State of Washington

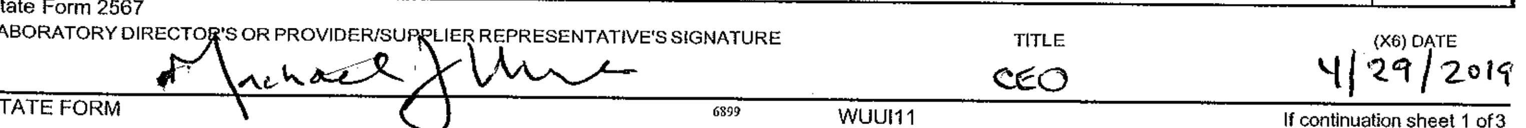
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: ______ B. WING ______	C 03/21/2019

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
L000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals conducted this complaint investigation. Onsite date: 03/20/2019, additional information obtained on 03/21/2019 Case number: 2019-822 Intake number: 87782 The investigation was conducted by: Surveyor #19812	L000		
L 420	322-040.1 ADMIN-ADOPT POLICIES WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients; This Washington Administrative Code is not met as evidenced by: Based on interviews, record review and review of policy and procedure, the hospital failed to assess patient intake and output as ordered by the physician for 1 of 1 patients reviewed (Patient #1). The hospital's failure to do so resulted in Patient #1 not having his prescribed fluid restriction (intake) documented and assessed by licensed staff and potentially placed all patients with the same needs at risk for unmet health needs.	L420		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J [signature] — TITLE: CEO — (X6) DATE: 4/29/2019



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L420	Continued From page 1 Findings include: 1. Review of Patient #1's medical record showed that the physician had written multiple orders for restriction on fluid intake for the patient. The review was conducted throughout the onsite investigation on 03/20/2019, and the Director of Nursing Services (Staff #1) and the Director of Risk Management and Quality (Staff #2) participated in the review. Review of the medical record did not contain documentation that the patient's fluid intake had been observed and recorded per the physician's orders, which was confirmed by Staff #1 and Staff #2. Review of the medical record did not contain documentation that the patient's fluid intake status had been assessed by the licensed staff, which was confirmed by Staff #1 and Staff #2. 2. Record review of the hospital policy and procedure "Vital Signs, Weights, I&O", policy number PC.V.300, revised 1/2019, showed that the policy did not contain directions on how 1&0 [intake and output] was to be implemented, aside from noting that intake and output amounts were to be documented on the graphic form. 3. On 03/20/2019, at 12:20 PM, concurrent interviews with Staff #1 and Staff #2 confirmed that the hospital did not have a written process to guide staff practice regarding communication of fluid restriction to the aides, or to guide staff practice regarding documentation of the assessment of the intake and output of patients by the licensed staff. 4. On 03/20/2019, at 12:30 PM, a nurse manager	L420	**Tag L420** **How:** I & O is helpful or necessary in the management of patients. The policy *PC.V.300 Vital Signs, Weights, I&O* was revised on 3/2019 to include: a. Every episode of intake and output are to be documented on the I & O form and the total values on the Graphic form. b. Conditions added to consider monitoring I & O's: Shock or history of shock, Failure to Thrive, Polydipsia were added to the existing list of conditions. c. A registered nurse can initiate the monitoring without a medical practitioners order. d. Patients on I & O's are weighed daily. e. Fluid volume restrictions per 24 hours, when ordered, are to be written on the top of the I & O sheet by the Registered Nurse. f. Specify Fluid type included in restrictions, (E.G: all liquids or water only.) g. Registered Nurse will assess fluid intake status at least every 8 hours and document trend, effectiveness and response to fluid restriction on daily patient assessment form.	

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L 420	Continued From page 2 (Staff #3) stated that he was unaware of any policies and procedures regarding the process for documenting and assessing intake and output. He stated that it was difficult to accurately assess a patient's intake because all patient rooms contained sinks with running water. The nurse manager stated that he had assigned a one-to-one sitter to watch Patient #1, but the patient was independently ambulatory and it was impossible to know how much fluid the patient drank.	L 420	The Input and Output Record was revised to include: a. The patients daily fluid restriction volume (documented at the top of the form.) b. Fluid restriction type (E.G: water only or all fluids.) c. Volume of intake by the patient is totaled by each shift and at the end of a 24 hour period. d. Registered Nurse's review every shift and signature. **Who:** The Chief Nursing Officer, Patricia Brewer, made revisions to the Policy and Graphic form. It was reviewed and approved by the Quality Council in March 2019. Staff were educated regarding these changes and expectations during the monthly nursing staff meetings in March 2019. **What:** Nurse Managers will audit 100% of the patients records where I & O monitoring is indicated to assess that proper assessment, documentation and follow up are completed. Any remediation or re-education pertaining to documentation or assessments will occur with the responsible staff immediately. The 100% chart audit process will continue for 3 months, if compliance is greater than 90% auditing will continue on a monthly basis moving forward. **When:** Changes were fully implemented April 2019. Auditing began in April 2019.	