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 05/31/2023

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

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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: 05/17/23 to 05/18/23, 05/22/23 to 05/26/23, and 05/31/23 Case number: 2021-3919 Intake number: 111189 This investigation was conducted by Investigator #15, #16, and #19 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 06/24/23. 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter.	
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within	L1065		

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State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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L1065	Continued From page 1	L1065		

seventy-two hours following admission:
(i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan;
This Washington Administrative Code is not met as evidenced by:
.

Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure hospital staff initiated a treatment care plan for all patients that addressed psychiatric and medical needs, and included patient specific goals, interventions, monitoring, and reassessment, as demonstrated by 4 of 6 records reviewed (Patient #1501, #1502, #1503, and #1513).

Failure to develop an individualized treatment plan of care can result in inappropriate, inconsistent, or delayed treatment of patients and may lead to lack of appropriate treatment for a medical condition, patient harm, or death.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care," policy number L.PPPC.100, last revised 10/21, showed the following:

a. The program has an interdisciplinary approach

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L1065	Continued From page 2	L1065		

to treatment planning. Those involved in the treatment planning process include the patient's physician, nursing, clinical therapists, activity therapists, and mental health technicians. The team is responsible for the development of the individualized treatment plan and review and evaluation of ongoing treatment.

b. Treatment plans are reassessed by the team at regular intervals as needed. Patient progress in meeting the treatment goals is documented in the progress notes.

Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number PC.T.200, last revised 08/22, showed the following:

a. The purpose of treatment planning is to provide a complete, individualized plan of care based on an integrated assessment of the patient's specific needs and problems and prioritization of those needs/problems; to provide appropriate communication between team members that fosters consistency and continuity in the care of the patient and to formulate a plan of care that meets the patient's objectives and needs.

b. The initial treatment plan, and any subsequent revisions of the plan shall:

i. Reflect the patient's clinical needs, condition, function, strengths, and limitations.

ii. Specify goals for achieving emotional and/or physical health.

iii. Specify intermediate steps toward those goals in measurable terms.

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L1065	Continued From page 3 iv. Specify target dates or timeframes for completion of goals and steps. v. Specify services and interventions to be provided to achieve patient goals. vi. Specify frequency of services and criteria for discharge. c. Within 8 hours of admission, the Registered Nurse (RN) will initiate the Initial Nursing Treatment Plan, which will include behavioral and medical problems. d. The interdisciplinary Treatment Plan will be initiated with 24 hours of admission and completed by day 3 of admission. e. Within 72 hours of admission, the treatment team shall develop the Interdisciplinary Master Treatment Plan that is based on a comprehensive assessment of the patient's presenting problems, physical health, emotional and behavioral status. The team will consist of the physician, the RN, the social worker, and representatives from other clinical disciplines, as appropriate. Patient #1501 2. Patient #1501, a 61-year-old female, was admitted on 04/08/23 after decompensating due to medication noncompliance. She was involuntarily detained due to danger to self and others. On the Psychiatric Evaluation dated 04/09/23, the psychiatric provider documented that the Patient had a psychiatric history of Bipolar Disorder and a medical history of Chronic Kidney Disease (CKD), Hypertension (HTN), Hyperlipidemia (HLD - High cholesterol), and Diabetes (DM).	L1065		

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L1065	Continued From page 4 a. On the History and Physical Evaluation dated 04/09/23, the medical provider documented that the patient had uncontrolled DM and was insulin dependent. b. On the Initial Nursing Assessment dated 04/09/23, nursing staff included the medical problem of DM on the Initial Treatment Plan. Nursing staff documented that the plan of care to address the DM was that the Patient would be assessed and monitored for symptoms and would be medicated per physician's orders. c. The Investigator's review of the Patient's medical records found that staff failed to include the Patient's uncontrolled diabetes medical diagnosis on the Interdisciplinary Master Treatment Plan or initiate an individualized treatment plan for DM. Patient #1502 3. Patient #1502 was a 31-year-old male admitted to the hospital on 04/04/23 after an overdose on olanzapine. Clinical data provided to the screening/admission department showed that the Patient had an active medical history of Asthma. An EKG (electrocardiogram) performed at the sending facility noted a slightly prolonged QT interval, which suggested a possible right atrial enlargement. Review of the medical record showed the following: a. On the Initial Nursing Assessment dated 04/04/23, nursing staff failed to document the active medical problem of Asthma as reported in the clinical data from the sending hospital or address in the Initial Treatment Plan.	L1065		

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L1065	Continued From page 5 b. On the H&P dated 04/05/23, the medical provider noted that the Patient's medical diagnosis as Asthma and Insomnia. The medical provider documented on the review of systems that the Patient complained of chest pain and reported rectal bleeding, with bright red blood, that had a 7-year duration. c. The Investigator's review of the Patient's medical records found that staff failed to include a plan of care for the Patient's reported medical problems, including Asthma, chronic rectal bleeding, chest pain, and a slightly prolonged QT interval, which suggested a possible right atrial enlargement. Patient #1503 4. Patient #1503 was 38-year-old male admitted to the hospital on 03/25/23. Clinical data provided to the screening/admission department showed that the Patient was diagnosed with Rhabdomyolysis (a breakdown of the muscle tissue that releases a damaging protein in the blood, which can damage the kidneys) and open wounds on his hands. Review of the medical record showed the following: a. On the H&P dated 03/26/23, the medical provider noted that the Patient had the open wounds on his hands and was diagnosed with Rhabdomyolysis. b. Review of the medical records found that staff had failed to include the Patient's diagnosed medical problems in the Multidisciplinary Master Treatment Plan or initiate an individualized treatment plan for the Patient's Rhabdomyolysis or open wounds on his hands.	L1065		

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L1065	Continued From page 6	L1065		

Continued From page 6

Patient #1513

5. Patient #1513 was a 19-year-old female, admitted on 05/03/23 after a suicide attempt by overdose and continued suicidal ideation. Clinical data from the sending medical hospital found that the Patient's current medications included: albuterol with a peak flow meter (asthma), docusate (constipation), labetalol (HTN and chest pain), Keppra (seizure disorder), Vyvanse (attention deficit disorder ADHD), melatonin (insomnia), Procardia XL (HTN and chest pain), and Zoloft (depression).

a. On the H&P dated 05/04/23, the medical provider noted that the Patient's current medication list included: albuterol with a peak flow meter (asthma), docusate (constipation), labetalol (HTN and chest pain), Keppra (seizure disorder), Vyvanse (attention deficit disorder ADHD), melatonin (insomnia), Procardia XL (HTN and chest pain), and Zoloft (depression). The medical provider failed to address the Patient's current medications used to manage and treat seizures, HTN, chest pain, and asthma. The provider did not continue the Patient's current medications or document a reason to defer the treatment of these chronic cooccurring medical problems.

b. Review of the medical records found that staff had failed to include the Patient's active medical problems on the Multidisciplinary Master Treatment Plan or initiate an individualized treatment plan, including a plan of care, goals, and interventions.

6. On 05/22/23 at 2:15 PM, during an interview with Investigator #15, an RN (Staff #1507) stated that Patient #1501's change in condition, her

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L1065	Continued From page 7 increasingly bizarre behavior, was not a one-day problem. The Patients behavior and decompensations had been discussed many times during treatment team. Staff #1507 stated that no one knew that the Patient was diabetic and was not being treated for her medical problem. The RN stated that the doctors and nursing staff did not know. The Investigator had the RN review the medical record for Patient #1501, noting the Initial Nursing Treatment Plan that listed DM as a medical problem, and the H&P completed by the medical provider documenting that the Patient had uncontrolled DM. Staff #1507 stated that someone should have caught that, she should have been given medication and had a treatment plan. 7. 05/22/23 at 2:50 PM, during an interview with Investigator #15, the medical provider (Staff #1508) stated that he usually does not attend the treatment team meetings. He typically comes in the morning and talks to the nursing staff, then reviews the medical records for the newly admitted patients before he completes his H&P. Staff #1508 stated that he has a strong team including the charge RN, the other medical provider, the Substance Use Disorder Manager, as well as support from the CMO. 8. On 05/24/23 at 3:30 PM, during an interview with Investigator #15, the Chief Executive Officer (Staff # 1503) stated that under the current CMO's leadership and the addition of 2 new medical providers, the treatment team is more cohesive now. One of the psychiatric MD's has been providing support to the medical providers. Staff #1503 stated that the medical providers attend the treatment team meetings occasionally, when there is a patient with an acute medical concern.	L1065		

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L1065	Continued From page 8 .	L1065		
L1070	322-170.2F PHYSICIAN ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (f) Physician orders for drug prescriptions, medical treatments and discharge; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that hospital staff provided patients with the appropriate medical care during their hospitalization, as demonstrated by 2 of 4 records reviewed (Patient #1501 and #1506). Failure to provide patients with appropriate and timely medical care can result in inconsistent or delayed treatment of patients and may lead to patient harm or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care," policy number L.PPPC.100, last revised 10/21, showed the following: a. In accordance with federal and state	L1070		

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L1070	Continued From page 9	L1070		

Continued From page 9

regulations, professional practice standards and codes, the hospital provides the community with acute inpatient behavioral health care services for adult and geriatric patients.

b. At admission, a nursing assessment is performed by a registered nurse (RN) within 8 hours of admission and includes the patient's physical and mental health.

c. During the patient's admission, nursing care services are provided by RN's who are qualified by education and experience to assume the responsibility for patient care. The primary goal of nursing services is to provide planned, comprehensive, therapeutic, safe, and consistent nursing care 24 hours a day, seven days a week.

Document review of the hospital's policy and procedure titled, "Assessment and Reassessment," no policy number, last revised 05/22, showed the following:

a. The initial assessment is the process of determining the treatment needs of the patient.

b. Information obtained from the initial inquiry includes the patient's current physical condition.

c. The comprehensive nursing assessment is performed within 8 hours of admission. The nursing assessment will include a review previous assessments and validation of the information with the patient. In addition, the nursing assessment includes:

i. Medical and surgical history.

ii. Current medications.

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L1070	Continued From page 10	L1070		

iii. Review of Systems to include respiratory, central nervous system, gastrointestinal, skin, endocrinology, cardiovascular, and musculoskeletal.

d. Reassessments are completed by the RN on day and evening shifts and documented on the Nursing Reassessment form. Each patient is reassessed based on the plan of care or change in their condition.

Document review of the hospital's document titled, "RN Job Description, Job Code RNF, dated 01/01/20, showed the following essential functions of the role:

a. Recognize that patient safety is a top priority.

b. Provide and coordinate care by assessing physical and behavioral health needs of the patient, develop and implement nursing care plans, maintain medical records, and educate patients and their families about various physical and behavioral health conditions.

c. Ensure patient's status is assessed on an ongoing basis and pertinent information is gathered and documented.

d. Notify physicians of significant changes in status such as medical emergencies or changes in medical status.

Document review of the hospital's policy and procedure titled, "Change in Condition - Triage of Critically Ill Patient," policy number PC.E.100, last revised 04/23, showed the following:

a. It is the policy of the hospital to identify in a timely manner those patients whose condition

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L1070	Continued From page 11	L1070		

Continued From page 11

declines and/or no longer meets criteria for behavioral health programs and transfer those patients to the appropriate level of care to ensure their well-being and safety.

b. The RN is to assess the patient for acute changes/declines in the patient's condition.

c. Notify the attending physician, on-call physician, or medical internist and document any new orders.

d. Obtain orders for tests/procedures/interventions, and instructions regarding when to re-notify the physician of the patient's condition/response to treatment.

Patient #1501

2. Patient #1501, a 61-year-old female, was admitted on 04/08/23 after decompensating due to medication noncompliance. She was involuntarily detained due to danger to self and others. On the Psychiatric Evaluation dated 04/09/23, the psychiatric provider documented that the Patient had a psychiatric history of Bipolar Disorder and a medical history of Chronic Kidney Disease (CKD), Hypertension (HTN), Hyperlipidemia (HLD - High cholesterol), and Diabetes (DM).

a. On the History and Physical Evaluation dated 04/09/23, the medical provider documented that the patient had uncontrolled DM and was insulin dependent.

b. On the Initial Nursing Assessment dated 04/09/23, nursing staff documented that the Patient was unable to provide most of the screening questions, including the review of

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L1070	Continued From page 12 systems. However, nursing staff documented that the patient had a diagnosis of DM, HLD, and CKD. The RN documented that the Patient was admitted for acute psychosis, and appeared to be confused, disorganized, and uncooperative. The RN Treatment Plan for Patient #1501 included the diagnosis of DM. Nursing staff documented that the plan of care to address the DM was that the Patient would be assessed and monitored for symptoms and would be medicated per physician's orders. c. The Investigator's review of the provider's orders and the Medication Administration Record (MAR) between 04/08/23 to 05/07/23 found that hospital staff failed to initiate any orders to monitor, assess or treat the Patient's diagnosed medical problem of uncontrolled Diabetes. d. Review of the Nursing Reassessment notes between 04/10/23 to 05/09/23 showed the following: i. On 04/10/23 nursing staff documented that the Patient was confused and disorganized but was medically stable. Patient #1501 was making nonsensical statements but was pleasant. On 04/11/23 nursing staff documented that the Patient was compliant with care, had fair hygiene, and appeared withdrawn and guarded. ii. On 04/14/23 nursing staff documented that the Patient was placed on 1:1 observation for safety, exhibiting poor boundaries by going into other patient's rooms. On 04/15/23, staff documented that Patient #1501 continued to exhibit poor boundaries and had also started to hoard items in her room from the cafeteria. Additionally, nursing staff noted on 04/15/23 that the Patient had a poor appetite and decreased food intake.	L1070		

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 05/31/2023

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

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L1070	Continued From page 13 iii. On 04/16/23 nursing staff documented that Patient #1501 began to disrobe and walk into the hallway on the unit. Initially, the Patient was able to be redirected. iv. On 04/19/23 nursing staff documented that the Patient's room was a mess. The Patient had begun to throw all her clothes and bedding on the floor of her room. Staff observed Patient #1501 pacing the hallway and responding to internal stimuli. On 04/20/23 nursing staff observed the Patient disrobe and go out into the hallway where she yelled profanity and sexually propositioned a male peer. The provider was contacted, and the Patient was placed on Sexual Acting Out precautions. No other orders were obtained from the provider. v. On the Nursing Reassessment Note dated 04/21/23, the RN documented that the Patient was disorganized, and her room was messy. The nurse documented that the Patient refused to clean her room. In response, the RN documented that the Patient was "very argumentative, she never listens to anyone. She has a negative attitude." On 04/22/23, nursing staff documented that the Patient was confused and destructive and continued to put her mattress on the floor. vi. On 04/23/23, the RN documented that the Patient continued to disrobe and was not redirectable. Patient #1501 was disorganized and had spilled water in her room after she had scattered her clothes and linens all over the floor of her room. vii. Further review of the Nursing Reassessment documents between 04/24/23 to 05/09/23 found that the Patient's status continued to deteriorate.	L1070		

State of Washington

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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L1070	Continued From page 14	L1070		

Prior to 05/09/23, nursing staff documented that the Patient's behavior had become increasingly bizarre, such as the Patient crawling and scooting across the floor in her room, sometimes jumping and skipping in between the two beds, and attempting to wash her hair in the toilet.

viii. On 05/09/23 at 9:35 AM, the Patient was sent to the hospital hospital due to weakness and delirium. The acute care medical hospital assessed the Patient after her arrival and discovered her blood glucose level was 998 (A normal fasting glucose level is from 100 to 125 mg/dL. A diabetic coma can occur when your blood sugar gets too high - over 600 mg/dL). The Patient was admitted to the medical hospital and diagnosed with Diabetic Ketoacidosis (DKA) without Coma (associated with DM) and Acute Metabolic Encephalopathy (a problem in the brain caused by a chemical imbalance in the blood) related to elevated glucose levels.

e. The Investigator's review found that nursing staff failed to document provider notification of the Patient's change in condition and increased decline in behavior for 57 of 58 Nursing Reassessment Notes reviewed.

f. Review of the Patient's medical record found that nursing staff had initiated an initial treatment plan for DM on 04/09/23, however, staff failed to document communication with the medical providers regarding the failure to initiate interventions, including assessments, dietary orders, lab orders, glucose monitoring, and medications, for the Patient's active medical diagnosis of Uncontrolled Diabetes for 58 of 58 Nursing Reassessment Notes reviewed.

Patient #1506

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 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1070	Continued From page 15	L1070		

3. Patient #1506, a 32-year-old male, was admitted on 04/14/23 after he was found breaking into his sister's store and was taken into police custody. Clinical data from the sending medical hospital showed that the Patient's psychiatric diagnosis was Schizophrenia. On the History and Physical dated 04/15/23, the medical provider documented that the Patient had a right foot wound. The medical provider failed to initiate any treatment interventions for the Patient's foot wound. Further review of the medical record showed the following:

a. On the Initial RN Nursing Assessment dated 04/14/23, the RN documented that the Patient had a wound on the dorsal right leg and right great toe. At the time of the assessment, the Patient reported a pain level of 6 out of 10 on his right foot.

b. On 04/14/23 the medical provider wrote an order for Doxycycline and Keflex (antibiotics to be taken for 7 days) to treat the Patient's right foot Cellulitis.

c. Review of the Daily Nursing Reassessments between 04/14/23 to 04/27/23 showed the following:

i. On 04/15/23 the RN documented that the Patient refused to take the antibiotics. The RN documented an assessment of the wound, noting that the Patient's right foot/toe was red, bleeding, with a discharge, and warm to the touch. Further review of the Daily Nursing Reassessments found that 26 of 27 notes failed to document the assessment of the Patient's wound.

ii. Nursing staff documented that the Patient

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 05/31/2023

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

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L1070	Continued From page 16 refused all treatments and interventions for his right foot wound for 17 of 27 notes reviewed. Nursing staff failed to notify the provider of the patient's refusal of medications and interventions (wound care) or document an assessment of the Patient's wound. iii. Nursing staff documented that the Patient's Skin assessment was "normal" for 4 of 27 notes reviewed and 1 of 27 RN's documented that they were unable to assess the patient's skin. On 04/25/23, nursing staff documented on the skin assessment that the Patient "denied skin issues." iv. On 04/17/23 and 04/20/23 the RN's documented that the medical provider was notified of the Patient's refusal of treatments for his right foot Cellulitis. The RNs failed to document the provider's response or the initiation of additional orders or interventions. v. On 04/22/23 and 04/23/23 nursing staff documented that they provided wound care to the Patient. However, the RNs failed to document assessments of the wound at the time of the interventions. vi. On 04/24/23 the RN documented that the wound on the Patient's leg was improving. vii. On 04/26/23 the nurse failed to document a skin assessment for the Patient or document the status of the right foot cellulitis. The RN failed to document the pain level for Patient #1506 or if the Patient was compliant with all medications and treatments. viii. On 04/27/23 the medical provider wrote an order to transfer the Patient to the Emergency Department at the medical hospital due to	L1070		

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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

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L1070	Continued From page 17 worsening cellulitis to right foot related to noncompliance with medications/treatments. ix. Review of the nursing notes found no evidence of documentation between the nursing staff and the medical provider to request a medical consultation for Patient #1506. d. The Investigator's review of Patient #1506's medical record found that the nursing staff failed to consistently document the assessment of the Patient's medical condition or refusal for medications and treatments. The RN's documentation of the status of the Patient's right foot Cellulitis varied greatly, ranging from "normal" or patient "denies skin issues" to red, bleeding, with a discharge, and warm to the touch. Two days before the medical provider wrote the order to transfer the Patient to the medical hospital, nursing staff documented that the Patient's leg wound was improving. On 04/26/23, the day before the Patient was sent to the medical hospital, the RN did not document the skin assessment or the status of the Patient's wound. 4. One 05/22/23 at 3:40 PM, during an interview with Investigator #15, a Registered Nurse (RN) (Staff #1509) stated that when a patient is admitted, the nursing staff will look at the clinical information that is provided by the sending hospital, if the patient has a diagnosis of a medical condition, such as Hypertension (HTN) or Diabetes (DM) the nurse would call the medical provider to get orders for medications and interventions, such as glucose monitoring. If the patient has a change in their status or condition, the RN will notify the provider of the observed changes and transcribe any orders, when indicated. The nursing staff would then document	L1070		

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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

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L1070	Continued From page 18 the observed change in the patient's condition, the provider notification, and any new orders for interventions/medications, in the Daily Nursing Reassessment note. 5. On 05/25/23 at 4:00 PM, during an interview with Investigator #15, the Chief Nursing Officer (CNO) (Staff #1504) stated that the leadership team is still auditing several charts daily to evaluate the nursing care provided. Staff #1504 verified that while the medical providers should be writing orders for treatment of the patient's medical conditions, the nurses should review the patient's clinical information and notify the provider of any missing orders, treatments, or change in condition. Staff #1504 stated that most of the nurses were new nurses with limited nursing experience and not great at recognizing a change in the patient's condition or acuity and responding to those changes. .	L1070		
L1075	322-170.2G SIGNED ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (g) Current written policies and orders signed by a physician to guide the action of staff when medical emergencies or threat to life arise and a physician is not present; This Washington Administrative Code is not met as evidenced by: .	L1075		

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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

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L1075	Continued From page 19	L1075		

Based on interview, record review, and review of the hospital's policies and procedures, the hospital failed to ensure that telephone or verbal orders were authenticated by providers within the time period prescribed by hospital policy for 6 of 7 patients reviewed (Patients #1901, #1902, #1903, #1904, #1906, #1907).

Failure to authenticate telephone or verbal orders in a timely fashion can lead to errors not being identified and providers failing to assess patients, both of which can lead to serious decompensation, illness, or injury.

Findings included:

1. Review of the hospital policy titled, "Medication Order," #PC.M.100, last reviewed on 04/23, showed that verbal orders are not allowed except in an emergency, and that the provider should write the orders for medications. The policy showed that the provider was required to authenticate telephone or verbal orders within 48 hours.

Review of the hospital document titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," effective 11/21, showed that telephone or verbal orders are to be authenticated no later than 48 hours after the order is given.

Patient #1901

2. Patient #1901 was a 61-year-old female admitted involuntarily on 04/08/23 for unspecified psychosis.

a. Review of the medical record showed that a

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 05/31/2023

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

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L1075	Continued From page 20	L1075		

telephone or verbal order was written by a Registered Nurse (RN) on 04/29/23 for the discontinuation of a medication and initiation of a new dose of the same medication. It was authenticated by the provider on 05/04/23. Another telephone or verbal order to increase safety checks to every 5 minutes was written on 04/14/23 and was authenticated by the provider on 04/18/23.

b. Review of the medical record showed that a telephone or verbal order, dated 05/03/23, was not authenticated by the provider. The order was for discontinuing a medication and initiating a new dose of a similar medication.

Patient #1902

3. Patient #1902 was a 65-year-old male admitted voluntarily on 04/02/23 for drug and alcohol rehabilitation.

a. Review of the medical record showed that the admission orders were written as a telephone order by an RN on 04/02/23. The provider authenticated the order on 04/16/23.

b. Review of the medical record showed that an order for the initiation of a medication was written on 04/09/23 and authenticated by the provider on 04/16/23. Another order for the initiation of a medication was written on 04/02/23 and was authenticated by the provider on 04/06/23.

Patient #1903

4. Patient #1903 was a 19-year-old female admitted voluntarily for depression and suicidal ideation.

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 05/31/2023

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
L1075	Continued From page 21	L1075		

a. Review of the medical record showed that admission orders were written by an RN on 05/03/23. The provider authenticated the orders on 05/08/23.

Patient #1904

5. Patient #1904 was a 61-year-old male admitted involuntarily on 03/15/21 for schizophrenia.

a. Review of the medical record showed that admission orders were written by an RN on 03/15/21. The provider authenticated the orders on 05/18/21.

b. Review of the medical record showed that the medication reconciliation orders, in which the provider reviews an admitting patient's home medications and determines which to continue, was written by an RN as a telephone order on 03/15/21 and authenticated on 05/18/21.

Patient #1906

6. Patient #1906 was a 32-year-old male admitted involuntarily on 04/14/23 for schizophrenia.

a. Review of the medical record showed that a telephone or verbal order for the discontinuation of a medication was written on 04/14/23 and authenticated on 04/18/23.

b. Review of the medical record showed that a telephone or verbal order written on 05/03/23 was not authenticated. The order was for the initiation of a medication.

c. Review of the medical record showed that the patient's admission orders were written by an RN on 04/14/23 and authenticated on 05/04/23.

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 05/31/2023

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
L1075	Continued From page 22 Patient #1907 7. Patient #1907 was a 34-year-old male admitted involuntarily on 04/08/23 for bipolar disorder. a. Review of the medical record showed that a telephone or verbal order written for the initiation of a medication was written by the RN on 04/14/23. The provider authenticated the order on 04/21/23. 8. On 05/25/23 at 4:00PM, an interview with Staff #1901, the Chief Nursing Officer, showed that the hospital requires verbal or telephone orders to be authenticated within 48 hours, and she stated that verbal orders should be used only in an emergency. She stated that nurses will flag verbal and telephone orders for the providers to authenticate, and that sometimes the flagged orders "just sit there" waiting for authentication for a long time. .	L1075		
L1095	322-170.3A MEDICAL 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: (a) Medical services, including: (i) A physician on call at all times; and (ii) Provisions for emergency medical services when needed; This Washington Administrative Code is not met as evidenced by:	L1095		

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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
L1095	Continued From page 23	L1095		

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Item #1 - Oversight of Medical Staff and Medical Care Provided

Based on observation, interview, and document review, the hospital, including the hospital's governing body failed to ensure accountability for the quality of patient care provided by the hospital medical staff to provide treatment for all patient's active medical conditions during their admission, as demonstrated by 3 of 4 records reviewed (Patient #1501, #1502, and #1503).

Failure to ensure that hospital medical staff identifies, assesses, treats, and monitors all active medical conditions places the patient at risk for inconsistent, inappropriate, or delayed treatment of patients and may lead to serious injury, serious harm, or death.

Findings included:

1. Document review of the hospital's document titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," no document number, dated 11/21, showed the following:

a. Each patient admitted to the hospital's acute program shall undergo a History and Physical Exam (H&P). The following shall be included in the H&P documentation: chief complaint, history of present illness, medical and surgical history, medications, review of systems, identification of potential problems needing further assessment, prior medical work-up, laboratory and imaging findings, impression/diagnosis, and plan of care.

b. Only practitioners may write orders for medical consultations other than initial H&P.

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	60429197	A. BUILDING: ____ B. WING ____	C 05/31/2023

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

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L1095	Continued From page 24 c. Medical consultations are requested by a written order, specifying the reason for the consultation request. Progress notes must indicate the reason for the consultation. d. A satisfactory consultation includes examination of the patient and the medical record. A progress note, followed by a formal report, in each case signed by the consultant, must be included in the medical record. 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 the following: a. Organization - the hospital is owned by Acadia Healthcare Company. Each facility, though fiscally responsible to the corporation, functions independently with a separate Governing Board, Chief Executive Officer, Chief Medical Officer, and management team. b. The Governing Board, as the governing body of the hospital, has ultimate responsibility and authority for all patient care services provided as described fully in its bylaws. The Medical Executive Committee, as the executive body of the medical staff, is accountable to the Governing Board for clinical and administrative aspects of patient care. c. Cascade Behavioral Hospital utilizes the medical model for patient treatment with a strong emphasis on interdisciplinary input in terms of screening, evaluation, diagnosis, and treatment of patients. d. Admission and Assessment Procedures	L1095		

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 05/31/2023

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

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L1095	Continued From page 25	L1095		

include an H&P. The examination includes a review of all systems, history of previous medical problems, present illness, and family medical history. Upon completion the physician identifies medical elements which need addressing during the hospitalization.

e. Medical services will be provided by a qualified physician by order of the admitting psychiatrist. The consulting medical physician is responsible for a complete medical history and general physical examination. The consulting medical physician is also responsible for the diagnostic work-up and test evaluation of any detected or suspected medical disorders, as well as their clinical management.

Patient #1501

2. Patient #1501 was a 61-year-old female admitted to the hospital on 04/08/23. Clinical data provided to the screening/admission department from the sending hospital, showed that the Patient had Diabetes Mellitus and the Patient's home medications included Trulicity (weekly injectable for the treatment of Diabetes). Review of the medical record showed the following:

a. On the H&P dated 04/09/23, the medical provider noted that the Patient had Diabetes and was insulin dependent. During the Patient's 30-day admission to the psychiatric hospital, the Patient's mental status declined. Between 04/24/23 to 05/09/23, staff documented that the Patient demonstrated increasingly bizarre behavior, disrobing, laying, and crawling on the floor. No plan of care was developed, no orders were initiated to treat the Patient's Diabetes, such as glucose monitoring, medications, or a nutritional consultation.

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 05/31/2023

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
L1095	Continued From page 26	L1095		

b. On 05/07/23 the psychiatric provider ordered blood and urinalysis tests to assess the patient's change in condition. On 05/09/23 at 7:32 AM, the medical provider wrote an order directing staff to call the lab and add an A1c test (simple blood test that measures average blood sugar levels over the past 3 month) to the existing lab requested on 05/07/23. In addition, the provider ordered glucose monitoring twice daily and metformin (anti-diabetic medication).

c. After receiving a report of a critical lab value (blood glucose 591) on 05/09/23 at 9:25 AM, the hospital transferred the Patient to the Emergency Department due to delirium, lethargy, altered mental status, and a critical lab value. The Patient was admitted to the medical hospital and diagnosed with Diabetic Ketoacidosis (serious diabetic complication) and metabolic encephalopathy, (problem in the brain due to chemical imbalance in blood).

Patient #1502

3. Patient #1502 was a 31-year-old male admitted to the hospital on 04/04/23 after an overdose on olanzapine. Clinical data provided to the screening/admission department showed that the Patient had an active medical history of Asthma. An EKG (electrocardiogram) performed at the sending facility noted a slightly prolonged QT interval, which suggested a possible right atrial enlargement. Review of the medical record showed the following:

a. On the H&P dated 04/05/23, the medical provider noted that the Patient's medical diagnosis as Asthma and Insomnia. The medical provider documented on the review of systems

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 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1095	Continued From page 27	L1095		

that the Patient complained of chest pain and reported rectal bleeding, with bright red blood, that had a 7-year duration.

b. Review of the Patient's medical record found that medical staff failed to assess, develop a plan of care, and initiate treatment interventions to address the Patient's medical problems identified during his H&P evaluation. The investigator found that staff failed to initiate a medical progress note regarding the care of the patient's chest pain and rectal bleeding.

Patient #1503

4. Patient #1503 was 38-year-old male admitted to the hospital on 03/25/23. Clinical data provided to the screening/admission department showed that the Patient was diagnosed with Rhabdomyolysis (a breakdown of the muscle tissue that releases a damaging protein in the blood, which can damage the kidneys) and open wounds on his hands. Review of the medical record showed the following:

a. On the H&P dated 03/26/23, the medical provider noted that the Patient had the open wounds on his hands and was diagnosed with Rhabdomyolysis. The medical provider documented that he would monitor the Patient's labs, ordering a CK (creatine kinase), CMP (comprehensive metabolic panel), CBC (complete blood count), and TSH with T4 (assess thyroid function) in one week. Review of the medical record found that there was no order written for these labs.

b. During the Patient's admission, no plans of care were developed, no orders were initiated, and no lab work was requested, to monitor and

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 05/31/2023

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

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L1095	Continued From page 28	L1095		

treat the patient's medical problems identified during his H&P evaluation.

5. On 05/22/23 at 2:50 PM, during an interview with Investigator #15, the medical provider (Staff #1506) reported that he had started working at the hospital in March of 2023. The medical provider stated that he was oriented to his role by the executive leadership team and all the department heads. Our role was to ensure compliance with regulations and policies and procedures. Staff #1506 stated that Patient #1501 should have had a DM protocol with her DM diagnosis. Staff #1506 stated that every patient that has a DM diagnosis is put on a DM protocol which initiates blood glucose monitoring and supplemental insulin with 3 different regimens or sliding scales depending on the patient. The medical provider gave this Investigator a template titled, "Insulin Subcutaneous Supplemental Coverage," for review. Staff #1506 verified that Patient #1501 did not have any orders to treat her uncontrolled diabetes. The medical provider stated that when a patient has a co-occurring medical condition, such as hypertension, whether it was controlled or uncontrolled, he would document that in the H&P. When asked by the Investigator where else that would be documented, Staff #1506 stated that it would be documented in a progress note. When prompted a third time where the medical problem would be documented, the provider stated that he would put an order in for any medications/interventions.

6. On 05/23/22 at 2:30 PM, during a phone interview with Investigator #15, the medical provider (Staff #1508) stated that he had started working at the hospital in March of 2023. The medical provider stated that he received his training for his role from the CEO, and then the

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 05/31/2023

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

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L1095	Continued From page 29	L1095		

outgoing medical provider. Staff #1508 stated that one of the other providers from the psychiatric team was available to the new medical providers for consultations, if needed. Staff #1508 stated that they (new medical providers) were hired to make sure the hospital is compliant with completing the H&Ps within 24 hours. Staff #1508 stated that if during the initial physical examination, the provider discovers that patient has a co-morbidity, he would communicate his findings with the team, including the nursing staff, and psychiatric provider via "tiger text." After he had confirmed that the patient was medically stable, he would document on the Plan of Care that the patient was medically stable for treatment. Staff #1508 stated that when treating a patient who has DM, he would review the clinical data from the sending hospital, monitor the patient, and change the sliding scale, if needed. If a patient needs an antibiotic, or other medication, Staff #1508 stated that he would convey that to the nursing staff and document in the medical progress note. Staff #1508 stated that when treating a patient for a chronic medical condition, such as DM or hypertension, he will attempt to educate the patient about their disease. If the patient does not cooperate, or does not want to take medications, he wouldn't write an order for a medication that they were not willing to take. The medical provider stated that this (hospital) was not like primary care.

Item #2 - Medical Care - Diagnositic Labs and Testing

Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to ensure that hospital staff provided patients with the appropriate medical

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 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1095	Continued From page 30	L1095		

care by ensuring that all diagnostic tests (such as labs, radiology, and cardiac monitoring) are performed and the provider is notified of test results and/or refusals, during their hospitalization, as demonstrated by 3 of 6 records reviewed (Patient #1501, #1503, and #1509).

Failure to provide patients with appropriate and timely medical care by ensuring that diagnostic testing is performed, can result in inconsistent, inappropriate, or delayed treatment of patients and may lead to patient harm or death.

Findings included:

1. Document review of the hospital's policy and procedure titled, "Plan for Provision of Care," policy number L.PPPC.100, last revised 10/21, showed the following:

a. During the patient's admission, nursing care services are provided by RN's who are qualified by education and experience to assume the responsibility for patient care. The primary goal of nursing services is to provide planned, comprehensive, therapeutic, safe, and consistent nursing care 24 hours a day, seven days a week.

b. Medical services will be provided by the consulting physician. The consulting physician is responsible for the initiating orders for diagnostic work-up and test evaluation of any detected or suspected medical disorders, as well as their clinical management.

c. Nursing staff are responsible for the patient's health problems, carrying out provider's orders, including medication administration, and responses to medications, interventions, and treatments (such as diagnostic workups).

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 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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L1095	Continued From page 31	L1095		

Document review of the hospital's policy and procedure titled, "Critical Values Policy," policy number ADM 02-28, last revised 05/22, showed the following:

a. Definition of Diagnostic Test - A procedure performed to detect, diagnose, or monitor disease, disease processes, susceptibility, or to determine course of treatment. It includes imaging studies, laboratory studies, electrocardiogram (ECG), and waived testing.

b. Definition of Critical Diagnostic Test Results - A test result that is beyond the normal variation whose values reflect an emergent situation including laboratory and imaging services provided through contractual agreement.

Document review of the hospital's document titled, "RN Job Description, Job Code RNF, dated 01/01/20, showed the following essential functions of the role:

a. Registered nurses are responsible for providing professional nursing care to patients. Recognize that patient safety is a top priority.

b. Ensure physicians orders are legible if taken verbally and transcribed appropriately per policy and procedure.

c. Accurately administer medications and treatments per ordered note.

d. Notify physicians of significant changes in status such as medical emergencies or changes in medical status.

Document review of the hospital's policy and

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 05/31/2023

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

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L1095	Continued From page 32	L1095		

procedure titled, "Change in Condition - Triage of Critically Ill Patient," policy number PC.E.100, last revised 04/23, showed the following:

a. It is the policy of the hospital to identify in a timely manner those patients whose condition declines and/or no longer meets criteria for behavioral health programs and transfer those patients to the appropriate level of care to ensure their well-being and safety.

b. The RN is to assess the patient for acute changes/declines in the patient's condition.

c. Notify the attending physician, on-call physician, or medical internist and document any new orders.

d. Obtain orders for tests/procedures/interventions, and instructions regarding when to re-notify the physician of the patient's condition/response to treatment.

Patient #1501

2. Patient #1501 a 61-year-old female, was admitted on 04/08/23 after decompensating due to medication noncompliance. She was involuntarily detained due to danger to self and others. There were no labs ordered for the Patient on the admit order dated 04/08/23. On the Psychiatric Evaluation dated 04/09/23, the psychiatric provider documented that the Patient had a medical history of Chronic Kidney Disease (CKD), Hypertension (HTN), Hyperlipidemia (HLD - High cholesterol), and Diabetes (DM).

a. On the Initial RN Treatment Plan dated 04/09/23, the RN documented that the Patient had Diabetes (DM). The interventions included

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60429197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 05/31/2023

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

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L1095	Continued From page 33	L1095		

that the Patient be assessed and monitored for symptoms and the Patient will be medicated per orders and symptoms.

b. On the History and Physical Evaluation dated 04/09/23, the medical provider documented that the patient had uncontrolled DM and was insulin dependent. No plan of care was initiated at the time of the assessment.

c. On 04/10/23 the medical provider wrote an order requesting an A1c lab (blood test that measures your average blood sugar levels over the past 3 months) due to elevated glucose levels.

d. The Investigator's review of the Medication Administration Record (MAR) found that nursing staff documented that the A1c lab draw was completed on 04/11/23. Review of the medical record found no evidence of the lab results from the 04/11/23 lab draw. This investigator requested the CNO (Staff #4) contact the lab for the missing results. Staff #4 reported that the lab did not have a record of the results. The medical provider (Staff #1506) also reported that he would obtain the lab results. Prior to the Investigator's exit from the hospital on 05/26/23, Staff #1506 had not provided the requested labs for Patient #1506.

e. Review of the Nursing Reassessment notes between 04/10/23 to 05/09/23 showed that nursing staff failed to notify the medical provider that the labs ordered on 04/10/23 were missing.

Patient #1503

3. Patient #1503 a 38-year-old male, was admitted on 03/25/23 after police responded to a complaint that the Patient was standing in the

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	60429197	A. BUILDING: ______ B. WING ______	C 05/31/2023

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

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L1095	Continued From page 34 road in Sequim, screaming at pedestrians, and throwing garbage in the road. He was involuntarily detained due to grave disability. The Patient's medical diagnosis was Rhabdomyolysis (rare life-threatening condition resulting in the breakdown of muscle tissue that releases a damaging protein in the blood). During the Patient's admission at the sending hospital, the Patient's CK (creatine kinase - protein that muscles release when they break down) levels taken on 03/24/23 were as follows: at 12:02 PM - CK level 1386, at 4:35 PM - CK level 1159, at 11:27 PM - CK level 1206. Review of the medical record showed the following: a. On the History and Physical dated 03/26/23, the medical provider documented that the Patient was discharged from the sending hospital with a medical diagnosis of Rhabdomyolysis. The medical provider documented that he had reviewed the labs from the sending hospital and the CK levels were trending down. The plan of care to monitor and treat the Patient's Rhabdomyolysis was to recheck the labs in one week (CK, CMP, CBC, TSH with T4). b. On the admit order dated 03/25/23, no labs or procedures were ordered by the admitting provider. Review of the provider's orders (between 03/25/23 to 04/12/23) found that the medical provider failed to initiate an order for the labs. c. On the Initial Nursing Assessment dated 03/25/23, nursing staff failed to document the medical diagnosis of Rhabdomyolysis. The RN noted that the Patient denied any medical issues. The RN did not initiate an initial treatment plan to address treatment of the medical condition.	L1095		

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 05/31/2023

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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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L1095	Continued From page 35	L1095		

d. Review of the Daily Nursing Reassessments from 03/27/23 to 04/12/23 found that nursing staff failed to notify the provider regarding the missed lab orders to check the Patient's CK levels one week after admission.

e. The Investigator reviewed the medical record to determine if the labs were drawn, and the medical record did not contain any lab results.

Patient #1509

4. Patient #1509 was a 45-year-old female, was admitted on 05/10/23. On 05/25/23 nursing staff reported that the Patient was complaining of chest pains. On 05/25/23 the RN documented in the Medical Consultation Log the Patient's reported symptoms, asking for a consultation from the medical provider. On that same day at 8:15 PM, the medical provider wrote an order for an Echocardiogram (EKG). On 05/25/23 at 9:56 PM, the medical provider wrote an additional order instructing nursing staff to notify the medical provider with the EKG results. The EKG was completed and resulted at 9:38 PM.

a. Review of the EKG results for Patient #1509 noted an atypical EKG - Low QRS voltage in limb leads (may be the hallmark of cardiomyopathies at risk of sudden cardiac death).

b. On 05/26/23 at 4:35 PM, Investigator #15 was on 3West unit and reviewed the medical consultation log with the Charge Nurse (RN) (Staff #1511). The Investigator asked Staff #1511 about the status of the medical consultation for Patient #1509 related to complaints of chest pain. The consultation log was not updated to reflect whether the provider had assessed the Patient or initiated any new orders. Staff #1511 stated that

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 05/31/2023

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

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L1095	Continued From page 36	L1095		

the medical provider had written an order for the EKG on 05/25/23 and it was completed and resulted that night. Review of the medical record found the 2nd provider order asking to be notified of the EKG results. When the Investigator asked the nurse if the provider had been notified, the RN stated that the provider had not been notified, almost 19 hours after the EKG results. Staff #1511 stated that she had tried to give the results to the medical provider, but he was busy and that the EKG results had been passed down from the previous two shifts: night and day shift.

5. On 05/25/23 at 4:55 PM, during an interview with Investigator #15, the RN (Staff #7) stated that the nurses are supposed to review all the clinical information provided by the sending hospital to gather information about the patient. The review of the sending hospital documents will let you know more about your patient, for example, Patient #1501, who had uncontrolled diabetes and was insulin dependent. The nurses should have caught that to make sure she was treated for DM.

6. On 05/26/23 at 4:35 PM, during an interview with Investigator #15, the Chief Nursing Officer (CNO) (Staff #1504) verified that the lab reports were missing for Patient #1501 and Patient #1503. Staff #1504 also confirmed that the medical provider had not been provided abnormal EKG results that were requested and resulted 19 hours ago.

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POC Revision rec'd 06.30.23
POC Reviewed 07.19.23
POC Approved 07.19.23
Mary Allew, MSN, RN
DOH

Cascade Behavioral Health Hospital
Plan of Correction
State & CMS Health Investigations
Case #2021-3919/111189

CEO

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 000	**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, 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.			
L 1065 **Treatment Plan-Comprehension-322-170.2E** **WAC** **246-322-170**	The CEO, CMO, and Corporate Director of Quality and Compliance reviewed the Rules and Regulations of the Medical Staff of Cascade Behavioral Health and the policy and procedure L.PPPC.100 titled "Plan for Provision of Patient Care", and " Treatment Planning " policy PC.T 200 and determined that policies met requirements. No changes were made. 100% of all active inpatient files will undergo a review that includes reconciling the clinical documentation from transferring facilities (if applicable) and admission assessments to verify that all identified active medical conditions (Acute or chronic) have been addressed on the H&P and have an appropriate disposition (orders, labs, etc.) and treatment plan (s). Treatment plan reviews and updates shall include the following steps: • Review of progress toward goals and effectiveness of interventions for each open problem on the Problem List. • Modifications or additions made to goals and interventions, as appropriate. • Update discharge plan, estimated length of stay, and justification for continued stay.	CNO/DCS/CMO/ Dir. of Intake	6/15/2023	**Monitoring plan:** 100% of new admissions will be audited to ensure that any identified active medical problems in the clinical documentation from transferring facilities (if applicable) and admission assessments have appropriate dispositions and treatment plans daily. Any deficiencies will be immediately reported to the CEO, who notifies The Governing Board and Medical Executive Committee. The Chief Medical Officer will immediately contacts the treating provider to ensure the proper orders are provided for active medical problems and that documentation supports orders and review of clinical documentation.

L 1065 **Treatment Plan-Comprehension-322-170.2E** **WAC** **246-322-170**	Continue from page 1 All providers currently employed and caring for patients have been educated to ensure they review clinical documentation from transferring facilities (if applicable) and admission assessments to ensure that all identified active medical problems have been addressed on the H&P and have an appropriate disposition (orders, labs, etc.) and treatment plans. All currently employed nursing staff actively caring for patients have been educated to assess all active medical problems every shift, to document the assessment (including pain level if applicable) on the nursing progress note, to carry out all interventions documented on the treatment plan, and to document the interventions carried out, patient response to those interventions, and progress toward the treatment plan goal on the nursing progress note. They also have received training that includes ensuring they immediately notify the provider for any newly identified medical problems, change in condition, refusal of medications and/or treatments, or active medical problems not addressed to obtain orders. They have been educated to document the notification in a nursing progress note including any new orders received and to ensure all problems and interventions are documented on the treatment plan and problem sheets. The patient's progress and status in meeting the long-term and short-term goals and objectives of his/her treatment plan shall be regularly recorded in the patient's medical record. A patient's inability or refusal to participate in treatment planning, and the patient's reason for such shall be documented on the treatment plan.	CNO/DCS/CMO/ Dir. of Intake	6/15/2023	Aggregated audit results and actions taken will also be reported monthly in Quality Council and Medical Executive Committee meetings and Quarterly to the Governing Board. **Target for Compliance:** 100% of active medical problems identified from clinical documentation from transferring facilities (if applicable) and admission assessments will be identified on the H&P, and all have an appropriate plan of care with orders to treat the medical issue when necessary.

L1070 **Physician Orders** **322-170 2F** **WAC** **246-322 -170**	Continue from page 3 Director of Intake and CNO reviews 100% of new admissions and reconciles the nursing admission assessment, nursing notes, and treatment plans interventions to verify that all identified active medical conditions are addressed by the provider currently employed and providing patient care. Any reviews found to be deficient are immediately brought to the attention of the provider to obtain orders for any necessary interventions. Provider notification and any orders received or reason none were necessary will be documented in the narrative section of the nursing progress notes. All problems and interventions carried out will be documented on a treatment plan problem sheet. All currently employed nursing staff treating patients have been educated to assess all active medical problems every shift, to document the assessment (including pain level if applicable) on the nursing progress note, to carry out all interventions documented on the treatment plan, and to document the interventions carried out, patient response to those interventions, and progress toward the treatment plan goal on the nursing progress note. They also received training that includes ensuring RNs immediately notify the provider for any newly identified medical problems, change in condition, refusal of medications and/or treatments, or active medical problems not addressed to obtain orders. RNs have been educated to document the notification in a nursing progress note including any new orders received and to ensure all problems and interventions are documented on the treatment plan problem sheet.	CNO/DCS/CMO/ Dir. of Intake	6/15/2023	**Target for Compliance:** 100% of active medical problems identified from clinical documentation from transferring facilities (if applicable) and admission assessments will be identified on the H&P, and all have an appropriate plan of care with orders to treat the medical issue when necessary.

L1075 **322-170 2G** **Signed Orders** **WAC** **246- 322 170**	The CEO, CMO, and Corporate Director of Quality and Compliance reviewed the policy and procedure PC.M.100 titled "Medication Order;" the document titled "Rules and Regulations of the Medical Staff of Cascade Behavioral Health" and determined that they met requirements. No changes were made. The CNO will reviewed 100% of all active inpatient files to ensure that all telephone orders were authenticated within 48 hours of the order being given. All currently employed providers providing patient care have been trained to ensure all the telephone orders are authenticated within 48 hours of the order being given. The CNO revised the charge nurse shift checklist work flow : • Shift checklist report to the house supervisor, CNO, and attending of record; { Staff that is employed and providing patient care} • Any outstanding orders on checklist that are needing authentication and are at or near 36-hours without authentication, are listed and reported by RN at the end of each shift.	CNO/DCS/CMO/ Dir. of Intake	6/15/2023	**Monitoring plan:** 100% of admissions will be audited to ensure all telephone orders are authenticated by the provider within 48 hours of being provided to nursing staff for initial admission order set. All other orders will be audited each shift for compliance with the 48-hour time frame and reported each shift. Additionally, the revised audit tool reviews orders that have not been authenticated within 36-hours and are reported to the CMO/CNO/House Supervisor and attending. The House Supervisor/CNO will immediately notifies the CMO and follow-up with the attending provider to authenticate the order. Audits and actions taken will be reported daily in Flash, monthly in Quality Council and Medical Executive Committee and Quarterly to the Governing Board. **Target for Compliance:** 100% of all telephone orders will be authenticated within 48 hours of being given.

L1095 **Medical Services** **–** **322-170 3A** **WAC 246-322-170**	The CEO, CMO, and Corporate Director of Quality and Compliance reviewed the Rules and Regulations of the Medical Staff of Cascade Behavioral Health and the policy and procedure L.PPPC.100 titled "Plan for Provision of Patient Care" and determined that they met requirements. No changes were made. Any deficiencies or omissions of care by medical staff found through the audit process will be reported to the CEO and CMO for immediate correction by the provider. The governing body will review the findings from the Director of Intake/CNO weekly. Any areas of deficiency (identified active medical problems that were not addressed) will be addressed with the CMO and the individual provider through the FPPE process. The provider responsible will have FPPE for all admissions until 100% compliance is achieved and sustained for the next weeks' worth of admissions. The Governing Board will provide direct oversight to the FPPE process to ensure all areas are addressed and all active medical problems are treated appropriately.	CNO/DCS/CMO/ Dir. of Intake	6/15/2023	**Monitoring Plan:** 100% of medical staff audits will be reported weekly to the Governing Board. Any areas of deficiency will be addressed with the CMO and individual provider through the FPPE process. Target for Compliance: 100% of Governing Body oversight to medical providers ensuring appropriate care is provided for patients with active medical problems.

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

July 20, 2023

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

Re: Complaint #111189/2021-3919

Dear Mr. Fenton,

Investigators from the Washington State Department of Health] conducted a state and CMS hospital complaint investigation at Cascade Behavioral Hospital on 05/17/23 to 05/18/23, 05/22/23 to 05/26/23, and 05/31/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 07/19/23.

Under the Washington State Psychiatric regulations (WAC 246-322), typically there is a requirement for the submission of a Progress Report, however with the upcoming closure of the hospital on 07/31/23, a Progress Report will not be required.

The Department of Health accepts Cascade Behavioral Health's attestation that it will correct all deficiencies cited at Chapter WAC 246-322. We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Mary New

Mary New, MSN, BSN, RN
Nurse Investigator