(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: ___ С B. WING 03/05/2020 60429197 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL TUKWILA, WA 98168 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 000 LOOD INITIAL COMMENTS 1. A written PLAN OF CORRECTION is STATE COMPLAINT INVESTIGATION required for each deficiency listed on the Statement of Deficiencies. The Washington State Department of Health (DOH), in accordance with Washington 2. EACH plan of correction statement Administrative Code (WAC) 246-322 Private must include the following: Psychiatric and Alcoholism Hospital, conducted * The regulation number and/or the tag this complaint investigation. number; * HOW the deficiency will be corrected; On site date: 01/28/21 * WHO is responsible for making the Off-site dates: 01/27/21-03/05/21 correction; Case number: 2020-2702 Intake number: 98075 * WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and There were violations found pertinent to this * WHEN the correction will be completed. complaint. 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 03/31/21 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter. L 315 L 314 322-035.1C POLICIES-TREATMENT 322-035 1C Policies - Treatment Item #1 How: The Chief Nursing Officer educated all WAC 246-322-035 Policies and RNs on Nursing Standard for Patient Care Procedures. (1) The licensee shall Policy, nursing assessment/reassessment, develop and implement the following documentation of provider notification of change written policies and procedures in condition, active medical problems, documentation of patient assessment each shift consistent with this chapter and or whenever there is a change in patient's services provided: (c) Providing condition using the Nursing or arranging for the care and Assessment/reassessment form and a progress treatment of patients; note. This Washington Administrative Code is not met as evidenced by:

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State of Washington

RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 60429197 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL TUKWILA, WA 98168 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 1 L 315 L 315 Continued From page 1 Who: Chief Nursing Officer Based on interview, document review, and review of policy and procedure, the hospital failed ensure What: Chief Nursing Officer completed trainings implementation of the policy and procedure for for RNs on 02/04/2021 and 3/11/2021. The Chief nursing assessment/reassessment (Item #1); Nursing Officer implemented daily morning (Patient #1, #2, #3). meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Failure to implement policies for providing or Managers, House supervisor, Charge Nurse of arranging for the care and safety of patients each unit in the hospital, Infection Control Nurse places patients at risk for physical and mental and Director of Risk and Quality. During these meetings, treatment plans, care management harm, and can result in poor outcomes. and protocols are reviewed to ensure medical needs of the patients are addressed Findings included: immediately. Item #1 Assessment/Reassessment When: Chief Nursing Officer and or designee is auditing five Medical records with patients with medical needs to ensure, nursing 1. Review of the facility policy, "Nursing assessment/reassessment, documentation of Standards for Patient Care", #PC.N.200 provider notification of change in condition, Reviewed 01/2018, showed that "Patients are active medical problems, documentation of patient assessment each shift or whenever there reassessed as indicated by the patient's care is a change in patient's condition are being needs and condition, or unit specific completed within the guidelines of the hospital requirements.", and "All significant changes in the Nursing assessment and reassessment policy. patient's clinical condition will be communicated All deficiencies are corrected immediately. Staff by the nurse to the responsible physician in a not in compliance will receive re-education and timely manner". or corrective action as necessary. Audit results will be submitted for three consecutive months to 2. Record review of Patient #1's medical record monthly quality meetings and governing body quarterly until 90% compliance is achieve and showed that: 05/31/2021 sustained. a. On 12/05/19 at 3:00 PM, a nurse documented in the skin portion of an assessment a new bruise on Patient #1's left collar bone and an abrasion on the left side of her head. There was no documentation of provider notification of this change in condition. b. On 12/05/19 at 8:00 PM, a nurse documented in the skin portion of an assessment that Patient

#1's skin was normal but that a left arm skin tear was present. There was no documentation of

State of Washington (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C 03/05/2020 60429197 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L 315 L 315 Continued From page 2 provider notification of this change in condition. c. On 12/06/19 at 10:00 AM, a nurse documented in the skin portion of an assessment that a left shoulder bruise was present. There was no documentation of provider notification of this change in condition. 3. Record review of Patient #2's medical record showed that: a. On 01/22/21 at 12:00 PM, a nurse documented in the Medical/Physical Update portion of an assessment that Patient #2 had "no active medical problems" as well as "active medical problems". The skin portion of the assessment indicates bilateral great toe gangrene. b.On 01/22/21 at 3:00 PM, a nurse documented nothing in the behavior portion and "no active medical problems" in the Medical/Physical update. c. On 01/27/21 at 3:00 PM, a nurse documented "no active medical problems" in the Medical/Physical update portion of the Nursing Reassessment. 4. Record review of Patient #3's medical record showed that: a. On 01/23/21, no time documented, a nurse documented nothing in the Behavior portion and nothing in the Thought Processes portion of the Nursing Reassessment. b. On no date, no time documented, a nurse did not document any portion of the nursing assessment for Patient #3. The evening assessment dated 01/24/21 at 9:00 PM on the

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FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 60429197 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL TUKWILA, WA 98168 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 315 L 315 Continued From page 3 same page was completed. 5. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff # 4 and Staff #5) showed that all RNs are expected to assess patients each shift or whenever there is a change in a patient's condition using the Nursing Assessment/reassessment form and a progress note, and that nurses are expected to notify a provider as soon as possible in person or by telephone, of changes in a patient's condition. Based on interview, document review, and review of policy and procedure, the hospital failed ensure implementation of the policy and procedure for Fall Risk Assessment and Prevention and falled to document individualized fall precaution interventions for 2 of 2 patients reviewed (Item #2). Failure to implement and document fall risk prevention procedures risks patient safety and can result in adverse outcomes for patients. Item #2 Fall Risk Interventions Item #2 Fall Risk Interventions How: Chief Nursing Officer completed trainings 1. Review of the facility policy, "Fall Risk to RNs on facility Fall Risk Assessment and Prevention Policy. Assessment and Prevention", #PC.F.100 Reviewed 03/19, showed that patients are to be Who: Chief Nursing Officer assessed for fall risk using the Morse Fall scale. The policy further states that Interventions will be What: Chief Nursing Officer completed trainings initiated or changed based on the Morse Fall Risk to all RNs on facility Fall Risk assessment policy Assessment score, and will be documented on on 2/4/2021 and 3/11/2021. Training included: the interdisciplinary treatment plan and daily on

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the Nursing Reassessment form. The policy

further states that a Post Fall Assessment Form

will be completed on all patients after any fall and placed in the medical record. The "Potential for

Morse Fall Scale, interventions initiated or

Assessment Score and documentation on the

changed based on the Morse Fall Risk

State of Washington (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: _ С B. WING 03/05/2020 60429197 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 4 L 315 L 315 Continued From page 4 Interdisciplinary treatment plan, Fall Injury Related to Falls" document referenced on interventions, and daily nursing reassessment the Morse fall risk sheet was not mentioned in form. The Chief Nursing Officer this policy. Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief 2. Record review of Patient #1's medical record Nursing Officer, Nurse Managers, House showed that: supervisor. Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of a. On 11/28/19 at 8:00 PM, a nurse documented Risk and Quality. During these meetings, treatment plans, care management and in the Morse Fall Risk Assessment portion of the protocols are reviewed to ensure Fall Risk initial Nursing Assessment that Patient #1 had a Interventions are completed in a timely manner. fall risk score of 65, which indicated that Patient #1 was at high risk to fall. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs b. On 11/28/19 at 5:00 PM a nurse did not are following facility specific Falls policy. Falls document on the High Risk Notification form that Audit includes but not limited to: Morse Fall Patient #1 was a fall risk. Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the plan, Fall interventions, and daily nursing reassessment form. Falls Audit is being Master Treatment plan that the fall prevention submitted for three consecutive months to interventions indicated were "apply wrist band", monthly quality meetings and governing body "comfort rounds", "bed in low position", "apply bed quarterly until 90% compliance is achieve and alarms", "apply chair alarms" and "reassess fall sustained. Staff not in compliance will receive rerisk". No further documentation was found in education and or corrective action as necessary. 5/31/2021 nursing reassessments to indicate that the and Ongoing specific and individualized precautions were implemented. 3. Record review of Patient #3's medical record showed that: a. On 1/23/21, no time documented, a nurse documented in the Falls portion of the Nursing Reassessment that the patient's gait was both unsteady and steady, that the patient used a front wheel walker, and that no fall precautions were in place. b. On 1/23/21 at 11:00 PM, a nurse documented that the patient had an unsteady gait, used a front

PRINTED: 03/19/2021 FORM APPROVED State of Washington (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 60429197 03/05/2020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L 315 Continued From page 5 L 315 wheel walker and neither yes nor no in the Fall Precaution portion of the Nursing Reassessment. 3. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff #4 and Staff #5) showed that none were aware of an expectation that individual fall prevention interventions were to be documented daily on the nursing reassessment form or progress note. L1070 322-170.2F PHYSICIAN ORDERS 322-170.2F Physician Orders WAC 246-322-170 Patient Care How: The Chief Nursing Officer educated all RNs on following the physician order Services. (2) The licensee shall reconciliation process and avoid delay or provide medical supervision and incomplete orders. treatment, transfer, and discharge planning for each patient admitted or Who: The Chief Nursing Officer retained, including but not limited to: (f) Physician orders for drug How: The Chief Nursing Officer educated all prescriptions, medical treatments and RNs on following physician order reconciliation discharge; process and avoid delays or incomplete orders This Washington Administrative Code is not met on 2/4//2021. The Chief Nursing Officer has implemented 24 hour chart check form and as evidenced by: revised the 24 hour chart check process to reflect completion of physician orders. Based on interview, record review, and review of hospital policy and procedure, the hospital failed When: The Chief Nursing Officer or designee is to implement and ensure staff followed the order auditing five charts per unit to ensure all reconciliation process for 2 of 2 patients reviewed physician orders and order reconciliation (Patient #1, #4).

outcomes.

Failure to implement and ensure order

reconciliation places patients at risk for delayed

or incomplete orders. Delayed or incomplete orders place patients at risk for physical and

emotional harm and may lead to adverse

05/31/2021

and Ongoing

process is being followed per hospital policy. Audit results will be submitted for three

compliance will receive re-education and or

and governing body quarterly until 90%

corrective action as necessary.

consecutive months to monthly quality meetings

compliance is achieve and sustained. Staff not in

State of Washington (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: __ C B. WING 03/05/2020 60429197 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) L1070 L1070 Continued From page 6 Findings included: 1. Review of the facility policy, "Noting and Transcribing Physician Orders", #PC.M.110, revised 02/19, shows that the purpose of the policy is to "Transcribe medication orders from doctor's order form accurately and as soon as possible for timely implementation." and that "The licensed nurse will review the orders to ensure that they have been accurately transcribed to the MAR, and that any appropriate notifications have been made (Pharmacy, Lab, etc.), and that "By indicating 'Noted' and signing the order, the nurse is attesting that the order has been accurately and completely transcribed, and that the appropriate steps have been taken to implement the order. 2. Record review of Patient #1's medical record showed that: a. On 12/02/19 at 11:40 a provider wrote an order for a urinalysis to rule out organic causes of Patient #1's increasing confusion. On 12/2/19 the order was transcribed to the medication administration record (MAR) and every subsequent day until 12/09/19. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. b. On 12/10/19, eight days after the order was placed, a Lab Result document indicated that urine had been collected on 12/09 and results were positive for 100.000+ eschericla coll. 3. Record review of Patient #4's medical record showed that:

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State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

CASCADE BEHAVIORAL HOSPITAL

STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER:

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:

A. BUILDING:

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STREET ADDRESS, CITY, STATE, ZIP CODE

12844 MILITARY ROAD SOUTH

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(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
L1070	a. On 01/19/21 a provider placed an order to obtain EKG results for QTc ASAP. The order was transcribed to the MAR on 1/19/21 and every subsequent day as of 01/28/21. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. 4. On 02/25/21 at 2:00 PM an interview with two RNs (Staff # 4 and Staff #5) showed that orders of all types are routinely transcribed to the MAR. Staff #4 and Staff #5 were unsure of the process to indicate or communicate that an order other than a medication order, had or had not been	L1070		
L1665	completed. 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. This Washington Administrative Code is not met as evidenced by: . Based on interview and document review the hospital failed to report an Adverse Event within 48 hours of confirmation for one of one patients reviewed. Fallure to report a serious adverse event to the DOH may cause delays in reviewing and	L1665	322-260.2 Adverse Health Events How: The Director of Risk educated all leadership team the hospital specific Adverse Health Events policy. Who: Director of Risk What: The Director of Risk educated all leadership team on hospital specific adverse health events policy on 2/2/2021. When: The Director of Risk will audit all serious adverse events for notification of DOH and to ensure hospital Sentinel Adverse Events policy is followed. Audit results will be submitted to monthly quality and medical executive committee and quarterly governing body until 100% compliance is achieved and sustained.	05/31/2021

State Form 2567 STATE FORM

State of Washington (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING 03/05/2020 60429197 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) L1665 Continued From page 8 L1665 analyzing the adverse event. Findings included: 1. Review of the facility policy titled, "Sentinel and Adverse Events, "Policy No. ADM.S.300 Revised 02/20, showed that "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 forty-eight hours of confirming an adverse event..." 2. Review of a document showed that the patient fall incident was confirmed on 12/07/19. A DOH report of the incident was submitted on 12/15/19, 8 days after confirming the incident. 3. On 3/3/21 at 11:30 AM, an interview with a Risk Manager showed that the event report was made by the former Director of Risk Management and the reason for the late submission is unclear.

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STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE	E CONSTRUCTION
A. BUILDING:	

(X3) DATE SURVEY COMPLETED

B. WNG ___ 60429197

С 03/05/2020

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(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
∟ 000	INITIAL COMMENTS	L 000		7
	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 date: 01/28/21 Off-site dates: 01/27/21-03/05/21 Case number: 2020-2702 Intake number: 98075 There were violations found pertinent to this complaint.		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 03/31/21 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter.	
L 315	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: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by:	L 315	Item #1 How: The Chief Nursing Officer educated all RNs on Nursing Standard for Patient Care Policy, nursing assessment/reassessment, documentation of provider notification of change in condition, active medical problems, documentation of patient assessment each shift or whenever there is a change in patient's condition using the Nursing Assessment/reassessment form and a progress note.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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If continuation sheet 1 of 9

	OF CORRECTION	IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	COMPL	
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L 315	Continued From page	9 1	L 315	Continued From page 1		
L 315	Based on interview, of policy and procedul implementation of the nursing assessment/r (Patient #1, #2, #3). Failure to implement arranging for the care places patients at risk harm, and can result if Findings included: Item #1 Assessment/findings inc	locument review, and review are, the hospital failed ensure a policy and procedure for reassessment (Item #1); policies for providing or and safety of patients are for physical and mental in poor outcomes. Reassessment ity policy, "Nursing Care", #PC.N.200 howed that "Patients are ted by the patient's care or unit specific All significant changes in the attent will be communicated sponsible physician in a attent #1's medical record	L 315	Who: Chief Nursing Officer completed for RNs on 02/04/2021 and 3/11/2021. Nursing Officer implemented daily morn meetings with each unit, Attendees in the meeting include the Chief Nursing Officer and Director of Risk and Quality. During meetings, treatment plans, care manage and protocols are reviewed to ensure meeds of the patients are addressed immediately. When: Chief Nursing Officer and or desauditing five Medical records with patient medical needs to ensure, nursing assessment/reassessment, documental provider notification of change in conditing active medical problems, documentation patient assessment and reassessment and reassessment. All deficiencies are corrected immediate not in compliance will receive re-education corrective action as necessary. Audivill be submitted for three consecutive monthly quality meetings and governing quarterly until 90% compliance is achies sustained. Audit results for March: 91% 90% and May 93%	The Chief ning he er, Nurse of rol Nurse g these gement nedical signee is nts with tion of ion, n of ever there eing nospital t policy. ely. Staff tion and it results months to g body ve and April	
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CASCADE	BEHAVIORAL HOSPITA	AL TUKWILA	A, WA 98168				
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	provider notification of	of this change in condition.					
	c On 12/06/10 at 10.	00 AM, a nurse documented					
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	change in condition.						
	onange in contenion						
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	showed that:						
	a. On 01/22/21 at 12:	00 PM, a nurse documented					
	in the Medical/Physical Update portion of an						
	assessment that Pati	ent #2 had "no active					
	medical problems" as	well as "active medical					
	problems". The skin p	portion of the assessment					
	indicates bilateral gre	at toe gangrene.	***************************************				
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		in the Behavior portion and					
		nt Processes portion of the					
	Nursing Reassessme	•					
		· · · ·					
	b. On no date, no time	e documented, a nurse did					
	not document any po					i	
	assessment for Patie						
		/24/21 at 9:00 PM on the					

PRINTED: 03/19/2021 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING: C B. WING 03/05/2020 60429197 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12844 MILITARY ROAD SOUTH CASCADE BEHAVIORAL HOSPITAL **TUKWILA, WA 98168** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) L 315 L 315 Continued From page 3 same page was completed. 5. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff # 4 and Staff #5) showed that all RNs are expected to assess patients each shift or whenever there is a change in a patient's condition using the Nursing Assessment/reassessment form and a progress note, and that nurses are expected to notify a provider as soon as possible in person or by telephone, of changes in a patient's condition. Based on interview, document review, and review of policy and procedure, the hospital failed ensure implementation of the policy and procedure for Fall Risk Assessment and Prevention and failed to document individualized fall precaution interventions for 2 of 2 patients reviewed (Item #2). Failure to implement and document fall risk prevention procedures risks patient safety and can result in adverse outcomes for patients. Item #2 Fall Risk Interventions Item #2 Fall Risk Interventions How: Chief Nursing Officer completed trainings

State Form 2567 STATE FORM

1. Review of the facility policy, "Fall Risk

Assessment and Prevention", #PC.F.100 Reviewed 03/19, showed that patients are to be

assessed for fall risk using the Morse Fall scale. The policy further states that Interventions will be

initiated or changed based on the Morse Fall Risk

Assessment score, and will be documented on

the interdisciplinary treatment plan and daily on

further states that a Post Fall Assessment Form will be completed on all patients after any fall and placed in the medical record. The "Potential for

the Nursing Reassessment form. The policy

to RNs on facility Fall Risk Assessment and

What: Chief Nursing Officer completed trainings

to all RNs on facility Fall Risk assessment policy

on 2/4/2021 and 3/11/2021. Training included:

Morse Fall Scale, interventions initiated or

changed based on the Morse Fall Risk Assessment Score and documentation on the

Prevention Policy.

YP0411

Who: Chief Nursing Officer

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL COMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DREFEX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) L 315 Continued From page 4 Injury Related to Falls "document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: 2. Record review of Patient #1's medical record in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 had a fall risk score of 65, which indicated that Patient #1 had a fall risk score of 65, which indicated that Patient #1 had a fall risk score of 65, which indicated that Patient #1 was a fall risk. D. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. C. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	
STREET ADDRESS, CITY, STATE, ZIP CODE						C	
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 XA ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COntinued From page 4 Injury Related to Falls" document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: a. On 11/28/19 at 8:00 PM, a nurse documented in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 was at high risk to fall. b. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the potential for Injury related to Fall section of the protection of the potential for Injury related to Fall section of the protection of the protection of the potential for Injury related to Fall section of the protection of the potential for Injury related to Fall section of the protection of the potential for Injury related to Fall section of the protection of the protection of the potential for Injury related to Fall section of the protection of the protection of the protection of the protection of the potential for Injury related to Fall section of the protection of			60429197	B. WING		1	
CASCADE BEHAVIORAL HOSPITAL TUKWILA, WA 98168	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	FATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE L 315 Continued From page 4 Injury Related to Falls" document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: 2. Record review of Patient #1's medical record showed that: 2. Record review of Patient #1's medical record in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 had a fall risk score of 65, which indicated that Patient #1 was at high risk to fall. 3. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. C. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Previous Record Profile Prevalence in the Recursive Action Should be PREVIOUS (EACH OCRRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY) Continued From page 4 Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocols are reviewed to ensure Fall Risk Interventions are completed in a timely manner. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs are following facility specific Falls policy. Falls Audit includes but not limited to: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment plans, and daily nursing continued to Morse Fall Risk Assessment Score and docume	CASCADI	E BEHAVIORAL HOSPITA	4L		SOUTH		
L 315 Continued From page 4 Injury Related to Falls' document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: a. On 11/28/19 at 8:00 PM, a nurse documented in this initial Nursing Assessment portion of the initial Nursing Assessment that Patient #1 was at high risk to fall. b. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the Potential for Injury related to Fall section of the percentage in the Morse Fall Risk Assessment Score and documentation on the High Risk Notification form that Patient #1 was a fall risk. Continued From page 4 Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocools are reviewed to ensure Fall Risk Interventions are completed in a timely manner. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs are following facility specific Falls policy. Falls Addit includes but not limited to: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily nursing reassessment form. The Chief Nursing Officer Implemented ally nursing reassessment form. The Chief Nursing Officer Implemented ally nursing reassessment form. The Chief Nursing Officer Implemented ally nursing reassessment form. The Chief Nurs		OLIMANU OT		1	PROVIDENCE AL AL OF CORDECTION	.1	
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the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: a. On 11/28/19 at 8:00 PM, a nurse documented in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 had a fall risk score of 65, which indicated that Patient #1 was at high risk to fall. b. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the initial Patient #1 was a fall risk. interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocols are reviewed to ensure Fall Risk Interventions are completed in a timely manner. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs are following facility specific Falls policy. Falls Audit includes but not limited to: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment plan, Fall interventions, and daily nursing	L 315	Continued From page	9 4	L 315	Continued From page 4		
interventions indicated were "apply wrist band", "comfort rounds", "bed in low position", "apply bed alarms", "apply chair alarms" and "reassess fall risk". No further documentation was found in nursing reassessments to indicate that the submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained. Staff not in compliance will receive reducation and or corrective action as necessary. Audit results for March 85%, April 91% and May 5/31/2021		Injury Related to Falls the Morse fall risk shot this policy. 2. Record review of F showed that: a. On 11/28/19 at 8:0 in the Morse Fall Risk initial Nursing Assess fall risk score of 65, v #1 was at high risk to b. On 11/28/19 at 5:0 document on the High Patient #1 was a fall r c. On 11/28/19 a nurs Potential for Injury rel Master Treatment pla interventions indicate "comfort rounds", "becalarms", "apply chair risk". No further documursing reassessment specific and individual implemented. 3. Record review of P showed that: a. On 1/23/21, no time documented in the Fa Reassessment that the unsteady and steady, wheel walker, and that place.	eet was not mentioned in Patient #1's medical record O PM, a nurse documented a Assessment portion of the sment that Patient #1 had a which indicated that Patient fall. O PM a nurse did not a Risk Notification form that risk. De documented in the sated to Fall section of the in that the fall prevention d were "apply wrist band", d in low position", "apply bed alarms" and "reassess fall mentation was found in the to indicate that the lized precautions were Patient #3's medical record De documented, a nurse alls portion of the Nursing the patient's galt was both that the patient used a front it no fall precautions were in		interventions, and daily nursing reassestorm. The Chief Nursing Officer Implemented daily morning meetings wunit, Attendees in the meeting include to Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit hospital, Infection Control Nurse and Drisk and Quality. During these meeting treatment plans, care management and protocols are reviewed to ensure Fall Formations are completed in a timely When: The Chief Nursing Officer and of designee is auditing all Falls to ensure are following facility specific Falls policy Audit includes but not limited to: Morse Scale, interventions initiated or change on the Morse Fall Risk Assessment Scadocumentation on the Interdisciplinary plan, Fall interventions, and daily nursing reassessment form. Falls Audit is being submitted for three consecutive months monthly quality meetings and governing quarterly until 90% compliance is achies ustained. Staff not in compliance will reducation and or corrective action as not Audit results for March 85%, April 91%	vith each the Chief se in the irector of gs, if kisk manner. r all RNs y. Falls Fall d based ore and treatment ng s to g body ve and eceive re- ecessary, and May	

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ONGONDE	. DEMATIONAL HOOF III	TUKWILA,	WA 98168			
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L 315	wheel walker and nei Precaution portion of 3. On 01/28/21 at 1:3 Director of Nursing (E (Staff #4 and Staff #5 aware of an expectat	ther yes nor no in the Fall the Nursing Reassessment. 0 PM an interview with the DON) (Staff #2) and two RNs o) showed that none were ion that individual fall ons were to be documented	L 315			
L1070	as evidenced by: Based on interview, rehospital policy and present to implement and enserconciliation process (Patient #1, #4). Failure to implement a reconciliation places por incomplete orders.	atient Care nsee shall rivision and nd discharge ient admitted or at not limited rs for drug I treatments and ninistrative Code is not met ecord review, and review of ocedure, the hospital failed sure staff followed the order of for 2 of 2 patients reviewed and ensure order oatients at risk for delayed Delayed or incomplete at risk for physical and	L1070	How: The Chief Nursing Officer educate RNs on following the physician order reconciliation process and avoid delay incomplete orders. Who: The Chief Nursing Officer How: The Chief Nursing Officer educate RNs on following physician order reconprocess and avoid delays or incomplete on 2/4//2021. The Chief Nursing Officer implemented 24 hour chart check form revised the 24 hour chart check process reflect completion of physician orders. When: The Chief Nursing Officer or desauditing five charts per unit to ensure a physician orders and order reconciliatio process is being followed per hospital physician orders and order reconciliation process is being followed per hospital physician orders and governing body quarterly until 90% compliance is achieve and sustained. Scompliance will receive re-education and corrective action as necessary.	ed all ciliation e orders has and s to signee is ll n colicy. meetings	

PRINTED: 03/19/2021 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING; ____ C 60429197 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH **CASCADE BEHAVIORAL HOSPITAL** TUKWILA, WA 98168 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From page 6 L1070 Continued From page 6 L1070 Audit results: March 83%, April 90% and May 05/31/2021 Findings included: and Ongoing 1. Review of the facility policy, "Noting and Transcribing Physician Orders", #PC.M.110, revised 02/19, shows that the purpose of the policy is to "Transcribe medication orders from doctor's order form accurately and as soon as possible for timely implementation." and that "The licensed nurse will review the orders to ensure that they have been accurately transcribed to the MAR, and that any appropriate notifications have been made (Pharmacy, Lab, etc.), and that "By indicating 'Noted' and signing the order, the nurse is attesting that the order has been accurately and completely transcribed, and that the appropriate steps have been taken to implement the order. 2. Record review of Patient #1's medical record showed that: a. On 12/02/19 at 11:40 a provider wrote an order for a urinalysis to rule out organic causes of Patient #1's increasing confusion. On 12/2/19 the order was transcribed to the medication administration record (MAR) and every subsequent day until 12/09/19. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. b. On 12/10/19, eight days after the order was placed, a Lab Result document indicated that

showed that:

urine had been collected on 12/09 and results were positive for 100.000+ eschericia coli.

3. Record review of Patient #4's medical record

PRINTED: 03/19/2021 FORM APPROVED State of Washington STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING 60429197 03/05/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH **CASCADE BEHAVIORAL HOSPITAL TUKWILA, WA 98168** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) L1070 L1070 Continued From page 7 a. On 01/19/21 a provider placed an order to obtain EKG results for QTc ASAP. The order was transcribed to the MAR on 1/19/21 and every subsequent day as of 01/28/21. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. 4. On 02/25/21 at 2:00 PM an interview with two RNs (Staff # 4 and Staff #5) showed that orders of all types are routinely transcribed to the MAR. Staff #4 and Staff #5 were unsure of the process to indicate or communicate that an order other than a medication order, had or had not been completed. L1665 322-260.2 ADVERSE HEALTH EVENTS L1665 322-260.2 Adverse Health Events The National Quality Forum identifies and defines How: The Director of Risk educated all twenty-nine serious reportable events (adverse leadership team the hospital specific Adverse health events) as updated and adopted in 2011. Health Events policy. (2) Psychiatric hospitals must comply with the Who: Director of Risk reporting requirements under chapter 246-302 WAC. What: The Director of Risk educated all leadership team on hospital specific adverse This Washington Administrative Code is not met health events policy on 2/2/2021. as evidenced by:

State Form 2567 STATE FORM

reviewed.

Based on interview and document review the

hospital failed to report an Adverse Event within

48 hours of confirmation for one of one patients

Failure to report a serious adverse event to the DOH may cause delays in reviewing and

YP0411

When: The Director of Risk will audit all serious

ensure hospital Sentinel Adverse Events policy

adverse events for notification of DOH and to

is followed. Audit results will be submitted to monthly quality and medical executive

committee and quarterly governing body until 100% compliance is achieved and sustained.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	` '	E CONSTRUCTION	(X3) DATE	
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(VA) ID	TP VGAMMIP	ATEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION	đ	(VE)
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L1665	Continued From page	8	L1665	Continued From page 8		
	analyzing the adverse	e event.		Audit results March: 90%; April 91% ar 93%.	id May	05/31/2021
	Findings included:					
	Adverse Events, "Poli 02/20, showed that "Ir a reportable event ha Risk Management will Department of Health will be reported using system within forty-eig adverse event" 2. Review of a docum fall incident was confireport of the incident was days after confirmin. 3. On 3/3/21 at 11:30 Manager showed that by the former Director.	ty policy titled, "Sentinel and icy No. ADM.S.300 Revised in the event it is believed that is occurred, the Director of ill report the event to the internet reporting ght hours of confirming an ent showed that the patient rimed on 12/07/19. A DOH was submitted on 12/15/19, ig the incident. AM, an interview with a Risk it the event report was made of Risk Management and es submission is unclear.				



June 29, 2021

Cascade Behavioral Health Hospital 12844 Military Road South Tukwila, WA 98168

RE: 98075 /2020- 2702

Hello Meghna.

I conducted a state hospital licensing complaint investigation at Cascade Behavioral Hospital in January and February 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 04/17/21.

The former risk manager sent a Progress Report dated 05/04/21 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Health 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,

Robin Shabica BSN, RN DOH Nurse Investigator