12:40 PM, during an interview with Investigator #15, the Risk Manager (Staff #1506) stated that the incident that happened on 12/24/22 was not discovered by the hospital until several days later on the evening of 12/27/22. Staff #1506 was apprised of the incident by the Chief Executive Officer (CEO) (Staff #1510) when he came to work the morning of 12/28/22. Staff #1506 stated that the protocol for sexual activity was initiated and followed. Per protocol, Staff #1506 stated he notified local law enforcement (Tukwila Police Department). The Risk Manager reported that the Tukwila Police Department declined to investigate as there was no evidence of misconduct. 5. On 01/13/23 at 4:20 PM, during an interview with Investigator #15, the Chief Executive Officer (Staff #1510) stated that the Risk Manager (Staff #1506) started the investigation process on	L 325		

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L 325	Continued From page 14 Wednesday, 12/28/22. Staff #1510 stated that the hospital notified the Tukwila Police Department, however the police "stated that it appeared to be consensual and they declined to come out" to take a report. 6. On 02/02/23, Investigator #15 contacted the Tukwila Police Department (TPD) to obtain a record of the incident report for the 12/24/22 incident. A TPD staff member in the Records Division reviewed the call record for all calls initiated by the hospital between 12/27/22 to 12/29/22. The TPD records showed that on 12/29/22 the hospital called to report an incident of possible sexual activity between patients. However, the TPD staff member reported that their officers made several attempts to contact the hospital and left messages, attempting to initiate a police report. The hospital did not return the calls and no police report was initiated. The TPD staff member stated that the hospitals' claim that the police department declined to take a police report was inaccurate. 7. Review of the incident reports, the investigation report, staff interviews, and information obtained from the TPD showed that no police report was initiated for the incident on 12/24/22. Additionally, the investigator found that staff failed to document, or report contact from the PTD in response to the call on 12/29/22, requesting a police report. The Investigator found that the reports from the hospital staff and TPD to be inconsistent and incongruent making it difficult to determine the reason for not filing a police report.	L 325		

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L 355	Continued From page 15	L 355		
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: . Item #1 - Staff Actions - Immediate Interventions After Incidents/Allegations Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure the immediate investigation of an adverse incident of sexual assault, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1502). Failure to ensure that incidents and allegation of sexual assault are responded to immediately and investigated places patients at risk for similar occurrences, barriers to patient safety, and violates patient rights. Findings included: 1. Document review of the hospital's policy and	L 355		

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L 355	Continued From page 16 procedure titled, "Sexual Activity Among Patients Policy," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. When sexual activity between patients does occur, the following protocol should be followed: i. Upon report or discovery of an allegation of sexual familiarity between clients immediately separate the alleged patients to maintain safety. ii. Complete an incident report and forward the report to Risk Management within 24 hours. b. In response to the incident, the investigation will include: i. Any allegations of sexual familiarity are investigated for reasons including, most importantly, patient rights. Investigations are conducted to assure safety, find causes, and to prevent similar occurrences. ii. The Patient Advocate and the Risk Manager will conduct independent investigations. Document review of the hospital's document titled, "Sexual Assault Allegation Checklist," no policy number, no date, showed the following: a. Make sure patient is safe and in a safe environment. b. The staff member first learning of the suspected or actual witnessed sexual activity between patients is to immediately report this to: Attending Physician, Charge Nurse House Supervisor, Director of Nursing, and Administrator on Call.	L 355		

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L 355	Continued From page 17 c. Take physicians orders, if needed. d. Staff must fill out an incident report. e. Get Witness Statements from Staff and Patients. f. Make a detailed progress note on the incident in the patient's medical record, documenting patient care, allegations of sexual familiarity, the staff's response to the allegations and how the safety of the client was maintained. g. Documentation of notification to physicians, parents, and guardians. h. Update Observation Precautions on patient, if applicable with Sexual Acting Out (SAO) and/or Sexual Victimization (SXV). Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed that the Shift Supervisor or Facility Designated Individual will conduct a preliminary incident review. The Facility Risk Manager will investigate and/or will document the incident under Level I (Tragic-Incidents which are considered sentinel) or II (Serious-Major injury or impairment in which the patient's function is altered requiring outside medical intervention). 2. Review of the hospital's incident reports, and investigation summary revealed that on 12/24/22 at approximately 9:00 AM an Activity Therapist (Staff #1506) entered a male patient's room and found two patients (Patient #1501 and #1502) that appeared to be "having sexual intercourse." Staff observed that Patient #1502 was laying on	L 355		

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L 355	Continued From page 18 her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. Staff #1506 requested assistance from a Mental Health Technician (MHT) (Staff #1514) who separated the patients and told the patients to stop. Staff #1514 escorted Patient #1502 back to her room. 3. Review of the medical record found that Patient #1501 was a 38-year-old male, admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder. During the initial psychiatric evaluation, Patient #1501 was disorganized, grandiose, and delusional and appeared agitated, yelling, screaming, and acting erratically. 4. Review of the medical record found that Patient #1502 was a 49-year-old female, admitted involuntarily for grave disability on 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). 5. The Investigator's review of the medical records for Patient #1501 and #1502 showed that the hospital failed to respond to the incident on 12/24/22 and initiate an investigation or implement interventions to ensure the safety of the patients until 12/28/22, three and a half days after the incident occurred. 6. On 01/13/23 at 12:15 PM, during an interview with Investigator #15, the Activity Therapist (AT) (Staff #1506) stated that after observing the incident on the morning of 12/24/22, she didn't know what to do. She was a new staff member and had started less that 3 weeks prior. After the patient's were separated, Staff #1506 left to conduct her scheduled groups. After the groups	L 355		

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L 355	Continued From page 19	L 355		

were finished for the day, Staff #1506 spoke with the Lead AT (Staff #1508) about the incident that was observed earlier that morning. Staff #1504 documented the incident on the Activity Therapy Group Progress Note, dated 12/24/22 at 3:00 PM, and placed the notes in both Patient's medical records. Staff #1506 stated that after the incident, Patient #1501 was transferred to another unit. Staff #1506 reported that she thought that Staff #1508 notified their manager about the incident. She was unsure if the MHT (Staff #1514) told anyone about what had happened. Staff #1506 verified that in addition to herself, the Lead AT (Staff #1508), and the MHT (Staff #1514) were aware of the incident.

7. On 01/13/23 at 3:50 PM, during an interview with Investigator #15, The Lead Activity Therapist (AT) (Staff #1508) stated that Staff #1506 had notified her of the incident of sexual activity that was observed between Patient #1501 and #1502 on 12/24/22. Staff #1508 stated that at approximately 5:30 PM on 12/24/22, she was filing her Progress Notes for the day on 3 North when she noticed that Patient #1501 had been transferred from 2 West to their unit. Staff #1508 spoke to the two Registered Nurses (RN) in the nurses' station, telling them about the incident that had happened earlier that day on 2 West when Patient #1501 sexually assaulted Patient #1502.

8. This Investigator made several requests to the hospital (between 01/13/22 to 02/06/22) to interview the two RNs from 3 North that were working the evening shift on 12/24/22 to confirm that they were aware of the incident that happened earlier that day, but neither RN was available for interviews.

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L 355	Continued From page 20 9. On 12/24/22 at 5:00 PM, the House Supervisor (Staff #1512) took a verbal order from the Chief Executive Officer (CEO) (Staff #1510) to transfer Patient #1501 from 2 West to 3 North. 10. On 01/13/23 at 4:22 PM, during an interview with Investigator #15, the Chief Executive Officer (CEO) (Staff #1510) stated that he was not aware of the incident that occurred on 12/24/22 between Patient #1501 and #1502, until he received a call on 12/27/22 at 9:00 AM. Staff #1510 state that the House Supervisor notified him that during the daily auditing process, someone on the leadership team had discovered the Activity Therapy Group Progress Note dated 12/24/22 in Patient #1502's medical record detailing the sexual assault incident. Additionally, Staff #1510 stated that the order that he had given to the House Supervisor on 12/24/22 at 5:00 PM to transfer Patient #1501 to a different unit, was an administrative order. The hospital had seen a lot of male admissions recently and they were attempting to open a potential bed for a female patient on 2 West. 11. On 02/02/23 at 1:20 PM, during an interview with Investigator #15, the House Supervisor (Staff #1503) stated that on 12/27/22 at approximately 7:00 PM, she received a phone call from the Attending Provider for Patient #1502. The provider reported that the hospital's Court Evaluator had been notified that Patient #1502's attorney discovered the AT progress note dated 12/24/22 when reviewing the medical record prior to the Patient's court date. The attorney requested information about the status of the investigation into the incident and the identity of the male peer involved. Staff #1503 stated that at 7:30 PM on 12/27/22, the investigation into the incident began. Staff #1503 first made sure that	L 355		

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L 355	Continued From page 21 Patient #1502 was safe and assessed the patient, documenting her findings. Staff #1503 then notified the CEO (Staff #1510), the Acting Director of Nursing, and the Risk Manager (Staff #1505) and began to interview staff who worked on 2 West on 12/24/22. 12. On 01/30/23 at 4:45 PM, during an interview with Investigator #15, with the Director of Corporate Compliance (Staff #1524) and the Chief Executive Officer (CEO) (Staff #1510), the CEO stated that he had misspoke during our earlier interview on 01/13/23. He did not receive notification of the incident in the morning on 12/27/22, but rather in the evening at approximately 7:30 PM when the House Supervisor (Staff #1503) called him to tell him what had happened. The investigation did not begin until the evening of 12/27/22 once the hospital was aware of the incident. Staff #1510 stated that prior to that, no one had knowledge of the incident except the AT's. 13. The interviews conducted with staff regarding this incident provided conflicting and incongruent information. Requests to interview additional staff with potential direct knowledge of this incident was not successful. This Investigator's review of the medical records for Patients #1501 and #1502, review of the investigation documents, and interviews with staff found that hospital staff failed to immediately respond to the observed incident of sexual activity that occurred at approximately 9:00 AM on 12/24/22. The hospital staff initiated the investigation into the incident on 12/27/22 at approximately 7:30 PM, three and a half days afterwards. Item #2 - Staff Actions - Notifications	L 355		

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L 355	Continued From page 22 Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff provided the required notifications, such as physicians/providers or appointed guardians, after adverse events and incidents of sexual assault, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1502). Failure to provide the required notifications after incidents of sexual assault may create barriers or delays for needed interventions and violate the patient's rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients Policy," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. All sexual interactions between patients and/or staff at the hospital is prohibited to ensure as safe an environment as possible. b. When sexual activity between patients does occur, the following protocol should be followed for reporting the incident: i. Attending physicians are contacted and notified of the allegation and pending investigation. ii. Most circumstances of sexual familiarity involving minors, or patients with legal guardians will need to be reported to the parents or legal guardians of those clients involved. Parents or guardians shall be notified of the allegation by the Charge Nurse or Supervisor. c. Notification of the incident should include: the	L 355		

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L 355	Continued From page 23 attending psychiatrist and the guardian/parents, as applicable. Document review of the hospital's document titled, "Sexual Assault Allegation Checklist," no policy number, no date, showed that the staff member first learning of the suspected or actual witnessed sexual activity between patients is to immediately report this to: a. Attending Physician b. Charge Nurse House Supervisor c. Director of Nursing d. Administrator on Call Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed the following: a. An "incident" is an unanticipated event which was not consistent with the standard of care that results in, or nearly causes, a negative impact on a patient(s) receiving care at the facility. Any harm caused can be temporary, long-term, or permanent, and range in severity from "no obvious or significant injury up to death." b. Incidents of Sexual Allegations include Patient to Patient Sexual Intercourse - Any allegation of sexual intercourse/contact between patients. c. Severity Classifications include Level II Serious - Major injury or impairment in which the patient's function is altered requiring outside medical intervention. For example: Sexual misconduct with oral, sexual, or digital penetration.	L 355		

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L 355	Continued From page 24 2. Review of the hospital's incident reports, and investigation summary revealed that on 12/24/22 at approximately 9:00 AM a staff member entered a male patient's room and found two patients (Patient #1501 and #1502) that appeared to be "having sexual intercourse." Staff observed that Patient #1502 was laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. The incident reports for the incident that occurred on 12/24/22 classified the incident as "Sexual Allegations include Patient to Patient Sexual Intercourse" and rated the incident as a Level II (Serious) Severity Classification. 3. Patient #1501, a 38-year-old male, was admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder. During the initial psychiatric evaluation, Patient #1501 was disorganized, grandiose, and delusional and appeared agitated, yelling, screaming, and acting erratically. 4. Patient #1502, a 49-year-old female, was admitted involuntarily for grave disability on 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). On the Intake Assessment dated 11/21/22, staff documented that Patient #1502 had a court appointed guardian ad litem (GAL) (individual appointed by the court to represent the best interest of the child or incapacitated person). Review of the Psychiatric Progress notes of the days leading up to the incident on 12/24/22, showed that the providers documented that	L 355		

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L 355	Continued From page 25 Patient #1502 was "disorganized when she talks and gravely disabled" and "mute, staring blankly ahead and urinating and defecating on herself." 5. Review of the Attending Psychiatric Provider's Daily Progress Notes (between 12/24/22 to 12/30/22) and Daily Nursing Assessment and Reassessment Notes (between 12/24/22 to 12/30/22) for Patient #1501 found that staff failed to document the notification of the Patient's Attending Provider of the sexual assault incident that occurred on 12/24/22. 6. Review of Attending Psychiatric Provider's Daily Progress Notes (between 12/24/22 to 12/30/22) and Daily Nursing Assessment and Reassessment Notes (between 12/24/22 to 12/30/22) for Patient #1502 found that staff failed to document the notification of the Patient's Attending Provider of the sexual assault incident that occurred on 12/24/22. On the Psychiatric Progress Note dated 12/28/22, the provider documented that she was made aware of the event that had occurred several days earlier. 7. Review of Patient #1502's medical record found that staff failed to document notification of the Patient's legal representative (GAL) after the sexual assault incident on 12/24/22, as directed by hospital policy. 8. On 01/17/23 at 12:10 PM, during an interview with Investigator #15, the Director of Clinical Services (Staff #1516) reported that the Chief Medical Officer directed staff to contact Patient #1502's family to notify them of the incident that took place on 12/24/22. Staff #1516 was not involved in the notification of the Patient's GAL. 9. On 01/13/23 at 10:10 AM, during an interview	L 355		

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L 355	Continued From page 26 with Investigator #15, the House Supervisor (Staff #1503) stated that she was made aware of the incident at approximately 7:00 PM on 12/27/22 when the Patient's Provider contacted her. Staff #1503 reported that the Attending Provider gave a verbal order to move Patient #1502 to a different unit and place her on Sexual Victimization (SVP) Precautions. The male patient involved had not been identified at that time. 10. On 01/31/23 at 11:15 AM, during an interview with Investigator #15, the Attending Psychiatric Provider (Staff #1525) for Patient #1501 reported that he had taken over the care of the Patient on 12/26/22. The previous provider did not report to him any sexual assault incidents or concerns for Patient #1501. Staff #1525 stated that he did not know the details of the event and review of the previous provider's progress notes did not reference the incident. Staff #1525 stated that typically they (the Attending Providers) would be notified if their patients were involved in an incident, such as the incident on 12/24/22, or if there was a request to move their patient to a different floor or unit. 11. On 01/31/23 at 1:20 PM, during an interview with Investigator #15, the House Supervisor (Staff #1503) stated that she was made aware of the incident at approximately 7:00 PM on 12/27/22 when the Patient's Provider contacted her. Staff #1503 reported that the Attending Provider gave a verbal order to move Patient #1502 to a different unit and place her on Sexual Victimization (SVP) Precautions. The male patient involved had not been identified at that time. Item #3 - Staff Actions - Obtain Orders for Interventions Post Sexual Activity Between	L 355		

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L 355	Continued From page 27 Patients Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff responding to an incident of sexual activity between patients by contacting the provider to obtain orders for an evaluation, a medical hospital visit, Sexually Transmitted Disease (STD)/Sexually Transmitted Infections (STI) testing, and Human Immunodeficiency Virus (HIV) testing, as demonstrated by 1 of 2 records reviewed (Patient #1501). Failure to ensure that staff responds consistently and appropriately with interventions specific to incidents of sexual activity between patients, may create barriers or delays for needed interventions and violate the patient's rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients Policy," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. When sexual activity between patients does occur, the following protocol should be followed for reporting the incident: i. Separate the patients. i. Attending physicians are contacted and notified of the allegation and pending investigation. ii. Speak with the physician to obtain orders related to an evaluation which may include an Emergency Room (ER) visit, rape kit, STD/STI testing, Human Immunodeficiency Virus (HIV)	L 355		

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L 355	Continued From page 28 testing, and pregnancy testing. Patient #1501 2. Patient #1501 a 38-year-old male, was admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder. During the initial psychiatric evaluation, Patient #1501 was disorganized, grandiose, and delusional and appeared agitated, yelling, screaming, and acting erratically. 3. On 12/24/22 at approximately 9:00 AM a staff member entered a male patient's room and found two patients (Patient #1501 and #1502) that appeared to be "having sexual intercourse." Staff observed that Patient #1502 was laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. The incident reports for the incident that occurred on 12/24/22 classified the incident as "Sexual Allegations include Patient to Patient Sexual Intercourse" and rated the incident as a Level II (Serious) Severity Classification. 4. Review of Patient #1501's medical record (between 12/24/22 to 01/13/23 found that nursing staff failed to document the provider notification of the incident. 5. Review of the provider orders and Medication Administration Record (MAR) (between 12/24/22 to 01/13/23) found that staff failed to obtain a provider order for any of the recommended interventions after incidents of sexual activity between patients, including a medical evaluation, an Emergency Room (ER) visit, STD testing, and Human Immunodeficiency Virus (HIV) testing.	L 355		

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L 355	Continued From page 29 6. On 01/23/23 at 4:05 PM, during an interview with Investigator #15, the Attending Psychiatric Provider (Staff #1519) for Patient #1502 reported that after learning about the sexual assault that occurred on 12/24/22, an order was written to transfer the Patient to the ER so that a Rape Kit can be obtained, including any STD and HIV testing. The Patient declined to be transported to the ER but did agree to an STI test. 7. On 01/31/23 at 11:15 AM, during an interview with Investigator #15, the Attending Psychiatric Provider (Staff #1525) for Patient #1501 reported that he had taken over the care of the Patient on 12/26/22. The previous provider did not report to him any sexual assault incidents or concerns for Patient #1501. Staff #1525 stated that the review of the previous provider's progress notes did not reference the incident that occurred on 12/24/22. Staff #1525 stated that typically they (the Attending Providers) would be notified if their patients were involved in an incident, or if there were any pending test results related to the sexual assault incident.	L 355		
	Item #4 - Staff Actions - Incident Reports for Sexually Inappropriate Behavior Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff completed an incident report after the observations of a patient's sexually inappropriate behavior, as demonstrated by 2 of 2 records reviewed (Patient #1503 and #1505). Failure to ensure that staff initiates an incident report after observed incidents of sexually			

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L 355	Continued From page 30 inappropriate behaviors places patients at risk for similar or escalating behaviors and limits the hospital's ability to manage risk and increase safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Safety Precautions Policy," policy number PC.SSP.101, last reviewed 08/21, showed the following: a. Sexual safety precautions are part of our strategy to plan, coordinate, monitor, and respond to breaches of sexual safety. b. Staff will assess patients at admission and throughout hospitalization for indicators of sexual vulnerability and sexual violence towards others. Registered Nurse (RN) will assess and institute the appropriate precautions and interventions. c. Definition - Sexual disinhibition: Poorly controlled behavior of a sexual nature where sexual thoughts, impulses, or needs are expressed in a direct or disinhibited way. Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed the following: a. The Incident Management Tool is a risk management tool that raises awareness of potential exposure to perils that may/did cause harm. b. The Incident Management Tool enables the facility to manage risk, increase safety, and improve the quality of healthcare provided in the	L 355		

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L 355	Continued From page 31 facility. c. An incident is an unanticipated event which was not consistent with the standard of care and/or operation of the facility and may have occurred due to a violation of policy and procedure. d. Any facility staff member who witnesses, discovers, or has direct knowledge of an incident must complete an Incident Report before the end of the shift/work day. e. Types of incidents include: i. Misconduct/Body Exposure - Patient to Patient: Any allegation of deliberate action where a patient's genitals were exposed or touched by another patient. ii. Misconduct/Body Exposure - Patient to Staff: Any allegation of deliberate action where genitals were exposed or touched between patient and staff. Document review of the hospital's training presentation titled, "Incident Reporting," dated 03/21, showed the following: a. Incident reporting is the cornerstone of a healthcare risk management program and it begins when recognizing that an incident has occurred. b. An incident is usually unintended or unexpected. c. Can interrupt the care of patient(s) and be disruptive to the milieu.	L 355		

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L 355	Continued From page 32 d. Results in, or nearly causes, a negative impact on a patient(s) receiving care at the facility. e. Employees are expected to complete an Incident Report (IR) when they become aware an incident has occurred. Failure to complete an IR could result in disciplinary action, up to and including termination. 2. Review of the hospital's incident reports from 10/01/22 to 01/13/23 showed only one incident that occurred on 12/24/22 when staff entered Patient #1502's room and observed the two patients engaging in what appeared to be "sexual intercourse." Staff observed that Patient #1502 was laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. There were two IR's entered for this incident, one was entered on 12/27/22 at 9:00 PM, and the other was entered on 12/28/22 at 12:45 PM. The requested log of incident reports contained no other incidents of sexual activity or sexually inappropriate behavior, as defined by hospital policy. 3. During the investigation, this Investigator reviewed the medical records for three patients with Sexual Acting Out (SAO) precautions, currently admitted to 2 West. 4. The medical record review for Patient #1503 showed the following: a. Patient #1503 a 36-year-old male, was admitted involuntarily on 12/06/22, with a psychiatric diagnosis of Schizoaffective Disorder. On the admission order, dated 12/06/22, the psychiatric provider placed Patient #1503 on Sexual Acting Out precautions and observations	L 355		

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L 355	Continued From page 33 every 5 minutes. b. On the Psychiatric Evaluation dated 12/07/22, the provider documented that the Patient was psychotic, agitated, and exposing himself to staff. c. On 12/09/22, the psychiatric provider wrote an order to discontinue observations every 5 minutes and placed the Patient on one-to-one (1:1) observations with male staff due to poor boundaries. The Patient remained on 1:1 observations until 12/17/22. d. Review of the Nursing Reassessment Daily Progress Note showed the following: i. 12/07/22 - Nursing staff documented Patient sexually inappropriate. Patient #1503 pulled his pants down and asked staff "do you know what it is?" ii. 12/08/22 and 12/09/22 - Nursing staff documented "poor boundaries, requires constant redirection." iii. 12/10/22 - Nursing staff documented that Patient #1503 was sexually inappropriate and required constant redirection. The Patient put his hands down his pants. Patient displaying Sexually Acting Out behaviors, coming up behind female staff. iv. 12/11/22 - Nursing staff documented that the Patient was sexually inappropriate with poor boundaries. Patient #1503 pulled down his pants while standing in the hallway. Required constant redirection. e. On Psychiatric Progress Note dated 12/09/22, the provider documented that the Patient has	L 355		

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L 355	Continued From page 34 been exposing himself to staff. Asking what they think of his penis. f. The Investigator's review of the Patient's medical record and review of the incident report log found that staff failed to initiate an incident report for the sexually inappropriate behaviors exhibited by Patient #1503. 5. The medical record review for Patient #1505 showed the following: a. Patient #1505 a 19-year-old female, was admitted involuntarily on 11/02/22, with a psychiatric diagnosis of Schizophrenia. On the admission order, dated 11/02/22, the psychiatric provider placed Patient #1505 on Assault precautions and observations every 15 minutes. b. On the Psychiatric Evaluation dated 11/03/22, the provider documented that the Patient had a history of running around their home naked. The provider placed the Patient on SAO precautions. c. On 11/03/22, the psychiatric provider wrote an order to place the Patient on observations every 5 minutes. On 11/10/22, the psychiatric provider discontinued observations every 5 minutes and placed the Patient on 1:1 observation for poor boundaries and intrusive behaviors. d. Review of the Nursing Reassessment Daily Progress Note showed the following: i. 11/11/22 - Nursing staff documented that the Patient continues to wander into male patients' room and expose her body. ii. 11/24/22 - Nursing staff documented that the Patient exhibited flirtatious behaviors towards	L 355		

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L 355	Continued From page 35 male staff. Patient walked out of bedroom, naked, talking to herself. iii. 11/25/22 - Nursing staff documented that Patient #1505 had poor boundaries with male peer and attempted to hug male peer. iv. 12/06/22 - Nursing staff documented that the Patient disrobed in the milieu during the evening shift. v. 01/07/23 - Nursing staff documented Patient walking in hallway, attempted to remove her clothing. e. On Psychiatric Progress Note dated 12/19/22, the provider documented that the Patient had been observed naked in the hallway. f. The Investigator's review of the Patient's medical record and review of the incident report log found that staff failed to initiate an incident report for the sexually inappropriate behaviors exhibited by Patient #1505. 6. On 01/13/23 at 12:05 PM, during an interview with Investigator #15, the Clinical Educator (Staff #1526) stated that Patient #1503 and #1505 did not have incident reports related to the sexually inappropriate behaviors exhibited during their admissions. Staff #1526 stated that all staff are trained using the Incident Reporting PowerPoint presentation and each class includes a discussion of the examples of "types of incidents" that are reportable. Staff #1526 stated that the patient's exposure of their body, including genitals would require an incident report to be initiated. 7. On 01/13/23 at 4:40 PM, during an interview with Investigator #15, the Chief Executive Officer	L 355		

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L 355	Continued From page 36 (CEO) (Staff #1510) reported that the hospital has had very few incidents of patients who exhibited sexually acting out behaviors requiring an incident report. Staff #1510 stated that the last incident (prior to the incident on 12/24/22) was an incident in September or October. 8. On 01/26/23 at 1:25 PM, during an interview with Investigator #15, the Risk Manager (Staff #1505) stated that any incident where a patient exposes themselves and/or genitals is considered a reportable event and an incident report should be initiated. Staff #1505 verified that staff failed to initiate an IRs for Patient #1503 and #1505 .	L 355		
L 585	322-050.6i ORIENTATION-APPROP TRAINING WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (i) Appropriate training for expected duties This Washington Administrative Code is not met as evidenced by: . Based on interview, personnel record review, and review of hospital policies and procedures, the hospital failed to ensure that all staff received appropriate discipline specific training for their expected duties when responding to incidents of sexually inappropriate behavior and/or sexual allegations/assaults, as demonstrated by 4 of 5 personnel records reviewed (Staff 1506, #1514, #1520, and #1526).	L 585		

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L 585	Continued From page 37 Failure to ensure that staff are provided the appropriate discipline specific training to respond to incidents of sexually inappropriate behaviors and/or sexual assaults, places barriers to providing patient care in a safe environment and puts the patients at an increased risk of harm, including adverse and/or sentinel events. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients Policy," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. All sexual interactions between patients and/or staff at the hospital is prohibited to ensure as safe an environment as possible. b. When sexual activity between patients does occur, the following protocol should be followed for reporting the incident: i. Immediately separate the alleged patients to maintain safety. ii. Complete an incident report. iii. Contact the physician for orders. c. Investigation - Any allegation of sexual familiarity are investigated for reasons including, most importantly, the protection of patient rights. In addition, the investigations are conducted to assure safety, to find causes, and to prevent similar occurrences. d. The Patient Advocate and the Risk Manager will conduct independent investigations.	L 585		

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L 585	Continued From page 38 e. Notifications include: i. Risk Manager ii. Patient Advocate Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed the following: a. An "incident" is an unanticipated event which was not consistent with the standard of care that results in, or nearly causes, a negative impact on a patient(s) receiving care at the facility. Any harm caused can be temporary, long-term, or permanent, and range in severity from "no obvious or significant injury up to death." b. Incidents of Sexual Allegations include Patient to Patient Sexual Intercourse - Any allegation of sexual intercourse/contact between patients. c. Severity Classifications include Level II Serious - Major injury or impairment in which the patient's function is altered requiring outside medical intervention. For example: Sexual misconduct with oral, sexual, or digital penetration. d. Any facility staff member who witnesses, discovers, or has direct knowledge of an incident, must complete an incident report before the end of the shift/day. e. All staff must be trained in the importance of incident reporting required under our facility Risk Management Program. Document review of the hospital's policy and	L 585		

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L 585	Continued From page 39 procedure titled, "Training and Development," policy number HR.172, effective date 09/01/15, showed the following: a. New Employee Orientation topics failed to include identifying and implementing interventions to respond to incidents of sexually inappropriate behaviors and incidents of sexual assault or sexual allegations. b. Department Orientation should include a review of the functional role of the employee. c. It is appropriate to provide a preceptor to help the new employee to complete a residency checklist which both will sign. d. Inservice and Mandatory meetings will be ongoing and may address the following situations: i. To emphasis specific job-related aspects of safety. ii. To reinforce the need and ways to report unanticipated adverse events. Document review of the hospital's "Sexual Allegation Packet," not dated, found the following documents: a. Sexual Assault Allegation Checklist (To be returned to Supervisor with folder) b. Sexual Acting Out (SAO) and Sexual Victimization (SVP) Risk Assessment c. Nursing Progress Notes documenting Behavior (B), Intervention (I), Response (R), Plan (P) d. Witness Statements	L 585		

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L 585	Continued From page 40 e. Incident Report Form Document review of the hospital's education document titled, "Incident Reporting," last updated 03/21, found that the training addressed requirements for Incident Reporting. The training did not contain guidelines or specific interventions for staff when responding to incidents of sexual assaults/allegations. The training failed to define specific events which would require staff to initiate an Incident Report, other than was the incident unintended or unexpected or a distinct occurrence that could interrupt the care of the patient. 2. Review of the hospital's incident reports, and investigation summary revealed that on 12/24/22 at approximately 9:00 AM a staff member entered a male patient's room and found two patients (Patient #1501 and #1502) that appeared to be "having sexual intercourse." Staff observed that Patient #1502 was laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. a. The incident reports for the event that occurred on 12/24/22 classified the incident as "Sexual Allegations include Patient to Patient Sexual Intercourse" and rated the incident as a Level II (Serious) Severity Classification. b. Review of the patient's medical records and incident report logs found that staff failed to initiate an investigation or complete an incident report until 12/28/22 (four days after the incident on 12/24/22). c. The Investigator's review of the medical	L 585		

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L 585	Continued From page 41 records and the incident investigation report found that staff failed to initiate an independent investigation (separate from the Risk Manager's investigation), to be performed by the Patient Advocate, as directed by hospital policy. 3. Over the course of the investigation (01/13/23 through 02/02/23), the Investigator requested the hospital's policies and procedures and training curriculum that directed staff in their response to incidents or allegations of sexual assault. The hospital failed to provide this Investigator with additional documents to provide staff with guidance in their response and interventions, other than what is noted above. 4. On 01/13/23 at 12:15 PM, during an Interview with Investigator #15, the Activity Therapist (AT) (Staff #1506) stated that she had recently been hired by the hospital a few weeks ago, in early December. Staff #1506 reported that on 12/24/22, before the 9:15 AM group activity, she discovered Patient #1502 lying on her back on the bed and Patient #1502 was kneeling on the bed above her between her legs, with one of Patient #1502's legs raised. The AT stated that she yelled at the patients and requested assistance from the Mental Health Technician (MHT) (Staff #1514). The two staff members separated the patients and Staff #1514 escorted Patient #1502 back to her room. Staff #1506 reported that she then proceeded to conduct her activity groups assigned for the day. Staff #1506 stated that she was a new employee and didn't know what to do about the incident, so she reported the incident to the AT Lead (Staff #1508) at the end of her shift, who assisted her in documenting the incident on a progress note for each patient, without revealing the other patient's identify, and placing them in the medical record. No incident report	L 585		

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L 585	Continued From page 42 was initiated by staff on 12/24/22. 5. On 01/17/23 at 1:00 PM, during an interview with Investigator #15, the MHT (Staff #1514) stated that the AT (Staff #1506) called out for help in Patient #1501's room. The MHT reported that when she entered the room, Patient #1501 was on the bed and Patient #1502 was standing by the window. Staff #1514 stated that Patient #1501 told staff that "he didn't do anything." Staff #1514 took Patient #1502 back to her room. The MHT reported to the Registered Nurse (RN) that Patient #1502 was confused and found in Patient #1501's room. Staff #1514 stated that the RN placed Patient #1502 on increased observations (every 5 minutes, instead of every 15 minutes). Review of the Patients medical record found that nursing staff failed to change the Patient's level of observations or document a report from the MHT that the Patient was confused. Staff #1514 stated that Patient #1501 was transferred to a different unit (3 North) during the next shift (after 3:30 PM). Staff #1514 stated if an incident of sexual assault does happen, they are supposed to do an incident report. The MHT reported that she couldn't remember any training on how to respond to incidents of sexual assault, but every policy is in the computer, and they do have other training on HealthStream (electronic training system). No incident report was initiated by staff on 12/24/22. 6. On 01/13/23 at 3:55 PM, during an interview with Investigator #15, the Lead AT (Staff #1508) stated that Staff #1506 reported the incident that occurred earlier in the day (12/24/22) at approximately 3:30 PM. Staff #1508 assisted Staff #1508 in figuring out which patient were involved, and with how to document the incident on the group activity group progress notes. Staff	L 585		

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L 585	Continued From page 43 #1508 noted that she was not aware if any of the nursing staff on 2 West (where the incident occurred) knew about the incident. At approximately 5:15 PM, Staff #1508 was on 3 North, to place her progress notes for each of the patients on that unit in their medical records. Staff #1508 noticed that Patient #1501 had been transferred up to 3 North. Staff #1508 reported that she asked two RN's standing in the nurses station if they were aware of the sexual assault incident earlier that day between Patient #1501 and a female patient on 2 West. Staff #1508 stated that the one of the nurses on 3 North did not know about the incident that happened earlier in the day. No incident report was initiated by nursing staff on 3 North. Staff #1508 stated that now she knows to tell everyone about any incidents, not just the nursing staff, who failed to initiate a report. 7. On 01/26/23 at 4:05 PM, during an interview with Investigator #15, the Chief Nursing Officer (CNO) (Staff # 1523) stated that the hospital did not do any training or re-education after the incident on 12/24/22. The Clinical Educator did review Sexual Acting Out (SAO) precautions during their annual training faire in July 2022. Staff #1523 stated that she was not aware that other staff knew about the incident on 12/24/22 and did not complete an incident report. Any training that the staff have received, including the attestations should be in their personnel files. The CNO stated that she was not sure about any training that the MHTs receive but did know that they are supposed to notify the nurses of the event and the nurses are responsible for initiating an incident report. 8. On 01/24/23 at 4:45 PM, during an interview with Investigator #15, the Patient Advocate (Staff	L 585		

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L 585	Continued From page 44 #1520) stated that she was on leave when the incident took place on 12/24/22 and returned on 12/29/22. Staff #1520 stated that the Risk Manager (Staff #1505) advised her of the investigation that was being conducted, however no detailed were shared with the Patient Advocate. Staff #1520 reported that since this was "such a high risk investigation they kept details to themselves" and she was not brought into the loop. Staff #1520 stated that she did not know the names of the patients involved or the unit where the incident took place until recently. Staff #1520 stated that when she was hired (July 2022) she completed New Employee Orientation (NEO) and then received role specific training from the previous Risk Manager, including training on how to handle grievances and complaints. Staff #1520 stated that she didn't need any additional training help and that there are many resources available, such as all the hospital's policies and procedures available electronically. The Investigator asked Staff #1520 if she was familiar with the hospital's Sexual Activity Among Patients policy that directs the Risk Manager and the Patient Advocate to conduct independent investigations after incidents of sexual activity between patients. Staff #1520 state she was not aware of that requirement. Staff #1520 stated that she does perform investigations when a patient's belongings are lost or misplaced. The Patient Advocate stated that it is possible due to the weight of the investigation, she was not included in the investigation process. 9. On 01/30/23 at 3:20 PM, Investigator #15 and the Human Resource (HR) Director (Staff #1526) reviewed 5 personnel files to verify the documentation for any training (including attestations of training) related to how to handle	L 585		

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L 585	Continued From page 45 incidents of sexually inappropriate behaviors, sexual allegations, or incidents of sexual intercourse or sexual assault. The review included the following disciplines: Patient Advocate, Registered Nurse, Activity Therapist, and Mental Health Technician. The review showed the following: a. Patient Advocate - Review of Staff #1520's training record found evidence of Role Specific Training, conducted on 07/25/22, however no evidence of training related to responding to incidents of sexual assault or allegations and no evidence of training related to the investigation requirements for adverse sexual events. b. Registered Nurse (RN) - Review of the training record for the RN (Staff #1526) found evidence of attendance at the Mandatory Meeting in July 2022. Staff #1526 verified that there was no evidence that the RN attended the December Job Fair and no evidence of training related to responding to incidents of sexual assault or allegations. c. Activity Therapist (AT) - Staff #1506 was hired on 12/05/22 and completed New Employee Orientation (NEO) and Clinical Orientation. Staff #1526 stated that the AT did attend the December Job Fair, however the attestation was not in the employees personnel file. Staff #1526 stated that that the attestation may be in a stack of documents waiting to be filed. Staff #1508 was hired on 03/07/22. Review of the AT's personnel file found no evidence that Staff #1508 attended the Mandatory Meeting in July. The HR Director verified that neither personnel file contained evidence of training specifically guiding staff on how to respond to incidents of sexual assault or sexual allegations.	L 585		

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L 585	Continued From page 46 d. Mental Health Technician (MHT) - Staff #1514 was re-hired on 06/10/21 when she changed status from per diem to full-time. The personnel file did not contain evidence documenting Staff #1514's attendance at NEO training, the Mandatory Meeting in July, or the Job Fair in December. Staff #1526 verified that the attestations were missing from the employee's personnel file. The HR Director stated that he will attempt to locate the missing training attestations. These documents were not provided to the Investigator prior to exiting the hospital. .	L 585		
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 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: . Item #1 - Inter Unit Transfer of Patients Based on interview, medical record review, and review of the hospital's policies and procedures,	L1105		

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L1105	Continued From page 47 the hospital failed to ensure that when a patient was transferred to a different unit within the hospital, nursing staff notified the attending or covering physician and obtained an order from the provider for transfer, as demonstrated by 1 of 2 records reviewed (Patient #1501). Failure to ensure that when a patient was transferred to a different unit within the hospital, the patient's attending or covering physician/provider is notified of the transfer and if inidcated, initiates an order for transfer, places the patient at risk for inappropriate or delayed treatment and creates barriers to the patient's continuity of care. Findings included: 1. Document review of the hospital's policy and procedure titled, "Inter Unit Transfer," policy number PC.IUT.101, last revised 09/21 showed that whenever a change in program or unit is indicated, the following procedure will be used: a. Obtain an order from the attending or covering physician. Document review of the hospital's policy and procedure titled, "Plan for Provision of Patient Care," policy number L.PPPC.100, last revised 10/21, showed that each attending psychiatrist is responsible for the medical management of the patient. Document review of the hospital's document titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," not dated, showed the following: a. The Practitioner participates in effective	L1105		

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L1105	Continued From page 48 hand-off communications, including up-to-date information regarding the patient's care, treatment, condition, and any recent or anticipated changes. b. Only Practitioners may write orders for the following: Admission to a program and transfers between programs, program levels and units. 2. Review of the medical record for Patient #1501, a 38-year-old-male with a psychiatric diagnosis of Schizoaffective disorder found that on 12/24/22 at 5:00 PM, the House Supervisor (Staff # 1512) obtained a verbal/telephone order from the Chief Executive Officer (CEO) (Staff #1510) to move the Patient from one unit to another unit. The CEO is a Registered Nurse (RN) and was the Administrator on Call (AOC) for the day. Staff #1512 noted that "per supervisor verbal order," Patient #1501 was to be transferred from 2 West Unit to 3 North Unit. The order was written and noted by a RN on 3 North on 12/24/22 at 5:00 PM. The Investigator's review of the medical records found that nursing staff failed to document communication with the Patient's Attending Physician to notify them of the patient's transfer. 3. On 01/17/23 at 1:05 PM, during an interview with Investigator #15, the House Supervisor (Staff #1512) stated that he received a call from a staff member in the Intake Department who reported that they had received a call from Emergency Medical Services (EMS) who was enroute to the hospital with a combative patient that may need to be immediately placed into seclusion. Staff #1512 stated that he walked to 2 West and spoke to the nurses on the unit, requesting the most appropriate patient to be transferred to 3	L1105		

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L1105	Continued From page 49 North to free up a male bed for the incoming patient. The House Supervisor reported that the nursing staff on 2 West suggested that Patient #1501 be transferred to 3 North. Staff #1512 stated he could not remember the names of the nurses that he had spoken to on 2 West, 3 North, or Intake. Staff #1512 reported that he called the CEO (Staff #1510) because he was unable to reach the provider on call. Staff #1512 stated he was unable to remember who the on-call provider was that evening, or the times that he attempted to contact the provider. The House Supervisor stated that the nursing staff on 3 North insisted that they write an administrative order to move the patient, since Staff #1512 was unable to reach the provider to obtain an order. 4. On 01/13/23 at 4:22 PM, during an interview with Investigator #15, the Chief Executive Officer (Staff #1510) stated that on 12/24/22 Patient #1501 was transferred. Staff #1510 reported that the hospital had seen a lot of male admissions, and they were trying to open up potential female beds on 2 West. Staff #1510 stated that he gave an "administrative order" to move Patient #1501. Staff #1510 stated that he called the House Supervisor (Staff #1512) to notify him of the transfer. Staff #1510 reported that it is typical for him to give administrative orders to transfer patients from one unit to another. The CEO stated that he was not familiar with the hospital's policy that required an order from the patient's Attending Physician to transfer to another unit within the hospital. 5. On 01/17/23 at 5:00 PM, during an interview with Investigator #15, the Director of Intake (Staff #1517) stated that "99% of the time" they don't	L1105		

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L1105	Continued From page 50 get phone calls from ambulances or EMS staff for admissions. The majority of the involuntary admissions are first medically cleared at the hospital. Staff #1517 was not familiar with a combative patient requiring seclusion upon admission during the weekend of 12/24/22. Staff #1517 stated that it did sound like a patient from last week, not Christmas week. 6. On 01/23/23 at 4:05 PM, during an interview with Investigator #15, the Psychiatric Provider (Staff #1519) stated that they were aware that the CEO has moved Patient #1501 on 12/24/22. Staff #1519 noted that this was not a typical order that the CEO would put in. Typically, staff will consult with the providers prior to transferring a patient, since the attending providers are most familiar with their patients. The provider stated that Patient #1501 was exhibiting delusional behaviors, and this would not be a typical patient selected to transfer to 3 North, that has a lower acuity level. Staff #1519 stated they had never seen the CEO write an order. 7. On 01/30/23 at 4:45 PM, during an interview with Investigator #15, the CEO (Staff #1510) stated that he did not have knowledge of the incident that occurred on the morning of 12/24/22 between Patient #1501 and Patient #1502. Staff #1510 reported that Patient #1501 was moved to free up beds and consolidate patients. Staff #1510 stated that he was not able to speak to the staff's attempts to reach the Patient's provider prior to the transfer. The CEO stated that they "do it routinely" and sometimes he is involved in this process to meet the needs of the Intake Department and admissions. This Investigator referenced the hospital's policy requiring a provider's order to move patients from unit to unit (Inter Unit Transfer). Staff #1510 was not familiar	L1105		

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L1105	Continued From page 51 with that policy and stated that they write administrative orders all the time. Staff #1510 was not aware of the hospital's policy requiring a provider/physician's notification and the initiation of a provider order for inter unit transfers. Item #2 - Nurse to Nurse Documentation when Transferring Patients Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that when nursing staff provided detailed critical patient information (Nurse to Nurse Report) and when transferring the care of a patient to another unit within the hospital, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1502). Failure to ensure that the hospital implemented a process detailing the exchange of relevant patient information when transferring the care of patients within the hospital, places the patient at risk for inappropriate or delayed treatment and may result in serious physical patient harm. Findings included: 1. Document review of the hospital's policy and procedure titled, "Inter Unit Transfer," policy number PC.IUT.101, last revised 09/21 showed that whenever a change in program or unit is indicated, the following procedure will include: a. Discuss transfer with patient and explain clinical rationale. b. Document transfer on a progress note which includes date, time, and method of transfer, condition of patient, and patient response to the	L1105		

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L1105	Continued From page 52 transfer. c. Assist in transferring the patient: Hand off communication provides for the opportunity for discussion between the giver and the receiver of patient information. d. Introduce patient to clinical staff on his/her new unit. e. Make new staff aware of patient's treatment plan during nurse to nurse report. 2. On 12/24/22 at 5:00 PM, an order was written to transfer Patient #1501, a 38-year-old-male with a psychiatric diagnosis of Schizoaffective disorder, from 2 West Unit to 3 North Unit. a. Review of the Nursing Assessment Progress Note dated 12/24/22 at 5:20 PM showed that the nursing staff on 2 West documented that the Patient was transferred to 3 North per supervisor request and report was given to receiving nurse. Nursing staff on 2 West failed to document the time, method of transfer, condition of patient, or patient's response to the transfer. b. Review of the Nursing Assessment Progress Note dated 12/24/22 showed that nursing staff on 3 North (receiving unit) failed to document the Patient's transfer or evidence of the nurse-to-nurse communication regarding the newly transferred patient. 3. On 12/27/22 at 6:50 PM, the psychiatric provider wrote an order to transfer Patient #1502, a 49-year-old-female with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking), from 2 West Unit to 3 North Unit.	L1105		

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	60429197	A. BUILDING: _____ B. WING _____	C 02/02/2023

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L1105	Continued From page 53 a. Review of the Nursing Assessment Progress Note dated 12/27/22 at 11:00 PM showed that the nursing staff on 3 North documented that the Patient was transferred from 2 West at 7:20 PM. Nursing staff on 3 North failed to document evidence of the nurse-to-nurse report, the method of transfer, condition of patient, or patient's response to the transfer. b. Review of the Nursing Assessment Progress Note dated 12/27/22 showed that nursing staff on 2 West (sending unit) failed to document the Patient's transfer or evidence of the nurse-to-nurse report, the date, time, and method of transfer, the condition of the patient, or the patient's response to the transfer. 4. On 12/28/22 at 10:55 AM, the psychiatric provider wrote an order to transfer Patient #1501 from 3 North Unit back to 2 West Unit. a. Review of the Nursing Assessment Progress Note dated 12/28/22 at 11:12 AM showed that the nursing staff on 3 North documented that the Patient was transferred to 2 West at 11:12 AM. Nursing staff on 3 North failed to document evidence of the nurse-to-nurse report, the method of transfer, condition of patient, or patient's response to the transfer. b. Review of the Nursing Assessment Progress Note dated 12/28/22 at 10:10 PM showed that nursing staff on 2 West (receiving unit) failed to document the Patient's transfer or evidence of the nurse-to-nurse report, the date, time, and method of transfer, the condition of the patient, or the patient's response to the transfer. 5. On 01/23/23 at 3:45 PM, during an interview	L1105		

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L1105	Continued From page 54 with Investigator #15, the Registered Nurse (RN) (Staff #1518) stated that she was working on 3 North on 12/24/22 (Day and Evening Shift). Staff #1518 stated that she did not remember any transfers to their unit that day. The RN reported that it had been a while and didn't remember. Staff #1518 stated that when a patient is transferred from another unit, the nurses will do a nurse to nurse report and the receiving nurse will do a whole new reassessment when the patient comes to the unit. 6. On 01/30/23 at 4:05 PM, during an interview with Investigator #15, the Chief Nursing Officer (CNO) (Staff #1523) stated that when a patient is transferred to a different unit, there should be communication between the nurses on each unit. The sending nurse will gather all of the patient's belongings and a report is given to the receiving nurse, that includes the patient's behaviors and response to the transfer. Staff #1523 verified that the medical records for Patient #1501 and #1502 failed to contain documentation of the transfers that took place on 12/24/22, 12/27/22, and 12/28/22. The CNO stated that the hospital did not do any staff education after the incident on 12/24/22, however this training was contained in the staff training in July 2022.	L1105		
L1665	322-260.2 ADVERSE HEALTH EVENTS The National Quality Forum identifies and defines twenty-nine serious reportable events (adverse health events) as updated and adopted in 2011. (2) Psychiatric hospitals must comply with the reporting requirements under chapter 246-302 WAC.	L1665		

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L1665	Continued From page 55 This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure compliance with reporting requirements that require the hospital to report adverse health events to the department within 48 hours of confirmation, as demonstrated by 2 of 2 records reviewed (Patient #1501 and #1502). Failure to report an adverse health event to the department may create barriers to identifying systemic areas of risk affecting overall patient safety and delay the implementation of performance improvement measures. Findings included: 1. Document review of the hospital's policy and procedure titled, "Sentinel and Adverse Events," policy number ADM.S.300, last revised 02/22, showed the following: a. This policy outlines the process to be followed in order to meet the Department of Health's (DOH) mandatory adverse event notification requirements and the Joint Commission of Accreditation of Healthcare Organization's (JCAHO) requirement for responding to a Sentinel Event. b. Definition of Sentinel or Adverse Event: An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. c. Adverse Events that are reportable to the	L1665		

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L1665	Continued From page 56 Washington State Department of Health include sexual assault on a patient within or on the grounds of the hospital. d. In the event it is believed that a reportable event has occurred, the Director of Risk Management will report the event to the Department of Health per regulations. The event will be reported using the internet reporting system within 48 hours of confirming an adverse event has occurred. A complete report is required within 45 days of the event and shall include findings of the root cause analysis. Document review of the hospital's policy and procedure titled, "Sexual Activity Among Patients," policy number PC.SAAP.120, last reviewed 08/22, showed the following: a. When sexual activity between patients does occur, the following protocol should include: i. Reporting of the Event ii. Some circumstances require administration to report the allegation to authorities. Administration will determine if any outside authorities are to be notified. If other authorities are to be notified, staff will be directed by the Risk Manager on the course of action. Document review of the hospital's policy and procedure titled, "Incident Reporting - Risk Management Program," policy number RM.200, last reviewed 12/21, showed the following: a. The Risk Management Program provides a systematic, multidisciplinary approach to managing and reporting incidents of injury, damages, and loss.	L1665		

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L1665	Continued From page 57 b. An "incident" is an unanticipated event which was not consistent with the standard of care that results in, or nearly causes, a negative impact on a patient(s) receiving care at the facility. Any harm caused can be temporary, long-term, or permanent, and range in severity from "no obvious or significant injury up to death." c. Incidents of Sexual Allegations include: i. Patient to Patient Sexual Intercourse - Any allegation of sexual intercourse/contact between patients. d. Severity Classifications include: i. Level I Tragic - incidents which are considered sentinel or considered tragic in nature. For example: Sexual intercourse with penetration. ii. Level II Serious - Major injury or impairment in which the patient's function is altered requiring outside medical intervention. For example: Sexual misconduct with oral, sexual, or digital penetration. e. The facility Risk Manager will notify appropriate agencies of reportable incidents as required, for example: DJJ, OIG, State Agency, etc. f. Under-reporting or failure to report is not acceptable. g. In states where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements. 2. On 12/24/22 at approximately 9:00 AM, an Activity Therapist (Staff #1506) entered the room	L1665		

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L1665	Continued From page 58 of Patient #1501, a 38-year-old male, who was admitted involuntarily for grave disability on 12/21/22, with a psychiatric diagnosis of Schizoaffective Disorder and found Patient #1502 laying on her back on the bed and Patient #1501 was kneeling on the bed above her, between her legs, and had raised up one of her legs. Patient #1502, a 49-year-old female, was admitted involuntarily for grave disability on 11/21/22, with a psychiatric diagnosis of Schizophrenia with catatonia (symptoms of sluggish movements, not talking). 3. Two staff members completed Incident Report Forms documenting the incident that took place on 12/24/22: a. On 12/27/22 at 9:00 PM, the House Supervisor (Staff #1503) documented that the incident occurred during day shift on 12/24/22. Staff #1503 noted the incident under the category of Misconduct/Sexual/Boundary Violation, and specifically identified the incident as "Sexual Intercourse - Patient to Patient." The House Supervisor summarized the event, documenting "it was noted on an (Activity Therapist) AT Progress Note that the patient (Patient #1502) was found under a male patient (#1501) in his bed where it appeared like they were having sexual intercourse." b. The Risk Manager completed the Incident Report Form dated 12/27/22 and classified the event as Level II - Serious. c. On 12/28/22 at 12:45 PM, the Activity Therapist (Staff #1506) documented that the incident occurred at approximately 9:15 AM on 12/24/22. Staff #1506 noted the incident under the category of Misconduct/Sexual/Boundary Violation, and	L1665		

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L1665	Continued From page 59 specifically identified the incident as "Sexual Intercourse - Patient to Patient." The AT summarized the event, documenting that she was going around inviting patients to the 9:15 AM group. "I knocked on (Patient 1501's) closed door and found (Patient #1502) lying on her back with (Patient #1502) kneeling over her, with her leg raised." Patient #1501 "looked at me and gave me the "shh" symbol." Staff #1506 yelled at the patients and asked a Mental Health Technician (MHT) for help. The MHT yelled at the patients, and they became separated. The MHT walked Patient #1502 back to her room and I went to conduct my group. d. The Risk Manager completed the Incident Report Form dated 12/28/22 and classified the event as Level II - Serious. 4. On 01/26/23 at 1:25 PM, during an interview with Investigator #15, the Risk Manager (Staff #1505) stated that when he was notified of the incident on 12/28/22. Staff #1505 notified their Corporate Risk person and they advised him on the next steps to follow based on the reported incident. Staff #1505 reported that they also reached out to local law enforcement. Staff #1505 stated that he was unaware of any other notifications that he was responsible for. Staff #1505 stated that he did not receive training for his position addressing protocol for adverse/sentinel events. Staff #1505 reported that he did not notify the Department of Health of the incident that took place on 12/24/22. .	L1665		

POC revision recd 04/04/23
POC Accepted 04/05/23
Mary Drew, MSN. RN
DOH

Cascade Behavioral Health Hospital
Plan of Correction
State Licensing Investigation
Case #2022-15740/127738
Exit 02/02/23 – Correct by Date 04/03/23 (60 days from exit)

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 the receipt of the statement of deficiencies on 03/06/2023, 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		
L 320 322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Polices and Procedures	Item #1 - Safe Environment of Care Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff implemented interventions to maintain a safe environment, providing patient's sexual safety by maintaining separation between patients who are alleged to have engaged in sexual behavior • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined that it met requirements in regard to providing a safe environment by maintaining separation between patients that are alleged to engage in sexual activity. • The CNO, DCS, DRM, CEO, and Corp DQC determined a system was required to ensure all staff are aware of the interventions to maintain a safe environment for patients alleged to have engaged in sexual acting out. A flagging system was devised to identify patients that have had, were alleged, or at risk for engaging in sexual behavior. The flagging system includes a form placed in the	CNO	04/03/2023	Monitoring Process All patients that have had or are alleged to have engaged in sexual behaviors will be discussed daily in the Flash meeting. Patients that have had or allegedly have engaged in sexualized behavior will be added to the leadership rounds. The assigned Administrator on call (AOC) will round on each unit and ensure that patients that have had or are alleged to have engaged in sexual behavior are separated appropriately per interventions assigned on the treatment plan and that the medical record is appropriately flagged daily. Leadership rounds are conducted seven (7) day a week. The results regarding the appropriate separation of patients that have had or allegedly

	chart and a red sticker placed on the outside of the chart. This will alert staff members to any sexual behavior between two patients, signify the need to obtain a transfer order for one of the patients involved, and to alert the new unit of the need to increase monitoring because of the patient history of sexual behavior. • The CEO determined that the Leadership rounds did not address ensuring that patients that have engaged in sexual behaviors maintained continuous separation through specific intervention identified on the treatment plan and revised the Leadership rounds to include rounding on the units and ensuring appropriate interventions have been carried out, including separation, for patients who have had or who allegedly have engaged in sexual behaviors. A question relating to incidents of sexual behavior will be added to the leadership rounding tool and any results will be reported in the daily flash meeting. The data collected will be entered into the Quality Workbook and shared with QAPI, Med Exec, and Flash. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring patients were immediately separated and placed on close observations. ✓ Ensuring patients are added to the safety huddle, conducted daily at each shift change, and permanent interventions for maintaining safety are implemented and added to the treatment plan. ✓ Placing patient on SVX/SAO, documenting the precautions in the progress note and adding the intervention to the treatment plan and ObservSmart electronic rounding system. ✓ Ensuring the charts are flagged to identify the risk and that the incident is communicated in report (shift report, unit transfers, provider, etc.) • The CNO and DCS determined that based on discussion with direct care staff members including nurses, BHA's, SW, LADC, and AT staff required further education and training on the protocol for reporting and communicating high risk interactions needed to be conducted to ensure all staff were aware of the process. The training included:			have engaged in sexual behavior will be reported daily in Flash and tracked via the Leadership Round workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The target goal for educating staff on the process for immediately separating patients that have been identified as engaging in sexual behavior, adding them to the safety huddle, discussing appropriate interventions in treatment team meetings and updating the treatment plan, and the medical record flagging system is 100% of active staff. The target goal for daily completion of Leadership Rounds is 90%. The target goal for ensuring patients are appropriately separated by interventions specific to the patients determined by the treatment team,

	✓ Any two patients that are alleged to have sexual behavior will immediately be separated and placed on a close observation status. ✓ At the next safety huddle and/or treatment team meeting whichever comes first; permanent interventions to maintain separation will be determined such as: place patient on SAO/SVX precautions, provide at least 5 ft separation at all times, room changes, unit changes, close observation orders such as Q5 minute or 1:1, etc. ✓ All interventions need to be documented on the treatment plan and updated weekly ✓ The medical record flagging system to identify patients who have had, alleged to have had, or are at risk for engaging in sexual behaviors ✓ The revised checklist and all of the components			that interventions are added to the treatment plan, and that the medical record is flagged appropriately is 90% compliance achieved and maintained for 90 days .
L 320 322-035.1D POLICIES- PATIENT RIGHTS WAC 246-322-035 Polices and Procedures	Item #2 - Right to Interpreter and Translator Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that patients with limited English proficiency and language barriers are provided access to interpreters and translators • The DCS, CNO, CEO, DRM, Director of Intake, and Corp DQC reviewed the policy titled Communication with Persons with Limited English Proficiency" PC.CLEP.101 and determined that revision was required in regard to providing guidance to clarify that translator services will be provided as soon as possible to conduct assessments. • The Director of Intake, CNO, and DCS determined further education and training was needed to ensure that staff understood the process for obtaining interpretation or translation services. • Education for Intake, Clinical Services, Nursing, and Providers included: ✓ How to recognize the need for interpreter services ✓ Any time a patient is identified on either the intake, nursing, PE, PSA, H&P, AT or other assessment as needing an interpreter, the DCS will be notified by telephone and email during business	DCS	04/03/23	Monitoring Process The Director of Intake or designee will audit all intake assessments to determine if the need for an Interpreter was identified and obtained. This question has been added to the audit tool. The Director of Clinical Services or designee will audit 5 psychosocial assessments and 5 activity therapy assessments per week to determine if the need for an interpreter was identified and subsequently obtained. The Director of Risk Management or designee will audit 5 psychiatric evaluations and 5 history and physicals per week to determine if the need for an interpreter was

	hours. The House Supervisor will be notified outside of business hours. The language line will be used until an interpreter is available. If a need for interpreter services are identified Intake staff will schedule interpreter services beginning the first day of admission and at any point that it is needed during admission.			identified and subsequently obtained. The Chief Nursing Officer or designee will audit 5 nursing admission assessments per week to determine if the need for an interpreter was identified and subsequently obtained. The results of the audits will be tracked via the Chart Audit workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported weekly in a focused leadership meeting, monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The Target goal for education of the intake, nursing, clinical service, and provider staff is 100% of full time and active employees. The target goal for compliance with obtaining an interpreter service when identified in assessments is

				90% compliance achieved and maintained for 90 days
L 325 322-035.1E POLICIES-ABUSE PROTECTION WAC 246-322-035 Polices and Procedures	Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that the local police department was notified of an incident of nonconsensual sexual misconduct/sexual intercourse between two patients. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined that revision was required in regard to providing guidance for notifying authorities in the event of sexual misconduct/sexual intercourse. The policy was revised to state: ✓ All incidents of sexual misconduct/sexual assault will be reported to the local police department within 24 hours by the risk manager, AOC, or designee. ✓ The person reporting the incident will document a case number and provide a direct phone number for any follow-up questions or concerns related to the investigation. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the investigation summary worksheet and determined it required revision. ✓ The worksheet was revised to include the name of the person taking the report at the local police department, time and date the report was made, the case number assigned to the investigation, and the call back number provided to the local police department. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring proper notifications are made: ▪ Local Police Department • All members of the leadership team accepting responsibility for administrator on call including the Risk Manager and House Supervisors were trained on the following:	CEO	04/03/23	Monitoring Process The CEO and Corporate Director of Quality and Compliance will review all investigation summaries related to actual or alleged sexual assaults to ensure proper notification were made to the police department within 24 hours of the incident. The results of the review will be reported monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Board. Target for Compliance The Target goal for education of the leadership team accepting administrator on call (AOC) duties and House Supervisors is 100% of full time and active employees. The target goal for compliance with notifications of the local police department after actual or alleged incidents of sexual assault is 90% compliance achieved and maintained for 90 days

	✓ The revision to the policy requiring local police notification of alleged or actual sexual assaults. ✓ Documentation on the investigation summary of the name of the person taking the report at the local police department, time and date the report was made, the case number assigned to the investigation, and the call back number provided to the local police department.			
L 355 322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Polices and Procedures	Item #1 - Staff Actions - Immediate Interventions After Incidents/Allegations Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure the immediate investigation of an adverse incident of sexual assault • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were necessary in regard to initiation of an investigation immediately following an adverse incident of sexual assault. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Incident Reporting – Risk Management Program, policy number RM.200 and determined no revisions were necessary regarding reporting and investigating incidents. • The CNO determined a formalized process for reporting incidents and initiating investigations was not clearly delineated to staff members and developed an algorithm to post on the units based on the policy Incident Reporting – Risk Management Program, policy number RM.200 clearly describing what to report to whom and when. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring the investigation was initiated immediately ▪ Obtaining staff witness statements ▪ Obtaining statements of patients involved	Director of Risk	04/03/2023	Monitoring Process The Director of Risk Management will review all incidents to ensure any actual or alleged sexual assaults had an investigation begin immediately. The results of the review will be reported monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Board. Target for Compliance The Target goal for education of all staff – AT, Nursing, BHA, SS, Dietary, Maintenance, Administration, Housekeeping, Security Techs, Intake – on reporting incidents including sexual assault allegations to the Charge Nurse is 100% of active employees. The Target goal for education of Charge Nurses to ensure they report all allegations of sexual assault to the House Supervisor is 100%. The target goal for education of House Supervisor on what to report including all allegations of sexual

	▪ Obtaining statement of patient witnesses ▪ Reviewing rounding documentation ▪ Reviewing the medical record ▪ Reviewing pertinent policies • The CNO, DCS, and CEO determined that all staff members including direct care (AT, Nursing, BHA, Security Techs, Social Services) and non-direct care (Housekeeping, Maintenance, Administration, Intake, Dietary) required further education and training on the policy and protocols for reporting and communicating incidents and initiating investigations when applicable to ensure all staff were aware of the process. Training will be conducted in groups by the CNO and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging attendance and accountability for the material presented. The training will include: ✓ All staff – AT, Nursing, BHA, SS, Dietary, Maintenance, Administration, Housekeeping, Security Techs, Intake – will be trained on reporting incidents including sexual assault allegations to the Charge Nurse. ✓ Charge Nurse training to ensure they report all allegations of sexual assault to the House Supervisor. ✓ House Supervisor training on what to report including all allegations of sexual assault to the Risk Manager during business hours and Administrator on Call (AOC) after business hours. ✓ AOC training on the investigation process to include immediate initiation and the immediate separation of patients alleged to have engaged in sexual behaviors. ✓ The revised checklist and its components			assault to the Risk Manager during business hours and Administrator on Call (AOC) after business hours is 100%. The target goal for education of AOC on the investigation process to include immediate initiation and the immediate separation of patients alleged to have engaged in sexual behaviors is 100%. The target goal for compliance with immediate investigation after actual or alleged incidents of sexual assault is 90% compliance achieved and maintained for 90 days
L 355 322-035.1K POLICIES- STAFF ACTIONS	Item #2 - Staff Actions - Notifications Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff provided the required notifications, such as physicians/providers or	CNO	04/03/2023	Monitoring Process The CNO will review all sexual acting out checklists to ensure the proper notifications to the provider and

WAC 246-322-035 Polices and Procedures	appointed guardians, after adverse events and incidents of sexual assault • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were necessary in regard to notifications that are required to be made. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Incident Reporting – Risk Management Program, policy number RM.200 and determined no revisions were necessary regarding reporting and investigating incidents. • The CNO determined a formalized process for reporting incidents and initiating investigations and making notifications was not clearly delineated to staff members and developed an algorithm to post on the units based on the policy Incident Reporting – Risk Management Program, policy number RM.200 clearly describing what to report to whom and when. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring proper notifications are made: ▪ Provider ▪ Family/Guardian if applicable • The CNO, DCS, and CEO determined that all nursing staff members including required further education and training on the policy and protocols for notifications required after an actual or alleged sexual assault. Training will be conducted in groups by the CNO and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. The training will include:			guardian if applicable are documented per the checklist. The CNO will audit 100% of medical records post actual or alleged sexual assaults to ensure notifications are made and documented in the progress notes. The Director of Risk Management will review all incidents to ensure any actual or alleged sexual assaults have a sexual acting out checklist completed and follow proper procedure. The results of the medical record audits will be tracked via the Chart Audit workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported weekly in a focused leadership meeting, monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The Target goal for education of the nursing staff on making notifications, using the checklist appropriately,

	✓ All nursing staff on notification of the provider and guardian if applicable after all incidents including actual and alleged sexual assaults ✓ The new algorithm describing who to notify and when ✓ The revised checklist to include notifications required ✓ Documentation in the progress note of notifications made			documenting notifications, and referencing the algorithm is 100% of full time and active employees. The target goal for compliance with making notifications to the provider and guardian when applicable and documenting is 90% compliance achieved and maintained for 90 days
L 355 322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Polices and Procedures	Item #3 - Staff Actions - Obtain Orders for Interventions Post Sexual Activity Between Patients Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff responding to an incident of sexual activity between patients by contacting the provider to obtain orders for an evaluation, a medical hospital visit, Sexually Transmitted Disease (STD)/Sexually Transmitted Infections (STI) testing, and Human Immunodeficiency Virus (HIV) testing • The Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were necessary in regard to obtaining orders for evaluation, medical hospital visit, STD/STI testing, and HIV testing as applicable. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring orders are received for both patients to include: ▪ Transfer to a medical facility if necessary ▪ In house medical evaluation if applicable ▪ STI/STD testing ▪ HIV testing ▪ Precautions ✓ Ensuring that, if a patient refuses testing or outside evaluation that the refusal is documented in the chart and noted in the progress and treatment notes. • The CNO, CMO, and CEO determined that all providers and nursing staff members including required further education and training on	CMO	04/03/2023	Monitoring Process The CNO will review all sexual acting out checklists to ensure the proper notifications to the provider and guardian if applicable are documented per the checklist. The CNO will audit 100% of medical records post actual or alleged sexual assaults to orders for medical evaluation or transfer, STD/STI and HIV testing are obtained and carried out for both patients involved in the sexual behavior. The Director of Risk Management will review all incidents to ensure any actual or alleged sexual assaults have a sexual acting out checklist completed and follow proper procedure. The results of the medical record audits will be tracked via the Chart Audit workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported weekly in a focused leadership meeting, monthly to the

	the policy and protocols for order to be obtained after alleged or actual sexual activity.. Training will be conducted in groups by the CNO and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. The training will include : ✓ Ensuring orders are received for both patients to include: ▪ Transfer to a medical facility if necessary ▪ In house medical evaluation if applicable ▪ STI/STD testing ▪ HIV testing ▪ Precautions ✓ Documentation in the progress note of orders obtained and carried out or, if a patient refuses testing or outside evaluation that the refusal is documented in the chart and noted in the progress and treatment notes.			Quality Council and Medical Executive Committee, and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The Target goal for education of the provider and nursing staff on obtaining, carrying out and documenting orders for medical evaluation or send out, STD/STI and HIV testing is 100% of full time and active employees. The target goal for compliance with obtaining, carrying out and documenting orders for medical evaluation or send out, STD/STI and HIV testing is 90% compliance achieved and maintained for 90 days
L 355 322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Polices and Procedures	Item #4 - Staff Actions - Incident Reports for Sexually Inappropriate Behavior Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that staff completed an incident report after the observations of a patient's sexually inappropriate behavior, • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were	Director of Risk	04/03/23	Monitoring Process The Director of Clinical Services or designee will audit 5 medical records per week to review all social services documentation from the previous day to ensure that any documentation of sexually inappropriate behavior has a corresponding incident report. The Director of Risk Management or designee will audit 5 medical records

	necessary in regard to completing an incident report after observations of a patient's sexually inappropriate behavior. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Incident Reporting – Risk Management Program, policy number RM.200 and determined no revisions were necessary regarding reporting and investigating incidents. • The CNO determined a formalized process for reporting incidents and initiating investigations and making notifications was not clearly delineated to staff members and developed an algorithm to post on the units based on the policy Incident Reporting – Risk Management Program, policy number RM.200 clearly describing what to report to whom and when. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Ensuring an incident report is completed • The CNO, DCS, and CEO determined that all staff members including direct care (AT, Nursing, BHA, Security Techs, Social Services) and non-direct care (Housekeeping, Maintenance, Administration, Intake, Dietary) required further education and training on the policy and protocols for reporting and communicating, and completing incident reports. Training will be conducted in groups by the CNO and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. The training will include: ✓ All staff – AT, Nursing, BHA, SS, Dietary, Maintenance, Administration, Housekeeping, Security Techs, Intake – will be trained on reporting incidents including sexual assault allegations to the Charge Nurse. ✓ All staff – AT, Nursing, BHA, SS, Dietary, Maintenance, Administration, Housekeeping, Security Techs, Intake – will			per week to review all provider documentation from the previous day to ensure that nay documentation of sexually inappropriate behavior has a corresponding incident report. The Chief Nursing Officer or designee will audit 5 medical records per week to review all nursing documentation from the previous day to ensure that nay documentation of sexually inappropriate behavior has a corresponding incident report. The results of the audits will be tracked via the Chart Audit workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported weekly in a focused leadership meeting, monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The Target goal for education of all staff – AT, Nursing, BHA, SS, Dietary, Maintenance, Administration, Housekeeping, Security Techs, Intake

	be trained on how to recognize when a behavior or incident should be reported on an incident report. ✓ Charge Nurse training to ensure they report all allegations of sexual assault to the House Supervisor and ensuring the incident report is completed. ✓ The revised checklist and its components including completing the incident report.			– on reporting incidents and completing incident reports including sexual assault allegations and sexually inappropriate behaviors to the Charge Nurse is 100% of active employees. The Target goal for education of Charge Nurses to ensure the incident report is completed and that they report all allegations of sexual assault to the House Supervisor is 100%. The target goal for completing incident reports for all sexually inappropriate behaviors is until a target of 90% is achieved and maintained for 90 days
L 585 322-050.6i ORIENTATION-APPROP TRAINING WAC 246-322-050 Staff	Based on interview, personnel record review, and review of hospital policies and procedures, the hospital failed to ensure that all staff received appropriate discipline specific training for their expected duties when responding to incidents of sexually inappropriate behavior and/or sexual allegations/assaults • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were necessary in regard to staff training required. • The Chief Nursing Officer (CNO), Director of Clinical Services (DCS), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Incident Reporting – Risk Management Program, policy number RM.200 and determined revisions were necessary in regard to the investigation process. ✓ The policy was revised to ensure a thorough investigation is completed by the Risk Manager with CEO oversight.	Human Resources Director	04/03/23	Monitoring Process The HRD will review all employee education files to ensure they completed training and have the attestations/exams in their employee education files for the following items: • Nursing Staff including Charge Nurses and House Supervisors – when to notify RM/AOC and when to initiate an investigation • All staff (clinical and non-clinical) – specific events requiring an incident report, how to complete an incident report, who to report and turn in the incident report to • All staff (clinical and non-clinical) – how to handle incidents of sexually inappropriate behaviors, sexual allegations, or incidents of

	✓ The policy was revised to remove the requirement that an independent second investigation was required by the Patient Advocate. • The Human Resources Director (HRD), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Training and Development HR.172 and determined the following revisions were necessary: ✓ Ensuring New Employee Orientation included identifying and implementing intervention to respond to incidents of sexually inappropriate behaviors and incidents of sexual assault or sexual allegations • The Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Director of Clinical Services (DCS), and Human Resource Director (HRD) reviewed the new hire onboarding education and training titled "Incident Reporting" as well as the electronic training materials and determined the following additions were required: ✓ Guidelines and specific interventions for staff when responding to sexual assaults/allegations ✓ Incident reporting requirements including: ▪ The definitions of incidents ▪ When to complete and incident report including specific events requiring an incident report ▪ Who is responsible for completing the incident report ▪ What is the process for turning in the incident report and to whom to they turn it in to • The Chief Executive Officer (CEO), Chief Nursing Officer (CNO), Director of Clinical Services (DCS), and Human Resource Director (HRD) reviewed the new hire onboarding education and training for job specific requirements and determined the following additions were required: ✓ Nursing Staff including Charge Nurses and House Supervisors – when to notify RM/AOC and when to initiate an investigation ✓ All staff (clinical and non-clinical) – specific events requiring an incident report, how to complete an incident report, who to report and turn in the incident report to			sexual intercourse or sexual assault • Risk Manager – protocols for adverse/sentinel events including reporting requirements and scoring of incidents using the classification system The results of the employee education file audits will be tracked via the education workbook to determine any trends and monitoring sustainability. The results of the workbook will be reported monthly to the Quality Council and Medical Executive Committee, and quarterly to the Governing Board. Monitoring for compliance will continue until 90% compliance is reached for 3 consecutive months at which time monitoring will resort to the indicators and plan approved by the Quality Council. Target for Compliance: The Target goal for education of Nursing Staff including Charge Nurses and House Supervisors – when to notify RM/AOC and when to initiate an investigation is 100% of active staff. The target goal for all staff (clinical and non-clinical) education on specific events requiring an incident report, how to complete an incident

	✓ All staff (clinical and non-clinical) – how to handle incidents of sexually inappropriate behaviors, sexual allegations, or incidents of sexual intercourse or sexual assault ✓ Risk Manager – protocols for adverse/sentinel events and scoring of incidents using the classification system • The CNO, DCS, and CEO determined staff training was required for existing staff on and all staff were trained on the following: ✓ Nursing Staff including Charge Nurses and House Supervisors – when to notify RM/AOC and when to initiate an investigation ✓ All staff (clinical and non-clinical) – specific events requiring an incident report, how to complete an incident report, who to report and turn in the incident report to ✓ All staff (clinical and non-clinical) – how to handle incidents of sexually inappropriate behaviors, sexual allegations, or incidents of sexual intercourse or sexual assault • Training will be conducted in groups by the Human Resources team and appropriate departments and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. • The Chief Executive Officer (CEO), Human Resources Director (HRD), and employee educator reviewed the employee education files and determined a process was needed to ensure they were complete with all required education and training. ✓ An audit tool was devised to capture all required incident reporting and responding to sexual allegation training requirements. ✓ A workbook was developed to track compliance and identify trends in employee education files			report, who to report and turn in the incident report to is 100% of all active staff. The target goal all staff (clinical and non-clinical) education on how to handle incidents of sexually inappropriate behaviors, sexual allegations, or incidents of sexual intercourse or sexual assault is 100% of all active staff. The target goal for the Risk Manager training on protocols for adverse/sentinel events and scoring of incidents using the classification system is 100%.
L1105 322-170.3C NURSING SERVICES	Item #1 - Inter Unit Transfer of Patients Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that when a patient was transferred to a different unit within the hospital, nursing	CMO	04/03/23	Monitoring Process The CNO will report any patient transfers done the previous day after

WAC 246-322-170 Patient Care Services	staff notified the attending or covering physician and obtained an order from the provider for transfer • The Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Inter Unit Transfer PC.IUT.101 and determined no revisions were necessary. • The Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Plan for Provision of Patient Care L.PPPC.100 and determined no revisions were necessary. • The Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the document titled Rules and Regulations of the Medical Staff of Cascade Behavioral Health and determined no revisions were necessary but that a date for reviewed need added. • The CNO, CEO, and CMO determined a process was required to monitor that orders were obtained prior to transferring patients to another unit for any reason. The process developed is as follows: ✓ House Supervisor to document any patient transfers on the House Supervisor report to be sent daily to the CNO attesting an order was obtained prior to the transfer. • The CNO, DCS, and CEO determined that the checklist for actions to be taken, including immediate investigations, post allegation of sexual assault needed to be revised. Revisions included: ✓ Report tool completed if patient is transferring units • The CNO, CEO, and CMO determined further education is required on the policies and procedures for inter unit transfer of patients for providers and the nursing staff including the House Supervisor. Training will be conducted in groups by the CNO and will be presented in verbal and written formats. Staff will be given the applicable policy and procedure and an algorithm to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. The training will include:			reviewing the House Supervisor report in the daily Flash meeting. The CNO will audit the medical record of any inter unit transfers to ensure a provider order was obtained. The CNO will report audit findings monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Board. Target for Compliance: The Target goal for education of providers and nursing staff on who can provide orders, the difference between a provider order and an administrative directive, the requirement to contact the provider for an order prior to conducting inter unit transfers, the process for reaching a provider when another is not available, waiting to carry out directives until an order is obtained when required, and documentation of inter unit transfers with attestations that orders were obtained on the House Supervisor report is 100% of active staff. The target goal for obtaining an order prior to carrying out inter unit transfers until a target of 90% is achieved and maintained for 90 days

	✓ Who could provide telephone orders ✓ Re-affirming the distinction between provider orders, which are patient treatment related orders, which cannot be issued by anyone other than an independent licensed provider, and administrative directives, which are procedures specific to the day to day operations of the organization and have no impact on clinical outcomes. ✓ Re-affirming that only licensed independent practitioners can place orders and that administrative directives do not become part of the medical record. ✓ Contacting the provider for transfer orders when moving patients between units ✓ The process for reaching a provider when one is not available ✓ Waiting to carry out administrative directives until a provider is notified and an order is also obtained when one is required ✓ Communicating patients were transferred and orders were obtained prior to inter unit transfers via the House Supervisor report			
L1105 322-170.3C NURSING SERVICES WAC 246-322-170 Patient Care Services	Item #2 - Nurse to Nurse Documentation when Transferring Patients Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that when nursing staff provided detailed critical patient information (Nurse to Nurse Report) and when transferring the care of a patient to another unit within the hospital • The Chief Nursing Officer (CNO), Chief Medical Officer (CMO), Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Inter Unit Transfer PC.IUT.101 and revised the form to include the option to use add the inter unit report tool as an addendum to the progress notes when carrying out orders to conduct an inter unit transfer. • The CNO determined that a form was required to ensure that hand-off communication was properly achieved when carrying out orders for inter unit transfers. A report sheet was designed as a tool to prompt nursing staff in the elements of required documentation	CNO	04/03/2023	Monitoring Process The CNO will report any patient transfers done the previous day after reviewing the House Supervisor report in the daily Flash meeting. The CNO will audit the medical record of any inter unit transfers to ensure an inter unit report tool or progress note documents that the patient was educated on the transfer and the reason for the transfer; date and time of the transfer; method of transfer; condition of the patient; patient response to the transfer; and transferring and receive nurse signatures.

	per hospital patient when giving nurse to nurse report on inter unit transfers. The form includes: ✓ That the patient was educated on the transfer and the reason for the transfer ✓ Date and time of the transfer ✓ Method of transfer ✓ Condition of the patient ✓ Patient response to the transfer ✓ Nurse transferring and nurse receiving signature • Education was provided to nursing staff on the inter unit transfer policy as well as the inter unit report tool including: ✓ That the patient was educated on the transfer and the reason for the transfer ✓ Date and time of the transfer ✓ Method of transfer ✓ Condition of the patient ✓ Patient response to the transfer ✓ Nurse transferring and nurse receiving signature			The CNO will report audit findings monthly to the Quality Council and Medical Executive Committee and quarterly to the Governing Board. Target for Compliance: The Target goal for education of nursing staff on the inter unit report tool or progress note documentation to include that the patient was educated on the transfer and the reason for the transfer; date and time of the transfer; method of transfer; condition of the patient; patient response to the transfer; and transferring and receive nurse signatures is 100% of active staff. The target goal documenting on the inter unit report tool or progress note that the patient was educated on the transfer and the reason for the transfer; date and time of the transfer; method of transfer; condition of the patient; patient response to the transfer; and transferring and receive nurse signatures until a target of 90% is achieved and maintained for 90 days
L1665 322-260.2 ADVERSE HEALTH EVENTS	Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure compliance with reporting requirements that require the hospital to report adverse health events to the department within 48 hours of confirmation. • The Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Sentinel and Adverse Events ADM.S.300 and determined no revisions were necessary.	CEO	04/03/2023	Monitoring Process All incidents will be reviewed in the daily Flash meeting. The CEO will review the classification and scoring system of each incident collected by the Director of Risk Management to ensure the Director has reported any adverse/sentinel events to the

	• The Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled "Sexual Activity Among Patients" and numbered PC.SAAP.120 and determined no revisions were necessary in regard to reporting requirements. • The Director of Risk Management (DRM), Chief Executive Officer (CEO), and Corporate Director of Quality and Compliance (Corp DQC) reviewed the policy titled Incident Reporting – Risk Management Program, policy number RM.200 and determined no revisions were necessary in regard to reporting serous events. • The CEO and Corporate DQC determined the Director of Risk Management required further education and training on ensuring protocols for adverse/sentinel events including reporting were followed appropriately.			appropriate agencies when indicated within the 48 hour time frame. The Corporate Director of Risk Management for the facility will review all electronically submitted incidents monthly to ensure appropriate classification. Any that have been inappropriately classified will be sent back to the Risk Manager for re-classification and completion of an investigation and reporting when indicated. Target for Compliance The target goal for the Risk Manager training on protocols for adverse/sentinel events and scoring of incidents using the classification system is 100%. The target goal for reporting adverse/sentinel events to the appropriate agencies is 100%

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 #127738/Case #2022-15740

Dear Mr. Fenton,

Investigators conducted a state hospital complaint investigation at Cascade Behavioral Hospital on 01/13/23, 01/17/23, 01/30/23, and 02/02/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 04/05/23.

Hospital staff members sent a Progress Report dated 05/03/23 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