PRINTED: 12/30/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL SUMMANY PROTECTION OF PROPIDENCES PREFIX (CASCADE BEHAVIORAL HOSPITAL SUMMANY PROPIDENCY OF REPORTINGES A 000 INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-2/12/016 by Washington State Department of Health surveyors. Paul Knordrat., RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Washs RN, MS, Sake Glei, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (FU/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See FI/L'S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #86120; #89393; #70130: #70131: #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital for the IMMEDIATE JEOPARDY are remained in place at the time of survey team exit.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 9168	504011 B. WING		B. WING _			12/21/2016		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A 000 INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RIN, MN, MHA: Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS, Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S) inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130, #70131; #70133, and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in			AL.		12844 MILITARY ROAD SOUTH			
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This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/2/0/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY remained in	A 000	INITIAL COMMENTS		A 0	00			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		#69393; #70129; #70 #70136. During the course of the surveyors determined of serious harm, injurient extent of deficiencies of IMMEDIATE JEOP. Failure to provide sufficiencies to meet the services to meet the services of the patients. The hospital initiated 12/20/2016 but surve the plan's implementate hospital for the IMME state of IMMEDIATE, place at the time of sufficiency.	this survey, the DOH I that there was a high risk y, and death due to the This resulted in one finding ARDY in the following area: ficient pharmaceutical scope, complexity, and served. corrective actions on yors were unable to verify ation developed by the DIATE JEOPARDY and the JEOPARDY remained in urvey team exit.					

01/20/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	1, /	(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			12/21/2016	
	ROVIDER OR SUPPLIER	AL.		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
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A 000	Continued From page	÷ 1	A 0	00			
	was verified on a revi	of IMMEDIATE JEOPARDY sit on 12/29/2016 at 12:30 RN, MN, MHA and Joy					
	Cascade Behavioral I COMPLIANCE with M of Participation:	Hospital is NOT IN Medicare Hospital Conditions					
	42 CFR 482.12 Gove	rning Body					
	42 CFR 482.13 Patie	nt Rights					
	42 CFR 482.21 Quali Performance Improve	-					
	42 CFR 482.25 Pharr	maceutical Services					
	42 CFR 482.41 Physi	cal Environment					
A 043	Shell # 27QV11 GOVERNING BODY CFR(s): 482.12		A 0	43		2/10/17	
	legally responsible for If a hospital does not governing body, the part for the conduct of the	ective governing body that is r the conduct of the hospital. have an organized persons legally responsible hospital must carry out the this part that pertain to the					
	This CONDITION is	not met as evidenced by:					
	reviews, the hospital	n, interviews, and document failed to meet the FR 482.12 Condition of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504011	B. WING		12/21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
A 043	Participation for Gov. Failure to meet paticand performance imservices and physic risks an unsafe heapatients, visitors, and the services and physic risks an unsafe heapatients, visitors, and the services and physic risks an unsafe heapatients, visitors, and the services and the function patients from harmal IMMEDIATE JEOPA 12/20/2016 for failure pharmaceutical services and performent Programs Staff. 2. Failure to protect rights. 3. Failure to protect rights. 4. Failure to maintain plant and the overall care. Due to the scope and detailed under 42 Condition of Participation for Pat Condition of Participand Performance In Pharmaceutical Ser Condition of Participation of Par	ent rights, quality assessment aprovement, pharmaceutical all environment requirements at the care environment for ad staff. ody failed to effectively ning of the hospital to protect as evidenced by the ARDY condition identified on are to provide sufficient vices to meet the scope, and of the patients served. e oversight of the Performance am delegated to the Medical and promote each patient 's and promote each patient 's and severity of deficiencies FR 482.13 Condition of ient Rights; 42 CFR 482.21 pation for Quality Assessment approvement; 42 CFR 482.41 pation for Physical condition of Participation for	A 04	3	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
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	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
, •		Α0	43	
CFR(s): 482.12(e)(1) The governing body r services performed us in a safe and effective. This STANDARD is reached and comments, the hospid quality assurance and (QAPI) processes independent calculations of all conservices places patient improper or inadequation outcomes. Findings: On 12/20/2016 at 9:0 the hospital's quality (State #2 reviewed the hospital performance of conservices places patient improper or inadequation outcomes.	must ensure that the inder a contract are provided a manner. In our met as evidenced by: Ind review of hospital ital failed to ensure that its id performance improvement illuded a systematic review of itre services. In occess to oversee the intracted patient care into at risk for provision of ite care and adverse patient O AM, during a discussion of ite care and adverse patient O AM, during a discussion of ite care and adverse patient of Member #12), Surveyor in ital's process for evaluating intracted health services. In ited services documents, were was no evidence that the services had ever been part of the QAPI program for invided:	AO	84	2/10/17
-Universal Hospital - I	R&M Equip, Biomed			
	CONTRACTED SER' CFR(s): 482.12(e)(1) The governing body r services performed u in a safe and effective that safe and effective adocuments, the hospit quality assurance and (QAPI) processes incontracted patient call failure to develop a performance of all contracted patient call failure to develop a performance of al	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Cross-Reference: Tags A0115, A0263, A0490, A0700 . CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes.	TOURIER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 Cross-Reference: Tags A0115, A0263, A0490, A0700 CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided:	ROWIDER OR SUPPLIER BEHAVIORAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) COntinued From page 3 Cross-Reference: Tags A0115, A0263, A0490, A0700 CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (OAPI) processes included a systematic review of contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services bade course heen formally reviewed as part of the QAPI program for quality of services provided:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING	B. WING		12/21/2016	
	ROVIDER OR SUPPLIER	AL.		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 084	-Dietician Services	eutical - Pharmacy Services erapy - Physical Therapy	A	084			
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must prote patient's rights. This CONDITION is	ct and promote each not met as evidenced by:	A	115			10/22/17
	review, and review of procedures, the hosp promote patient rights Failure to protect and	ital failed to protect and s. promote each patient's s loss of personal freedom,					
	their rights to privacy 2. Failure to utilize the to the use of seclusio 3. Failure to release the earliest possible treflected no imminent 4. Failure to investigate closure of the complation.	he patient from seclusion at ime when documentation trisk of danger. te patient complaints prior to					

PRINTED: 12/30/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504011	B. WING	B. WING		12/	21/2016
	ROVIDER OR SUPPLIER	AL.		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 115	patient safety and pro . Due to the scope and under 42 CFR 482.13 Participation for Patie . Cross Reference: Tag A0174	al's inability to provide for otect patient rights. severity of deficiencies		115			2/10/17
	CFR(s): 482.13(a)(2)(2)(At a minimum: In its resolution of the must provide the patie decision that contains contact person, the st patient to investigate the grievance process completion. This STANDARD is real. Based on interview, do f hospital policies and failed to ensure that provide written response to the grievances reviewed to their grievance viole.	egrievance, the hospital ent with written notice of its is the name of the hospital teps taken on behalf of the the grievance, the results of its, and the date of the date of the entry of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		12/21/2016	
	ROVIDER OR SUPPLIER	NL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
A 123	1. The hospital's police "Patient Grievance Policy # G.1001) reace Advocate will: Review investigation Com Grievance Resolution report to patient for resignature." 2. Four patient complements of process and included the patient or review of process and included the patient or reviewed for evidence investigation, findings grievance issue with the patient who filed to a pon 6/3/2016 making a cleaning of the patien area, shower and bat grievance log indicate and the patient who filed to t	ey and procedure titled colicy" (Revised 10/2015; din part: "The Patient versults of the preliminary plete a written report on the process. Give written eview, comments and earned are selected for diresolution. Sources complaint log. Each was eview, comments are of receipt, hospital review, example and resolution of the earned from the grievance. The findings reviewed with the grievance. The findings reviewed with the grievance of inadequate to rooms, patient kitchen throoms. A review of the earned the complaint was closed. The findings reviewed with the grievance of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed. The findings review of the earned the complaint was closed.	A 12			
A 129	CFR(s): 482.13(b) Patient Rights: Exerc	XERCISE OF RIGHTS use of Rights unot met as evidenced by:	A 12	29	2/10/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER	AL.	•	12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 129	review, and review of procedures, the hosp rights. Failure to allow patier skin/clothing checks repersonal dignity, private. Findings: 1. The hospital's policing Responsibilities" (Review ADM.P.300) under the "To assure that a patierights and responsibilities and service from Caster and to assure that the hospital staff, physicial providers." "B. The list of patient not limited to the follopersonal privacy, and invasion of privacy, and invasion of privacy, Pearches may be conto detect and prevent possessed or used or right to care that is concerned to the promoting dignity and control to the control of the promoting dignity and the control of the promoting dignity and control of the control of the promoting dignity and control of the control of the promoting dignity and control of the control of the promoting dignity and control of the control o	n, interviews, document hospital policy and ital failed to protect patient ints the right to refuse isks patient's loss of acy, and respect. Ey titled "Patient Rights and viewed 10/2016; Policy # e section "PURPOSE" read: ent is informed of his or her ities upon receiving care cade Behavioral Hospital ese rights are known by ans and other health care Erights shall include but are wing: 4. The right to to be protected from ROVIDED, that reasonable ducted or other means used contraband from being in the premises 13. The ensiderate and respectful of a values, beliefs, and the treated in a manner is self-respect." Ey titled "Skin/Clothing vizo16) read in part: expatients who are not self-harm behaviors, who are check, will be given	A	129			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		,	12/21/2016	
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP CO 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
A 129	observed Patient #11 hospital. During the sepatient #1 was asked gown and hand his obsupervisor (Staff Mercontraband (hospital agreed but stated, I as off, I am here voluntated. The other regist (Staff Member #2) interviewed for contrabated for contrabat	nospital." 12:00 PM, Surveyor #3 being admitted to the skin/clothing check process, It to change into a hospital lothing over to a nursing mber #1) to be checked for prohibited items). Patient #1 am not taking my underwear urily and am not going to do ered nurse in attendance formed Patient #1 that was tient #1's clothing had been and, Staff Member #1 asked nd cough so they could traband. Staff Member #2 er #1 that squatting and r part of the process. 1:37 PM, Surveyor #2 red nurse (Staff Member #3) ng check done at admission. firmed that part of the ring the patient squat and king for any visible or #2 found similar process while interviewing nurses (Staff Member #4, the chemical dependency ts. 2:30 PM, Surveyor #2 cal Director of Adult (Staff Member #6) about the rocedure process. Staff to the hospital had received	A 1:	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER			128	REET ADDRESS, CITY, STATE, ZIP CODE 444 MILITARY ROAD SOUTH KWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 164	required the patient to allowed the patient to surveyor asked Staff the current policy dired discharge voluntary pskin/clothing check probeing unaware of that Member #6 stated that responsible for disserinformation to their responsible for dissering files staff members (Staff reviewed had no record staff followed had no record Skin/Clothing Check (Skin/Clothing Check (Skin/Clot	The new policy no longer or squat and cough and now refuse the skin check. The Member #6 to explain why exted staff to administratively eatients who refused the rocess. S/he acknowledged aspect of the policy. Staff at each clinical director was minating the new policy spective clinical staff. I:50 PM, Surveyor #3 of the hospital's human as Three of the four nursing Members #1, #3, # 4) ord of completing the new Competency as required. ESTRAINT OR In may only be used when entions have been fective to protect the patient, there from harm. Interest as evidenced by: I wew, interview, and review of procedures, the hospital or the effectiveness of less as before applying both		129			2/10/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	, . 		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
A 164	personal freedom a . Findings: . 1. The hospital polic "Seclusion and Phy (Revised 2/2016; Posection "Policy" reach be used for the mark self-destructive beh immediate physical member or others a interventions are incompleted. The section titled "I "Restraint or seclus less restrictive interventions from harm seclusion used must intervention that will patient, a staff mem . 2. On 12/12/2016 ar reviewed the hospit seclusion order she that under the section labeled "Mechanica chest)" does not sp to be applied by the . 3. On 12/15/2016 ar interviewed the hos educator (Staff Men restraints are to be are ordered by a ph	es and seclusion s patients at risk for loss of and dignity. by and procedure titled sical & Mechanical Restraint" blicy # PC.R.100) under the d in part: "Restraints may only nagement of violent or avior that jeopardizes the safety of the patient, a staff fiter less-restrictive effective or ruled-out " Patient Rights" read ion may only be used when ventions have been effective to protect the patient a. The type of technique or at be the least restrictive I be effective to protect the aber, or others from harm." t 2:30 PM, Surveyor #3 al's pre-printed restraint and et for Patient #5 observing on titled "Type", the box al Restraints (wrist, ankle, pecify how many restraints are	A 1	64			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		E SURVEY PLETED
		504011	B. WING		12	/21/2016
	ROVIDER OR SUPPLIER	AL.		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
A 174	member acknowledge generally start with relegs. The chest restratoccasions. 4. On 12/14/2016 and reviewed the secluside Patients #4 and #6 not placed Patients #4 arrestraints and seclusis 8/12/2016 and 9/29/2 upon a physician orderindicating that a less been considered or a simultaneous application restraints and seclusion. PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion the earliest possible to fitme identified in the This STANDARD is researched to ensure that proceedings and patients reviewed (Patients reviewed (Patients).	are initially used. The staff ed that hospital staff straining both the arms and aint is only used in rare If 12/15/2016, Surveyor #3 con/restraint records of oting that hospital staff at #6 in both physical on simultaneously on 016 respectively based er. No documentation restrictive alternative had ttempted first prior to the tion of both physical on could be found. ESTRAINT OR		174		2/10/17

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		504011	B. WING		12/21/2016
	ROVIDER OR SUPPLIER	ITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	12/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
A 174	Continued From pa . Findings:	age 12	A 17	74	
	1. The hospital's por "Seclusion and Phy (Revised 2/2016; F section "PATIENT" "Restraints or section earliest possible tire. 2. On 12/15/2016 a interviewed the host trainer/educator for and restraints (Starasked Staff Member released from section acknowledged that physician would rebehavior to determ could be discontinuary was described.	at 1:15 PM, Surveyor #3 spital's principal r staff on the use of seclusion ff Member #7). The surveyor er #7 when a patient should be usion. Staff Member #7 the trained registered nurse or view and assess the patient's ine if seclusion or restraints ued. When asked by the uld happen if the documented ribed as sleeping, s/he should be unlocked and the			
	psychiatric unit (2 the medical record into seclusion on 1 released from seclusion seclus placed in seclus grabbing a food carepeatedly striking Documentation on indicated the patien "resting" or "sleepi AM, a period of 90 written at 10:30 AM	At 11:30 AM in the adult West), Surveyor #3 reviewed of Patient #3 who was placed 2/1/2016 at 8:30 AM and usion at 11:30 AM. The patient usion after being observed rt and running down a hallway the cart against the wall. the seclusion flow sheet nt's observable behavior as ing" from 9:00 AM to 10:30 minutes. A progress note I indicated the patient was with eyes closed and			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	AL.	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 174	staffing allows for 1 to . 4. On 12/14/2016 and reviewed seclusion/re Patients #4 and #5 a . a. Hospital staff place and restraint on 9/29/him/her from seclusio of 28 hours. Surveyo observed documente resting for the followi . From 9/29/201 period of 2 hours and . From 9/29/201 at 7:45 AM, a period . From 9/30/201 a period of 2 hours. From 9/30/201 a period of 3 hours. b. Hospital staff place 12/11/2016 at 10:30 is seclusion on 12/12/2 noted the patient's obehavior on the seclu "sleeping" from 11:35 of 7 hours and 40 min on evidence in the secindicate the hospital staff place indicate the hospital staff place indicate the hospital staff place 12/11/2016 at 10:30 is seclusion on 12/12/2 noted the patient's obehavior on the seclusion of 12/12/2 noted the patient from 12/12/2 noted the patient from seclusion of 12/12/2 noted the patie	ding for the need for intinue seclusion when to 1 support." d 12/15/2016, Surveyor #3 estraint flowsheet records of and noted the following: ed Patient #4 in seclusion /2016 and did not release on until 9/30/2016, a period or #3 noted the patient's ed behavior of sleeping or ang periods: 6 at 6:45 PM until 9:30 PM, and 445 minutes. 6 at 10:45 PM until 9/30/2016 of 9 hours. 6 at 8:45 AM until 10:45 AM, 6 at 12:30 PM until 3:30 PM, ed Patient #5 in seclusion on PM and was released from 016 at 7:15 AM. Surveyor #3 observed documented usion flow sheet as 5 PM until 7:15 AM, a period nutes. The surveyor found eclusion documentation to staff considered removing	A	174			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	AL	•	12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 174	Continued From page Member #6) confirme review.	e 14 d the findings at the time of	A	174			
A 263	QAPI CFR(s): 482.21		А	263			2/10/17
		ongoing, hospital-wide, sessment and performance					
	the program reflects thospital's organization hospital departments those services furnish arrangement); and for	n and services; involves all and services (including ned under contract or cuses on indicators related utcomes and the prevention					
		intain and demonstrate program for review by CMS.					
	Based on observation and review of the hos quality documentation develop and impleme	not met as evidenced by: n, interview, record review, pital's quality program and n, the hospital failed to ent a hospital-wide, esessment and performance					
	improvement (QAPI) Failure to systematica hospital-wide perform action plans to improve	program. ally collect and analyze hance data and to develop we performance based on hospitals ability to identify					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		E SURVEY IPLETED
		504011	B. WING	·····	1:	2/21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPI	ITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 263	Continued From pa	ge 15	A 26	63		
	Findings:					
	sufficient personnel	harmaceutical services lacking I to meet the scope, eds of the patients served.				
	Failure to provide o Improvement Progr	oversight of the Performance ram;				
	Governing Body, Po	nd analyze data for ures assigned by the erformance Improvement Medical Staff for the year				
	Failure to measure, patient events;	, analyze and track adverse				
	Failure to develop a reviewing reportable	a process for identifying and e adverse events;				
		ompletion of action plans eview of adverse events;				
	environment was m	nd monitor the overall hospital naintained in such a manner well being of patients was				
	resulted in the hosp	ect of these systemic problems bital's inability to identify prove patient care, safety and				
	cited under 42 CFR	nd severity of deficiencies R 482.21, the Condition of ality Assurance and				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		3) DATE SURVEY COMPLETED	
		504011	B. WING			12/	21/2016	
	ROVIDER OR SUPPLIER	AL	•	12	REET ADDRESS, CITY, STATE, ZIP CODE 844 MILITARY ROAD SOUTH JKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
A 263	MET. Cross Reference: A-C A0490, A0700	ement Program was NOT 0273, A-0286, A-0309,	A	263				
A 273	DATA COLLECTION CFR(s): 482.21(a), (b) (a) Program Scope (1) The program musto, an ongoing prograimprovement in indicate vidence that it will in (2) The hospital must track quality indicator performance that ass hospital service and comparts of the program mustindicator data includir other relevant data, for submitted to, or received Quality Improvement (2) The hospital must (i) Monitor the effectives and quality control of the program of the program for the program of the program	t include, but not be limited and that shows measurable ators for which there is approve health outcomes measure, analyze, and s and other aspects of ess processes of care, operations. It incorporate quality appatient care data, and or example, information wed from, the hospital's Organization. use the data collected to-ectiveness and safety of	A	273			2/10/17	
		not met as evidenced by:						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		504011	B. WING		12/21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
A 273	quality program and hospital failed to colliperformance measur Governing Body, Per Committee and the M 2016. Failure to measure, a related to performance leaves the hospital unconcern that may reconcern	quality documents, the ect and analyze data for res assigned by the formance Improvement Medical Staff for the year analyze and track data be measures as assigned nable to identify areas of quire improvement. Formance Improvement Plan and a document titled "see - 2016" revealed that the ect and analyze data for 16 er was assigned to a specific action and analysis, and the was defined. The Governing the performance measures riewed the Director of Clinical per #13) about Performance ion, analysis and reporting 5 PM. The interview g: Measure titled "Patient	A 2'	73	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		504011	B. WING		12/	21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	AL	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	, .=.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
A 273	Director stated that the not been meeting and collected or analyzed b. The Performance Patient Safety Goals' hospital was to collect were reviewed by Sulikelihood of patient hanticoagulant therapy Medication Reconcilidischarge. The Chier Risk Manager were recollection and analyst Committee and the Committee of Nursing responsible for the dand for reporting more and Governing Board patients placed in responsible for the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available for redocumentation of resulting the Committee to the Goreport available	d for surveyor review. The he grievance committee had d that the data was not being d. Measure titled "National " listed 5 goals that the ct and analyze data for, two liveyor #2: 1) Reduce harm associated with y (Warfarin), and 2) ation upon admission and of Nursing Officer and the responsible for data his, and for reporting to the PI Governing Board monthly. It containing this information for review. Measure titled "was to measure proper estraint and seclusion. The land the Risk Manager were lata collection and analysis, anothly to the PI Committee d. While the number of estraint and seclusion were later and seclusion were later and seclusion were later and seclusion. Measure titled "Risk to Safety/Quality" was to measure titled "Risk to Safety/Quality" was to	A 273			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
		504011	B. WING _			12/21/2016
	ROVIDER OR SUPPLIER	TAL.		STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 273	Governing Board. The review the data colles medication variance was data presented and medication variate containing analysis of e. The Performance Consultations/Treatmedical consultation appropriateness to the The Risk Manager at were responsible for and for reporting the Performance Improvement Containing this surveyor review. f. The Performance is Services and quality in and Chief Executive data collection and a information annually Improvement Comment Executive Committee containing this information in the surveyor review. Cross-reference: Tager of the The Performance and Therapeutics witilization, medication medication and calculation, medication and calculation, medication and calculation, medication and calculation, medication and calculation and calculation, medication and calculation and calculation and calculation, medication and calculation and calculation and calculation, medication and calculation a	Improvement Committee and the surveyor requested to action and analysis for and elopement. While there to the surveyor for elopement ances, there was no report of the data. Measure titled "Medical ment" was to measure for timeliness and the patient's individual needs. Ind Chief Nursing Officer adata collection and analysis, information quarterly to the rement Committee and the committee. There was no information presented for the Contract log for scope of the asure titled "Contracted of the Contract log for scope of the analysis, and for reporting this to the Performance wittee and the Medical to the Contracted of the Contracted of the Contracted of the Contract log for scope of the analysis, and for reporting this to the Performance wittee and the Medical to the Contracted of the Contracted of the Contracted of the Contract log for scope of the asure titled "Contracted of the Contract log for scope of the Contract log fo	A 2	273		
		Pharmacist was responsible and analysis, and for reporting				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		504011	B. WING _			12/21/2016
	ROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY, STATE, ZIP COI 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
A 273	Improvement Comm Executive Committee	ge 20 rterly to the Performance nittee and the Medical ee. There was no report mation presented for surveyor	A 2	273		
A 286	to, an ongoing prog improvement in indi evidence that it will medical errors. (2) The hospital mu trackadverse pati (c) Program Activitie (2) Performance im track medical errors analyze their cause actions and mechar and learning throug (e) Executive Responsive governing body (or who assumes full lefor operations of the administrative official accountable for ensigned evidence to the individual of the serior of the administrative official accountable for ensigned evidence to the individual of the serior of the	ram Scope ust include, but not be limited ram that shows measurable cators for which there is identify and reduce st measure, analyze, and tent events es aprovement activities must a and adverse patient events, s, and implement preventive nisms that include feedback		286		2/10/17
	This STANDARD is	s not met as evidenced by:				

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		,	12/21/2016	
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP C 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 286	Continued From page		A 2	286			
	ITEM #1 - Analysis a Patient Events	nd Tracking of Adverse					
	,	record review and review of ne hospital failed to measure, verse patient events.					
	adverse patient even to identify root cause	gregate data related to ts risks the hospital's ability s and develop action plans o an unsafe patient care					
	Findings:						
	titled "Incident Repor (Policy #RM.200; Ap that the hospital's Ris	proved 12/2013) revealed sk Manager was responsible report data for statistical					
	12/2015) revealed the the Medical Executive Performance Improver risk management act results of incident repatient complaints to patient care occurrent	colicy #RM.300; Approved at it was the responsibility of the Committee and the ement Committee to review ivities by analyzing the ports, patient surveys and determine patterns of					
	Quality (Staff Member PM and 12/20/2016 of Clinical Services (S	he Manager of Risk and er #12) on 12/14/2016 at 1:04 at 1:20 PM, and the Director Staff Member #13) on M revealed the following:					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
A 286	Continued From pag	e 22	A 28	36	
	the Risk Manager an but the data was not looking for patterns, improvement.	ere reviewed individually by d other managers as needed reviewed in aggregate trends and opportunities for			
	individually but the d	s were logged and reviewed ata was not analyzed in r patterns, trends and rovement.			
	transfer were reported quarterly but the data	cients requiring a medical and to the Governing Board as was not analyzed in repatterns, trends and provement.			
	analyzed for the purp	a was not being collected or cose of looking for patterns, ties for improvement.			
	iTEM #2 - Reportable	e Adverse Events			
	hospital policies and	record review and review of procedures, the hospital rocess for identifying and adverse events.			
	inhibits the hospitals review of the events	reportable adverse events ability to perform in-depth and develop action plans. atients at risk for care in an			
	"Adverse health ever	6-302-010 Definitions nt" or "adverse event" means e serious reportable events			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT.	AL		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 286	Forum in 2011, in its reportable events in appendices. WAC 246-302-020 H (1) Notify the departrevent has occurred worth confirmation of the action of the a	d by the National Quality consensus report on serious health care including all low and When to Report ment that an adverse health within forty-eight hours of diverse health event of the department within confirmation of the adverse port must include a root corrective action plan on all Quality Forum (NQF) is twenty-nine serious me twenty-nine adverse mg but not limited to: events: injury of a patient or staff m a physical assault (i.e., within or on the grounds of a limited to report ents to the State, it must be	A	286			

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		504011	B. WING		12/21/2016	
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	12/21/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
A 286	requirement for repo submitting a root cau. 2. Surveyor #2 review patient assault result The patient was tran room for care and rehealth care appointmincident was reviewe and Quality (Staff Mellovestigation Chronocompleted with recommended with recommended with recommended with recommended with recommended with recommended at 2:12 Featient assault reveating was unaware that this considered an advernment was unaware that this considered an advernment was unaware that the considered to the policy. ITEM #3 - Completion Based on interview a hospital failed to ensplans developed during the patient was unaware to the policy.	clude the NQF list of vents nor did it include the rting adverse events and use analysis. Wed a report of a patient to sing in a serious patient injury. In sferred to the emergency quired follow-up specialty pents for his/her injuries. The end by the Manager of Risk ember #12), and the logy and Incident Recap was mmendations for on the investigation. The Manager of Risk and er #12) by Surveyor #2 on the investigation. The Manager of Risk and er #12) by Surveyor #2 on the investigation. The Manager of Risk and er #12) by Surveyor #2 on the investigation. The Manager of Risk and er #12 is particular incident was see event by NQF. Staff that a root cause analysis eted nor had the incident State as required by hospital The Action Plans and document review, the ure completion of action ing review of adverse events.	A 28	86		
		o correct systemic problems				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		12/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 286	Continued From page	25	A 2	86	
A 309	for 3 adverse events of Services (Staff Member 1:25 PM and with the Quality (Staff Member AM. Review of the accorrect identified issued as For the elopement change the policy "Costaff of a patient who the nursing unit) to "Completed although is E was being used by b. For the sexual assaitems was a change to followed by audits to were properly conducted audits to were properly conducted audits to the were properly conducted audits to the complete audits of the complete audits and the comp	r #12) on 12/20/2016 at 9:20 tion plans developed to es revealed the following: issue, the action item to ode Amber" (used to alert has wandered away from Code E" had not been taff were trained and Code the hospital. ault issue, one of the action o an assessment form ensure that assessments ted, documented, and risk were implemented. Staff hat the audits had not been ESPONSIBILITIES (e)(2), (e)(5) ing body (or organized no assumes full legal sibility for operations of the ff, and administrative ole and accountable for g:	A 3	09	2/10/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
		504011	B. WING _		12/21/2016		
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL				STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	12/21/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION		
A 309	and performance impriorities for improve safety and that all imevaluated. (5) That the determinance impriorities for improve safety and that all impriorities for impriorities	errors, is defined,	A 3	09			
	Based on interview a performance improve Governing Body faile ensure that the quali performance improve implemented. Failure to provide ov Assessment and Perprogram to ensure fur performance Improve hospital's ability to identify to identify the performance improvements of the perform	and review of the hospital's ement plan, the hospital's ed to provide oversight to ty assessment and ement (QAPI) plan was fully ersight of the Quality formance Improvement all implementation of the ement plan limited the entify systemic problems and to improve patient care and					
	(Policy #RM. 300; Ap "Medical staff and m leadership for and ac performance improve criteria for measuring	formance Improvement Plan oproved 12/2015) stated that anagement staff provide ctively participate in ement activities and establish g, assessing and improving ance of both clinical and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED	
		504011	B. WING _			12/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL		•	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 309	They assure implemeduality assessment and report the result Medical Executive Comprovement Common The Medical Executive Authority and Acceptage and assess contribute to the precontinual improvement appropriateness and outcomes. Medical responsibilities, duty performance improving the Medical Staff. The hospital's Medical 12/1/2013) under the Executive Committee Management: (a) The overseeing quality a improvement are to evaluation of the quassure its comprehedual document impropatient outcome studies.	es and patient outcomes. Internation of appropriate and improvement activities is to the Board through the committee and Performance bittee. Inve Committee is delegated countability necessary for the ment of all processes that evention of problems and the cent of the quality, if efficiency of patient care executive Committee and authority for ement activities are defined bylaws." In the staff Bylaws (dated as section titled "Medical e" read in part 11.4.1 Quality	AS	-		
	Quality (Staff Memb Clinical Services (St that the Medical Dire Performance Improv not participate in per activities other than	the Manager of Risk and er #12) and the Director of aff Member #13) revealed ector is a member of the vement Committee but does formance improvement those that have to do with evileging of medical staff. The				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED			
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER	AL.		STREET ADDRESS, CITY, 12844 MILITARY ROAD S TUKWILA, WA 98168	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 309		Quality stated that the ement Program has never ed as required by the	A	309			
A 405	administered in accor State laws, the orders practitioners responsi specified under §482 standards of practice. (i) Drugs and biologic administered on the conot specified under §4 practitioners are actin law, including scope of policies, and medical regulations. (2) All drugs and biologic administered by, or un or other personnel in and State laws and reapplicable licensing reaccordance with the applications and procedure. This STANDARD is reasonable licensing reaccordance with the applications and procedure.	cals must be prepared and dance with Federal and softhe practitioner or ble for the patient's care as 12(c), and accepted als may be prepared and orders of other practitioners 482.12(c) only if such ag in accordance with State of practice laws, hospital staff bylaws, rules, and orders of other practitioners 482.12(c) only if such ag in accordance with State of practice laws, hospital staff bylaws, rules, and orders of other practitioners 482.12(c) only if such ag in accordance with State of practice laws, hospital staff bylaws, rules, and in approved medical staff res.	A	405			2/10/17
		ew, interview, and review of the hospital failed to ensure					

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		504011	B. WING		1	2/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		12272010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 405	treatment of alcohoreviewed (Patient #Failure to follow sucreceiving inadequat which may result in Findings: 1. The hospital's por "CIWA" [Clinical Instance Assessment] (Polici 12/2013) established be assessed for synhow the patient's synsing a withdrawal medications were to the patient's score. pre-printed order sea Alcohol Withdrawal physicians to order medications to be a patient's withdrawal 2. Review of the mpatients who experiwithdrawal during the following: a. Patient #7 was a admitted on 12/10/2 withdrawal. On 12/ patient's physician of Withdrawal sea alcohol withdrawal services alcohol withdrawal ser	Illowed physician orders for I withdrawal for 1 of 3 patients 7). Ch orders risks patients are or improper treatment, patient harm. Dilicy and procedure titled titute Withdrawal y #AR.C.210; Approved and how often a patient was to imptoms of alcohol withdrawal; and titled "Lorazepam Orders for " (dated 5/15/2014) used by specific dosages of dministered based on the assessment score. edical records of three enced symptoms of alcohol neir hospital stay revealed the 59 year-old patient who was 2016 for treatment of alcohol 10/2016 at 9:30 PM the ordered the Alcohol I initiating treatment for	A 40	05		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		12/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
A 405	An interview by Surv Nurse (Staff Membe patients alcohol with administered medica the score assigned a patient's dose of Lor 0.5 mg at 9:40 AM a Member #4 did not k administered the hig	g of Lorazepam at 9:40 AM pam at 2:20 PM. reyor #2 with a Registered r #4) during review of the drawal scores and ations revealed that based on at 9:00 AM and 2:00 PM the azepam should have been and 0.5 mg at 2:20 PM. Staff know why nursing staff her doses.	A 40		2/40/47
A 490	that meet the needs institution must have registered pharmacis under competent sure is responsible for de procedures that minifunction may be deletorganized pharmace. This CONDITION is a Based on observation review, the hospital in pharmaceutical servicemplexity, and need.	ave pharmaceutical services of the patients. The a pharmacy directed by a set or a drug storage area pervision. The medical staff veloping policies and mize drug errors. This egated to the hospital's eutical service. In not met as evidenced by: In, interviews, and document failed to provide sufficient ices to meet the scope, ds of the patients served. Ilequate pharmacy services and safe medication	A 49		2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		12/	/21/2016
	ROVIDER OR SUPPLIER BEHAVIORAL HOSPITA	ıL.		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 490	prior to pharmacy ver in high number of autoverrides 2. Patient home media pharmacist prior to . 3. Medication errors r	administered to patients ification of orders resulting omatic dispensing machine cations not being verified by being administered.	Α	190		
	4. Expansion of hospi and patient census wi increase in pharmacy The cumulative effect resulted in the hospita safe dispensing, use tracking and control of Due to the scope and under 42 CFR 482.25 Participation for Pharm	of these systemic problems al's inability to provide for and administration, and f medications. severity of deficiencies				
A 491	PHARMACY ADMINIST CFR(s): 482.25(a) The pharmacy or drug administered in accorprofessional principles This STANDARD is recorded.	STRATION g storage area must be dance with accepted	Αź	191		2/10/17

(X3) DATE SURVEY COMPLETED
12/21/2016
·
ECTION (X5) HOULD BE COMPLETION PROPRIATE DATE
+

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		12/21/2016	
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	12/21/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
A 491	Continued From pag	ge 33	A 4	91		
	administered the me	tials of the pharmacist. Staff edication at 9:00 PM on 16/2016 prior to pharmacist				
	Sodium 40 mg table 180 mg capsules, w patient's medication room. The pharmac	me medications, Provastatin ts and Dilt [Diltiazem] XR SR ere found for Patient #9 in the tray in the Rehab medication ist verified and labeled the				
	date" label rather that verification label. Sta medications on 12/1	8/2016 at 9:00 AM. There der for the patient to take				
	c. Three bottles of h 300 mg capsules, N Truvada 200 mg tab #10 in the patient's medication room. T written directly on the Rayataz and Tru unable to tell if the ir evidence of pharman on pharmacist verification bottles. label with date and spharmacist verificati were in a plastic bag medication tray. Two one stated that the pand the other note is verified Norvir. The lang way to the bottle administered all three	ome medications, Rayataz orvir 100 mg tablets and lets, were found for Patient medication tray in the Rehab here was an initial and date e medication bottle label (for wada) but the surveyor was nitials and dates were cist verification. There were cation labels on the two				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504011	B. WING	B. WING		12/	21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			128	REET ADDRESS, CITY, STATE, ZIP CODE 344 MILITARY ROAD SOUTH KWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 491	d. One bottle of home capsules, was found patient's medication t medication room. The labeled the medication medication on 12/19/2	e medication, Dilantin 30 mg for Patient #11 in the ray in the Gero-psych unit e pharmacist verified and en. Staff administered the 2016 at 9:00 AM. There er for the patient to take	A	491			
A 493	pharmaceutical services.		Α.	493			2/10/17
	Based on document of hospital failed to ensustaffed with sufficient provide quality pharm to meet the needs of providing care. Failure to provide sufformedication delivery pharm due to medication. Findings: 1. The hospital expandy 42 beds within the	review and interview, the ure the pharmacy was number of personnel to naceutical services in order the patients and the staff ficient pharmacy staff to timely order processing and laces patients at risk of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		504011	B. WING _		12/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
A 493	(2 North - 18 beds; 2 the expansion, the hicensus (ADC) was 6 current ADC is 104.4 increase or an additional The hospital pharma not increase correspincreased workload. 2. On 12/20/2016, Standard pharmacy document key quality workload noted that the average doses administered in 12,000 doses since to 12,00	West - 24 beds). Prior to ospital's average daily 6.58 patients. This year's 1 which represents a 57% onal 37.58 patients per day. cy staffing or coverage didondingly despite the arveyor #3 reviewed a which captures a variety of elements. The surveyor ge number of medication monthly increased by over he beginning of the year. medication overrides averaged 2,593 per month Similarly, the "inventory matic dispensing machines non-controlled substances noreased to a monthly s. 11:30 AM, Surveyor #3 acist (Staff Member #9) of pharmacy staffing tent workload. Staff Member e pharmacy workload had ed within the past year. S/he ting work at this facility he hospital had added two	A 4	93	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING			12/:	21/2016
	ROVIDER OR SUPPLIER	\L		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 493	Member #8) about the overrides occurring we member of the hospit month" but acknowled medication overrides pharmacy is only on-shours. Surveyor #3 as s/he had sufficient phember #8 stated that pharmacy staff to do director of pharmacy worked over the contrector of pharmacy worked over the contrector of pharmacy staff to do director of pharmacy worked over the contrector of pharmacy worked over the first we secret for the first we staff number of medication over think medication over staff member acknow overriding because of to be verified in the sy also complained they medications in the au machines on the wee Monday mornings" results.	2:30 PM, Surveyor #3 tor of Pharmacy (Staff e high number of medication rithin the hospital. Staff at he/she had only been a all staff for "less than a dged the number of was "high" indicating that site during the day shift asked Staff Member #8 if armacy resources. Staff at "I don't have enough what we should." The indicated that he/she had racted hours every week sek when on orientation. 11:00 AM, Surveyor #3 tor of Adult Psychiatric aff Member #6) about the cation overrides occurring staff Member #6 indicated ides is a "problem" stating "I rides are dangerous." The reledged that nurses were f how long it takes for orders system. Staff nurses have frequently run out of tomatic dispensing	A	493			
A 500	DELIVERY OF DRUG CFR(s): 482.25(b)	is .	A :	500			2/10/17
		itient safety, drugs and ontrolled and distributed in					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER	AL	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 500	This STANDARD is a Based on document review of hospital pol hospital failed to enst and distributed in acc standards of practice. Failure to have adequent medication orders to in a safe and timely mand medication errors. Tindings: 1. The hospital policy "After-Hour Medication Pharmacy Review" (FPHR-169I) under the Policy" read "The fact importance of pharmator of new drug therapy. to decrease medication order for does not permit pharmoccurs in 'first doses' such cases, an exception to pharmatication order for does not permit pharmoccurs in 'first doses' such cases, an exception order, and outweigh the benefits. 2. On 12/20/2016, St.	iciable standards of practice, ral and State law. not met as evidenced by: reviews, interviews, and icies and procedures, the ure drugs were controlled cordance with applicable. uate processes in place for be received and dispensed nanner risks patient safety s. and procedure titled on Stock with or without Revised 4/2014; Policy # section titled "Statement of ility recognizes the acist review prior to initiation This review has been shown on errors associated with the essThe hospital allows for macist review of the certain situations when time macist review. This often or 'emergency' situations. In otion is allowed because rm could result in the delay	A	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		504011	B. WING			12/21/2016
	ROVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL	•	STREET ADDRESS, CITY, STATE, Z 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
A 500	medication variance The surveyor noted 23,348 medication in the first nine more expansion of the hospital average 2 month. With the ornursing units, the re had risen to a mon representing a 22% overrides. Similarly number of medicate by physicians had beginning of the year 3. On 12/19/2016 at reviewed the hospithe period 12/16/20 12/19/2016 at 7:00 the pharmacy in-hot day. During this tir admitted 14 patien medication override Of the 236 medicate over the weekend, "First Dose Needer pharmacy had not order in the automation over as the reason for the 4. On 12/19/2016 at interviewed the Dir Member #8) about overrides occurring Member #8 indicate override and obtain	and indicators that included es and medication overrides. If the hospital had a total of overrides performed by nurses in the of 2016. Prior to the ospital bed capacity, the capacity, the capacity in the dispersion overrides a pening of the two additional number of medication overrides the action overrides and the surveyor noted that the ion variances (potential errors) increased by four fold since the ear. At 3:00 PM, Surveyor #3 tal medication override list for 2016 at 4:00 PM until AM (the weekend) in which ouse coverage is only 6 hours a me period, the hospital ts and there was a total of 236 es initiated by the nursing staff. It is an overrides which occurred 85 of the overrides listed d' as the reason indicating the yet verified the medication ated dispensing system. Only rides listed "Emergency Use"	A	500		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING	B. WING		12/	21/2016
	ROVIDER OR SUPPLIER	NL	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
A 500	formulary was access any restriction. 5. On 12/20/2016 at interviewed the Direct Nursing Services (Stahigh number of medic within the hospital. Sthat medication overriproblem. The staff me was processing "too rincident reports. Staff member of the Pharm Committee to see if sprogress could be materially acknowledged discuss meetings with the pre (Staff Member #10) for (Staff Member #11) at	d that the hospital's entire sible to all nurses without 2:30 AM, Surveyor #3 for of Adult Psychiatric aff Member #6) about the sation overrides occurring taff Member #6 indicated des is a long standing ember confirmed that s/he many medication error" ff Member #6 asked to be a macy & Therapeutics ome improvement or de on this issue. He/she sing medication overrides in vious pharmacy director ormer chief nursing officer and the quality risk manager and the decision was made	A	500			
A 700	CFR(s): 482.41 The hospital must be maintained to ensure and to provide facilities treatment and for speappropriate to the need. This CONDITION is a speaked on observation staff interviews, the homolition of the physi	constructed, arranged, and the safety of the patient, es for diagnosis and	A	700			2/10/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER	AL.		12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 701	was protected. Failure to maintain the facility plumbing and of the failure to follow manumaintenance activities. Failure to remove ligal areas. Failure to monitor and temperature devices of are maintained at the condition for Physical Methods and the failure to the scope and cited under 42 CFR 4 Participation for Physical Methods and the failure for the failure for the failure for the phospital environment maintained in such a well-being of patients. This STANDARD is resulted.	y and well-being of patients e structural integrity of the ventilation system. ufacturer-recommended and schedule. uture risks in patient care d provide appropriate food to ensure food temperatures required levels. severity of deficiencies 82.41, the Condition of ical Environment was NOT ups A0701, A0710, A0724, PHYSICAL PLANT whysical plant and the overall must be developed and manner that the safety and		700			2/10/17
	review the hospital fa	iled to maintain the condition and the overall hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		504011	B. WING _			12/21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 701	Continued From pag	e 41	A 7	01		
		ne physical plant increases o patients, staff and visitors.				
	Findings:					
	observed the door in Gero-psychiatric unit that posed a ligature "Proactive Risk Asse the facility had identiand assessed it as "Isurveyor noted the caction", "Time Fram Mediation Needed" for information provided 2. On 12/13/2016 at observed that the ha	had a closure mechanism risk. In review of the ssment dated August 2016, fied door risks in geriatric unit High" or "Severe Risk". The olumns labeled "What e", and "Intermediate or this item had limited or no in these columns.				
	observed that the floadult psychiatric unit underneath the vinyl	and that vinyl was rippled bathroom was located next				
	observed in the seclu psychiatric unit (2 Wi ceiling, the crack app exposed dry wall who done. On 12/14/2016 PM and 3:00 PM Sur soaked in water on the	10:25 AM Surveyor #1 usion room on the adult est) a large crack in the beared to be wet with ere work had previously been between the hours of 2:00 rveyor #1 observed towels ne floor in the same West where the ceiling was				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			12/21/2016	
	ROVIDER OR SUPPLIER	TAL	•	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 701	see what was above found that the three above were located the surveyor observe was in use during the 5. On 12/15/2016 be AM Surveyor #1 obsthe shower onto the 303. During the incidifacility staff (Staff Mand pull out small ardid a visual inspection flashlight and found 6. On 12/13/2016 be and 11:00 AM Surveyor and the patient kitchen as a potential fire hazara 8. On 12/13/2016 be	veyor #1 went to 3 West to the seclusion room and showers previously stated above the seclusion room, ed that one of the showers e incident. Etween 9:00 AM and 10:00 served flooding over the rim of floor on 3 West next to room dent, the surveyor observed ember #17) "snake" the drain mounts of hair. Surveyor #1 on of the pipes using a the pipes were occluded. Etween the hours of 10:25 AM eyor #1 observed water tile located in the Rehab unit etween the hours of 10:25 and #1 observed a burnt outlet in rea in the Rehab unit, this is	A 7	,			
	9. On 12/15/2016 be and 3:00 PM Survey outpatient building (ventilation system hire. Surveyor #1 ob used for group sess did not have any wir	etween the hours of 1:30 PM or #1 entered into an PHP Building), the buildings ad not been replaced after a reserved 2 large rooms that are ions for patients, one room andows and the other room had topen creating no means to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		12/21/2016		
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	AL	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION		
A 701	Continued From page	e 43	A 701				
A 710	CFR(s): 482.41(b)(1) (1) Except as otherw (i) The hospital muprovisions of the Life Fire Protection Associated of the Federal NFPA 101 2000 edition issued January 14, 20 reference in accordant 1 CFR Part 51. A copinspection at the CMS Center, 7500 Security or at the National Arc Administration (NARA availability of this mat 202-741-6030, or go http://www.archives.ggfederal_regulations/Copies may be obtain Protection Association Quincy, MA 02269. If of the Code are incorwill publish notice in the announce the change (ii) Chapter 19.3.6 the adopted edition of hospitals. (2) After consideration findings, CMS may we the Life Safety Code would result in unreast facility, but only if the	ise provided in this sectionals meet the applicable Safety Code of the National siation. The Director of the Register has approved the on of the Life Safety Code, 2000, for incorporation by nee with 5 U.S.C. 552(a) and by of the Code is available for Sinformation Resource (a) Boulevard, Baltimore, MD shives and Records (a). For information on the terial at NARA, call to: 1000/federal_register/code_of sibr_locations.html 1101 ned from the National Fire 1101 ned from the Nat	A 710		2/10/17		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE COMF	SURVEY PLETED
		504011	B. WING			12/	21/2016
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIF 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
A 710	apply in a State wher safety code imposed protects patients in her the safety code imposed protects patients in her the safety code imposed protects patients in her the safety and quality. This STANDARD is requirements of the L National Fire Protective dition. Findings: Refer to the deficiency care Hospital MEDIC reports. FACILITIES, SUPPLI MAINTENANCE CFR(s): 482.41(c)(2) Facilities, supplies, all maintained to ensure safety and quality. This STANDARD is resulted in the safety and compared to the safety and compared to the safety and designated expiration. Based on observation review, the hospital facare supplies did not designated expiration. Failure to ensure patience of the safety and control of the sa	if the Life Safety Code do not be CMS finds that a fire and by State law adequately ospitals. Interview, and document alled to meet the Life Safety Code of the on Association (NFPA), 2012 Sies written on the Acute CARE Life Safety inspection JES, EQUIPMENT Ind equipment must be an acceptable level of the an acceptable level of the level		724			2/10/17

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		504011	B. WING _		12/21/2016
	ROVIDER OR SUPPLIER	AL	•	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
A 724	Continued From pag	e 45	A	724	
	Findings:				
	West adult psychiatri	11:00 AM during a tour of 3 c unit, Surveyor #3 found the wound supplies cabinet:			
		of 0.9% Sodium Chloride for iration date of 4/2016.			
		of 0.9% Sodium Chloride for iration date of 9/2016.			
	c. One box of sterile with an expiration da	cotton-tipped applicators te of 2/2016.			
	d. One box of sterile with an expiration da	cotton-tipped applicators te of 9/2016.			
	e. One box of povido expiration date of 10	ne-iodine swabsticks with an /2016.			
	f. One 14 french Fole expiration date of 7/2	ey urethral catheter with an 2016.			
		1:00 PM, Surveyor #3 t emergency cart and found			
	a. Two 1000 ml 0.9% Intravenous fluids wit 5/2016.	Sodium Chloride th an expiration date of			
		Sodium Chloride pre-filled iration date of 5/2016.			
	c. One 60 ml bottle o with an expiration da	f povidone-iodine solution te of 7/2016.			
	İ		1	I I	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	1, ,	TE SURVEY MPLETED	
		504011	B. WING _			2/21/2016	
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSP	ITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 724	inspected the gero- emergency cart and a. Two 1000 ml 0.9 intravenous fluids v 5/2016. b. Nine 10 ml 0.9% syringes with an ex c. Five Tegaderrm i expiration dates of 4. On 12/13/2016 a the medication roor three 10 ml 0.9% S syringes with an ex a. On 12/14/2016 b and 2:25 PM Surve (transparent adhes expiration date 4/20 on the Detox unit. 5. On 12/13/2016 a inspected the emer and found the follow a. Two 1000 ml 0.9 intravenous fluids v 5/2016. b. Nine 10 ml 0.9% syringes with an ex	at 1:35 PM Surveyor #4 -psychiatric unit (4 West) d found the following: % Sodium Chloride with an expiration date of Sodium Chloride pre-filled spiration date of 5/2016. Intravenous site dressings with 11/2015 and 4/2016. Intravenous site dressings with 2016 and 1:11 PM Surveyor #2 toured on on the Detox Unit and found codium Chloride pre-filled spiration date of 5/2016. Detween the hours of 1:00 PM eyor #1 found Tegaderm ive film dressing) with an 2016 in the crash cart located at 1:30 PM Surveyor #2 regency cart on the Rehab Unit	A 7	24			
	2:25 PM Surveyor	#1 interviewed central supply #18). During the course of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		12/21/2016		
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH FUKWILA, WA 98168	701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
A 724	supplies in the crash central supply perso part of his/her respondents monthly. He/she checked the crash call tem #2 Ice Machine Based on observation interview the hospital manufacturer's instrumaintenance, installation installation, promote microorganisms, whi risk. Reference: Follett Se	or #1 asked how often the carts are checked. The was unaware that it was estated that he/she had earts 4 months previously. s on, document review and al failed to follow for preventive eation and routine cleaning of enufacturer's instruction for nace, routine cleaning and	A 724	,			
	Installation, Operation numbers above D25 provided a diagram of Information on incomplete in the Information of Information on Information	on and Service Manual Serial 455 stated on page 15 of incorrect installation. rect installation as followed: vater can collect that restricts ice flow at results in wet ice and problems ymphony Plus: On page 4 the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	1 ' '	
		504011	B. WING	<u>-</u>	12/21/2016	6
	ROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	12/2//2010	<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLE	ETION
A 724	Continued From pa	ge 48	A 72	24		
	Follett Symphony lo following cleaning f page 14 and 17: "th	ce machine 400 Series and ce Machine Manual stated the requency for both models on the frequency in cleaning and the according to the schedule				
	Semi-annually prev Drain Line - weekly Drain Pan/Drip Pan					
	Findings:					
	and 1:45PM Survey from a Follett Ice M to the floor drain. T the patient kitchen preventive mainten	retween the hours of 1:00PM yor #1 observed a drain-line achine was not slope to grade the ice machine was located in area on the Rehab unit. The ance sticker was past due te on the drip pan had residue				
	and 10:00 AM, Sur- hospital plant mana Member #19 stated maintenance was b a company to get th how often they get he/she said, annua from the company, several machines re maintenance betwee September but the which machines we	retween the hours of 8:30 AM veyor #1 interviewed the ager (Staff Member #19). Staff I in part that the ice machine whind so they contracted with mem caught up. When asked preventive maintenance, ally. In review of work orders "MacDonald-Miller" it showed eccived preventive men the months of July through work order did not indicate are done and what was ventive maintenance. In				
	addition, Surveyor	#1 reviewed a work order hospital system that indicated				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING			12/21/2016	
	ROVIDER OR SUPPLIER	AL.		STREET ADDRESS, CITY, STATE, ZIF 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
A 724	date of 8/10/16 was p work was done. 3. On 12/14/2016 bet and 2:45 PM Surveyon the drip pan and d	e on 3-North unit was tive maintenance on ed out and a hand written provided to indicate when the ween the hours of 1:00 PM or #1 observed soil buildup rain line of the ice machine	A	724			
A 726	located in the Detox unit.		A	726		2/10/17	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	504011	B. WING _			12/	21/2016
	NL		128	844 MILITARY ROAD SOUTH		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
document cooling tim Reference: Washingtow WAC 246-215-03515 2. On 12/12/2016 bet PM Surveyor #1 obset Member #20) using a inaccurately when tak "Ruben Sandwich". Totemperature indicator stem; the staff inserted sandwich thereby pot reading. The type of the staff was not designed meat patties, fish filled In addition, Surveyor thermometer's accurate thermometer with 2 of ice-bath registered at the thermometer used to registered at 20 degree off calibration. Dietary confirmed this. Reference: Washingtow WAC 246-215-04335 Reference: Washingtow	es for the pasta. on State Retail Food Code a FDA Food Code 3-501.14 ween 11:00 AM and 12:15 erved dietary staff (Staff food probe thermometer sing the temperature of a the thermometer is located half way up the d only the tip into the entially giving an inaccurate thermometer used by the d to temp thin foods such as its, and other thin food items. #1 checked to see the they by placing the ther thermometers in an 32 degrees Fahrenheit. The temp the "Ruben Sandwich" these Fahrenheit, 12 degrees or staff (Staff Member #20) on State Retail Food Code,	Α7	726			
. INFECTION CONTROCFR(s): 482.42(a)(1) The infection control of develop a system for investigating, and cor	officer or officers must identifying, reporting, trolling infections and	Α7	749			2/10/17
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page document cooling tim Reference: Washington WAC 246-215-03515. 2. On 12/12/2016 bethe PM Surveyor #1 obsest Member #20) using a inaccurately when taken "Ruben Sandwich". The temperature indicators in the staff inserted sandwich thereby pother reading. The type of the staff was not designed meat patties, fish filled. In addition, Surveyor thermometer with 2 or ice-bath registered at thermometer used to registered at 20 degree officialibration. Dietary confirmed this. Reference: Washington WAC 246-215-04335 Reference: Washington WAC 246-215-04580 INFECTION CONTROCCER(s): 482.42(a)(1) The infection control of develop a system for investigating, and control of the control of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580 INFECTION CONTROL PROGRAM	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. 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Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580 . Reference: Washington State Retail Food Code, WAC 248-245-04580 . INFECTION CONTROL PROGRAM CFR(s): 482-42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and	ROWIDER OR SUPPLIER SUMMARY STATEMENT OF DETRICIENCIES (EACH DEPOCINCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer used to temp thin foods such as meat paties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit. 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580 INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and	SOMMERCION SOME STREET ADDRESS, CITY, STATE, ZIP CODE 12/2

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		504011	B. WING			12/21/2016	
	ROVIDER OR SUPPLIER	AL.	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 749	Continued From page personnel.	÷ 51	A	749			
	This STANDARD is r	not met as evidenced by:					
	Item #1 Hand Hygien	е					
		n and review of hospital staff failed to perform hand after administering					
	Failure to perform has staff at risk for infection	nd hygiene puts patients and on.					
	Findings:						
	III. INDICATIONS FO ANTISEPSIS C. Do having direct or indire Decontaminate hands	d 10/2016 read in part: " OR HANDWASHING AND econtaminate hands before ect contact with patients F. s after contact with a G. Decontaminate hands y fluids or excretions,					
	administer oral medic not perform hand hyg the medications, and with the patient's oral	Inurse (Staff Member #14) ations to a patient. S/he did iene (HH) before preparing though s/he came in contact					
		d nurse (Staff Member #15) ations to a patient. S/he did					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIF 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIAT	(X5) COMPLETION DATE	
A 749	the patient's skin. Item #2 Dietary Sanif Based on observation implement policies and compliance with the Prood Code (246-215 and Drug Administration of the Proof Code (246-215 and Drug Administration of the P	tation In, the hospital failed to and procedures to ensure Washington State Retail WAC) and the Federal Food tion. If ood practices places sitors at risk for foodborne It ween 11:00 AM and 12:15 and a chlorine indicator test enchorine concentration level et for in-use wiping cloths. The enchorine concentration level et for insure wiping cloths. The enchorine concentration level et for insure wiping cloths. The enchorine concentration level et for insure wiping cloths. The enchorine concentration level et for insure wiping cloths. The enchorine concentration level et for insure wiping cloths. The enchoring th	A 7	749			
	Based on observation	n, review of hospital's policy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		12/21/20	16
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMP	X5) PLETION PATE
A 749	hospital staff failed to cleaning patient room Failure to follow man use and hospital poli increases the risk of staff and visitors. Reference: Virex II 2 solution to hard, non surfaces. All surfaces minutes. Wipe surface minutes. Wipe surface with titled: "Daily Cleaning 8/2016) stated in parthe room to clean. Cat all times." 2. On 12/13/2016 at observed a houseked during a daily clean of "Virex 256 disinfectal hand sink then process."	nstructions for use, the ofollow procedures when ins. nufacturer's instructions for instructions for infection/illness to patients, 56 Diversey: "Apply use porous environmental is must remain wet for 10	A 749	,		
	3. On 12/13/2016 at observed a houseked during a daily clean of surveyor observed the clean a shower flothe same brush.	9:38 AM Surveyor #1 eper (Staff Member #22) of a patient room. The ne housekeeper use a brush or after cleaning a toilet with				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			12/21/2016	
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
A 749	during a daily clean of surveyor observed the light fixture over the provided was sleeping, potential dust particles. 5. On 12/13/2016 at 9 observed housekeeping care the housekeeping care for 12/15/2016 at 4 reviewed a facility do Prevention" the document of the housekeeping care for 2016. Of identified was Patient "Target" of success of the provided for success of the provided for the housekeeping care for 12/15/2016 at 4 reviewed a facility do Prevention the document of the housekeeping care for 12/15/2016 at 4 reviewed a facility do Prevention the document of the housekeeping care for 12/15/2016 at 4 reviewed a facility do Prevention the facility document of the housekeeping care for 12/15/2016 at 4 reviewed a facility do Prevention the facility document of the housekeeping care for 12/15/2016 at 4 reviewed a facility document of the housekeeping care for 12/15/2016 at 4 reviewed a facility document of the housekeeping care for 12/15/2016 at 4 reviewed a facility document of 12/15/2016 at 4 reviewed a facility documen	eper (Staff Member #22) If a patient room. The It is housekeeper dusting a It is patient's head while a patient It is patient to It is a patient t	A 7	749	GIENOT)		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X	3) DATE SURVEY COMPLETED
		504011	B. WING _			R 03/10/2017
	ROVIDER OR SUPPLIER	AL	,	STREET ADDRESS, CITY, STATE, ZIP C 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	CODE	00.10.2011
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{A 000}	INITIAL COMMENTS	3	{A 0	00}		
	MEDICARE HOSPIT FOLLOW-UP VISIT	TAL COMPLAINT SURVEY				
	March 7 - 10, 2017 b	visit was conducted on y Paul Kondrat, RN, MN, lon, RN, MN; Joy Williams, biel, REHS, PHA.				
	conducted on March	F/LS) follow-up visit was 7, 2017 by Washington Fire Marshal Don West.				
	issues related to the	rveyors also assessed following Medicare #71515; and #71516.				
	hospital complaint su	y correction of encies found during the rvey on 12/12-16/2016 and ch the facility was found not				
	42 CFR 482.12 Gove	erning Body				
	42 CFR 482.13 Patie	nt Rights				
	42 CFR 482.21 Qual Performance Improve					
	42 CFR 482.25 Phar	maceutical Services				
	42 CFR 482.41 Phys	ical Environmental				
	surveyors determined	the follow-up visit, the DOH d that there was a high risk				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE	·	(X6) DATE

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

(X6) DATE

01/20/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED		
		504011	B. WING _			R 03/10/2017		
	ROVIDER OR SUPPLIER	ıL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		00/10/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
{A 000}	serious of the findings declaration of IMMED following area: Failure to conduct efform when wanding newly identification of hazar to self and others (3/9). Removal of the state was verified on 3/10/2 Kondrat, RN, MN, MH	y, and death due to the s. This resulted in the HATE JEOPARDY in the ective security procedures admitted patients for ds associated with danger	(A 0)	00}				
{A 043}	Medicare Hospital Co 42 CFR 482.12 Gove 42 CFR 482.13 Patien Shell #27QV12 GOVERNING BODY CFR(s): 482.12 There must be an effet legally responsible for lif a hospital does not governing body, the patient of the functions specified in governing body	ective governing body that is	{A 0	43}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING			l	₹ 10/2017
	ROVIDER OR SUPPLIER			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	<u> 03/</u>	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{A 043}	reviews, the hospital requirements at 42 Cr Participation for Gove Failure to meet patier healthcare environments staff. Findings: 1. The Governing Body manage the functioning patients from harm as IMMEDIATE JEOPAR 3/9/2017 for failure to care in an environment well-being of patients 2. Failure to conduct of procedures for identification associated with danger Due to the scope and detailed under 42 CF Participation for Patier	a, interviews, and document failed to meet the FR 482.12 Condition of erning Body. Intrights risks an unsafe ent for patients, visitors, and the hospital to protect a evidenced by the RDY condition identified on ensure patients receive ent in which the safety and are assured. Effective safety and security ideation of hazards er to self and others. Severity of deficiencies R 482.13 Condition of erning Body was NOT MET.	{A C	143}			
A 144	PATIENT RIGHTS: C. CFR(s): 482.13(c)(2)	ARE IN SAFE SETTING	A	144			2/10/17
	setting.	ght to receive care in a safe not met as evidenced by:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING				₹ 10/2017
	ROVIDER OR SUPPLIER	I	<u>. I</u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH TUKWILA, WA 98168	1 03/	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 144	instructions for use, a and procedures, hosp follow manufacturer's hand held metal dete. Failure to ensure that competency verified to metal detector correct visitors at risk for condangerous hazards eserious threat which reserious the scannee to irrect allow the scanee to irrect under a shirt sleet investigate the source the scannee assures watch." Page 4 of the the proper technique	PROCEDURES AND HAZARDS Ins, review of manufacturer's and review of hospital policy bital staff members failed to instructions when using the ctor. It staff are trained and skill to operate the hand-held tly puts patients, staff, and traband and other intering the facility posing a may result in injury or death. The tall Detector Super Scanner The section din part, "All the prior to or immediately inpatient unit". The section din part: "Staff should not influence them as to what is larm. For instance, if the presence of a suspicious the alarm even though you that [it] is just his/her in hospital policy illustrates and procedure to use when wanding from the front to the	A	144			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		504011	B. WING			R 03/10/2017	
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		3,10,2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 144	Continued From page 4		A 14	14			
	Super Scanner unde "Components/Function "Interface Elimination factory set for maxim smallest of items. Th may produce alarms containing rebar. Pre decrease sensitivity respond to the rebard detector returns to no 2. On 3/7/2017 betwee Surveyor #1 requeste (CNA) (Staff Member of the hand-held met observation, the CNA on and the metal det malfunctioning with the LED lights were flash #2 pushed a button of detector and the flast except for a single gr proceeded to scan the continuously holding Staff Member #2 ack interview with Survey unaware of the side I 3. On 3/8/2017 at 9:0 interviewed the Direct Member #4) about the detectors and training confirmed the metal Staff Member #2 had battery had been rep	on" (pp 5-6) read in part: a Button- The detector is a Button- The detector is a um sensitivity to detect the e high level of sensitivity when approaching a floor as and hold this button to to a level that does not Release button and ormal sensitivity." een 8:00 PM and 8:28 PM, ed a certified nurse's aide or #2) to demonstrate the use all detector. During the A turned the metal detector ector appeared to be the surveyor noting that all aing on and off. Staff Member on the side of the metal hing LED lights shut off the en light. The CNA then the surveyor while (depressing) the side button. Inowledged in a follow-up or #1 that he/she was outton's function or purpose. Of AM, Surveyor #1 tor of Intake Personnel (Staff the use of hand-held metal					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			R 03/10/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		J3/10/2017	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 144	4. On 3/10/2017 betw AM, Surveyor #1 obs staff member (Staff Muse of the hand-held the observation, Staff side button (interferent proceeded to wand the metal detector beeper when the wand was lefeet. Staff Member #3 #5) if they had anythin #5 stated "no". Staff I wanding procedure to patient (left and right) wand the backside (patient as required by member failed to war patient's feet or invest the beeping as required. S. On 3/10/2017 at 2: reviewed eight medic Nursing Communicat noted the following: a. Four of eight recommarked "Yes" or "No" the patient had been b. One of eight record "No" reflecting that the wanded. c. Three of the eight marked "Yes" indicating the staff of the eight marked "Yes" indicating the eight	reen 11:00 AM and 11:45 erved an Intake Personnel flember #3) demonstrate the metal detector wand. During f Member #3 pushed the nce elimination button) and ne front of the patient. The d and a red light flashed ocated near the patient's asked the patient (Patient ng in his/her socks. Patient Member #3 continued the o include both sides of the a Staff Member #3 did not nosterior aspect) of the or hospital policy. The staff and the underside of the tigate further the source of red by hospital policy. 30 PM, Surveyor #1 al records and the "Intake to ion Hand-Off" forms and des reviewed were not to document and confirm	A1	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		504011	B. WING			R 03/10/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	I	03/10/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 144	Continued From pag	e 6	A 1	44		
	found after the patier cutting themselves. patient acknowledge his/her sock. 2. Patient #6 had during the skin/clothi upon arrival on the understay. 3. Patient #7 had on the day of dischar stay. ITEM #2 LINE OF SI Based on record revipolicy and procedure ensure that patients observation were kepinjury from other patients.	d a cellular phone discovered ge after a five day hospital GHT MONITORING ew and review of hospital as, the hospital failed to on "Line of Sight" (LOS) ot safe from self-harm or				
	harm by other patien or death.	ts may lead to serious injury				
	"Patient Observation Reviewed 1/2017) st Observation B. Lii be kept within eyesig times, day and night. could be used to hard should be removed. required when the pa	cy and procedure titled, "(Policy # PC.P.300; ated in part, "III. Levels of the of Sight. The patient will that and accessible at all Tools or instruments that the themselves or others This level of observation is attent could, at any time, themselves or others.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	03/1	0/2017		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
A 144	essential aspect of The hospital policy Rights and Respor Reviewed 1/2017) B. The list of pat not limited to the foreceive care in a second as 2/24/2017 for treat suicidal ideation. The 40 on the Suicide Acompleted on admirisk level scoring to is classified as a second than the routine evolution observation status physician had exart following day (2/25) was placed on line 3. On 2/27/2017 at (RN) (Staff Member patient's medical reexamined the patient's physician documented by the stated that the patients and that the	and procedure titled, "Patient his level of observation." and procedure titled, "Patient his biblities" (Policy # ADM.P.300; stated in part: " Procedure tient rights shall include but are oblowing: 5. The right to have setting." an 18 year-old admitted on ment of depression with he patient received a score of Assessment scale which was hission. A review of the overall hool indicated that medium risk core between 25 and 41. Other hery 15 minute checks that are hatter at the mined the patient on the wideling was assigned until after the mined the patient on the vi/2017) after which the patient	A 14	4				
	examined the patie her/his left wrist an patient's physician documented by the stated that the pati status and that the remaining in LOS ophysician had orde earlier in the day a phone call to the pi	ent and found multiple cuts on d arm. The RN notified the A telephone order RN on 2/27/2017 at 9:30 PM ent was on LOS observation patient was responsible for						

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	ROVIDER OR SUPPLIER	NL	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH TUKWILA, WA 98168	1 001	10/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
A 144	dated 3/2/2017 at 1:0 assessed the patient suicide risk. The physistaff monitoring of the order dated 3/2/2017 [every] 5-minute checks of the patient was noted to be blanket covering her/listated she/he cut the After further question the patient had used a blade]. The patient reblade hidden in her/his 1:00 PM, following threvealed that staff feltipatient was in LOS of checks the incident staff she/he felt that P on 1:1 observation stafficting of grabbing per harm herself/himself as LOS observation staff reported that Patient is	ian (Staff Member #9) note 0 PM showed the physician to have an increased ician ordered increased patient. The physician's at 10:45 AM stated "LOS Q iks for 24 hours." mentation, on 3/2/2017 censed nurse (Staff at Patient #3 was bleeding in thand/wrist area. The be sitting on the floor with a nis arm. Initially, Patient #3 mselves using a pencil. ing, it was discovered that a metal blade [X-Acto ported that she/he kept the is sock. Intation dated 3/2/2017 at the blade cutting incident, it the patient should have on status because while the is staff and on every 5 minute citil occurred. RN (Staff Member #7) on with Surveyor #2 showed attent #3 should have been attus as the patient had a encils and using them to even though she/he was on us. Staff Member #7 also #3 harmed themself with a LOS observation status with	A	144				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	304011		STREET ADDRESS, CITY, STATE, ZIP CO	DE I	03/10/2017
CASCADE	BEHAVIORAL HOSPITA	AL		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 PREFI) TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
A 144	Continued From page	9	A 1	44		
	Psychiatric Unit (Staf at 10:40 AM confirme Patient #3. Staff Mer she/he was unsure hipossession of such a Member #10 stated the she/he brought the black before the brought the black before was admitted on 2/13 the patient might harm was initially placed or 2/13/2017 to 2/18/20 LOS observation for a remained on LOS observation for semained in the medical results of the patient was documented "Pt. A&C Mood is anxious and Approached nurse with self-harm injury sustates while the patient was documentation in the to indicate the hospita patient from harming patient presenting the 10. On 3/9/2017 at 9 reviewed the medical who were involved in patient assault incide while on LOS monitor following:	2:00 AM, Surveyor #4 It record of Patient #4. S/he Id/2017 due to concerns that In themselves. Patient #4 In 1:1 observation from In, and then was placed on Idea of the servation until 3/8/2017. An Idea of the servation until 3/8/2017. An Idea of the servation of the servation until 3/8/2017. An Idea of the servation of the servation until 3/8/2017. An Idea of the servation of the servation until 3/8/2017. An Idea of the servation of the servation until 3/8/2017. An Idea of the servation of the				

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NAME OF PR	ROVIDER OR SUPPLIER	004011	1	STREET ADDRESS, CITY, STATE, ZIF	CODE	03/10/2017	
				12844 MILITARY ROAD SOUTH			
CASCADE	BEHAVIORAL HOSPITA	.L		TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
A 144	"exiting seeking, frequent Pt [patient] is observed bedroom & taking the pt. was observed pun who assaulted him be up the argument & relocations." b. On 2/11/2017 at 9:4 LOS monitoring was a "Patient threw a punce the ground Police investigate the case. [as needed] meds. Resulting the second patient the second patient the second patient that LOS is similar to the entire staff and not the entire staff and not the monitoring. Staff that only when a patien monitor the patient. 12. An interview with Risk (Staff Member # revealed that the facilion the use and effections in the control of the cont	noted in the record to be benefly trying to open doors	A 1	144			
[A 4C4]	patient monitoring.	concerning LOS and 1:1	(A 44	641			
{A 164}	PATIENT RIGHTS: R	ESTRAINT UK	{A 16	04}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		504011	B. WING _			R 03/10/2017	
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPI	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		03/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{A 164}	less restrictive interdetermined to be independent of the independent of the independent of the independent of the interventions before restraints and sector reviewed. (Patients Failure to utilize or alternatives to using simultaneously puts personal freedom a Findings: 1. The hospital polic "Seclusion and Phy (Reviewed 1/2017; section "Policy" rearrestraints may only of violent or self-desigeopardizes the imminishment of the intervention of	on may only be used when ventions have been effective to protect the patient, others from harm. Is not met as evidenced by: view and review of hospital ures, the hospital staff failed ctiveness of less restrictive applying simultaneously both sion for 3 of 6 patients is #1, #2, #3). Consider less restrictive both restraints and seclusion is patients at risk for loss of and dignity. Cy and procedure titled sical & Mechanical Restraint Policy # PC.R.100) under the din part: "Seclusion and be used for the management structive behavior that mediate physical safety of the aber or others after ventions are ineffective or	{A 16	54}			
	"Restraint or seclus less restrictive inter	ion may only be used when					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP (12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	CODE	00/10/2017	
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{A 164}	or others from harm. restraint or seclusion restrictive intervention protect the patient, as from harm." 2. On 3/8/2017 at 9: reviewed the records placed in either seclusions in the seclusion simultaneous application of the seclusion at 10:45 Placed in the seclusion at 10:45 Placed in either seclusion simultaneous applicates restraints and seclusion at 9:45 Placed in either seclusion at 9:45 Placed in either seclusion at 10:45 Placed in either seclusion at	The type of technique of used must be the least in that will be effective to staff member, or others 15 AM, Surveyors #3 and #4 of of five patients who were usion or restraints during their red the following: aced in 4-point restraints and ously by hospital staff on a Subsequently, Patient #1 estraints at 9:15 PM and from M. No documentation restrictive alternative had attempted first prior to the ation of both physical ion could be found. Aced in 4-point restraints and ously by hospital staff on M. Subsequently, Patient #2 estraints at 9:00 PM and from II. No documentation restrictive alternative had attempted first prior to the ation of both physical ion could be found. A Subsequently restraints and ously by hospital staff on M. Subsequently, Patient #2 estraints at 9:00 PM and from II. No documentation restrictive alternative had attempted first prior to the ation of both physical ion could be found. A Surveyor #2 toured the Adult est and reviewed the medical The surveyor noted the for both seclusion and outlaneously on 3/2/2017,	{A 1	64}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		504011	B. WING			03/	10/2017
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPITA	NL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH FUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE
{A 164}	Continued From page 13 (either seclusion or restraint used alone) was attempted prior to the simultaneous application of both physical restraints and seclusion.		{A 1	64}			
{A 286}	PATIENT SAFETY CFR(s): 482.21(a), (c)		{A 2	286}			
	to, an ongoing progra improvement in indica evidence that it will medical errors.	t include, but not be limited im that shows measurable ators for which there is identify and reduce measure, analyze, and					
	track medical errors a analyze their causes,	rovement activities must and adverse patient events, and implement preventive sms that include feedback					
	governing body (or or who assumes full legation	ring the following:					
	Based on interview, in policy and procedure,	not met as evidenced by: record review and review of , the hospital failed to track aff response to a patient's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT	TAL .		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		03/10/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{A 286}	and procedure. Failure to document event decreases the hospital can provide patient and leaves the the effectiveness of quality improvement. Findings: 1. The hospital's pol "Code Blue" (Policy 1/2017) stated that a be documented on the placed in the patient. 2. Patient #9 was a 12/19/2016 for treat. Patient #9 required withdrawal and was unit. On 12/21/2016 found unresponsive discoloration of the scalled a Code Blue (medical emergencies cardiopulmonary resperamedics arrived administering CPR upronounced dead at Review of Patient #8 that there was no de Record) of the staff cardiac arrest. 3. An interview with	a patient's cardiac arrest equality of the information the for ongoing treatment of the ne hospital unable to evaluate emergency response for purposes. icy and procedure titled #PC.C.100; Reviewed a patient cardiac arrest should he Code Blue Record and 's medical record. 49 year-old admitted on ment of alcohol use disorder. Treatment for alcohol admitted to the detoxification of at 12:54 PM the patient was and cyanotic (bluish skin). At the same time, Staff (a code used in hospitals for s) and started suscitation (CPR). at 1:10 PM and continued until the patient was	{A 28	6}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		504011	B. WING			1	۲
NAME OF D	ROVIDER OR SUPPLIER	304011	5	Т	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	10/2017
NAME OF FI	NOVIDER OR SUFFLIER				12844 MILITARY ROAD SOUTH		
CASCADE	BEHAVIORAL HOSPITA	NL			TUKWILA, WA 98168		
()(1) ID	STIMMADV ST	ATEMENT OF DEFICIENCIES	ID	<u> </u>			(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{A 286}	Continued From page confirmed these findir	÷ 15	(A 2		DEFICIENCY)	TE.	DATE

PRINTED: 12/30/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			R 05/05/2017
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP C 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
{A 000}	INITIAL COMMENTS		{A 00	00}		
	MEDICARE HOSPIT FOLLOW-UP VISIT	AL COMPLAINT SURVEY				
	- 5, 2017 by Paul Kor	N, MN; Joyce Williams, RN,				
	During the survey, su issues related to the complaints: #72537					
		encies found during the rvey revisit on March 7 -10,				
	42:CFR 482.12 Gove	rning Body				
	42 CFR 482.12 Patie	nt Rights				
	surveyors determined of serious harm, injur seriousness of the fin	the follow-up visit, the DOH If that there was a high risk y, and death due to the dings. This resulted in the DIATE JEOPARDY in the				
		when an emergency medical and requiring immediate action ardiopulmonary				
	was verified on 5/5/20	of IMMEDIATE JEOPARDY 017 at 2:15 PM by Elizabeth Joyce Williams, RN, BSN.				
ABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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

01/20/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OATE SURVEY COMPLETED
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		504011	B. WING _			05/05/2017
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{A 000}	Continued From page		(A 0	00}		
	The hospital remains Medicare Hospital Co	NOT IN COMPLIANCE with anditions for:				
	42 CFR 482.12 Gove	rning Body				
A 023	Shell #27QV13 LICENSURE OF PEF CFR(s): 482.11(c)	RSONNEL	A	023		2/10/17
	•	sure that personnel are or applicable standards that or local laws.				
	This STANDARD is r	not met as evidenced by:				
	policy and procedure	and review of hospital's the hospital failed to ensure ursing (DON) was properly ment.				
	Failure to ensure that appropriately licensed places patients at risk unqualified staff.	d prior to employment,				
	Findings:					
	titled, "License and C (Policy Number: HR - September 1, 2015) u "procedure", stated "t employment, candida	under the heading titled hat prior to offer of tes applying for positions must present proof of their human resources."				

, ,	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	504011	B. WING			05/	05/2017
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL			12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		
PREFIX (EACH DEFICIENCY MUST	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 023 Continued From page 2 interviewed the human res Member #6) in regards to to for new employees. During #1 asked to see the Direct (Staff Member #7) licensur resource manager indicate #7's nursing license had exasked to see the Staff Memburan resource manager did not have a current file to while the human resource vacation. The vacation of the human resource	the screening process the interview Surveyor or of Nursing (DON) re. The human ed that Staff Member expired in 2015. When mber #7's file, the stated in part that s/he because s/he was hired manager was on urce manager indicated e but was unable to . Staff Member #6 was re governing body that is conduct of the hospital. I an organized ans legally responsible bital must carry out the boart that pertain to the requirements at 42 Participation for the required ing to respond to their cal needs risks delays	A (A)	023			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011		B. WING		1	R
	ROVIDER OR SUPPLIER		D. Wille	12	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	05 <i>1</i>	05/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(A 043)	the functioning of the from harm as evidence JEOPARDY condition failure to intervene where situation was identified resulting in delay of consulting in delay of	failed to effectively manage hospital to protect patients ced by the IMMEDIATE in identified on 5/3/2017 for then an emergency medical and requiring immediate action ardiopulmonary I severity of deficiencies R 482.12 Condition of terning Body was NOT MET. The series of the series of the candidates for edical staff. Indicate the series of the series of the candidates for edical staff. The series of the	(A C	043}			2/10/17
	Failure to provide per	formance evaluations as an assistant delegation					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		504011	B. WING		R 05/05/2017
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPIT	AL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	1 00/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
A 045	agreement and to proconsistent with physical places patients' safe. Findings 1. In review of the hotitled, "Physician Assimus MS.P.310; Last Revi 2: "physician assistated, "make an independer patient should be addeduced and 10:30 AM Surved delegation agreement personnel file (Staff I delegation agreement Authority, the agreement Authority, the agreement Authority, the agreement on-certified physicial order, to administer and Schedule II-V condition to reviewing supervisory physicial as follows: Weekly fareviews twice a weeklevaluations. In review (Staff member #8) or was unable to validate meetings had occurrice conducted twice a wagreement. In additional staff in additional consistency of the conducted twice a wagreement. In additional consistency of the conducted twice a wagreement. In additional consistency of the conducted twice a wagreement. In additional consistency of the conducted twice a wagreement. In additional consistency of the conducted twice a wagreement.	expital's policy and procedure istant Privileges" (Policy No: ewed 1/2017) stated in part ants are not to write orders or ponsibility for that patient's a physician assistant is not to at decision as to whether the mitted to the hospital." een the hours of 8:30 AM yor #1 reviewed the at in a physician assistant's Member #8). In review of the ant, under Prescriptive ment allows a certified or an assistant to prescribe, to and to dispense legend drugs entrolled substances. In medical orders, the an must provide supervision ace to face meetings; chart a and quarterly performance wing physician assistant's edentialing file, Surveyor #1 the that face to face weekly ed or that chart reviews were each as required by the on, the physician assistant as not evaluated quarterly as	A 04		
	conducted twice a wagreement. In addition (Staff Member #8) was required by the agreem 3. On 5/4/2017 at 1:0	eek as required by the on, the physician assistant as not evaluated quarterly as			

DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED
	504011	B. WING		R 05/05/2017
OVIDER OR SUPPLIER BEHAVIORAL HOSPITA	AL	•	STREET ADDRESS, CITY, STATE, ZIP (12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	·
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			TION SHOULD BE COMPLÉTION THE APPROPRIATE
Physician Assistant (Since patient to the hose equired supervisory was not present in the confirmed by Human	Staff Member #9) admitted pital on 3/21/2017. The physician counter signature e record. This finding was	A	045	
EMERGENCY SERVICES CFR(s): 482.12(f)(2) If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures		A	093	2/10/17
This STANDARD is range. Based on interviews, review of hospital polinospital failed to ensurappropriate immediate emergency medical serial in the staff of the s	document review, and icy and procedures, the ure that staff took e action to address an ituation.			
patient's emergency ren activating the hosp system and initiating straining. The hospital policy Blue Response - Mecharrest" (Reference El read in part, "It is the administer cardiopuln when a person's brea	and procedure titled "Code dical Emergency / Cardiac M-024; Approved 8/2016) policy of this facility to nonary resuscitation (CPR) thing and/or pulse cease,			
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page Physician Assistant (State patient to the hosequired supervisory was not present in the confirmed by Human Member #6). EMERGENCY SERV DEFR(s): 482.12(f)(2) If emergency services nospital, the governing medical staff has writter appraisal of emergency and referral when appropriate immediate emergency medical staff to ensure staff the ensure staff that the ensure staff tha	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Physician Assistant (Staff Member #9) admitted the patient to the hospital on 3/21/2017. The equired supervisory physician counter signature was not present in the record. This finding was confirmed by Human Resource Manager (Staff Member #6). EMERGENCY SERVICES OFR(s): 482.12(f)(2) If emergency services are not provided at the nedical staff has written policies and procedures or appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Based on interviews, document review, and eview of hospital policy and procedures, the nospital failed to ensure that staff took appropriate immediate action to address an emergency medical situation. Failure to ensure staff had the required showledge, skills, and training to respond to a patient's emergency medical needs risks delays a activating the hospital emergency response system and initiating urgent treatment.	TOTAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Physician Assistant (Staff Member #9) admitted the patient to the hospital on 3/21/2017. The equired supervisory physician counter signature vas not present in the record. This finding was confirmed by Human Resource Manager (Staff Member #6). EMERGENCY SERVICES OFFR(s): 482.12(f)(2) If emergency services are not provided at the nospital, the governing body must assure that the nedical staff has written policies and procedures or appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Sased on interviews, document review, and eview of hospital policy and procedures, the nospital failed to ensure that staff took appropriate immediate action to address an emergency medical situation. Failure to ensure staff had the required showledge, skills, and training to respond to a valient's emergency medical needs risks delays an activating the hospital emergency response system and initiating urgent treatment. Findings: 1. The hospital policy and procedure titled "Code Blue Response - Medical Emergency / Cardiac Arrest" (Reference EM-024; Approved 8/2016) ead in part, "It is the policy of this facility to administer cardiopulmonary resuscitation (CPR) when a person's breathing and/or pulse cease,	IDENTIFICATION NUMBER: 504011 STREET ADDRESS, CITY. STATE, ZIPY 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 Physician Assistant (Staff Member #9) admitted he patient to the hospital on 3/21/2017. The equired supervisory physician counter signature was not present in the record. This finding was confirmed by Human Resource Manager (Staff Member #6). EMERGENCY SERVICES SPR(s): 482.12(f)(2) If emergency services are not provided at the lospital, the governing body must assure that the nedical staff has written policies and procedures or appraisal of emergencies, initial treatment, and referral when appropriate. This STANDARD is not met as evidenced by: Discovery of hospital policy and procedures, the hospital for the staff took appropriate immediate action to address an emergency medical situation. Failure to ensure staff had the required moveledge, skills, and training to respond to a patient's emergency medical needs risks delays a activating the hospital penergency response system and initiating urgent treatment. Findings: I. The hospital policy and procedure titled "Code Blue Response - Medical Emergency / Cardiac Arrest" (Reference EM-024; Approved 8/2016) and in part, "It is the policy of this facility to didminister cardiopulmonary resuscitation (CPR) when a person's breathing and/or pulse cease,

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		504011	B. WING			R 05/05/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168	ı	03/03/2017
(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 CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 093	2. During a review (term used by hospiresponse for patient resuscitation) which March and April 201 the following: REVIEW OF CODE a. Patient #1 was a 4/5/2017 for depres On 4/20/2017, a coresponse to finding bathroom door. b. On 5/2/2017 at 11 interviewed a regist Member #3) about t #1's death by hangi hospital on 4/20/20 s/he was the only R and was preparing the records for the next she/he heard the Cla loud noise and was just hanged themse immediately went to room and saw the patient down so the nurse's station a supervisor for help. s/he called a code to Once the nursing station of the station	of the two code blue events stals to activate emergency its requiring immediate occured during the months of 17, Surveyors #2 and #3 noted #1. 66 year-old admitted on sion with suicidal ideation. It is blue was initiated in the patient hanging on his/her 10:55 PM, Surveyors #2 and #3 ered nurse (RN) (Staff he events surrounding Patient ing which occurred in the 17. Staff Member #3 stated N on the unit with 15 patients the medication administration day. The RN indicated that NA (Staff Member #2) making as yelling that a patient had lives. Staff Member #3 indicated that at s/he and the CNA could get s/he decided to run back to and called the nursing Next, the RN indicated that oliue followed by calling 911. upervisor arrived (Staff emoved the patient from the	AC	93		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		504011	B. WING _			R 05/05/2017	
	ROVIDER OR SUPPLIER	AL		STREET ADDRESS, CITY, STATE, ZIP COL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168		13/03/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 093	Continued From page	e 7	A 0	93			
	interviewed the nursii Member #4) about th #1's death by hanging that exactly at 5:00 A adjustments and rece come to 2-North. Statim/her less than a munit. Upon arrival on observed Patient #11 bathroom door. The rewith assistance from immediately removed placed them on the group compressions. When the resuscitation wenthe code blue went a the circumstances but for assistance (code could have been stathen asked Staff Memproblems with any of indicated that there wand connecting the moself-inflating bag-valv Member #4 confirmer received no practice d. On 5/2/2017 at 11: interviewed a register about the events sum by hanging which occ 4/20/2017. Staff Memworking on another of the code blue notificates assist in the code blue surveyors asked if the	the patient from the door, round, and began chest asked by the surveyors how t, Staff Member #4 indicated s well as it could have given t acknowledged that the call blue) for the emergency ted earlier. The surveyors aber #4 if there were any					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011	B. WING		R 05/05/2017	
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSPI	TAL	1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	05/05/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
A 093	member indicated the on how to put the monohim the monohim the monohim to put the monohim the mo	having difficulty ng the "ambu bag". The staff hat s/he had to instruct them hask on the device. S/he y had not conducted any ing cardiopulmonary she began her employment de Blue Evaluation Form in I record revealed that the first alve mask ventilation were the mask connected to the mask was found and same form, staff did not under Code Standards which to "Yes" or "No" regarding ardiopulmonary resuscitation] and high quality. Charge summary dictated on to #1's medical record showed cian (Staff Member #10) that ther review of documentation cion efforts by staff there was to support that CPR was for high standards. 2:35 PM, Surveyor #3 pital clinical educator (Staff code blue education and	A 093			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING	_			⋜ 05/2017
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168	1 03/1	03/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 093	REVIEW OF CODE: 2. Surveyor #2 review that occurred on 3/15 year-old admitted for withdrawal syndrome summary in Patient #2 had a history of swithdrawal and was control seizures as a 3/15/2017 at 5:08 PM the floor apparently on his/her back, the his/her airway. A par registered nurse (RN the patient to his/her breathing again. The assisting him/her to be side then the RN left paramedics. Once the (licensed practical nursing assistants) at to manage the patient to the unit with the patient of the patient of the patient of the patient addition, no Code Blue For response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition, no Code Blue for response to the patient addition and the patient addition	wed another code blue event 5/2017. Patient #2 was a 58 alcohol dependence and a. According to the discharge £2's medical record, Patient eizures from alcohol blaced on medication to preventative measure. On M, the patient was found on the patient was found on the patient was assisting the 1)(Staff Member #11) moved left side. The patient started RN instructed the patient eep the patient on his/her the unit to meet the ne RN left the unit, an LPN arse) and 2 CNAs (certified and physician were left alone at situation. The RN returned aramedics and observed that ad on the patient. According code blue was called at 5:10 the unit, the paramedics took forts. In documenting the staff's ent's cardiac arrest could be 's medical record. In the Evaluation Form could be	A	093			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		504011	B. WING _		R 05/05/2017		
	ROVIDER OR SUPPLIER	TAL		STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION		
A 093	AM revealed that th cardiac arrest was o (Staff Member #11) unit with the patient member to meet the	on ber #12) on 5/4/2017 at 8:44 e response to the patient's disorganized and that the RN should have remained on the and sent another staff e paramedics.	A 0				
A 396	develops, and keep for each patient. The part of an interdiscip. This STANDARD is a sased on record record record and procedur staff assess patients admission for 1 of 3 (Patient #3). Failure to assess paradmission puts patients admission puts patients. 1. The hospital policies "Suicide Risk Assess Reviewed 1/2017) or Intake Personnel suicide risk assess possible but no late admission If any renders information immediately affect part of an interdisciplinary interdisc	ensure that the nursing staff is current, a nursing care plan is current, a nursing care plan is not met as evidenced by: view and review of hospital is for suicide risk upon is patient records reviewed attents for suicide upon it patients at risk for self-harm. Evy and procedure titled is ment (SRA form) as soon as risk as sessment it hat has potential to patient safety and/or results in severe, the psychiatrist shall	A 3'	96	2/10/17		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l l	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	ROVIDER OR SUPPLIER	504011	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	l	05/05/2017	
CASCADE	E BEHAVIORAL HOSPITA	NL		12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 396			A 3	396			
		ved the medical records of y admitted to the hospital ang:					
	PM with a chief comp being transferred from A review of the "Intak Hand-Off" form was d notification with the be with Plan". The initial was completed on 5/2 after admission. Patie	nitted on 4/30/2017 at 8:08 laint of being "suicidal" after n a local acute care hospital. e to Nursing Communication locumented as a high risk ox marked "Suicidal Ideation suicide risk assessment 1/2017 at 9:20 AM, 13 hours ent #3's suicide risk ermined to be at the high risk					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(AT) PROVIDER/SUPPLIEN/CLIA		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504011		B, WING		R 07/21/2017	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	<u> </u>	
CASCADE	BEHAVIORAL HOSP	PITAL		LITARY RO 4, WA 9816	OAD SOUTH 68		į
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A 000	INITIAL COMMENTS MEDICARE HOSPIT/FOLLOW-UP VISIT The Washington State (DOH) in accordance Participation set forth this health and safety Onsite dates: 07/19/1 The survey was cond Paul Kondrat, RN, MN Elizabeth Gordon, RN Kimberly Metz, RN, M DOH staff found the ficompliance with the Participation: 42 CFR 482.12 Gove 42 CFR 482.13 Patient 482.12 GOVERNING There must be an effect legally responsible for If a hospital does not governing body, the perfort the conduct of the	AL COMPLAINT SURV e Department of Health with Medicare Condition in 42 CFR 482, condu- survey. 7 to 07/21/17 ucted by: N, MHA I, MN ISN acility NOT IN ne following Conditions rning Body nt's Rights BODY ective governing body in	ons of cted of, hat is spital.	A 000		:	
	Based on interviews a Governing Body failed	met as evidenced by: and document reviews, d to maintain effective hat patients received on a safe environment.					
LAGODATOD	A DIDECTORIO OD DOOMBEE	VSUPPLIER REPRESENTATIV	EIO OLONIATUDE		TITLE		X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED				
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A 043	Continued From page	e 1		A 043					
A 043	Continued From page 1 Failure to ensure patients are provided with care that meets their needs in a safe environment risks poor patient healthcare outcomes. Findings included: 1. The Governing Body failed to ensure physician oversight of mid-level providers practice as stated in the delegation agreement after previously having been cited. 2. The Governing Body failed to maintain a safe and secure environment that risked serious injury for patients and staff. Due to the severity of deficiencies cited under 42 CFR 482.12 and 42 CFR 482.13, the Condition of Participation for Governing Body was NOT MET.			7 043	Immediately following the exit summa CEO, Governing Board Members, CI Risk Manager, Director of Clinical Se and Directors of nursing reviewed the and began formulation of a plan of or The Governing Board delegated the responsibility of ensuring completion corrective action action to the CEO/D who along with the Medical Director member of the Governing Board. The Designee is responsible for reporting results of corrective actions and use monitoring systems to the full Govern The Performance Improvement Cominglement increased monitoring for a that do not meet the thresholds that I established by the Committee. This i monitoring will continue until complia	NO, PI/ ervices, e findings prection. of all pesignee is a e CEO/ i the of ning Board. mittee will any items have been increased ance is	All corrective actions will be completed by 09-11-2017		
:	Cross-Reference: Tag	as A045. A0144			obtained and sustained for two repor periods.	rung			
A 045				A 045					
	[The governing body accordance with State practitioners are eligit appointment to the management of th	e law, which categories ole candidates for	s of						
	This Standard is not	met as evidenced by:							
	policy and procedure, the supervising physic followed the physician	ecord review, and revie the hospital failed to e cian for a mid-level pro n assistants' delegation to performance reviev	ensure ovider o						
	oversight of the physi	sing physician to providual assistant's practico on agreement risks pat or substandard care.	e as						

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL STREET ADDRESS, CITY, STATE, 2P CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 OKALO BOND SOUTH TUKWILA, WA 98168 OKALS CONTINUED From page 2 A 045 Continued From page 2 Findings included: 1. Record review of the document titled, "Physician Assistant Delegation Agreement and Standardized Procedures Reference & Quidelines," signed by the supervision plan included weekly face to face meetings, chart reviews twice a week and quarterly performance evaluations. The section of the agreement titled, "Alternate Supervision of the physician assistant was previously cited on 05/05/17. Record review of the hospitals plan of correction for the citation showed that evaluation results would be reported monthly to the performance improvement committee, and quarterly to the Medical Executive Committee, and governing body. Record review of meeting minutes for the performance improvement committee, and quarterly to the Medical Executive Committee, and Governing body showed there was no documentation including that the evaluation results would be reported monthly to the performance improvement committee, and quarterly to the Medical Executive Committee, and Governing Body showed there was no documentation including that the evaluation results for the physician assistant by the supervising physician were discussed. 3. During an interview with Surveyor #1 on 07/1917 at 2:58 PM, Staff C, the Manager of Risk and Quality stated that he was unable to find		ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
A 045 Continued From page 2 A 045 Findings included:		504011			B. WING		1		
PREPIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION A 0.45 Continued From page 2 Findings Included: 1. Record review of the document titled, "Physician Assistant Delegation Agreement and Standardized Procedures Reference & Guidelines," signed by the supervising physician (Staff A) and the Physician Assistant (Staff B) on 11/20/13, showed that the supervision plan included weekly face to face meetings, chart reviews twice a week and quarterly performance evaluations. The section of the greement titled, "Alternate Supervision of the physician assistant was previously cited on 05/05/17. Record review of the hospital's plan of correction for the citation showed that evaluation results would be reported monthly to the performance improvement committee, and quarterly to the Medical Executive Committee, and governing Body. Record review of meeting minutes for the performance improvement committee, and governing Body showed there was no documentation indicating that the evaluation results for the physician assistant by the supervising physician were discussed. 3. During an interview with Surveyor #1 on 07/19/17 at 2:58 PM, Staff C, the Manager of			ITAL	12844 N	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH				
Findings included: 1. Record review of the document titled, "Physician Assistant Delegation Agreement and Standardized Procedures Reference & Guidelines," signed by the supervising physician (Staff A) and the Physician Assistant (Staff B) on 11/20/13, showed that the supervision plan included weekly face to face meetings, chart reviews twice a week and quarterly performance evaluations. The section of the agreement titled, "Alternate Supervising Physician Data," was blank. 2. Lack of supervision of the physician assistant was previously cited on 05/05/17. Record review of the hospital's plan of correction for the citation showed that evaluation results would be reported monthly to the performance improvement committee, and quarterly to the Medical Executive Committee, and governing body. Record review of meeting minutes for the performance improvement committee, and governing body showed there was no documentation inclidating that the evaluation results for the physician assistant by the supervising physician were discussed. 3. During an interview with Surveyor #1 on 07/19/17 at 2:58 PM, Staff C, the Manager of	PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP	D BE	COMPLETION	
reports sent to the committees regarding physician assistant evaluations. Staff C suggested Surveyor #1 interview the Chief Medical Officer (Staff D) about the evaluations. 4. During an interview with Surveyor #1 on 07/19/17 at 3:10 PM, Staff D, the Chief Medical	A 045	Findings included: 1. Record review of the "Physician Assistant I Standardized Proceding Guidelines," signed by (Staff A) and the Physician Assistant I Standardized Proceding Guidelines," signed by (Staff A) and the Physician Standardized Weekly face reviews twice a week evaluations. The sec "Alternate Supervising blank. 2. Lack of supervision was previously cited of the hospital's plant showed that evaluation monthly to the perform committee, and quarte Executive Committee Record review of mes performance improve Executive Committee showed there was not that the evaluation reassistant by the superdiscussed. 3. During an interview 07/19/17 at 2:58 PM, Risk and Quality state reports sent to the colphysician assistant evaluation of the colphysician assistant evalu	ne document titled, Delegation Agreement ures Reference & y the supervising physician Assistant (Staff Et the supervision planto face meetings, charand quarterly performation of the agreement of Physician Data," was not for the physician Data," was not for the physician for the citron results would be represented in the Medical, and governing body. The ement committee, Medical and Governing Body documentation indicated sults for the physician revising physician were with Surveyor #1 on Staff C, the Manager of the ment committees regarding valuations. Staff C interview the Chief D) about the evaluation with Surveyor #1 on with Surveyor #1 on the committees regarding valuations. Staff C interview the Chief D) about the evaluation with Surveyor #1 on the committees regarding valuations.	ician 3) on t ance titled, s stant tview ation borted of to find	A 045	Corrective Action: All physician assistant privileges will updated to reflect the appropriate requirements for supervision and chamber of the Monitoring Plan: Evaluation Result reported out monthly to the CBH performance improvement committee, and quarterly to the MEG governing board. Persons Responsible:	art review. ts will be	corrective actions will be completed by	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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A 045	Officer stated that he to physician assistant medical staff during the executive committee in find the information in During the interview, presented an evaluate surveyor. The evaluate Chief Medical Officer 07/19/17, but had not physician assistant. was not listed in the pedelegation agreement physician. 5. Record review of the credentialing file by Sevidence supporting the was performing his own stated in the "Physicial Agreement". THIS CITATION WAS 05/05/17 482,13 PATIENT RIGATION TRIGATION TRIGA	discussed the issue re reversight requirement re June 2017 medical meeting. He was unable the meeting minutes, the Chief Medical Office ion for Staff B to the tion was completed by on the day of the interveyet been reviewed with The Chief Medical Office or system assistant's the as an alternate super the physician assistants the physician assis	s with le to er the view, h the cer vising ON	A 045	A 115 482.13 Patient Rights Corrective Action: All clinical staff will be educated regalinding of "PRN orders for restraints seclusion". All restraints and seclusionerformed at CBH will be audited by supervisor upon occurrence. Once a been completed they will then be restricted they may be a completed they will then be restricted to ensure that requirements are met they require a focus review. Cascad longer uses PRN orders for restrictivinterventions. Monitoring Plan: Audit results will be monthly to the performance improve committee, and quarterly to the MEC	and on the house audits have viewed by ng Officer and if e no ve be shared ement	All corrective actions will be completed by 09-11-2017
	Failure to protect and rights risk the patients	promote each patient's ' loss of personal freed harm and physical har	lom,		Governing Board. Persons Responsible: Chief Medic Chief Nursing Officer, and Pt/RM Dir		

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AND PLAN O	FCORRECTION	IDENTIFICATION NUMBE	ĒR;	A, BUILDING		COMPLETE		
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A 115	, -			A 144	A 144 482.13(c)(2) Patient Rights:	Care in	All corrective	
	1. The hospital failed	to ensure patients rece	eive		Cant Commig		actions will	
	care in a safe setting				Corrective Action:		be	
	vulnerable individuals	from harm from others	s.		1. A multi-disciplinary admissions tas	k force was	completed by	
					created on 08-02-2017 to review all a		09-11-2017	
	2. The hospital failed				criteria for CBH. Part of the focus of t			
	seclusion orders were needed basis (PRN).	e not written on an as			force will be to further refine exclusion			
	needed basis (FINN).				in the CBH policy ""Admission Criteri create, a "High Risk" addendum for f			
	Due to the severity of	deficiencies cited und	er 42		identifying patients that may pose a t			
		dition of Participation fo			patient safety.			
	Patient Rights was No	OT MET.					ar	
					2. Training will be developed and imp		199	
	Cross-Reference: Tag	gs A0144, A0169			regarding appropriate de-escalation and the appropriate interventions util		- 11	
A 144	482.13(c)(2) PATIENT SETTING	TRIGHTS: CARE IN S	AFE		CBH.	ız c u at	_	
	The patient has the risetting.	ght to receive care in a	safe		3. Safety Huddles (i.e. brief meeting team leaders on each unit at the beg each shift and documented) will be a review the appropriate capture of hig	inning of a		
	This Standard is not .	met as evidenced by:			patients and reviewed at leadership idaily.			
		ecord review and revie	w of		A. The use of the did intercention will	l bo		
	policy and procedure,	•			4. The use of the 1:1 intervention will compared organizationally, and pres		—	
	provide a safe and se	cure environment for n 1 of 5 patient records	. أ		Committee.	ontog at i	()	
	reviewed for patient to	•	'					
	TOVIOWOU TO PAUCITE I	o patient assault			5. The CNO or designee will attend a			
·	Failure to maintain a senvironment risked se patients and staff.	safe and secure erious injury or death fo	or		emergency responses (i.e. Code Gra review interventions, during and after			
	Findings included:				 Monitoring Plan: Audit results will b	e shared		
		oital's policy and proced ations," revised 6/2017			monthly to the performance improve committee, and quarterly to the MEC Governing Board.	ment		
		ecks, a level of observa e patient could make a			Persons Responsible: Chief Medic Chief Nursing Officer, and PI/RM Dir			

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL STREET ADDRESS, CITY, STATE, 2IP CODE 12424 MILITARY ROAD SOUTH TURWILL, AWA 98168 (K-4) ID PREDTY (RACH DEFINISHON MARE BE RECEDED BY TILL, RECOULATORY) A 144 Continued From page 5 attempt to harm themselves or others. b. 1:1 Observation Level was considered the highest level of observation and was reserved for patients who were so unpredictable that without a declicated staff member there was a risk of a patient harming self or others Staff assigned as 1:1 monitors of patients were required to remain within arm's reach of the patient at all times. 2. Review of the medical record of Patient #1 showed the following: a. Patient #1 was admitted on 06/22/17 for treatment of psychosis and disorganized behavior related to his diagnosis of bloolar/schizoaffective disorders. Review of the document titled "Intake to Nursing Communication Hand-off," dated 06/22/17, showed that the patient was psychotic, confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a previous history of property destruction at Cascade Behavioral Hospital. b. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, clictated on 06/23/17, showed that the patient #1 had a history of multiple assaultive behaviors. d. Upon admission, Patient #1* so beervation, every 16 minute checks" as were all patients admitted to the hospital unless the physician orders a higher level of beservation, and the property destricts and the patient #1* for observation, and the property destricts and the patient #1* for observation, and the patient #1* for observation, and the patient #1*	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBE			1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
A 144 Continued From page 5 attempt to harm themselves or others. b. 1:1 Observation Level was a risk of a patient within arm's reach of the patients were required to remain within arm's reach of the potential for aggression and had behavior problems. 2. Review of the document titled "Intake to Nursing Communication Hand-off," dated 06/22/17, showed that the patient had patient at all benefits who were subtended behavior confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a provious history of property destruction at Cascade Behavioral Hospital. b. Review of the document titled "Nurse to Nurse," dated 06/22/2017, showed that the patient was a payohotic, confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a previous history of property destruction at Cascade Behavioral Hospital. c. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, dictated on 06/22/17, showed that the patient with a that the patient was at the hospital. c. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, dictated on 06/22/17, showed that the patient with a had a history of multiple assaultive behaviors. d. Upon admission, Patient #1 so beervation level was "Every 15 minute checks" as were all patients admitted to the hospital unless the					B. WING		1	•
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PRETAY TAG CACH DEPICIENCY MIST BE PRECEDED BY FULL RESULATORY TAG A 144 A 144 Continued From page 5 attempt to harm themselves or others. b. 1:1 Observation Level was considered the highest level of observation and was reserved for patients who were so unpredictable that without a dedicated staff member there was a risk of a patient harming self or others Staff assigned as 1:1 monitors of patients were required to remain within arm's reach of the patient at all times. 2. Review of the medical record of Patient #1 showed the following: a. Patient #1 was admitted on 06/22/17 for treatment of psychosis and disorganized behavior related to his diagnosis of bipolar/schizoaffective disorder. Review of the document titled "Intake to Nursing Communication Hand-off," dated 06/22/17, showed that the patient was psychotic, confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a previous history of property destruction at Cascade Behavioral Hospital. b. Review of the document titled "Nurse to Nurse," dated 06/22/20/17, showed that the patient was h2-point restraints when he arrived at the hospital. c. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, dictated on 06/23/17, showed that Patient #1 had a history of multiple assaultive behaviors. d. Upon admission, Patient #1's observation level was "Every 16 minute checks" as were all patients admitted to the hospital unless the	CASCADI	: BEHAVIORAL HOSP	TIAL					
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b. 1:1 Observation Level was considered the highest level of observation and was reserved for patients who were so unpredictable that without a dedicated staff member there was a risk of a patient harming self or others Staff assigned as 1:1 monitors of patients were required to remain within arm's reach of the patient at all times. 2. Review of the medical record of Patient #1 showed the following: a. Patient #1 was admitted on 06/22/17 for treatment of psychosis and disorganized behavior related to his diagnosis of bipolar/schizoaffective disorder. Review of the document titled "Intake to Nursing Communication Hand-off," dated 06/22/17, showed that the patient was psychotic, confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a previous history of property destruction at Cascade Behavioral Hospital. b. Review of the document titled "Nurse to Nurse," dated 06/22/2017, showed that the patient was in 2-point restraints when he arrived at the hospital. c. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, dictated on 06/23/17, showed that Patient #1 had a history of multiple assaultive behaviors. d. Upon admission, Patient #1's observation level was "Every 15 minute checks" as were all patients admitted to the hospital unless the	A 144	Continued From page 5			A 144			
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priyotatan ordere a mgner terer or escentiation.		b. Review of the docu Nurse," dated 06/22/2 patient was in 2-point at the hospital. c. Review of the "Psy completed by Staff F 06/23/17, showed tha multiple assaultive be d. Upon admission, P was "Every 15 minute patients admitted to the	2017, showed that the trestraints when he arrection children Evaluation upon admission, dictated Patient #1 had a histophaviors. Patient #1's observation of the checks as were all the hospital unless the	ed on ory of				

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CASCADE	BEHAVIORAL HOSF	PITAL		LITARY RO 4, WA 9816	DAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 144	3:00 PM, showed that to internal stimuli, had was intrusive. The not Patient #1 would get observed going in an hard to redirect and in The patient's observed and continued at "Ever f. Review of a hospita 06/23/17 at 3:45 PM, encounter with anoth 4:00 PM the same dawrote an order to impedecks" and Sexually (SAO). g. On 06/24/17 at 9:4 physical altercation with #3). A nursing assistant Patient #3 in the hearing and in the altercation and physical hold and room. The on-call psymedications were or patient's psychiatrist an increase in the patient and increase in the patient and physical and personal psymedications were or patient's psychiatrist an increase in the patient and physical patient #4 that the patient continuation patient and peers. The patient's cat "Every 5-minute children in the patient of the patient's cat "Every 5-minute children in the patient stat "E	g note dated 06/23/17 It Patient #1 was respond poor boundary control of poor poor poor poor poor poor poor po	nding of and stry on. Inged at on all At strength at hit not at #1 dusion and or the er for I. I tote ted at to and all at to a the er for I.	A 144			
	a designated staff as	Every 5-minute checks signed to him.	" WITh				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE S COMPLE	TED
	504011		B. WING		07/	R / 21/2017
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE		·		
CASCADE BEHAVIORAL HOSPIT	ΓAL		LITARY RO A, WA 9816	AD SOUTH 58		
PREFIX (EACH DEFICIENCY MUST I	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE VTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 144 Continued From page	7		A 144			
j. On 06/27/17 at 11:30 entered into Patient #1 that the patient started hospital. Staff attempte but the patient continue administer medications Patient #1 threatened the was not released frocalled the patient's psy medication order. While preparing medication for attacked another patient him in the face multiple transferred Patient #3 the emergency department suffered a facial abrasion nasal bone fracture as according to discharge emergency department to a quiet room and addicted by the patient's phone call to the patient in an order for increased despite the severity of the k. Review of a physician 12:00 PM, showed that medication but that stainto taking his medication but that stainto taking his medication to that stainto taking note dated showed that Patient #1 attack patients. Staff ac of medication to the patient in an order documented potential to act out again to showed that the patient who showed that the patient in the patient	AM, a nursing note 's medical record state threatening to leave to the patient of the except the patient of the except the patient of the state that the patient of the staff were busy or Patient #1, the patient (Patient #3) by hitting times. The hospital to a local hospital the care. Patient #3 on, lip laceration, and a result of the assaul documentation from the staff escorted Patient instered medications of Patient and monitoring of Patient and coaxed the patient was refusited to the same not aff were afraid of the continued to threated dministered multiple of that the patient had in. Review of the nursing the patient had in.	the ent ried to ed. taff if f ent mg la t the ent #1 n as la				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C ND PLAN OF CORRECTION IDENTIFICATION NUMBER				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	504011			B, WING		07.	R /21/2017	
NAME OF PR	OVIDER OR SUPPLIER			ESS, CITY, STAT	•			
CASCAD	E BEHAVIORAL HOS	PITAL		ILITARY ROA A, WA 9816				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
A 144	monitoring, however monitoring document patient remained on m. On 06/28/17 at 4 entered into Patient that the patient threadischarged. The patient staff. A code gray (o more staff to help wito called due to the patient down at the patient of the	the physician's orders a tation showed that the every 5-minute checks. 32 PM, a nursing note #1's medical record statemed to break things if ient threw a tray and spiverhead page used to both a combative patient) dent's aggressive behavovider was notified and ons were administered. If the patient's physician or for an increase in the patients and staff. Immentation, on 07/01/17 hit another patient in the king in the hallway. Patient and placed in a quality of the patient of the patient do participated in the wanted to go back to unmentation dated 07/02/hit another patient (Patient refused to participate wanted to go back to unmentation dated 07/02/hit another patient (Patient refused to a significant is observed. The hospital ent for evaluation and ewere notified and took	ed not t on ring was ior did at face ent iet a te in jail. 17 at ent ient nds, t al	A 144				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X2) PROVIDER/SUPPLIER/					(Vo) DV(⊏ o		
		504011		B, WING		07/	R 21/2017
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL.			12844 M	ess, city, sta Illitary RC A, WA 9816	AD SOUTH		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIENCY MUS OR LSC ID		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 144	Continued From pag	e 9		A 144			
	07/19/17 at 5:15 PM, Services (Staff E) and (Staff D) were asked ordered observation of Checks). Both Staff E Patient #1 was dange Nursing Services staff a patient like this they safety as well as patient 4. An interview with the (Staff D) and the Chief	he Chlef Medical Office ef Nursing Officer (Stafi	is that re for r f E)				
	Medical Officer approto the hospital not unwas on the hospital "was placed on the "diviolent behavior resuldamage during a priod Medical Officer stated have increased the opatient from "Every 5 Observation" then to	terventions in order to	ent #1 tient patient pe his rty nould				
A 169	482.13(e)(6) PATIEN SECLUSION	T RIGHTS: RESTRAIN	TOR	A 169			
		restraint or seclusion n standing order or on a					
	This Standard is not	met as evidenced by:					
	hospital policies and failed to ensure that h	ecord review, and revie procedures, the hospita nospital staff members which were specific to the	al wrote				

	OF DEFICIENCIES : F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1''	LE CONSTRUCTION	(X3) DATE S COMPL	
					.		R
	504011			B. WING		07	/21/2017
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDRI	ESS, CITY, STAT	re, zip code			
CASCADE	E BEHAVIORAL HOSI	PITAL		ILITARY RO A, WA 9816	AD SOUTH 58		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE SENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE
A 169	Continued From pag	ge 10		A 169			
	type of restraint requ needed" basis.	ired and not on an "as					:
	specific as to type pla	ician orders for restraint aces patients at risk for e-evaluations based on	not				
	Findings:		,				
	1. The hospital's policy and procedure, "Seclusion and Physical & Mechanical Restraint," Policy # PC.R.100, last reviewed on 01/17 showed that orders for restraints shall never be written as a standing order or on as needed basis (PRN).			;			
	medical record of Pa on 06/27/17 for Acute 11:30 AM, Patient #5	reyor #3 reviewed the tient #5 who was admit e Psychosis. On 07/11/ became verbally and e and attempted to pour a peer.	17 at				
	3. The medical record following:	d review showed the					
	"Restraint/Seclusion staff called a "Code of Hospital Emergency potentially or actively patient was placed in	O AM, documentation o Progress Note" shows Gray" (a standardized Code that alerts all state combative persons) are a a physical hold and Restraints were applied.	the f to nd the				
	"RN Assessment-Secreflects the patient w	0 AM, documentation o clusion & Restraint Forr as placed in Physical al Restraint and "transfe	n"				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBI			LE CONSTRUCTION	(X3) DATE SUR'	
		504011		B, WNG	<u>. </u>	1	R 12047
NAME OF DE	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA		07721	/2017
	E BEHAVIORAL HOSF	ΡΙΤΔΙ			DAD SOUTH		
0.1100.110				LA, WA 981			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
A 169	-On 7/11/17 at 11:30 Physical Hold, Seclus Restraints was writted co-signed the order of the consigned and the second and "omit PJB on the physician order the physician order the consigned and R (right) leg restraint in place, arm and R (right) leg release." -On 07/11/17 at 1:40 "Patient lying supined leg restraint in place, arm and R (right) leg release." -On 07/11/17 at 2:45 "RN Assessment-Second released from restraint the section title Restraint/Seclusion," released from restraint the physician order the orders for Physical House the staff call the doctors the staff call the doctors of the orders the orders the order the orders the order	AM, a telephone order sion and Mechanical 4-n. A physician assistant on 07/11/17 at 11:30 AM. PM, the original order values on order check box 17/11@ 1205" was writter form. DPM, documentation steam in place." PM, documentation steam in place." PM, documentation steam and R Discussed criteria for I restraint and seclusion PM, documentation on clusion & Restraint Formation of Release from shows the patient was nt/seclusion at that times	point It It II	A 169	A 169 482.13(e)(6) Patient Rights or Seclusion Corrective Action: All clinical staff will be educated reg appropriate use of restraint and seconders for restraint and seclusion ar least restrictive means must be use seclusion and restraint, etc.) All resseclusion performed at CBH will be the house supervisor upon occurrer audits have been completed they were viewed by the PI/RM Director, and Nursing Officer to ensure that require and if they require a focus reviewed and if they require a focus reviewed monthly to the performance improve committee, and quarterly to the MEGOVERNING Board. Persons Responsible: Chief Medic Chief Nursing Officer, and PI/RM Director, and PI/RM Dire	parding the clusion (i.e., re not prn, d for straints and audited by nce. Once ill then be d Chief rements are sew. be shared sement C and	All corrective actions will be completed by 09-11-2017

Printed: 03/23/2017 FORM APPROVED

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/			LE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBI	äR:	A. BUILDING		COMPL		
		504011		B, WING		03	R /10/2017	
3	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CASCADI	E BEHAVIORAL HOSP	PITAL		MILITARY RO ILA, WA 9810				
(X4) IO PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
(A 000)	INITIAL COMMENTS			{A 000}				
	MEDICARE HOSPITA FOLLOW-UP VISIT	AL COMPLAINT SURV	ΈΥ					
	March 7 - 10, 2017 by	isit was conducted on / Paul Kondrat, RN, MN on, RN, MN; Joy Willian iel, REHS, PHA.						
	conducted on March 7	F/LS) follow-up visit wa 7, 2017 by Washington ire Marshal Don West.				·		
1	During the survey, sur issues related to the fo complaints: #71391; #							
	hospital complaint sur	correction of encies found during the vey on 12/12-16/2016 th the facility was found	and					
	42 CFR 482.12 Gover	ning Body						
	42 CFR 482.13 Patien	nt Rights	į					
	42 CFR 482.21 Quality Performance Improver		}					
ļ	42 CFR 482.25 Pharm	naceutical Services						
	42 CFR 482.41 Physic	eal Environmental						
	surveyors determined	ne follow-up visit, the D that there was a high r , and death due to the . This resulted in the	isk			,		
VROTARORAT	NIDECTOR'S OF PROVINCE	SUPPLIER REPRESENTATIVE	DELITATION OF	1	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

(X6) DATE

TITLE

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		1	R 0/2017
NAME OF PROVIDER OR SUPPLIER STREET				ESS, CITY, STA	TE, ZIP CODE		
ŀ	E BEHAVIORAL HOSE	υται.	12844 M	II ITARY RO	DAD SOUTH		i
071001101		1710		A, WA 981			
				-			0/6
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X6) COMPLETION DATE
{A 000}	declaration of IMMEDIATE JEOPARDY in the following area: Failure to conduct effective security procedures			{A 000}			
	when wanding newly identification of hazar to self and others (3/5	admitted patients for ds associated with dan M2017 at 2:45 PM).	ger				
	was verified on 3/10/2 Kondrat, RN, MN, MH	of IMMEDIATE JEOPA 2017 at 2:10 PM by Par IA; Elizabeth Gordon, I , PHA, and Joy William	ul RN,				·
		NOT IN COMPLIANCE				:	
	42 CFR 482.12 Gove	•					,
	Shall #27QV12	ii Ngito					
			}				
{A 043}	482.12 GOVERNING	BODY		{A 043}	A043 482.12 - Governing Body		
	There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body This Condition is not met as evidenced by:				Immediately following the March 10, summation, the CEO, Governing Bo Member, Chief Nursing Officer/Chie Operating Officer, PI/Risk Manager, of Clinical services and Directors of reviewed the findings and began for of a plan of correction. The Governi delegated responsibility of ensuring completion of all corrective actions to CEO/Designee who along with the Name of the CEO/Designee of CEO, Governing the CEO/Designee of CEO, Governing the CEO/Designee of CEO, Governing the CEO, Govern	pard f Director Nursing mulation ing Board	
	reviews, the hospital f	FR 482.12 Condition of			Director is a member of the Governi The CEO currently conducts a dally Leadership Meeting which includes of levels of observation, unusual occ results of unit rounds and any requir	ng Board. reporting currences,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIF A, BUILD(NO	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI			
;	504011			B. WING		R 03/10/2017			
NAME OF PR	OVIDER OR SUPPLIER	A CONTRACTOR OF THE PROPERTY O	STREETADDR	DDRESS, CITY, STATE, ZIP CODE					
	E BEHAVIORAL HOSP	ITAL		MILITARY ROAD SOUTH					
-	. TUKI			A, WA 981					
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION)N	(X5) COMPLETION		
PREFIX		TIBE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD) BE	COMPLETION		
TAG	OK LOG ID	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TRIALE			
{A 043}	Continued From page 2			{A 043}					
[OFO74]	Continued From page	5 Z		fra nami	corrective actions. The CEO/Design	ee is			
	Failure to meet patient rights risks an unsafe				responsible for reporting the results	of .			
	healthcare environment for patients, visitors, and				corrective actions and use of monitor				
	staff				systems to the full Governing Board.				
					The Performance Improvement Com	mittee will			
	Findings:				implement increased monitoring for				
1					that do not meet the thresholds that I	have been			
	1. The Governing Body failed to effectively				established by the Committee. The i				
,	manage the functioning of the hospital to protect				monitoring will continue until compile				
	patients from harm as evidenced by the IMMEDIATE JEOPARDY condition identified on				obtained and sustained for two repor periods.	ung			
·		ensure patients receiv	1		political				
		nt in which the safety a			See A115, A144, A164 and A286				
j	well-being of patients	are assured.	. [
	O Fathura to possessate	effective asfety made as							
	procedures for identifi	effective safety and sec	шпцу			İ			
	associated with dange		1						
			1						
	Due to the scope and	severity of deficiencies	;		·		•		
	detailed under 42 CFF								
		nt Rights, the Condition				·			
	Participation for Gove	rning Body was NOT M	IE1.			ĺ			
	Cross-Reference: Tag	s A0115							
{A 115}	482.13 PATIENT RIGI	HTS		{A 115}	A115 482.13 - Patient Rights				
	A hannital parest sector	البيد جانبيدموم امماء	ĺ		See A144 and A164				
	A hospital must protect patient's rights.	and promote each			OCC / (144 alid / 1104				
	patient's nyms.								
	This Condition is not met as evidenced by:								
	Based on observation, interview, record review,								
j	and review of hospital policies and procedures,								
İ	the hospital failed to protect and promote patient								
	rights.		`	-					
į	Failure to protect and	oromote each national					}		
		promote each patient's loss of personal freed]		
Ī	g. no ron are penette	The at beingling Hood	w114	}		1	- 1		

	OF DEFICIENCIES F CORRECTION	KAT) PROVIDENGOPPELEGOLIA		1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
	504011 B. WING			R 0/2017			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE		
GASCADI	E BEHAVIORAL HOSP	PITAL.		ILITARY R A, WA 981	DAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	DBE	(X5) COMPLETION DATE
{A 115}	privacy, dignity, and psychological harm.			{A 115}			
	Findings:						
	1. Failure to ensure patients receive care in a safe setting which safeguards vulnerable individuals from self-harm and harm from others. 2. Failure to utilize the least restrictive alternative when using seclusion and restraints. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights.						
				•			
	under 42 CFR 482.13	severity of deficiencies , the Condition of nt Rights was NOT ME	İ				
	Cross Reference; Tag	s A0144, A0164	·			,	
A 144	482.13(c)(2) PATIENT SETTING	RIGHTS: CARE IN SA	AFE	A 144	A144 482.13(c)(2) - Patient Rights: Safe Setting	: Care in a	
	The patient has the rig setting.	ght to receive care in a	safe		Security Procedures and identification Hazards	n of	
	This Standard is not r	met as evidenced by:	,		Corrective Action: All staff responsible for wanding pation been retrained on (1)the requirement		All
	ITEM #1 SECURITY PROCEDURES AND IDENTIFICATION OF HAZARDS				all individuals admitted to the hospita requirement to wand based on manu recommendations and "Wanding - U	al, (2)the ifacturer	corrective actions will be
	Based on observations, review of manufacturer's instructions for use, and review of hospital policy and procedures, hospital staff members failed to follow manufacturer's instructions when using the hand held metal detector.				Hand-Held Metal Detector Wand" an (3) requirement to document complet wanding on Nursing Communication form. Only staff members that have competency have been allowed to be wanding procedures as of March 9, 2	d lon of Hand-Off validated erform	completed by April 28, 2017
		staff are trained and sk o operate the hand-held					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION 9	(X3) DATE SUF	
		504011		B. WING _			R 0/2017
1	OVIDER OR SUPPLIER	i	!	RESS, CITY, ST			
GASCADI	E BEHAVIORAL HOSF	PITAL.		MILITARY R ILA, WA 981	OAD SOUTH		
(X4) ID	SLIMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY MUS	IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETION DATE
A 144	Continued From pag			A 144	Continued from page 4		
	metal detector correct visitors at risk for condangerous hazards eserious threat which reserious threat Muser Manual. Findings: 1. The hospital's policies "Wanding - Use of Haward" (Reviewed/20 patients will be wanded upon arriving on an intitled "Procedure" readilow the scannes to in actually causing an all detector denotes the pitem under a shirt slee investigate the source the scannee assures watch." Page 4 of the the proper technique as	tly puts patients, staff, itraband and other neering the facility positionary result in injury or detail Detector Super Scients and procedure titled and-Heid Metal Detector 17) stated in part, "All ad prior to or immediate patient unit". The section in part: "Staff should affluence them as to what arm. For instance, if the presence of a suspicious of the alarm even thou you that [it] is just his/he hospital policy illustrate and procedure to use we randing from the front to	ng a eath. anner f ion not at is eletely ugh er es	A 144	Continued from page 4 Monitoring Plan: The Directors of Nursing and Director Designee will be responsible for nuekly audits of staff performing was deficiencies in the wanding procedul identified and staff members retrained spot. The Directors of Nursing will perform random chart audits of the Nursing Communication Hand-Off form. Any adverse findings will be reported Leadership meeting daily and to Gov Board weekly unit 100% compliance attained for one month. Upon attain 100% compliance, monitoring will be monthly to the PI Committee and quit the Medical Executive Committee and Governing Board. Persons Responsible: CEO Directors of Nursing Director of Intake PI/Risk Manager	andom nding. Any re will be ed on the a 30 d in the verning has been ment of reported arterly to	
	Super Scanner under "Components/Function "Interface Elimination factory set for maximu	n" (pp 5-6) read in part: Button- The detector is m sensitivity to detect t	ihe				
	may produce alarms w	Release button and	or				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		504011		B, WING			R (0/2017
MANG ME BE				DECC CITY OT	ATE 7ID CODE	Val	10/2017
				DRESS, CITY, STA	·		
CMOCADI				ILA, WA 981	OAD SOUTH		
			· · · · · · · · · · · · · · · · · · ·	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
A 144	Continued From page	e 5		A 144			
	2. On 3/7/2017 betwe	en 8:00 PM and 8:28 F	PM,			•	
		ed a certified nurse's aid					
		#2) to demonstrate the	use	}			
	! · · · · · · · · · · · · · · · · · · ·	al detector. During the		Ì		•	}
		turned the metal detec	otor	'			
:	on and the metal dete	ector appeared to be le surveyor noting that	oll.				1 .
	_	ing on and off. Staff Me					
		n the side of the metal	JII IDCI				}
		ing LED lights shut off]			
		en light. The CNA the		•			
	proceeded to scan the						
	continuously holding ((depressing) the side b	utton.				
	Staff Member #2 ackn	nowledged in a follow-u	р				
	interview with Surveyo	or#1 that he/she was					
	unaware of the side b	utton's function or purp	080.			•	
	3. On 3/8/2017 at 9:00	O AM, Surveyor #1					
		or of Intake Personnel					1
j		use of hand-held met	al	•			
	detectors and training]
-		etector used on 3/7/20	17 by				
		malfunctioned and the aced. The hospital did i	nat				
	have a system in place		liot				
		eight metal detectors.					
]			i				
Ì	4. On 3/10/2017 between	en 11:00 AM and 11:4	15				
		erved an Intake Person					
Į		ember #3) demonstrate					
		netal detector wand. D					
	the observation, Staff Member #3 pushed the side button (interference elimination button) and proceeded to wand the front of the patient. The metal detector beeped and a red light flashed						
						1 1	
j	when the wand was located near the patient's feet. Staff Member #3 asked the patient (Patient						Į l
1	#5) if they had anythin	g in his/her socks, Pati	ent	ļ			
	#5 stated "no". Staff M	ember #3 continued th	ė				

OFFICE OF OFFICE OF OFFICE OF OFFICE OF OFFICE OF OFFICE OF OTHER OFFICE OF OTHER OFFICE OF OTHER OFFICE OF OTHER OFFICE OF OTHER OFFICE OFFIC				000 100 70	4 P 464 67 61 644	OMS N	0.0000-0001	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		1	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED	
		504011		B. WING		03/1	R 03/10/2017	
NAME OF DE	OVIDER OR SUPPLIER	J	QTDCCT ADDC	RESS, CITY, ST/	ATE ZIE CODE			
	· · ·	-164A 1						
CASCADI	E BEHAVIORAL HOSF	TIAL,			OAD SOUTH			
			IOKANI	LA, WA 981	68			
(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 (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	AGTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION CATE	
A 144	Continued From page	e 6		A 144		• "		
		Include both sides of t	he I					
		. Staff Member #3 did :					l .	
į		osterior aspect) of the			1			
		hospital policy. The s	taff		1		-	
		d the underside of the			·			
		tigate further the source	e of					
	the beeping as require		· ·					
-	the weeking on redail.	er m) Hookim keneji	ŀ					
	5, On 3/10/2017 at 2:	30 PM. Surveyor #1	[
		al records and the "Inta	ke to					
		ion Hand-Off" forms an						
	noted the following:				1			
			į				ļ	
į	a. Four of eight record	ds reviewed were not						
	₩	to document and confi	rm				ŀ	
	the patient had been	wanded.						
	•							
		ls reviewed was marke	d					
	"No" reflecting that the	e patient had not been						
	wanded.	•						
			1					
	c. Three of the eight re	ecords reviewed were						
		ng the patient had beer						
	wanded on admission	. Upon further review,	ihe					
}	surveyor found:							
ļ		i a metal "X-Acto: blade			i			
	found after the patient	t had done harm to self	by					
	outting themselves. T	he record indicated the	.					
	patient acknowledged	hiding the metal blade	in					
	his/her sock,		1			•	,	
				•				
	2. Patient #6 had	a cellular phone found	Ì		, i		1	
	during the skin/clothing check by the nursing staff						1	
İ	upon arrival on the un							
							{	
	3. Patient #7 had	a cellular phone discov	/ered				{	
.		e after a five day hosp					ļ	
	stay.	• • • • • • • • • • • • • • • • • • • •	,			•		
	•							

CENTER	S FOR MEDICARE & N	MEDICAID SERVICES				OMB NO	0.0938-0391	
		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			PLE CONSTRUCTION 3	(X3) DATE SUF		
		504011		Les manages 1			R 0/2017	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	· -		
CASCADI	E BEHAVIORAL HOSP	ITAL	12844 M	4 MILITARY ROAD SOUTH				
	F1 (F10)0F0	Seeme and the Market State of the State of t	TUKWIL	A, WA 981	68			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	1 '			
A 144	Continued From page	e 7		A 144				
	ITEM #2 LINE OF SIG	HT MONITORING	ļ		Line of Sight Monitoring			
			Ì		Corrective Action:			
	Based on record revie	w and review of hospi	al		Policy PC.P.300was reviewed and re	wiead to		
		, the hospital failed to			(1) clarify that LOS monitoring be ass			
		n "Line of Sight" (LOS)			specific staff member, (2) clarify that			
		t safe from self-harm o			must be visible to the assigned staff			
	injury from other patie	nts.			all times, (3)the staff member must to			
			i		to prevent potential for patient to han			
	Failure to protect patie	ents from self-harm and	4		others, and (4)staff must document e	fforts to		
	harm by other patients	s may lead to serious i	njury		prevent harm in the patient record.	-		
	or death.				Reeducation was initiated for all staff responsible for monitoring observation		!	
Ì			ŀ					
	Findings:				patients' regarding the changes to the RNs were reeducated on their ability			
			Ì		increase a patient's level of observati			
		y and procedure titled,			a physician order and all staff perform			
	"Patient Observation"				observations were reeducation on the			
		ted in part, "ill. Lev			factors for each level of precaution.	,		
		e of Sight. The patient	will		·			
		t and accessible at all	. [Monitoring Plan:	•		
		Tools or instruments th	iat		The Directors of Nursing/Designee w	rill		
		themselves or others			conduct rounds each shift on each u	nit to		
		This level of observation			ensure monitoring is performed as or			
İ		ient could, at any time, arm themselves or othe			Failure to perform monitoring as exp			
	Positive engagement		10.		be immediately addressed. Results			
		s level of observation."			observations will be reported daily in Leadership meeting and weekly to th		'	
}	account woher of the	o to tot of popol authority			Governing Board until monitoring is			
ļ	The hospital policy and	d procedure titled, "Pat	ient		maintained at 100% for one month.	Upon	•	
Í		ilities" (Policy # ADM.F		į	attainment of 100% compliance, resu	ilts will be	İ	
		ted in part: " Proced		2	reported monthly to the PI Committee			
į		t rights shall include bu			quarterly to Medical Executive Comm	nittee and	l	
j		ving: 5. The right to			Governing Board.	ļ	l	
	receive care in a safe		1		Persons Responsible:		l	
	•				CEO	ľ	l	
	2. Patient #3 was an 18 year-old admitted on				Directors of Nursing		l	
	2/24/2017 for treatmer			-	PI/Risk Manager	'	l	
		patient received a scor			- ,		•	
		essment scale which w					-	
		on. A review of the ove						
	risk level scoring tool is	ndicated that medium r	isk				-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
504011				B, WING		03/	R 10/2017	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CASCAD	E BEHAVIORAL HOSF	PITAL		MLITARY RO LA, WA 981	DAD SOUTH 68			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE	
A 144	than the routine every completed for all patic observation status we physician had examin following day (2/25/20 was placed on line of 3. On 2/27/2017 at 10 (RN) (Staff Member # patient's medical reconstruction of the patient's physician. Adocumented by the R stated that the patient status and that the paremaining in LOS of a physician had ordered earlier in the day at 2: phone call to the physicians related to the result in an order for it patient.	e between 25 and 41. (a) 15 minute checks that ants on the unit, no spe as assigned until after the det the patient on the 217) after which the patient (LOS). 2:00 PM, a Registered 1. (a) entered a note into the detailing that the RN 1 and found multiple cuts arm. The RN notified the telephone order N on 2/27/2017 at 9:30 was on LOS observatitient was responsible feasigned staff. The patie LOS observation statut 25 PM as well. The RN 20 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM as well. The RN 25 and 25 PM 25 PM 25 and 25 PM 25 PM 25 and 25 PM 25 PM 25 And 25 PM 25 PM 25 And 25 PM 2	tare cial he cial he lient Vurse he had s on e PM on or lent's ls	A 144				
	dated 3/2/2017 at 1:00 assessed the patient t suicide risk. The physistaff monitoring of the	DPM showed the physicon have an increased ician ordered increased patient. The physician' at 10:45 AM stated "LO	cian (
	the area of her/his left patient was noted to b blanket covering her/h	ensed nurse (Staff t Patient #3 was bleedi	tha					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/O	LIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SU	IRVEY
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A, BUILDIN	G	COMPLE	TED
		504011		B. WING		03/	R 10/2017
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET A			RESS, CITY, ST	ATE, ZIP CODE	- 17-34-	
CASCADI	E BEHAVIORAL HOSF	PITAL	12844 N	MILITARY R	OAD SOUTH		
	TUKV		TUKWII	_A, WA 981	168		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
. A 144	Continued From page	e 9	ļ	A 144		, , , , , , , , , , , , , , , , , , ,	
	After further question	ing, it was discovered t	hat				
	the patient had used	a metal blade [X-Acto					
	blade]. The patient re	ported that she/he kept	the				
	blade hidden in her/hi	is sock:	İ				
		ntation dated 3/2/2017					
į		ne biade cutting inciden					
		the patient should hav					
		on status because while staff and on every 5 m					1
	checks the incident st		iniute				
}	Olicovo (fie lifetacht at	in occurred.					
	7. An interview with a	RN (Staff Member #7)	on				
		with Surveyor #2 showe					
		atient #3 should have b			ļ		
		atus as the patient had					ļ
		ncils and using them to					[
	harm herself/himself e	even though she/he wa	s on				
ļ		is. Staff Member #7 als]
		#3 harmed themself wit					1
		OS observation status	with				
	every 6 minute checks	3.]
	O A b4	a Dina stan at the Astron			•	•	i
ŀ	8. An Interview with the	The state of the s	A47				1
}		Member #10) on 3/9/2 3 the incident related to				•]
		ber #10 revealed that	·				
		w Patient #3 came to b	ni e				
		dangerous object. Sta					
1		at Patient #3 told staff					
	she/he brought the bla	de from home.]
	9. On 3/09/2017 at 10:]]
	reviewed the inpatient record of Patient #4. S/he						
		2017 due to concerns t		İ			ļ
		themselves. Patient #	4]
	was initially placed on		İ				
		7, and then was placed	on				
	LOS observation for sa						[
ŀ	remained on LQS obse	ervation until 3/8/2017.	An	1			

OMITI LIN	STOR MEDICALIZE OF E	TILDIO TID OLIVIOLO	*****			CIVID	NO. 0836-038 I
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			1'''	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504011		B. WING		03	R /10/2017
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET			RESS, CITY, STAT	E, ZIP CODE		
CASCADI	CASCADE BEHAVIORAL HOSPITAL 1284			ILITARY RO	AD SOUTH		
				A, WA 9816			
			(<u> </u>	***************************************		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 144	Continued From pag	e 10		A 144			
, , , , ,	, -	ecord by a registered n	Urea				İ
		ited 3/7/2017 at 5:37 PI					
	, .	(alert and oriented) x	1				İ
		restless. Pacing about					-
		th blood streaming dow	,	İ			
,		elf-inflicted injury." The		ļ			1
		ined by Patient #4 occ					ļ
	while the patient was	ordered for LOS. No or	ther				
i		medical record was for	1				
		al staff attempted to sto					ļ
		themselves prior to the					· [
	patient presenting the	emselves to the nursing	staff.	1			
	10. On 3/9/2017 at 9:	15 AM Quruayar#3					
		records of three patien	ite				
		a total of eight patient					
		nts of which five occurr		ļ			
		ing. The surveyor note					
		:15 AM, Patient #8 whil noted in the record to b					
		ently trying to open do					
		ed wandering into peer			,		
		ir belongs. Staff stated		-	,		
	pt. was observed pun-	ching a much larger pe	er				
	who assaulted him ba	ick. Staff was able to bi	reak				1
	up the argument & rec	direct pt's to different					
İ	locations."		İ				
	h ("n 2/11/2017 at 0.2	t6 DM Dationt #2 while					
]	LOS monitoring was r	45 PM, Patient #2 while) (II)				
			antto				
. !	"Patient threw a punch and knocked patient to the ground Police officers arrived in unit [to] investigate the case. Patient medicated PRM			,			
							Į l
	investigate the casePatient medicated PRN [as needed] meds. Remain in room for a while						
		nt transferred for safety			1		
1			-				
	11. On 3/7/2017 at 9:1	5 AM, Surveyor #3					
1	interviewed a registere	ed nurse (Staff Membe	r #6)				1

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	504011			B. WING R 03/10/2017				
NAME OF PROVIDER OR SUPPLIER STREET AS			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
				MLITARY RO LA, WA 981	DAD SOUTH 68			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) GOMPLETION DATE	
A 144	about the different leving difference between the that LOS is similar to the entire staff and not the monitoring. Staff that only when a patie monitoring is a specific monitor the patient. 12. An interview with Risk (Staff Member # revealed that the facilion the use and effectionservation (i.e. LOS, also stated that there	rels of observation and em. The nurse indicate the 15 minute checks we one person responsib Member #6 acknowled ant is ordered for 1:1 ic individual assigned to the Director of Quality (11) with Surveyor #2 ity was not collecting diveness of levels of 1:1) of patients. He/si	ed with le for ged o and ata	A 144				
	SECLUSION Restraint or seclusion less restrictive interve determined to be ineff a staff member, or oth. This Standard is not respective to consider the effective interventions before a restraints and seclusion reviewed. (Patients #Failure to utilize or consider to utilize or consider the utilize or consider the utilize or consider the utilize or consider the utilize or consider to utilize or consider the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize or consideration the utilize the utilize or consideration the utilize or consideration the uti	ective to protect the paters from harm. met as evidenced by: w and review of hospit es, the hospital staff fai reness of less restrictive pplying simultaneously on for 3 of 6 patients 1, #2, #3). Insider less restrictive oth restraints and sectorations at risk for loss of	en tient, al eled re both	{A 164}	A164 482,13(e)(2) – Patient Rights or Seclusion Utilize least restrictive alternative we restraint or seclusion Corrective Action: Policy PC.R.100 "Seclusion and Phys Mechanical Restraint" was reviewed March 10, 2017 and providers and seeducated regarding the requirem utilize and document the utilization least restrictive alternative when us restraints or seclusion.	then using lical & d on staff were ent to of the	All corrective actions will be completed no later than April 28, 2017	

Printed: 03/23/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		504011		B. WING		R 03/10/20	017
	OVIDER OR SUPPLIER E BEHAVIORAL HOSF	PITAL			DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTK (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETION DAYE
{A 164}	Findings: 1. The hospital policy "Seclusion and Physic (Reviewed 1/2017; Posection "Policy" read restraints may only be of violent or self-destrip jeopardizes the immer patient, a staff membeless-restrictive interversuled-out" The section titled "Pati "Restraint or seclusion less restrictive interversuled-out" The section titled "Pati "Restraint or seclusion restrictive interversuled for others from harm." 2. On 3/8/2017 at 9:15 reviewed the records placed in either seclusion protect the patient, as from harm." 2. On 3/8/2017 at 9:15 reviewed the records placed in either seclusion protect as Patient #1 was placed in either seclusion simultaneous 2/9/2017 at 7:45 PM. was released from respectively at 10:45 PM indicating that a less repeated or at simultaneous applicati restraints and seclusion. Patient #2 was placed.	and procedure titled cal & Mechanical Restrolicy # PC.R.100) under in part: "Seclusion and a used for the managen uctive behavior that diate physical safety of error others after entions are ineffective or others after entions have been fective to protect the particular may only be used who intions have been fective to protect the particular member, or others that will be effective to staff member, or others of five patients who we sion or restraints during dithe following: ced in 4-point restraints saft on Subsequently, Patient # straints at 9:15 PM and No documentation estrictive alternative has tempted first prior to the on of both physical	r the nent the r tten tien tien f d #4 re their and from	{A 164}	Monitoring Plan: The Directors of Nursing/Designee of perform audits on each incident of or seclusion. Failure to adhere to PC will be immediately addressed with involved in the incident. Results of twill be reported daily in Leadership and weekly to the Governing Board monitoring is maintained at 100% from the Upon attainment of 100% monitoring, results of audits will cobe reported in Leadership but will be reported monthly to the PI Committ quarterly to Medical Executive Com and Governing Board. Persons Responsible: CEO Directors of Nursing Director of Intake PI/Risk Manager	restraint C.R.100 staff the audits meeting, until or one ntinue to e tee and	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O	MELANIN I		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	504011 B. WING 03/10/2					
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	Marana	
CASCADI	E BEHAVIORAL HOSF	PITAL		MILITARY RO ILA, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	(X5) COMPLETION DATE	
{A 164}	2/25/2017 at 6:00 PM was released from resectusion at 9:45 PM. indicating that a less abeen considered or assimultaneous application restraints and sectusion. 3. During the survey, Psychiatric Unit 2 We record of Patient #3. Tpatient was ordered 4-point restraints simula/3/2017, and 3/6/201 documentation could record to indicate a le (either sectusion or reattempted prior to the both physical restraint 482.21(a), (c)(2), (e)(3) (a) Standard; Program must	Subsequently, Patient Straints at 9:00 PM and No documentation restrictive alternative has tempted first prior to the straint of both physical on could be found. Surveyor #2 toured the strand reviewed the metric between noted the probability on 3/2/2017 respectively. No be located in the medic as restrictive technique straint used alone) was simultaneous applications and seclusion.	i from ad ad Adult adical 7, cal s son of	{A 164}	A286 482.21(a), (c)(2), E3 – Patient Program Scope, Activities and Execu Responsibilities Corrective Action: PI/RM was reeducated on the facilit Performance Plan on March 29, 201	<i>tive</i> y 7 which	All corrective actions will be completed no later
	improvement in indica evidence that it will medical errors. (2) The hospital must trackadverse patien (c) Program Activities (2) Performance improved the medical errors at analyze their causes, a actions and mechanist and learning throughout (e) Executive Response	tors for which there is identify and reduce measure, analyze, and it events overnent activities must adverse patient event ms that include feedball the hospital. sibilities, The hospital's parized group or individ	it nts, tive ck		Includes the objectives to: (1) achievely effective reduction of medical/healterrors and other factors that contribunintended adverse patient outcom (2) providing an effective, planned, see improve the performance of the faction facilitate a proactive approach towal continuous quality improvement anactions taken to assure that desired are achieved and sustained (4) to procommunication and reporting of per improvement activities by and between the departments, administration, medic Governing Board and others as deer necessary.	th care oute to es ystematic ess and lility (3)to rd d evaluate results omote formance een al staff,	than April 28, 2017

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED			
		50401 1		B. WING		R 03/10/2	l l		
NAME OF PE	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
CASCAD	E BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	DAD SOUTH				
	TUK			A, WA 981	68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES OF BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X6) COMPLETION DATE		
{A 286}	Continued From page	14		{A 286}	, , , , , , , , , , , , , , , , , , ,				
(1 200)	responsibility for opera medical staff, and adn	ations of the hospital), ninistrative officials are untable for ensuring the		(A 200)	Monitoring Plan: Unusual occurrences will be reporte Leadership, weekly to Governing Bo investigated by the PI/RM. Incident tracked, trended and reported by PI along with plans for improvement n PI Committee and quarterly to Medi Executive Committee and Governing	ard and s will be /RM nonthly to			
	This Standard is not met as evidenced by: Based on interview, record review and review of policy and procedure, the hospital falled to track and document the staff response to a patient's cardiac arrest event as required by hospital policy and procedure.				<u>Persons Responsible:</u> CEO PI/Risk Manager				
	Failure to document a patient's cardiac arrest event decreases the quality of the information the hospital can provide for ongoing treatment of the patient and leaves the hospital unable to evaluate the effectiveness of emergency response for quality improvement purposes.								
	Findings: 1. The hospital's policy "Code Blue" (Policy #P 1/2017) stated that a p be documented on the placed in the patient's in the patient's in the patient's in the patient #P was a 40 period to the patient	PC.C.100; Reviewed atient cardiac arrest sh Code Blue Record and medical record.							
	2. Patient #9 was a 49 12/19/2016 for treatme Patient #9 required treatwithdrawal and was ad unit. On 12/21/2016 at found unresponsive an discoloration of the skir called a Code Blue (a c	int of alcohol use disonatment for alcohol imitted to the detoxificated to the patient decay to the patient decay anotic (bluish n). At the same time, see the control of the control	ution was Staff						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		1 '	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	TED		
		504011	Arriforn a share	B. WING_		03/1	R [0/2017		
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSE	PITAL	12844	ADDRESS, CITY, STATE, ZIP CODE 44 MILITARY ROAD SOUTH CWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{A 286}	medical emergencies cardiopulmonary results arrived a administering CPR uppronounced dead at Review of Patient #9 that there was no det Record) of the staff recerdiac arrest.	and started sectation (CPR). st 1:10 PM and continue til the patient was 1:40 PM. s medical record revea alled record (Code blue asponse to the patient's the Chief Operating Offic n 3/8/2017 at 10:10 AN	ded e e	(A 286)	Corrective Action: PC.C.100 "Code Blue" was revienursing staff retrained regardin documentation requirements a utilized. Going forward the hoseonduct annual mock Code Blue Monitoring Plan: All Code Blue incidents will be a PI/RM and a staff debrief conditation to ensure documentat requirements have been met, findings will be reported in Leand results of investigations, acchart audits will be reported my Committee and quarterly to My Executive Committee and Governments PI/Risk Manager	ewed and all g nd forms to be spital will e drills. eviewed by scted post ion Adverse dership daily tion plans and onthly to Pl edical	All corrective actions will be completed no later than April 28, 2017		

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			.	(X3) DATE SURVEY COMPLETED		
·	504011			B. WING	** <u>**</u>	12/21	1/2016	
NAME OF PROVIDER OR SU		nrai		DDRESS, CITY, STATE, ZIP CODE				
CASCADE BEHAVIO	KAL HUSP	TIML		A, WA 981	OAD SOUTH 68			
	ICIENCY MUS	l'ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE	(X5) COMPLETION DATE	
A 000 INITIAL CO	DMMENTS E HOSPIT For the following the follo	AL COMPLAINT SURVal complaint survey was owing dates: 12/12-16/2 Washington State a surveyors: Paul Kondroeth Gordon, RN, MN; S; Alex Glel, REHS, Phl, BSN. F/L/S) Inspection was 2016 by Washington Starshal Donald West (Seart). issues related to the a complaints: #69120; 1130; #70131; #70133; this survey, the DOH at the there was a highly, and death due to the This resulted in one find ARDY in the following a ficient pharmaceutical scope, complexity, and	att, IA ate se and risk ading area:	A 000		is not an or that the tal ted and ate included: in the verrides;	2/10/17	
		OF IMMEDIATE JEOPA		y chael	Madre, CEO 211	8/17	(X6) DATE	

(X6) DATE

Any deficiency statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable to days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/OF AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	504011			B. WING		12/21	/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH JILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
A 000	PM by Paul Kondrat, Williams, RN, BSN. Cascade Behavioral	isit on 12/29/2016 at 12 RN, MN, MHA and Joy Hospital is NOT IN Medicare Hospital Cond erning Body ent Rights ity Assessment and ement	,	A 000				
A 043	There must be an eff legally responsible for if a hospital does not governing body, the for the conduct of the functions specified in governing body This Condition is not Based on observation reviews, the hospital requirements at 42 C Participation for Governing body	fective governing body to the conduct of the hor have an organized persons legally response hospital must carry out this part that pertain to met as evidenced by: n, interviews, and docutation to failed to meet the CFR 482.12 Condition of	spital. sible t the t the ment f		Upon completion of the survey, the Medical Director, COO/CNO, Govern members, and PI/RM Director review findings and began formulation of the Correction. The Governing Board del responsibility of ensuring completion corrective actions to the CEO. The Ciresponsible for reporting the results corrective actions and use of monitor Systems to the Governing Board. See A0115, A0263, A0490, A070	ling Board wed the ne Plan of legated n of all EO is of the oring	2/10/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRES	DRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	PITAL .	12844 MII	4 MILITARY ROAD SOUTH					
	,			, WA 9810					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION		
PREFIX TAG		T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROX		DATE		
ING	51(200 102	LITTE CHICAGO CHICAGO		17.0	DEFICIENCY)				
A 043	Continued From pag	ue 2		A 043	Amendment 2/1/2017: The CEO	will issue			
, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		hcare environment for			weekly reports to the Governing E	3oard			
	patients, visitors, and staff.				related to the hospital's ongoing e				
					toward compliance for all citations				
	Findings:				Conference calls will be held as n	,			
					dialogue. The target compliance		ļ		
		dy failed to effectively			all standards cited. Any score be				
		ng of the hospital to pro	tect		will require remediation with the a employee and/or further analysis				
	patients from harm as		1		possible system issues.	°'	1		
		RDY condition identified	1011		possible system issues.				
	12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope,								
		is of the patients served							
	•								
		oversight of the Perform							
	•	m delegated to the Med	lical		•				
	Staff.	•							
	 Failure to protect a 	and promote each patier	nt's						
:	rights.	ina promoto odom panor	.						
		the condition of thephy				}			
	•	hospital environment o	f						
	care.								
	Due to the scone and	d severity of deficiencie	e l						
	-	R 482.13 Condition of	9						
		ent Rights; 42 CFR 482	.21						
		ation for Quality Assess							
	and Performance Imp	provement; 42 CFR 482	2.25		·				
		ices; and 42 CFR 482.4	41		,				
	Condition of Participa		_				·		
		ndition of Participation i	юг				1		
	Governing Body was	NOIMEL							
	Cross-Reference: Ta	ngs A0115, A0263, A04	90.						
	A0700	<u> </u>							
	ř								
A 084	482.12(e)(1) CONTR	RACTED SERVICES		A 084					
	The governing body	must ensure that the							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE					
CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY ROAD SOUTH /ILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D 8E	(X5) COMPLETION DATE	
A 084	services performed u in a safe and effective. This Standard is not in Based on interview and documents, the hospituality assurance and (QAPI) processes independent of a performance of all conservices places patient improper or inadequation outcomes. Findings: On 12/20/2016 at 9:00 the hospital's quality (Statiet 2 reviewed the hospital 4 reviewed the hospital 5 formally reviewed as quality of services processing the performance of contracted as formally reviewed as quality of services processing the performance of contracted as formally reviewed as quality of services processing the performance of contracted as formally reviewed as quality of services processing the performance of performance of the perf	nder a contract are pro- e manner. met as evidenced by: nd review of hospital ital failed to ensure that it performance improve luded a systematic rev- re services. process to oversee the intracted patient care ints at risk for provision ite care and adverse pa- to AM, during a discussi- program with Director of ff Member #12), Survey ital's process for evalu- portacted health service ited services document ere was no evidence the ervices had ever been part of the QAPI progra- povided: R&M Equip, Biomed eutical - Pharmacy Services	t its ment iew of of atient on of yor ating es. In is, nat the am for		A084 Corrective Actions: 1. The department heads respon contracts evaluated all contract care services and submitted the evaluations to the Medical Execommittee for review and apposess for contract evaluation a. The PI/RM Director review dates to ensu timeliness. b. The Department Head responsible for overse contracted clinical se review the contract accomplete the evaluation complete the evaluation of improvement ensure patient care in met. d. Annually, all evaluation contracted clinical se be forwarded to the Executive Committee Responsible Person: PI/RM Director Monitor On an annual basis, the PI/RM Director of the list of contracted patient care service completed evaluations by the assigned of head in the MEC meeting. The evaluations the evaluation of the evaluation.	eted patient cose cutive roval, e QAPI n as: will calendar re id sight of the ervice will and tion, oncerns, the ill discuss the clinical nd develop a t in order to needs are ions for ervices will Medical e for review.	2/10/17	
A 115	-Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services . 5 482.13 PATIENT RIGHTS		(Y		include any service concerns with relate improvement. Committee minutes will r review and any actions taken on patient contracts.	eflect the		
,,,,,	A hospital must prote patient's rights.	•						

		(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504011		B. WING	·	12/21/2	2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSF	PITAL		MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DAT		
A 115	This Condition is not met as evidenced by:			. A 115	See A 0123, A 0129, A 0164, A 0174	4		
•	Based on observation, interview, document review, and review of hospital policies and procedures, the hospital failed to protect and promote patient rights.		k į		·			
	Failure to protect and promote each patient's rights risk the patient's loss of personal freedom, privacy, dignity, and psychological harm.						- Constitution of the cons	
	Findings:			·				
:		tients the right to exercise and refuse treatment.	se		·			
	2. Failure to utilize the to the use of seclusion	e least restrictive alterna on and restraints.	ative					
		the patient from seclusi time when documentatl t risk ofdanger.						
	4. Failure to investigate closure of the compla	ate patient complaints p aint.	riar to					
•	. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights.							
	Due to the scope and severity of deficiencies under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET.					a and a supply		
	Cross Reference: Tags A0123, A0129, A0164, A0174		64.					
A 123	482.13(a)(2)(iii) PATI GRIEVANCE DECISI	IENT RIGHTS: NOTICE ION	E OF	A 123				

		(X1) PROVIDER/SUPPLIER/C	1.64	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			RVEY		
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		COMPLETE			
		604011		B, WING		12/21	1/2016		
			OTDEET ADDI	DRESS, CITY, STATE, ZIP CODE					
	ROVIDER OR SUPPLIER				•		•		
CASCADI	E BEHAVIORAL HOSP	TAL	l	MILITART R LA, WA 981	OAD SOUTH 68				
0.41 (5	QUMMMDV CT	FATEMENT OF DEFICIENCIES	<u></u>	ID.	PROVIDER'S PLAN OF CORRE	CTION	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	COMPLETION DATE			
A 123	Continued From pag	e 5		A 123	A 0123 Corrective Actions		2/10/17		
	must provide the patidecision that contains contact person, the spatient to investigate the grievance process completion. This Standard is not a Based on interview, of hospital policies ar failed to ensure that pwritten response to the grievances reviewed. Failure to provide patto their grievance violinformed of how the bresolved the grievance.	met as evidenced by: document review, and red procedures, the hose patients were provided neir grievances for 1 of (Patients #2). dients with a written resultes their right to be nospital investigated ar	of its ital f the ults of review pital with a 4		The Patient Advocate reviewed the Grievance Policy on the requirem providing a written response to a The Clinical Educator reeducated staff on the grievance process wit responses provided to the patient was provided in staff meetings the and verbal communication. Amendment 2/1/2017: The hogrievance policy, log for grieval letters that are to be mailed to all been revised and will be preweekly PI Committee on Thurs February 9, 2017 for approval, they will go the Medical Execut Committee on February 9, 201 Governing Board at its next methereafter. Weekly data toward in the new processes is 90%, below 90% will require remedia affected employee and/or furth	ent of grievance. the clinical h written c. Education rough written spital's nces, and patients have sented at the day, From there, ive 7 and peting it compliance Any score ation with the			
•	"Patient Grievance P Policy # G.1001) read Advocate will: Review investigation Com Grievance Resolution report to patient for re signature." 2. Four patient comp review of process an included the patient of reviewed for evidence investigation, finding	cy and procedure titled olicy" (Revised 10/2016 d in part: "The Patient or results of the preliming plete a written report or Form Give written eview, comments and laints were selected for d resolution. Sources complaint log. Each ware of receipt, hospital reso, and resolution of the the findings reviewed were selected to the findings reviewed to the findings reviewed were selected to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings reviewed to the findings	6; nary n the n r s view,		Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present the grievance log and grievance r the monthly PI and quarterly MEC meeting is Feb 9, 2017) and Gove meetings. Any issues requiring im attention will be addressed by the department head.	an analysis of esponses to C(next rning Board mediate			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
	504011			B. WING 12/21/2			2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL			OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I'BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X6) COMPLETION DATE
A 123	the patient who filed to 3. Patient #2 filed a pon 6/3/2016 making a cleaning of the patien area, shower and bat grievance log indicate 4. On 12/15/2016 at 2 interviewed the Patier #7) about the hospital reviewing the complaaction was document	the grievance. patient concern notifical stream of inadequal trooms, patient kitcher trooms. A review of the dathe complaint was clearly and Advocate (Staff Merrit Ingrievance process. Wint log for Patlent #2, need indicating the patier dressed or resolved.	de 1 1 0 0 0 0 0 0 0 0 0	A 123			
A 129	RIGHTS Patient Rights: Exerc This Standard is not r Based on observation review, and review of	met as evidenced by:			A 129 Corrective Actions The Clinical Educator reeducated the staff on the policy titled Skin/Clothir Education included an emphasis on procedure for assessing patients and for patient's refusal. Education was during staff meetings through verbawritten communication with competesting.	ng Check. the proper d procedure provided I and	2/10/17
	Responsibilities" (Re ADM.P.300) under th "To assure that a pat rights and responsibi	risks patient's loss of	# read: or her re		Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will peleast 30 random audits per month to compliance of 90% or above for at leconsecutive months, Audit results we reported in the monthly PI and quand Governing Board meetings.	o ensure east 3 vill be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		LIA R:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR COMPLETE				
	504011			B. WING 12/21/2016			/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOS	PITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH JILA, WA 98168					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
A 129	and to assure that the hospital staff, physic providers." "B. The list of patien not limited to the foll personal privacy, an invasion of privacy, searches may be controlled to detect and prever possessed or used right to care that is of your personal cultur preferences and to a promoting dignity are 2. The hospital's policheck" (Reviewed 1 "Voluntary psychiatry voicing or exhibiting refuse the skin/cloth referral information and discharged from the Patient #1 was asked gown and hand his supervisor (Staff Medicontraband (hospital agreed but stated, 1 off, I am here volund that. The other regis (Staff Member #2) in acceptable. After Pasearched for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient to squat check further for contrattine patient for contrat	nese rights are known by sians and other health can trights shall include but lowing: 4. The right to do be protected from PROVIDED, that reason and contraband from being on the premises 13. To considerate and respective, values, beliefs, and be treated in a manner and self-respect." Icy titled "Skin/Clothing 10/2016) read in part: ic patients who are not self-harm behaviors, whing check, will be given and administratively	t are t are		Amendment 2/1/2017: The hospicheck/contraband policy has been to remove the administrative discipatients who refuse the skin check Staff education has been conducted to this change. Daily audits are a progress and the results of which shared at the weekly PI Committed Wednesday, February 1, 20 the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the attemployee and/or further analysis possible system issues.	n revised harge for sk process. ted related ilready in will be se to be 17 and to a on se target elow 90% iffected			

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		JRVEY TED		
		. 504011		B. WING		12/	21/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSE	PITAL	12844 N	IILITARY RO	AD SOUTH				
				.A, WA 9816					
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A 129	A 129 Continued From page 8			A 129					
	coughing is no longe					•			
	,	•	1				i		
	4. On 12/14/2016 at	1:37 PM, Surveyor #2							
		red nurse (Staff Memb							
		ng check done at admis	sion.	·					
		firmed that part of the	_				:		
		ring the patient squat a	nd						
	cough and then chec contraband. Surveyo								
		n #2 lounu similai process while intervie\	uina	Į					
		nurses (Staff Member							
		the chemical depende							
	and rehabilitative uni								
		,		1			1		
	5. On 12/12/2016 at	2:30 PM, Surveyor #2		•					
	interviewed the Clinic								
		(Staff Member #6) abo		Į					
		rocedure process. Stat		[
		d the hospital had rece	ivea		•				
•	complaints about the	ecently changed their p	olicu						
		The new policy no long							
•		to squat and cough and							
		o refuse the skin check							
		Member#6 to explain							
		ected staff to administr							
		patients who refused th					. 1		
		process. S/he acknowle			1				
		at aspect of the policy.							
		at each clinical director							
		eminating the new polic espective clinical staff .							
	I IIIOMAIION IO INGILIA	eapecuve cirrical stair.							
	6. On 12/20/2016 at 1:50 PM, Surveyor #3		ļ						
		of the hospital's human			·	•			
		s. Three of the four nu							
	staff members (Staff	Members #1, #3, # 4)							
		ord of completing the r			•				
	Skin/Clothing Check	Competency as requir	ed.						
l	I								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL			DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPROPERTY)	DBE	(X6) COMPLETION DATE
A 164	Continued From page 9			A 164	A 0164 Corrective Actions		
	482.13(e)(2) PATIENT SECLUSION Restraint or seclusion less restrictive interved determined to be inef a staff member, or of this Standard is not at the second record revision of the spital policies and staff failed to consider restrictive intervention restraints and seclusion (Patients #4, #6). Fallure to utilize less using both restraints simultaneously puts appersonal freedom and findings: 1. The hospital policy	or may only be used whe entions have been fective to protect the pathers from harm. The met as evidenced by: The effectiveness of least before applying both ion for 2 of 6 patients The effective alternatives if and seclusion patients at risk for loss of dignity.	en tient,	A 164	The Clinical Educator reeducated nu on the requirement of using less resinterventions prior to restraint and sprotecting patients, staff, and/or otherm. The education included an emde-escalation techniques as well as otherapeutic interventions. The Clinic provided the education during staff through the use of verbal and writte communication with return demons. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will au restraints and seclusions to determinal appropriateness of use with less restricted interventions. Any clinical issues requorective actions will be promptly a by the COO/CNO. The PI/RM Director report audit results in the monthly P	trictive reclusion in rers from rephasis on other al Educator meetings n tration. dit all ne trictive uiring ddressed or will	2/10/17
	(Revised 2/2016; Pol section "Policy" read be used for the mana self-destructive beha immediate physical s member or others aff interventions are inef. The section titled "Pa" "Restraint or seclusion less restrictive interventions of the properties of the propert	ffective or ruled-out atient Rights" read on may only be used wh	the y only e taff nen		quarterly MEC and Governing Board	meetings.	

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL. SAMMANY STATTMENT OF DEPTICIENCES. 127454 MILLITARY ROAD SOUTH TURWILA, WA 98168 PROVIDER'S PAN OF CORRECTION GRAPH OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PARTY TO MAKE OF PROVIDER'S PAN OF CORPECTION (PARTY TO MAKE OF PARTY TO		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SURV COMPLETE	
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A 174	Continued From pag	e 11	Ì	A 174	A 0174 Corrective Actions		
7, 17, 7			1			-	2/10/17
	of time identified in the order. This Standard is not met as evidenced by:				The Clinical Educator reeducated no on the requirement of releasing pat seclusion and restraint at the earlies	lents from st possible	
	Based on record review	ew, interview, and revie	ew of		time. The education included an en		
	hospital policies and	procedures, the hospita	al la		de-escalation techniques as well as		
	failed to ensure that p	patients were released	from		therapeutic interventions. The Clinic		
		est possible time for 3 o	of 6		provided the education during Nurs	ing staff	
ĺ	patients reviewed (Pa	atients #3, #4 and #5).			meetings through the use of writter	ì	
					communication and return demons	tration.	
		ients from seclusion at					
		puts patients at risk fo			Person Responsible:		
		oss of dignity, and pers	ioriai		PI/RM Director		
	freedom.				соо/сио		
	Findings:						
	i iridirigo.	•			Monitoring:		
	1. The hospital's polic	cy and procedure titled			The PI/RM Director/designee will au		
	"Seclusion and Physi	cal & Mechanical Rest	raint"		restraints and seclusions for release		
		icy # PC.R. 100) under			earlies possible time. Any clinical iss		
	section "PATIENT RI				to length of use requiring corrective		
	"Restraints or seclusi	on shall be ended at th	е		be addressed by the COO/CNO. Res	ults of the	
	earliest possible time	in the second se			audit will be reported by the PI/RM	Director in	
					the monthly Pi and quarterly MEC a	ind	
		1:15 PM, Surveyor #3	İ		Governing Board meetings.		
1	interviewed the hospi	ital's principal					
,		taff on the use of sectu					
		Member #7). The surve #7 when a patient shou					
	released from seclus		ald De				
		ne trained registered nu	rse or		·		
•	nhysician would revie	ew and assess the patie	ent's				
	behavior to determine	e If seclusion or restrai	nts				
		d. When asked by the					
		t happen if the docume	nted				
	behavior was describ	ed as sleeping, s/he					
]		ould be unlocked and l	he				,
	patient released from	n seclusion.					
	3. On 12/13/2016 at	11:30 AM in the adult					

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		504011		B. WING	· · · · · · · · · · · · · · · · · · ·	12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER	Without the second title	STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	LITARY R	OAD SOUTH		-
0,				A, WA 981			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
A 174	Continued From pag	e 12		A 174	Amendment 2/1/2017: Seclusion		
A 1/4	psychiatric unit (2 We the medical record of into seclusion on 12/released from seclusion was placed in seclusion on the grabbing a food cart a repeatedly striking the Documentation on the indicated the patient's "resting" or "sleeping" AM, a period of 90 mi written at 10:30 AM in resting on the bed with verbalized understand	est), Surveyor #3 review Patient #3 who was plud 1/2016 at 8:30 AM and ion at 11:30 AM. The plud pon after being observe and running down a hale cart against the wall. The esclusion flow sheet is observable behavior at from 9:00 AM to 10:30 inutes. A progress note indicated the patient wat heyes closed and ding for the need for ntinue seclusion when	aced atient d Ilway as		restraint forms were changed to death standards and staff were edithose changes. Audits are alread progress and the results of which shared at the weekly PI Committed Held Wednesday, February 1, 20 the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the employee and/or further analysis possible system issues. 100% or restraint charts are being audited	comply ucated on dy in will be ee to be 17 and to e on e target elow 90% affected of f all	
	reviewed seclusion/re Patients #4 and #5 and a. Hospital staff place and restraint on 9/29/ him/her from seclusion of 28 hours. Surveyor observed documente resting for the followin From 9/29/2010 period of 2 hours and From 9/29/2010 at 7:45 AM, a period a period of 2 hours.	6 at 6:45 PM until 9:30 I 45 minutes. 6 at 10:45 PM until 9/3	on use which a cor PM, a co/2016				

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AND PLAN O	F CORRECTION	,,	214.				
		504011		B. WING		12	/21/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL	12844 N	RESS, CITY, STA MILITARY RO LA, WA 9810	OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
A 174	b. Hospital staff place 12/11/2016 at 10:30 seclusion on 12/12/20 noted the patient's observoir on the seclusion on the seclusion of 7 hours and 40 min no evidence in the secindicate the hospital sthe patient from seclus.	ed Patient #5 in seclusi PM and was released for the properties of	from /or #3 eriod und o to ing (Staff	A 174			
A 263	maintain an effective	velop, implement and , ongoing, hospital-wide		A 263	See A0273, A0286, A0309 A0700), A0490,	
	improvement prograr The hospital's govern the program reflects hospital's organizatio hospital departments those services furnisi arrangement); and fo	ning body must ensure the complexity of the in and services; involve and services (includin- hed under contract or iouses on indicators rel utcomes and the preve	that es all g				
		aintain and demonstrat program for review by					
	This Condition is not	met as evidenced by:	-				
	and review of the hos	n, interview, record rev spital's quality program n, the hospital failed to	and				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	.E CONSTRUCTION	(X3) DATE SUR COMPLETE		
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NAME OF PR	OVIDER OR SUPPLIER	STREET AL		ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL	l .	844 MILITARY ROAD SOUTH JKWILA, WA 98168				
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A 263	Continued From pag develop and impleme data-driven quality as improvement (QAPI) Failure to systematica hospital-wide performaction plans to improvement data limited the hopoblems and formula findings: Failure to identify phasufficient personnel to complexity, and need a sufficient personnel to complexity, and need failure to collect and performance measure Governing Body, Per Committee and the M 2016; Failure to measure, a patient events; Failure to develop a previewing reportable failure to ensure continued to ensu	e 14 ent a hospital-wide, seessment and perform program. ally collect and analyzed ance data and to develoe performance based nospitals ability to identify a cation plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans. armaceutical services laborate action plans.	elop on ify acking d. nce t ar	A 263	DEFIGIENCY)			
	environment was ma	d monitor the overall ho Intained in such a man rell being of patients wa	ner	. •				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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CASCADE	BEHAVIORAL HOSP	ITAL		ILITARY RO A, WA 9810	OAD SOUTH 68		
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A 273	resulted in the hospital opportunities to improductomes of care. Due to the scope and cited under 42 CFR 4 Participation for Qualit Performance Improve MET. Cross Reference: A-0 A0490, A0700 482.21(a), (b)(1),(b)(2 COLLECTION & ANA (a) Program Scope (1) The program must to, an ongoing progra improvement in indicate evidence that it will im (2) The hospital must track quality indicators performance that assends performance that assends performance that assends indicator data including other relevant data, for submitted to, or received Quality Improvement (2) The hospital must (1) Monitor the effectives and quality control of the program quality of the program quality of the frequency (3) The frequency	of these systemic probal's inability to identify we patient care, safety severity of deficiencies 82.21, the Condition of the Assurance and ament Program was NO 273, A-0286, A-0309, D(i), (b)(3) DATA LYSIS Include, but not be liming that shows measurators for which there is prove health outcomes measure, analyze, and s and other aspects of eas processes of care, perations. Incorporate quality ag patient care data, and or example, information wed from, the hospital's Organization. use the data collected ectiveness and safety of the safet	and s f DT ited lble d b to- of		A 0273 Corrective Actions The PI Director reviewed the list of performance indicators, assigned by Governing Body, PI Committee, and Staff for 2016. Of note, the following data was aggregated, analyzed, and to the PI and MEC committees for as of patient care processes. -Grievances -Anticoagulation therapy and medicate reconciliation upon admission and defect and reconciliation where and medication variances and medication variances and medication variances (drug umedication variances, adverse drug untibiotic usage, and nursing unit/m checks)	Medical g clinical presented esessment ation scharge riances tilization, reactions,	2/10/17
	body.						

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A 273	Continued From pag	e 16			Persons Responsible: Pl Director COO/CNO		2/10/17
	This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan			Monitoring On a monthly basis, the Pi/RM Direct facilitate the tracking and analysis of performance measures for presenta PI committee. Committee members implement action plans as documen meeting minutes. Negative or undes will be discussed by the committee for performance improvement action needed. The Medical Staff and Gove will be informed of data analysis and initiatives on a quarterly basis to ensimplementation of the quality and pimprovement program.	tion to the will ted in ired trends for initiation is as ire ire ire ire ire ire ire ire ire ire		
	Performance Databashospital was to collect different performance performance measure person for data collect reporting frequency was to review on a quarterly basis. 2. Surveyor #2 interviservices (Staff Memix Measure data collect on 12/16/2016 at 1:41 revealed the following a. The Performance is Rights and Grievance	e was assigned to a specion and analysis, and was defined. The Gover the performance measures wed the Director of Cliper #13) about Performance, analysis and report 5 PM. The interview or	ecific the ning ures inical ance				

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			<u>L</u>		PROVIDER'S PLAN OF	CORRECTION	(X5)
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A 273	grievances. The info and analyzed by the Director and the Pati to the Performance I monthly. There was information presented Director stated that the not been meeting an collected or analyzed b. The Performance Patient Safety Goals hospital was to colle were reviewed by Stikelihood of patient is anticoagulant therap Medication Reconcil discharge. The Chie Risk Manager were collection and analys Committee and the Committee and the Committee and the Committee and the Committee and for survey and for reporting monand Governing Boar patients placed in rereported by the Perf Committee to the Goodstand and the Governing Boar patients placed in rereported by the Perf Committee to the Governitee to the Governite was no reported by the Perf Committee to the Governite of	rmation was to be colled. Performance Improventient Advocate, and report on report containing this add for surveyor review. The grievance committed that the data was not dot. Measure titled "National" listed 5 goals that the ct and analyze data for, urveyor #2: 1) Reduce tharm associated with by (Warfarin), and 2) liation upon admission are four sing Officer and the responsible for data sis, and for reporting to the containing this information review.	nent orted e s s The e had being al two and ne the PI sly. tion er he were ysis, ee ere as no	A 273	Amendment 2/1/2017: Tigrievances, anticoagulan seclusions, elopements, consultations, Pharmacy indicators, and contracte been abstracted and anathe PI Committee on or be Executive Committee on February 9, 2017 and Gothereafter. The target co Any score below 90% wiremediation with the affe and/or further analysis of issues.	The 2016 data for sits, restraints & medication & Therapeutics d services have alyzed and will go before Thursday, en to the Medical Thursday, overning Board ampliance is 90%. Il require cted employee	
	documentation of re d. The Performance Management/Patien	straint and seclusion. Measure titled "Risk to Safety/Quality" was to Licide attempts, falls,					

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL SUMMAY STATEMENT OF DEFICIENCES 12424 MILITARY ROAD SOUTH TURWILA, WA 98168		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SUF COMPLET	
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168			504011		B. WING		12/2	1/2016
PACKED PROVIDERS PACKED PROVIDERS PACKED PACK	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
PRÉTIX TAG RISCIDENTEYINE INFORMATION RISCIDENTEYINE INFORMATION A 273 Continued From page 18 medication variances, elopements, contraband and patient setisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quastrely to the Performance improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract tog for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting the information annually to the Performance improvement Committee and the Medical Executive Officer were responsible for data collection and analysis, and for reporting the information annually to the Performance improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therepeutices" was to measure drug	CASCADE	BEHAVIORAL HOSP	PITAL.			The state of the s		
medication variances, elopements, contraband and patient selisfaction. The Risk Manager and Chien Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/T reatment" was to measure medical consultations/T reatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information and analysis, and for reporting this information and analysis, and for reporting this information and analysis, and for reporting this information and analysis, and for reporting this information and analysis, and for reporting this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therspectics" was to measure drug	PREFIX	(EACH DEFICIENCY MUST	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	YOULD BE	COMPLETION
utilization, medication variances, adverse drug	A 273	medication variances and patient satisfaction. Chief Nursing Officer collection and analys to the Performance in Governing Board. The review the data collection variances was data presented to and medication variance in the Performance of Consultations/Treatmedical consultation appropriateness to the Risk Manager ar were responsible for and for reporting the Performance Improve Medical Executive Coreport containing this surveyor review. f. The Performance in Services of the Service and quality mand Chief Executive to data collection and an information annually improvement Committee containing this information annually improvement Committee containing this information. Cross-reference: Tag. The Performance and Therapeutics we want to the performance and Therapeutics was a strength of the performance and Therap	is, elopements, contrabation. The Risk Manager at were responsible for dis, and for reporting monprovement Committed elopement. While of the surveyor for elopement. While of the surveyor for elopement, was to measure for timeliness and the patient's individual near ment of the formation quarterly to ement Committee and the contract log for section and the Performance of the Performance the Performance of the	and ata anthly a and b there ement ort eeds. r lysis, the the o for ted ope of nager le for g this	A 273			

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A 273	Continued From pag	e 19		A 273			
7(2)3	reactions, antibiotic uroom checks. The Pl for data collection antibis information quart Improvement Committee Committee	sage and nursing unit/on thermacist was respons d analysis, and for repo erly to the Performance	ible orting		A 286 Corrective Actions		
A 286	482.21(a), (c)(2), (e)(A 286	1) Analysis and Tracking of Adverse F Events	'atient	2/10/17
	(1) The program mus to, an ongoing progra improvement in indication evidence that it will medical errors. (2) The hospital must trackadverse patie (c) Program Activities (2) Performance impression of the control of the cont	The hospital must measure, analyze, and tackadverse patient events Program Activities Performance improvement activities must ack medical errors and adverse patient events,			All elements of the PI plan and 2016 performance improvement activities reviewed by senior leadership, the PI improvement Committee (1/11/17). Medical Staff committees (1/10/17 a 1/11/17). The processes for adverse analysis and tracking including the RA Analysis process was highlighted. 20 analysis and recommendations for acreviewed by PI and MEC committees. Persons Responsible:	were erformance and the and e event oot Cause 016 data ction were	
	actions and mechanicand learning through (e) Executive Resport governing body (or ownous assumes full leg responsibility for ope medical staff, and ad	sms that include feedba out the hospital. nsibilities, The hospital's rganized group or indiv al authority and rations of the hospital), ministrative officials are ountable for ensuring th	ack s idual		PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director facilitate the tracking and analysis of measures for adverse events for preto the PI and MEC committees. Negaundesired trends will be discussed by committee for initiation of performatimprovement actions as needed. The Staff and Governing Board will be interested.	FPI sentation ative or y the unce e Medical	
	This Standard is not	met as evidenced by:			adverse event data analysis and trac quarterly basis to ensure implement performance improvement program	king on a ation of the	

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	R;	A, BUILDING		COMPLETE	D
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		TUKWILA	A, WA 9816	38		
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ITEM #1 - Analysis and Teatient Events Based on interview, reconquality documents, the heanalyze and track adverse patient events ristoldentify root causes an and may contribute to an environment. Findings: 1. Review of the hospital titled "Incident Reporting" (Policy #RM.200; Approving that the hospital's Risk M for collecting incident replanalysis and trending. Review of the hospital's Improvement Plan (Policy 12/2015) revealed that it the Medical Executive Conference Improvement results of incident reports patient complaints to determine the conference occurrences corrective action is or have extent possible. 2. An interview with the Mouality (Staff Member #1 PM and 12/20/2016 at 1: of Clinical Services (Staff 12/16/2016 at 1:45 PM results PM results Services (Staff 12/16/2016 at 1:45 PM results PM results Services (Staff 12/16/2016 at 1:45 PM results PM resul	Tracking of Adverse ord review and review no spital failed to mease patient events. I gate data related to isks the hospital's aloud develop action plan unsafe patient care and policy and procedure of the patient care and the responsibility of the patient committee and the cent Committee to review by analyzing the its, patient surveys and ensure that as been taken to the Manager of Risk and 12) on 12/14/2016 and 12/20 PM, and the Direct of the month of the patient which are the patient of the manager of Risk and 12) on 12/14/2016 and 12/20 PM, and the Direct of the member #13) on	w of asure, bility ans e ed sible eal lity of view nd d t 1:04 ector	-	Amendment 2/1/2017: Going for PI Committee will receive action peach Root Cause Analysis conduction at time frame for the complete those action items. The PI Commadd those items to minutes and refollow-up at each of its meetings items are resolved. Action items typically be resolved within 90 daysooner, depending on the urgencassociated with that action item. compliance is 90% of all items cowith 90 days. Any score below 9 require remediation with the affect employee and/or further analysis possible system issues	plans for cted along on of nittee will eceive until all will ys, some y The target mpleted 0% will	

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A 286	the Risk Manager and but the data was not looking for patterns, in improvement. b. Patient grievances individually but the data aggregate looking for opportunities for improce. The number of pattransfer were reported quarterly but the data aggregate looking for opportunities for improduced the purpose of	ere reviewed individually of their managers as not reviewed in aggregate trends and opportunities were logged and reviewata was not analyzed in a patterns, trends and overnent. The coverning Board was not analyzed in a patterns, trends and overnent. The was not analyzed in a patterns, trends and overnent. The was not being collected one of looking for patterns.	eeded s for wed al	A 286	ITEM #2 — Reportable Adverse Even	ts	2/10/17
	hospital policies and failed to develop a progression reviewing reportable. Failure to recognize inhibits the hospitals review of the events. This failure places parasafe environment. Reference: WAC 246 "Adverse health eventhe list of twenty-nine."	record review and revie procedures, the hospit rocess for identifying ar	al ad onts opth ans. an		The COO/CNO has educated the Pi Director on the requirements of WAC246-302-010. All reportable e outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elem of submitting a root cause analysis discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	vents le or ents	

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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH			
			TUKWIL	/ILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 286	3 Continued From page 22			A 286	ITEM #2 continued			
A 286	Forum in 2011, in its reportable events in happendices. WAC 246-302-020 He (1) Notify the department has occurred we confirmation of the additional confir	consensus report on secential care including allow and When to Report ent that an adverse he ithin forty-eight hours of verse health event the department within confirmation of the adverse or must include a root prective action plan and Quality Forum (NQ twenty-nine serious e twenty-nine adverse ag but not limited to: events: njury of a patient or stam a physical assault (i ithin or on the grounds it titled "Incident Report proved 12/2013) stated facility is required to rents to the State, it mus	t alth of erse F) iff e., of a ing" that port			er ee and		
	notification of comple Management and Cli The same policy stat incidents require a R	ction to Corporate Risk nical Services Departm ed that "All Level I and isk Manager investigation Investigation Chronol	II ion					

			Kt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		VEY ID
	•	504011		B. WING	AL AMEN	12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	STREET ADDR	ESS, CITY, ST/	ATE, ZIP CODE		1
	BEHAVIORAL HOSP	PITAL	12844 MILITARY ROAD SOUTH				
ONGONDE			TUKWILA, WA 98168				
	CALIBRATION CON	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 286	86 Continued From page 23			A 286			
71200	The policy did not include the NQF list of		İ		A 286 Item #3- Completion of Action	Plans	2/10/17
	reportable adverse events nor did it include the						
	requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury.			1	The COO/CNO and PI Director were	trained on	
					analysis of adverse events and credi	ble root	
				*	cause analysis elements by the Region		
			t to		Director. Adverse reportable event	s will be	
			njury.		reviewed with credible action plans	formulated	
		sferred to the emergeno			and implemented in a timely manner	i	
	room for care and rec	quired follow-up special	ty				
	health care appointm	ents for his/her injuries	. The		Persons Responsible:		
	incident was reviewed	d by the Manager of Ri	sk (PI Director		
	and Quality (Staff Me	imber #12), and the logy and Incident Reca	n was			ļ	
	completed with recon		h Mas		Monitoring	}	
	improvement based of				On a monthly basis, the PI/RM Direct	tor will	
,	improvement based c	Mitte in tooligation.			present action plans based on analy	sis of	
	3. An interview with ti	he Manager of Risk and	l k	•	adverse events to the PI committee.	Action	•
		er #12) by Surveyor #2		•	plans will include date/s actions take	en and	
	12/20/2016 at 2:12 P	M about the patient to	1		persons responsible for action. The	Medical	
	patient assault revea	led that Staff Member #	112		Staff and Governing Board will be in	formed of	
	was unaware that this	s particular incident wa	ន		actions taken in response to adverse		
	considered an advers	se event by NQF. Staff	_		a quarterly basis to ensure impleme	ntation of	
	Member #12 stated to	hat a root cause analys	sis		the analysis and actions taken in res	ponse to	
	had not been comple	ted nor had the incider	t		adverse events.		
		State as required by ho	spitai				
	policy.				,		
					,		
	TTEM #3 - Completio	n of Action Plans					
• '	Based on interview a	and document review, th	ne				
	hospital failed to ens	ure completion of action	n				
	plans developed during review of adverse events.		vents.				
	Failure to ensure cor	npletion of action plans	limits				
	the hospitals ability to placing patients at ris	o correct systemic prob sk for harm.	lems				
	Francis Francis				1		
	Findings:						
	-						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	55, CITY, ST/	ATE, ZIP CODE .			
CASCADE	BEHAVIORAL HÖSI	PITAL		1844 MILITARY ROAD SOUTH JKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE JENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE .	(X5) COMPLETION DATE	
A 286	Continued From pag	ge 24		A 286			· · · · · · · · · · · · · · · · · · ·	
	1. Surveyor #2 revier for 3 adverse events Services (Staff Mem 1:25 PM and with the Quality (Staff Member AM. Review of the accorrect identified issue. For the elopement change the policy "Costaff of a patient who the nursing unit) to "	wed the root cause ana with the Director of Clir ber #13) on 12/16/2016 and manager of Risk and er #12) on 12/20/2016 action plans developed to use revealed the following the issue, the action item to code Amber" (used to also has wandered away frought for the code E" had not been staff were trained and C	at 9:20 programmer of the second seco					
	Items was a change followed by audits to were properly condu reduction precaution Member #12 stated to done.	sault issue, one of the actor an assessment form ensure that assessment cted, documented, and is were implemented. Sithat the audits had not be	nts risk eaff peen					
A 309	RESPONSIBILITIES The hospital's gover group or individual wauthority and responsions to officials are responsionsuring the following improvement and pareduction of medical implemented, and many performance improvement and pareduction of medical implemented, and many performance implemented implemented implemented and performance improvement and performance implemented impleme	ning body (or organized tho assumes full legal asibility for operations of aff, and administrative ible and accountable for ag: program for quality stient safety, including the errors, is defined,	the ne nt		A 309 Corrective Actions The PI Director and Medical Director all elements of the PI plan and 2016 performance Improvement activities Medical Staff and MEC committees and 1/11/17). The processes for clinon-clinical analysis and tracking we highlighted. 2016 data analysis and recommendations for action were rethe MEC. The Medical Staff assigned representation to the Infection Cont Pharmacy & Therapeutics, EOC, Safe Performance Improvement committee participants will report cactivities to the MEC at least quarte	s with the (1/10/17 nical and ere eviewed by d physician trol, ety and tees. These	2/10/17	

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	<u> </u>		
•	BEHAVIORAL HOSP	ITAL	12844 IV	ILITARY R	OAD SOUTH			
			TUKWIL	VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EAGH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETION DATE		
A 309	Continued From pag	e 25		A 309	The MEC reviewed the 2017 PI Plan	and	2/10/17	
,,,,,,,		provement actions are			recommended priorities for quality a	ınd		
	evaluated.				performance improvement activities	i.		
	(5) That the determin	nation of the number of						
	distinct improvement	projects is conducted		•				
	annually.				Persons Responsible:		1	
					Medical Director			
				•	President of the Medical Staff			
	This Standard is not i	met as evidenced by:						
	I I I a ordinara la noci	HOLDO GALGOLIÓOM WAY			Monitoring			
	Based on interview a	nd review of the hospit	al's	On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI				
	performance improve	ment plan, the hospital	'8		measures for presentation to the PI			
,	Governing Body faile	d to provide oversight t	0		committees. Negative or undesired			
	ensure that the qualit				be discussed by the committee for it			
	•	ement (QAPI) plan was	tully		performance improvement actions			
	implemented.	•			The Medical Staff and Governing Bo			
·	Failure to provide ove	arciabt of the Quality			informed of data analysis and Pl init			
	Accessment and Per	formance Improvement			quarterly basis to ensure implement			
	program to ensure fu	li implementation of the	,		quality and performance improvement			
	performance Improve	ment plan limited the				, ,		
	hospital's ability to ide	entify systemic problem	ns and					
		to improve patient care	and					
	ensure safety.							
	Findings:							
	 1 The hospital's Perl	formance Improvement	Plan			i	,	
	(Policy #RM. 300: An	proved 12/2015) state	d that					
	"Medical staff and ma	anagement staff provid	e					
	leadership for and ac	tively participate in	1					
	performance improve	ement activities and est	ablish					
	criteria for measuring	, assessing and impro	ving			•		
organization performance of both clinical and		a						
	non-clinical processe	es and patient outcome	S.					
	I ney assure impleme	entation of appropriate and improvement activit	ies					
	and report the results	s to the Board through	the					
	Medical Executive Co	ommittee and Performs	ance			•		
	Improvement Comm				1			

27QV11

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504011		B. WING		12/2	1/2016	
ALAME OF DE	OVIDER OR SUPPLIER		STREET ADDS	RESS, CITY, STA	TE. ZIP CODE			
		IT A 1			OAD SOUTH			
CASCADE	BEHAVIORAL HOSP	ITAL	-, -, , ,	.A, WA 9816				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 309	Continued From page 26			A 309				
	the Authority and Acc delivery and assessn contribute to the prev continual improvement		or the at I the					
;	appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duly and authority for performance improvement activities are defined in the Medical Staff Bylaws."							
	The hospital's Medica 12/1/2013) under the Executive Committee Management: (a) The overseeing quality as improvement are to a evaluation of the quality assure its compreher and document improventient outcome studients.	al Staff Bylaws (dated section titled "Medical "read in part 11.4.1 Que duties involved in sessment and perform perform at least an an lity management prograsiveness and effective vement in patient care	uality ance mual am to ness, and					
	2. An interview with the Quality (Staff Member Clinical Services (Stathat the Medical Director Performance Improved not participate in performance than the credentialing and priviles of Risk and Performance Improved		of ed loes ith					

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011				/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL	12844 MI	REET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		JLATORY PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		DBE	(X5) COMPLETION DATE	
	A 405 A 405 Continued From page 27 482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing		and d e as nd ners tate al	A 405	A 0405 Corrective Actions The Clinical Educator reeducated th staff on the requirement of administ medications as ordered for the treat alcohol withdrawal. The Clinical Edu provided education during Nursing s meetings through verbal and writter communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perandom audit of at least 30 records to ensure compliance of 90% or aborconsecutive months. Any deficiencie promptly addressed. Audit results we presented to the monthly PI and quarter.	rating ment of cator taff rform a per month ve for four s will be III be	2/10/17	
	and State laws and reapplicable licensing raccordance with the policies and procedure. This Standard is not be assed on record revipolicy and procedure that nursing staff folk treatment of alcoholy reviewed (Patient #7).	equirements, and in approved medical staff res. met as evidenced by: ew, interview, and revie, the hospital falled to exwed physician orders to withdrawal for 1 of 3 parts. I orders risks patients or improper treatment,	ew of ensure for tients		and Governing Board meetings.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504011		B. WING 12/2*			/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOS	PITAL		LITARY RI I, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE BENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
A 405	1. The hospital's por "CIWA" [Clinical Inst Assessment] (Policy 12/2013) established be assessed for syn how the patient's syrusing a withdrawal a medications were to the patient's score. The pre-printed order set Alcohol Withdrawal" physicians to order set andications to be acceptationary withdrawal 2. Review of the met patient's withdrawal during the following: a. Patient #7 was a set admitted on 12/10/2 withdrawal. On 12/11 patient's physician of Withdrawal Protocol alcohol withdrawals. Review of the medic for Patient #7 reveal patient received 1 m and 1 mg of Lorazet An interview by Surv. Nurse (Staff Member patients alcohol with administered medicates core assigned a patient's dose of Lorazet patient's do	licy and procedure titled itute Withdrawal #AR.C.210; Approved the how often a patient was aptoms of alcohol withdraptoms were to be scored to be administered according to titled "Lorazepam Order (dated 5/15/2014) used specific dosages of diministered based on the assessment score. Indical records of three enced symptoms of alcohol at 9:30 PM the procedure of the Alcohol initiating treatment for symptoms. Indical records of three enced symptoms of alcohol initiating treatment for symptoms. Indical records of three enced symptoms of alcohol initiating treatment for symptoms. Indical records of three enced symptoms of alcohol initiating treatment for symptoms.	as to rawai; red ow ing to ers for I by e was chol d the was chol red he I AMI		Amendment 2/1/2017: CIWA procurrently being audited daily by the Director of CD Services. Analysical audits will go to the PI Committee weekly PI Committee starting Weekly PI Committee start	ne Nursing s of the e at each ednesday, mpliance is require bloyee e system ompliance	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1''	LE CONSTRUCTION	(X3) DATE, S COMPLI		
		504011		B. WING		12/21/2016		
•	OVIDER OR SUPPLIER BEHAVIORAL HOSI	PITAL.			DAD SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	S GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 405	Continued From pag Member #4 did not k administered the hig	now why nursing staff		A 405		A distance		
A 490	that meet the needs institution must have registered pharmack under competent superscending is responsible for deprocedures that minifunction may be deleorganized pharmace. This Condition is not Based on observation review, the hospital pharmaceutical serv complexity, and need risks patient safety a administration practicular pharmaceutical services. Findings:	ave pharmaceutical server of the patients. The a pharmacy directed bet or a drug storage are pervision. The medical eveloping policies and mize drug errors. This egated to the hospital's autical service. The met as evidenced by: In, interviews, and docurated to provide sufficient interviews are decently interviews. The scope, do of the patients server dequate pharmacy servind safe medication.	y a a staff ment d. ces	A 490	See Tags A0491, A0493, A0	500		
	a pharmacist prior to . 3. Medication errors overrides of the auto	resulting from medicati matic dispensing mach	ion ines.					
	1.4 Expansion of hos	nital services, clinical ur	nts.					

STATEMENT	OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		R:	A. BUILDING		COMPLETE	D	
		504011	NW MAN	B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH		
			TUKWIL	A, WA 981	68	÷.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 490	Continued From pag	ie 30		A 490			
7 400	and patient census without a comparable increase in pharmacy services coverage. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications.		71 130				
			for			a de la constante de la consta	
	Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET.					and the state of t	
	Cross Reference: Ta	gs A0491, A0493, A05	00				
A 491	482.25(a) PHARMAC	CY ADMINISTRATION		A 491	A 0491 Corrective Actions The Clinical Educator reeducated the staff on policy titled "Medications B		2/10/17
		ig storage area must be rdance with accepted es.	•		with Patients." Education was provi Nursing staff meetings through verk written communication. Education	ded during oal and included:	
	This Standard is not	met as evidenced by:			-Use of home medications only afte verification process is complete.		
	policy and procedure	n, interview, and review o, the hospital failed to e owed hospital procedul n medications.	ensure		Proper labeling and Initialing of the process on home medication bottle Physician orders needed for use of medications.	s.	
	Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors.				The medical staff were educated or requirement of documenting dosag medication administration and order allowance of patient home medicat	es for home ering	
	Findings:				Education was provided through waverbal communication.		
		y and procedure titled					
		nt in with Patients" (Poli			Persons Responsible		
		/2014) read as follows:			Medical Director	•	:
		ions that will be used by idmission at the facility,			Pharmacy Director COO/CNO		

			(X3) DATE SURVEY COMPLETED					
		504011		B. WING	12/21/2016		6	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
	BEHAVIORAL HOSP	PITAL	12844 M	ILITARY R	OAD SOUTH			
•			TUKWIL	A, WA 981	68			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 491	Continued From pag	je 31		A 491	Monitoring			
	medications will be in				rform a			
		g, and visual evaluation	as		random audit of at least 30 patient's own			
	part of the pharmacis	st verification process. (Once		medication orders to ensure compli			
	a medication is verific	ed, the pharmacist will	olace		the verification process. Any deficie			
	a sticker on the pack	aging with the pharmac	ist's		addressed promptly. Audit results w			
		nedication as evidence	the		reported in the monthly PI and quar	terly MEC		
	medication has been	verified"		•	and Governing Board meetings.			
	medication must be v	ent to take his/her own written by the attending		Amendment 2/1/2017: The pharmacy director is auditing 100% of home		•		
	physician on the Phy	sician's Order form.			medications and will first report h	s findings		
	2. A tour of the modic	ation room of three pat	ent		to the weekly PI Committee on W			
		ch, Rehab and Detox) o			February 1, 2017, to the Medical			
		2;00 PM and 3:00 PM			Committee on February 9, 2017			
	revealed the following				Governing Board thereafter. Aud			
		_			continue until several weeks of coat or greater than 90% has been			
	a. One bottle of home	e medication, Latuda 12	:0 mg		and sustained. The target compl			
	tablets, was found fo	r Patient #8 in the patie	nt's		90%. Any score below 90% will i	require	}	
	medication tray in the	e Rehab unit medication	ו		remediation with the affected em			
		st attached a white print	er		and/or further analysis of possible	e system		
		on bottle with "verified"	ļ		issues.			
	written on the label a		D1 - 55					
	(12/17/2016) and init	ials of the pharmacist.	Stan					
		dication at 9:00 PM on 6/2016 prior to pharma	oiot					
	verification.	6/20 to prior to priarria	Ciot					
	b. Two bottles of hon	ne medications, Provas	tatin			ļ		
		ts and Dilt [Diltiazem] X				}		
	180 mg capsules, we	ere found for Patient #9	in the					
	patient's medication	tray in the Rehab medi	cation		1			
		st verified and labeled t			-			
		"date opened/expiration				[
	date" label rather tha	an the pharmacy medic	ation		,	[
	verification label. Sta					[,	
		8/2016 at 9:00 AM. The				[
	was no physician ord	der for the patient to tak	B					
	his/her own medicati	uns.						
			}					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1.	LE CONSTRUCTION	(X3) DATE S COMPLI		
		504011		B. WING	· · · · · · · · · · · · · · · · · · ·	12	/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	E BEHAVIORAL HOS	PITAL	,	2844 MILITARY ROAD SOUTH UKWILA, WA 98168				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 491	300 mg capsules, No Truvada 200 mg tab #10 in the patient's r medication room. The written directly on the Rayataz and Tru unable to tell if the in evidence of pharmac no pharmacist verification bottles. I label with date and sepharmacist verification were in a plastic bag medication tray. Two one stated that the pand the other note is verified Norvir. The rany way to the bottle administered all threat 9:00 AM. There was administration of the but the order did not d. One bottle of hom capsules, was found patient's medication medication on 12/19 medication on 12/19	ome medications, Raya orvir 100 mg tablets and lets, were found for Patimedication tray in the Rayare was an initial and demedication bottle laberada) but the surveyor nitials and dates were cist verification. There wation labels on the two The Norvir medication his ignature indicating on. All of these medication placed in the patient's onotes were found in the charmacist verified Truvetated the pharmacist hands were not attached as a physician order for patient's own medication include specific dosage e medication, Dilantin 3 I for Patient #11 in the tray in the Gero-psychine pharmacist verified a on. Staff administered to 1/2016 at 9:00 AM. The der for the patient to take	ent ent ehab ate el (for was vere ad no ions e bag, ada d l in /2016 ons es. 0 mg unit nd he re	A 491				
A 493	adequate number of	MACY PERSONNEL service must have an personnel to ensure qu ices, including emerger		A 493				
]		1	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504011			8. WING 12/21			/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE				
CASCADE	BEHAVIORAL HOSP	ITAL .		ILITARY R A, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES I' BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE {	(X5) COMPLETION DATE
A 493	Continued From pag	e 33		A 493	A 0493 Corrective Actions		2/10/17
	This Standard is not an an an an an an an an an an an an an	review and interview, the pharmacy was number of personnel to acceutical services in outher patients and the statement of the patients and the statement of the patients and the statement of the patients and the statement of the patients and the statement of the patients and the statement of the patients and the statement of the patients at risk of the patients at	o rder aff o gand f pacity g that ened to to		Upon completion of the survey, the COO/CNO, Pharmacy Director, and F Clinical Director reviewed pharmacy order to ensure a sufficient number personnel. Effective 12/20/16, the P Director increased pharmacy staffing two (2) additional evening hours, seper week. The increase in pharmacy prioritized on verification of new order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track to additional staffing hours and report in the monthly PI and quarterly MEC Governing Board meetings for a permonths. Any related deficiencies will addressed promptly.	Regional staffing in of harmacy g hours by ven days hours are ders and use of the utilization and iod of 3	
	pharmacy document key quality workload noted that the average doses administered r 12,000 doses since to The total number of r performed by nurses or nearly 87 per day. count off' in the autor monthly totals reflect	irveyor #3 reviewed a which captures a variet elements. The surveyor per number of medication monthly increased by or he beginning of the year medication overrides averaged 2,593 per mossimilarly, the "inventor matic dispensing machinon-controlled substant mon-cased to a monthly	n n ver ver onth y				·

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		VEY		
	,	504011		B. WING		47/04	mata		
	* TORONIA	00-1011		12/2//2010					
	OVIDER OR SUPPLIER			RESS, CITY, STA	• • • • •				
CASCADE	BEHAVIORAL HOSP	ITAL			OAD SOUTH				
		,	IOKWIL	IILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
A 493	Continued From pag	e 34		A 493	Addendum 2/1/2017: Pharmad	y has			
	average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3				increased its hours of coverage ir evening hours. Overrides are bei daily and analyzed for time of day	ing tracked			
		ı 1:30 Awı, Surveyor #3 ıcist (Staff Member #9)			drug, and reason for the override.		1		
	about the adequacy of				Director and Pharmacy Director v				
		ent workload. Staff Me	mber		present their findings at the week				
		pharmacy workload h			Committee meeting beginning We				
		ed within the past year.	S/he		February 1, 2017. Pharmacy hou				
		ing work at this facility			continue to be adjusted as neces				
		e hospital had added to	NO		minimize the use of the override p				
	more inpatient clinical	i units without a se in pharmacy operati	ina		The facility will continue to evalua needed by the pharmacy through				
		se in pharmacy operati Staff Member #9 indicat			recommendations by the contract				
•		around time for verifyin			provider, number of over-rides du				
	*	s 30 minutes but may	•		of pharmacist to conduct the first				
	delayed up to an hou	r depending on volume	of		review, and medication errors rela				
	new admissions.				overrides.				
							'		
		2:30 PM, Surveyor #3							
		tor of Pharmacy (Staff e high number of medi	cation						
		ithin the hospital. Staff							
		at he/she had only bee					1		
j		al staff for "less than a							
	month" but acknowled								
		was "high" indicating t							
		site during the day shif							
		sked Staff Member #8							
		armacy resources. Sta at "I don't have enough							
		what we should." The							
		indicated that he/she h	ad						
		racted hours every wee							
	except for the first we	ek when on orientation	າ.			•			
	,								
		11:00 AM, Surveyor #3			·				
		tor of Adult Psychiatric		•					
		aff Member #6) about t cation overrides occurr							
		taff Member #6 indicate							
	mann and noopitals of	was anominast iro injulgati							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		1''	LE CONSTRUCTION	(X3) DATE SURV COMPLETER	
	!	504011		B. WING		12/21/	2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH		
			TUKWIL	A, WA 9810	68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
A 493	Continued From pag	e 35		A 493		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
A 483	that medication over think medication over staff member acknow overriding because of to be verified in the stalso complained they medications in the au machines on the wee Monday mornings" re	ides is a "problem" stat rides are dangerous." riedged that nurses wel f how long it takes for c ystem. Staff nurses hav frequently run out of	The re orders ve		·		
A 500	482,25(b) DELIVERY	THE DRIVES		A 500	A 0500 Corrective Actions		2/10/17
A 500	In order to provide particle biologicals must be consistent with applications of the standard is not a seed on document review of hospital polynospital failed to ensistence biological failed biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed to ensistence biological failed biological failed biological failed biological failed biological failed biological failed biological failed b	atient safety, drugs and controlled and distribute licable standards of praral and State law. met as evidenced by: reviews, interviews, and dictes and procedures, the drugs were controlled and procedures or drugs were drugs by:	d in notice, d the ed		The Pharmacy Director, COO/CNO, Director reviewed the process of moverrides in the automated dispens To ensure safe delivery of medication following system revisions were man revisions for overrides. Two nurse witness system when owneeded review of overrides to asset trends, rationale, and any needed improvements	edication ing system. ons, the de: verrides are	
	medication orders to in a safe and timely rand medication error. Findings: . 1. The hospital policy "After-Hour Medication Pharmacy Review" (PHR-169I) under the Policy" read "The facing portance of pharmacy of pharmacy rand "The facing portance of pharmacy of pharmacy of pharmacy rand "The facing portance of pharmacy rand "The facing portance of pharmacy rand timely rand timely rand timely rand rand rand rand rand rand rand rand	y and procedure titled on Stock with or withou Revised 4/2014; Policy section titled "Stateme	nsed fety It # ent of		The Clinical Educator educated the medical staff on the revised system oversight of the override system. Educated during Nursing and Medical meetings through verbal and writte communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	changes for ducation was al Staff	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	504011		B. WING		12/21	/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CASCADE BEHAVIORAL HOSE	SCADE BEHAVIORAL HOSPITAL 128			DAD SOUTH		
דטא			A, WA 981	88		:
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
medication-use proces an exception to phan medication order for does not permit phan occurs in 'first doses' such cases, an excepsignificant patient had involved for a pharm medication order, an outweigh the benefits. 2. On 12/20/2016, Stepharmacy document key quality workload medication variances. The surveyor noted to 23,348 medication or in the first nine month expansion of the hospital average 2,22 month. With the open nursing units, the nursing units, the nursing units, the nursing units, the nursing units, similarly, number of medication by physiclans had in beginning of the yea. 3. On 12/19/2016 at reviewed the hospitat the period 12/16/201 12/19/2016 at 7:00 / the pharmacy in-hou day. During this time admitted 14 patients medication overrides. Of the 236 medication.	on errors associated witess The hospital allow macist review of the certain situations when macist review. This offer or 'emergency' situation of the cortain sillowed because the could result in the discist review of the district of a pharmacist review arreview of a pharmacist review arreview of the hospital had a total vertides performed by result of the two addition more of medication overrides in the two addition of the two addition more of medication over ity average of 2,700 norease or 479 addition the surveyor noted that in variances (potential ecreased by four fold sing.	ws for time en ons. In se elay ould ould out ty of des. of nurses s a al erides nal et the errors) nce the st for ours a of 236 g staff. urred		Monitoring The Pharmacy Director/designee will the total number of overrides with a trends, analysis, and system improves the monthly PI and quarterly Pharm Therapeutics committees. Findings, recommendations and actions will be and reported at quarterly MEC and Board meetings. Committee minute data reporting, analysis, and system A500 Amendment 2/18/2017 Cascade Behavioral Health was pharmaceutical services not meeting and control of these systemic problems/findir in the hospital's inability to provide dispensing, use and administration tracking and control of medication Immediate response included incoharmacy hours by two (2) additional tracking enhancement result overrides being reduced to approach to per day. Since then, the medical staff connight locker concept with a small inventory of medications but ultiredecided not to endorse this idea. Collectively, these systemic issue additional time to implement prochange, arrange additional pharm coverage, establish 24/7 coverage to review all orders, and eliminatic access and overrides.	aggregated ements to acy and re reviewed Governing s will reflect changes. Cited for eting the eative effectings results reflect on, and ons. Creased conal er week, ted in eximately sidered a er nately res require cess macy ge solution	

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1''	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y		
		504011		B. WING 12/21/2			016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL	12844 MI	DDRESS, CITY, STATE, ZIP CODE \$ MILITARY ROAD SOUTH VILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ALD BE	(X5) COMPLETI ON DATE		
A 500	"First Dose Needed" pharmacy had not ye order in the automate 11 medication overrid as the reason for the . 4. On 12/19/2016 at 2 interviewed the Direct Member #8) about the overrides occurring with Member #8 indicated override and obtain a hospital's automated He/she acknowledge formulary was access any restriction. 5. On 12/20/2016 at 2 interviewed the Direct Nursing Services (Stahigh number of medic within the hospital. State medication over problem. The staff member of the Pharm Committee to see if sprogress could be meacknowledged discuss meetings with the pres (Staff Member #10) for (Staff Member #11) at 20.	as the reason indicating the verified the medication of dispensing system. Of the listed "Emergency Coverride. 2:30 PM, Surveyor #3 for of Pharmacy (Staffer high number of medications and all medications dispensing machines. It was all medications dispensing machines. It was all nurses without the hospital's entitle to all nurses without the foliation overrides occurring the medication overrides occurring the medication error of Member #6 asked to the macy & Therapeutics ome improvement or ade on this issue. He/siesing medication overrides on the quality risk man and the decision was mand the decision was mand the situation.	n Drily Jse" cation can in the dire dire dire dire dire dire dire dir		Proposed Interim Plan Temporary night and weekend plead provide additional coverage will be by February 24, 2017. They will present in the pharmacy to reviewall new orders during their shift, juday-shift pharmacists currently denurses' ability to override medical disabled permanently. All medical disabled permanently. All medical will be verified by a pharmacist pradministration. Responsible Person Pharmacy Director (Pharmacist in Proposed Long Term Plan) On or about April 1, 2017, the fact transition pharmacist coverage to through a combination of pharmal and remote order entry. The Pharmacy Director, CEO and COO are evaloptions to obtain the necessary restablish this service within this estimeframe.	pe in place physically be w and enter ust as the b. The tions will be ation orders rior to cility will be 24/7 acist on site armacy uating esources to			
A 700	The hospital must be	NVIRONMENT constructed, arranged the safety of the patie	, and	A 100					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		504011		B. WING "	· · · · · · · · · · · · · · · · · · ·	12/21	/2016			
NAME OF PR	OVIDER ÖR SUPPLIER		STREET ADDRE	ADDRESS, CITY, STATE, ZIP CODE						
CASCADE	BEHAVIORAL HOSP	PITAL		44 MILITARY ROAD SOUTH						
			TUKWILA	4, WA 98	3168					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION			
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				TAG	DEFICIENCY)					
A 700	Continued From pag	je 38		Α						
	and to provide facilitie			700			i			
		ecial hospital services	ļ							
	appropriate to the needs of the community.									
	This Condition is not	met as evidenced by:								
	,	mot de ortanion sy		•						
	Based on observation	ns, document review, a	nd		· ·					
		ospital failed to ensure								
		ical plant and the overs								
		was maintained in suc ty and well-being of pat								
	was protected.	ry and won boing or pa	, ica ac							
		e structural integrity of	the							
	facility plumbing and	ventilation system.								
	Fallure to follow man	ufacturer-recommende	d							
	maintenance activitie		~		• .					
					·					
	-	ature risks in patient ca	re							
	areas.									
	Failure to monitor and	d provide appropriate f	ood							
		to ensure food tempera								
	are maintained at the	e required levels.								
	Ph. 1 11									
		d severity of deficiencle 482.41, the Condition o			•		•			
	1	sical Environment was								
	MET.									
					_					
		igs A0701, A0710, A07	24,		·					
	A0726									
V 201	ADO AAAN MAINTEN	ANCE OF DUVOICAL			A 701 Corrective Actions		2/10/17			
A 701	482.41(a) MAINTENA PLANT	ANCE OF PHYSICAL			A 701 Corrective Actions 1. and 2. The Facilities Director reedu	cated staff	4/ 10/ 1.1			
	I GORIL			701	on environmental factors contributing	to ligature				
	The condition of the	physical plant and the	overall		and self-harm risks particularly related	d to doors				
	hospital environment	t must be developed ar	ıd		and handles. Training included mitiga					
	maintained in such a	manner that the safety	/ and		strategies such as patient observation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21/2016	
NAME OF DE	CHARLES OF CHARLIES		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
	OVIDER OR SUPPLIER	NPT A I			OAD SOUTH		1
CASCADE	BEHAVIORAL HOSP	TI AL		LA, WA 981		,	
		***************************************				ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC)N
A 701	701 Continued From page 39			A 701	A 0701 Corrective Action		
7,101	well-being of patients are assured.						
	Wolf bollig or parional				Increased monitoring of high risk pa	tients.	
	This Standard is not a	met as evidenced by:			Staff required to successfully comple		
					training test.		
	Based on observation	n, interview and record			3. Bathroom flooring was repaired	by	
	review the hospital fa	illed to maintain the cor	ndition		(contractor) on 1-12-17.	•	
	of the physical plant a	and the overall hospital			4. Ceiling links were repaired by (co	ntractor) on	
	environment of care.				1-12-17,		
					5. Occluded pipes were repaired by	contractor	
	Failure to maintain th	e physical plant increa	sés		1-12-17		
	the risk of infection to	patients, staff and visi	tors.		6. Ceiling tiles were changed 1-16-1	7 bv	
					Maintenance staff	'	
	Findings:				7. Burnt outlet was replaced by Ma	intenance	
					staff by 12/23/16	, , , , , , , , , , , , , , , , , , , ,	
	observed the door in	10:00 AM Surveyor #1			8. Shower mold was remediated, of	d caulk was	
		had a closure mechan	iem		removed and the area cleaned and		
	that posed a ligature		13111	,	by Maintenance staff (1/9/17)		
		ssment dated August 2	016.		9. Oscillating fans have been install	ed in all	
	the facility had Identif	ied door risks in geriati	ic unit		PHP patient care areas. Permanent		
		ligh" or "Severe Risk".			systems are being evaluated.		
		olumns labeled "What			aysterns are nema strained		
	Action", "Time Frame				Persons Responsible:		
		or this item had limited	or no		Plant Operations Director	0	
	information provided	in these columns.			CEO		
		10:00 AM Surveyor #1			Monitoring:		
	observed that the ha				The Plant Operations Director/design	nee will	
		in the sunroom posed	ឧ		perform environmental rounds of the		
	ligature risk				care areas to monitor ligature risks,		
	0 0 40M0/0040 1	ADIAN ASS CITATION 44			flooring/walls/cellings, furnishings,		
		10:10 AM Surveyor#1 oring in the bathroom o	n the		cleanliness and structures. Any defi		
	adult psychiatric unit	omig in the battiroom o (3 Meet) wee eoft	at trie		be promptly addressed during the	MICHOLOG AALII	
	adult psychiatric drift	and that vinyl was ripp	led		environmental round. Results of the		
•		bathroom was located			environmental rounds will be repor		
	to 3 showers on 3 W				monthly PI committee and quarterly		
	C C CHOWOIG ON 5 W	~~				, IVILO	
	4. On 12/13/2016 at	10:25 AM Surveyor #1			meetings.		
		ision room on the adult	t ·		•		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		504011		B. WING	. All Albert Comments	12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH		
				A, WA 981			
0/10/10	CLEMANA DV CT	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT!	281	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	THE PRECEDED BY FULL RE		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	COMPLETION DATE	
A 701	Continued From pag	e 40		A 701	Amendment 2/1/2017: The pi	oes were	
	psychiatric unit (2 We	est) a large crack in the			occluded by temporary obstru-		
	ceiling, the crack app				have been assessed by an		
	exposed dry wall whe	re work had previously	been		independent, professional plur	nher	
,	done. On 12/14/2016	between the hours of	2:00		The pipes have no on-going n		
	PM and 3:00 PM Sun	veyor #1 observed tow	els		except routine cleaning and		
	soaked in water on th		1		maintenance. To improve clea	hae paige	-
		West where the ceiling			maintenance, the hospital pure		
		eyor #1 went to 3 Wes			distinct brushes to scour the d		
		the seclusion room and			to remove hair and other debr		
		howers previously stat			ì		
		bove the seclusion roo d that one of the show			cleaning will occur monthly an		
	was in use during the		51.5		needed and has been added t	- 1	
	was in dee duning the	mouona			and housekeeping rounds. Th		
	5. On 12/15/2016 bet	ween 9:00 AM and 10:	00		hospital has switched to psych		1
		erved flooding over the			paper towels that dissolve who	I	
		loor on 3 West next to			address drain clogging issues	•	
		ent, the surveyor obser					
		mber #17) "snake" the					
		ounts of hair. Surveyor	#1		A701 Amendment 2/18/2017		
	did a visual inspection		_		We propose to cool, circulate, an		
	flashlight and found the	he pipes were occluded	d,		dehumidify our outpatient/PHP ro		
	0.0		F A84		two portable air conditioners desi		
•		ween the hours of 10:2 or #1 observed water	o Aivi		that purpose, one in each room we patient care is delivered.	viiei e	
		ile located in the Rehal	a unit		The rooms measure:		
	laundry room.	na incared itt fite Lænar	, Citat		1) 19 feet by 19 feet (361 squa	re feet)	
	laditary rooms				2) 17 feet by 29 feet (493 squa		
	7. On 12/13/2016 bet	ween the hours of 10:2	5 and				
		1 observed a burnt out			Before the summer heat arrives,	we will	
•		ea in the Rehab unit, th			install two Honeywell model MM		
	a potential fire hazard				similar, units which are designed		·
	-				500 square feet. These quiet unit		
		ween the hours of 10:2			14,000 BTU cooling. They can be		
		1 observed mold under			cool or use the fan and dehumidi		
	the caulking in the sh	ower room in the rehab	unit.		The units' venting kits would be in		
	D 0: 40WE00401 4		F38.4		the air conditioner to operate pro	perly.	
	9. On 12/15/2016 per and 3:00 PM Surveyo	ween the hours of 1:30	PIVI				
		or #1 entered into an HP Building), the buildi	nge				}
	varpations building (F	in Dallang), ine bullui	nga				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1	LE CONSTRUCTION .	(X3) DATE SURY COMPLETE		
		504011		B, WING		12/21	/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL	12844 MI	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH IILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X6) COMPLETION DATE	
A 701	ventilation system ha fire. Surveyor #1 obs used for group session did not have any wind skylights that did not ventilate in both room	nd not been replaced af erved 2 large rooms the ons for patients, one ro- dows and the other room open creating no means.	at are om m had ns to		Between now and the installation units, ventilation of these patient arrooms will be accomplished by the forced heaters currently in use ar oscillating fans. No policy is need staff to turn on the air conditioning be based on a consensus of the patients and staff at the time as it comfort.	care e fan- id led for g. This will group of		
A 710	(1) Except as otherw (i) The hospital mi provisions of the Life Fire Protection Assoc Office of the Federal NFPA 101 2000 editi issued January 14, 2 reference in accorda 1 CFR Part 51. A cop inspection at the CM Center, 7500 Securit or at the National Arc Administration (NAR, availability of this ma 202-741-6030, or go http://www.archives.g federal_regulations. Copies may be obtai Protection Associatic Quincy, MA 02269. I of the Code are inco will publish notice in announce the chang (ii) Chapter 19.3.6	A). For information on to terial at NARA, call to: gov/federal_register/co /ibr_locations.html ined from the National I on, 1 Batterymarch Pari f any changes in this er rporated by reference, the Federal Register to	etion- etional the I the ode, oy a) and ble for e the de_of Fire k, dition CMS		A 0710 Corrective Actions The hospital will not require a waive comply with 482.41(b)(1)(2)(3).	r to		
	findings, CMS may v the Life Safety Code	ion of State survey age waive specific provision which, if rigidly applied sonable hardship upon	s of d,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	EE CONSTRUCTION	(X3) DATE SURY COMPLETE			
		504011		B. WING		12/21	/2016		
	OVIDER OR SUPPLIER	A STATE OF THE STA	STREET ADDRESS, CITY, STATE, ZIP CODE						
CASCADE	BEHAVIORAL HOS	PITAL	ł .	LITARY R 4, WA 981	OAD SOUTH 68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE		
A 710	facility, but only if the affect the health and (3) The provisions of apply in a State who safety code impose protects patients in This Standard is not Based on observation review, the hospital requirements of the	e walver does not adver d safety of the patients. If the Life Safety Code doere CMS finds that a fire d by State law adequate hospitals. It met as evidenced by: Interview, and documents	o not and ely	A 710					
A 724	Care Hospital MED reports. 482.41(c)(2) FACIL EQUIPMENT MAIN Facilities, supplies, maintained to ensu safety and quality. This Standard is not litem #1 Medical Su Based on observat review, the hospital	TENANCE and equipment must be re an acceptable level of t met as evidenced by: pplies on, interview, and recon falled to ensure that pa of exceed the manufactu	d tient	A 724	A 0724 Corrective Actions #1- Medical Supplies The COO/CN directed/delegated monthly inspendaterials Department staff, Nursin Pharmacy staff to ensure that all s medications are not expired and w specified on the manufacturers lak Expired/nearing expiration product properly disposed of timely. All esupplies and medications were rer discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee wi environmental rounds of the patie to monitor integrity of products, s medications. Any deficiencies will addressed during the environmen	ctions by the original staff and upplies and vithin date deling or the spired moved and are areas upplies and be promptly	2/10/17		
	exceed their expira	atient care supplies do n tion dates risks deteriora supplies being available	ated		Results of the environmental roun reported in the monthly PI commi quarterly MEC meetings.	ids will be			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		1''	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE:			
		504011		B, WING		12/21/	2016		
MALEOFER	STREET			SS. CITY, STA	TE, ZIP CODE				
	OVIDER OR SUPPLIER	HT A I							
CASCADE	BEHAVIORAL HOSP	TIAL		MILITARY ROAD SOUTH ILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
A 724					Amendment 2/1/2017: Daily at being conducted on each of the u champions are responsible for ch	nits. Unit ecking the			
	Findings: 1. On 12/12/2016 at 11:00 AM during a tour of3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet:				ice machine logs to make sure the cleanings are happening at least. The results of those audits first go weekly PI Committee on Wednes February 1, 2017. The target cor	weekly. to the day, npliance is			
	a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016.			-	90% per unit. Any score below 90 require remediation with the affec employee and/or further analysis)% will ted			
	b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016.				possible system issues.	·			
	c. One box of sterile of with an expiration dat	cotton-tippedapplicator e of 2/2016.	s				ŗ		
	d. One box of sterile of with an expiration dat	cotton-tipped applicator e of 9/2016.	S						
	e. One box of povidor expiration date of 10/2	ne-ìodíne swabsticks wi 2016.	th an						
	f. One 14 french Fole expiration date of7/20	y urethral catheter with 016.	an						
	2. On 12/12/2016 at inspected the 3 West the following:	1:00 PM, Surveyor #3 emergency cart and fo	ound						
	a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016.					A A A	·		
,	b. Five 10 ml 0.9 % S syringes with an expi	Sodium Chloride pre-fille ration date of 5/2016.	ed						
	c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016.								
	3. On 12/13/2016 at	1:35 PM Surveyor #4							

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	504011			B. WING		12/2	1/2016		
NAME OF PR	OVIDER OR SUPPLIER	A bit distance	STREET ADDRI	DDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	TAL		4 MILITARY ROAD SOUTH WILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
A 724	inspected the gero-ps emergency cart and f a. Two 1000 ml 0.9%	sychiatric unit (4 West) found the following:		A 724					
	5/2016. b. Nine 10 ml 0.9% So syringes with an expire	odium Chloride pre-fille ration date of 5/2016.					and the state of t		
	c. Five Tegaderrm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016.								
	and 2:25 PM Surveyo (transparent adhesive	ween the hours of 1:00 or #1 found Tegaderm e film dressing) with an 6 in the crash cart loca							
	5. On 12/13/2016 at inspected the emerge and found the following	ency cart on the Rehab	Unit						
	a. Two 1000 ml 0.9% intravenous fluids wit 5/2016.	Sodium Chloride h an expiration date of							
	syringes with an expi	odium Chloride pre-fille ration date of 5/2016. tween the hours of 1:00 interviewed central su	O and						
	staff (Staff Member# the interview Surveyo	118). During the course or #1 asked how often carts are checked. The	of the						

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOF CORRECTION (DENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		604011		B. WING	A STATE OF THE STA	12/21	/2016		
MANE OF BE	OVIDER OR SUPPLIER		STREET ADD	DDRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	HT A I		14 MILITARY ROAD SOUTH					
CASCADE	BEHAVIORAL HOOF	IIAE		WILA, WA 98168					
	CALLAND AND A	ATTEMENT OF DECIDIFINATE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X6)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	COMPLÉTION DATE		
A 724	Continued From pag	e 45		A 724	A724				
7.1		was unaware that it w	as		#2 Ice Machines				
	part of his/her responsibilities to check the crash				The Plant Operations Director has o	btained a			
		e stated that he/she ha			certified contractor to perform the				
	checked the crash ca	rts 4 months previously	y.		manufacturer recommended maint				
					cleaning for the Ice machines. All m				
	Item #2 Ice Machines	,			were serviced during the week of 1/		2/10/17		
	_				1/20/17.This certified contractor wi				
		n, document review and	a		Plant Operations Staff on proper cle	aning			
	interview the hospital manufacturer's instru-	talled to follow			techniques.				
	manutacturer's institu	ction for preventive ition and routine cleani	na of						
	its ice machine.	don and rodure ordani	ig o		Person Responsible:				
	to loc module.				Director of Plant Operations		:		
		ufacturer's instruction f			la la la la la la la la la la la la la l				
•		nce, routine cleaning ar	ıd		Monitoring: The Plant Operations	atiliado e			
	installation, promotes	the growth of			Director/designee will perform mor				
		ch places patients heal	that		inspections of all ice machines to m cleanliness and operations. Any de-				
	risk.				will be promptly addressed during t				
	Deference Follott Se	ries/W, MCD400A/W,			environmental round. Results of the				
	RANNAAM MEDANNA	/W, D400A/W ice Mac	nines		environmental rounds will be repor				
	Installation Operation	n and Service Manual	Serial		monthly PI committee and quarter				
	numbers above D254	155 stated on page 15			meetings.	, ,,,,,,,			
	provided a diagram o	f incorrect installation.							
	Information on incorre	ect installation as follov	ved:						
						'			
	Dips in tube where w Splice or tight bend to	ater can collect							
		t results in wet ice and			·				
	potential dispensing								
	potential dispanioning	p. 20.121112							
		mphony Plus: On page	4 the				,		
	following was noted:	"Water shut-off							
	recommended within	10 ft. (3 m) of dispens	⊖r. ·						
ı	Drain to be hard-pipe	ed and insulated. Maint	ain						
		foot (20 mm per 1 m) r	un of						
	slope."								
	Reference: Foliattics	e machine 400 Series a	and						
		Machine Manual state							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLÍA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		504011		B. WING		12/2	1/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOS	PITAL	12844 N	ADDRESS, CITY, STATE, ZIP CODE 344 MILITARY ROAD SOUTH KWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	BTATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
A 724	following cleaning fr page 14 and 17: "th	equency for both models e frequency in cleaning ne according fo the sche entive maintenance	and	A 724					
	and 1:45PM Survey from a Follett Ice Ma to the floor drain. Th the patient kitchen a preventive maintena	etween the hours of 1:00 or #1 observed a drain-l achine was not slope to g e ice machine was locat area on the Rehab unit. T ance sticker was past du e on the drip pan had re	line grade ted in The						
	and 10:00 AM, Survivospital plant mana Member #19 stated maintenance was beacompany to get the how often they get he/she said, annual from the company, several machines remaintenance betwee September but the which machines we included in the prevaddition, Surveyor generated from the a "Follett" ice mach scheduled for prevee 2/11/2015, was crossed.	etween the hours of 8:30 reyor #1 interviewed the ger (Staff Member #19). In part that the ice machenind so they contracted them caught up. When as preventive maintenance, iy. In review of work ord "MacDonald-Miller" it she ceived preventive en the months of July the work order did not indicate done and what was rentive maintenance. In #1 reviewed a work order hospital system that indine on 3-North unit was entive maintenance on seed out and a hand write provided to indicate who	Staff hine d with sked ers owed hrough ate						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOS	SPITAL	12844 N		ATE, ZIP CODE OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)	S GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION 9 CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
A 724	work was done. 3. On 12/14/2016 b and 2:45 PM Surve	between the hours of 1:00 byor #1 observed soil buil I drain line of the ice mad x unit.	ldup	A 724	A 0726 Corrective Actions		2/10/17
	TEMPERATURE C There must be proper temperature control preparation, and of this Standard is not a safety of the standard in the standard implement policies with the Washingto WAC 246-215 and Administration.	ONTROLS per ventilation, light, and is in pharmaceutical, foo her appropriate areas. It met as evidenced by: ion, the hospital staff falle and procedures consisten State Retail Food Code Federal Food and Drug	ed to ent e,		The Dietary Manager purchased thermometers and provided trathe new thermometers. The Director and provided trathe new thermometers. The Director and requirements of temperatures and maintaining of the provided the perature requirements will person Responsible: Director of Dietary	Ining on use of letary Manager he proper f obtaining food refrigerator and red	
	staff, and visitors a Findings: 1. On 12/12/2016 b PM, Surveyor #1 o pasta greater than refrigerator. For fo 2 inches, staff mus and times to ensur- cooling time-frame State Retail Food 0 document cooling t Reference: Washir WAC 246-215-035	e food code places patier t risk for foodborne illnes between 11:00 AM and 1: bserved two containers of 2 inches in the walk-in of ods with a depth greater t document temperature e foods cool within the re as specified by Washing Code. The hospital did not times for thepasta. Ington State Retail Food 0 15. FDA Food Code 3-56 Detween 11:00 AM and 1 Descripted diatage staff (State)	s. 2:15 ooling than dates quired pton ot Code 01.14		Monitoring: The Dietary Director perform weekly inspections of a refrigerator, and freezer temper monitor adherence to the WAC and FDA3-501.14 codes. The Director/designee will perform observation monitors of staff ptemperature checks. Any defi promptly addressed during the of the both monitors will be resmonthly PI committee and quameetings.	all food, ratures logs to 246-215-03515 ietary weekly random erforming ciencies will be monitor. Results	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C ID PLAN OF CORRECTION IDENTIFICATION NUMBER			A, BUILDING		(X3) DATE SURVEY COMPLETED			
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	REET ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOS	PITAL	12844 MII TUKWILA						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE		
A 726	inaccurately when ta "Ruben Sandwich". temperature indicate stem; the staff insert sandwich thereby poreading. The type of staff was not designed meat patties, fish filled in addition, Surveyor thermometer's accurate themometer with 2 dice-bath registered at the registered at 20 degistered at 2	a food probe thermome king the temperature of the thermometer is located half way uped only the tip into the dentially giving an inacc thermometer used by the doto temp thin foods suets, and other thin food if #1 checked to see the	the curate he ch as tems. in it. The dwich" grees		Amendment 2/1/2017: Daily at being conducted in the kitchen. It is under revision. Staff education process. The dietary manager were process. The dietary manager were possible for monitoring real-tire compliance related to food temper throughout the department. The Control nurse will double check, weekly basis, to make sure staff a complying with standards. The rethose audits first go to the weekly Committee on Wednesday, February The target compliance is Secore below 90% will require remwith the affected employee and/oranalysis of possible system issued	Fhe policy I is in III be II be III be III be III be III be III be III be III be III be III be III be III be III be III be III be III be III be III be III b			
A 749	Reference: Washing WAC 246-215-0433 Reference: Washing WAC 246-215-0458 AS AS AS AS AS AS AS AS AS AS AS AS AS	tion State Retail Food Co TION CONTROL PROC I officer or officers must r identifying, reporting, ontrolling infections and ases of patients and met as evidenced by: ne	ode, GRAM	A 749	A 0749 Corrective Actions 1) The Infection Control Practitioner reeducated the nursing staff on the of hand hygiene per policy during madministration. Education was provistaff meetings through verbal and with communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner in the Infection passes a minimum of 10 medication passes. Any deficiencies will be addressed a medication pass. Monitoring results.	importance nedication ided during written brand tration with sper unit. during the swill be	2/10/17		
	policy and procedur hygiene prior to and	e, staff failed to perform after administering	hand		reported during the monthly PI and MEC meetings.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X8) DATE SURVEY COMPLETED				
		504011		B, WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET AUUR	ET ADDRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	PITAL	12844 M						
	•		TUKWIL	A, WA 981	68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	S ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	OTION SHOULD BE COMPLETED BATE			
IAO	-,,,				DEFICIENCY)				
A 749	Continued From pag		A 749	2) The Dietary Manager obtained n	ew				
91110	medications			thermometers designed to measure					
	medicanona				temperatures properly. The Dietary	Manager			
	Failure to perform ha	nd hygiene puts patien	ts and		educated the dletary staff on the pro-				
	staff at risk for infection				the food thermometers with an emp				
	otali at non tot imposi				accurate insertion. The education w				
	Findings:				during staff meetings with the use o				
					written communications				
	1. Facility policy titled	l "Hand Hygiene",							
	#IC.HH.100, reviewe	d 10/2016 read in part:	»		 Person Responsible:				
		R HANDWASHING AN			Dietary Manager				
		econtaminate hands be			2,000,000				
		ect contact with patients	S F.		Monitoring				
	Decontaminate hand				The Dietary Manager will perform a	minimum			
		G. Decontaminate har	ias		of 30 random audits per month x 3				
		dy fluids or excretions,			ensure proper temperature monitor				
	mucous membranes.	•••			deficiency will be promptly addresse				
	2. On 12/13/2016 at !	0:00 AM Qumayor #A			of the audit will be reported in the r				
	2. OII 12/13/2010 at a	d nurse (Staff Member	#14\		and quarterly MEC meetings.	,,,,,,,			
	administer and medic	cations to a patient. S/h	e did		and quarterly twice meetings.	ļ			
	not perform band hvo	giene (HH) before prep	arina		 3) The Infection Control Practitione	r			
	the medications, and	though s/he came in c	ontact		reeducated the housekeeping staff				
	with the patient's oral	I secretions during			following procedures for proper clea				
	administration, did no	ot perform HH afterward	i.		patient care areas:				
	3 On 12/13/2016 at 1	9:45 AM Surveyor #4			-Allowing for a 10-minute contact t				
	observed a registere	d nurse (Staff Member	#15)		using Virex 256 disinfectant solution				
	administer oral medic	cations to a patient. S/ł	e díd		-Avoidance of cross-contamination	when using	į		
	not perform HH prior		ľ		cleaning brushes.				
		te numerous contacts v	vith		-Proper dusting procedures to avoid	l patient			
[the patient's skin.				exposure.				
	,				-Maintaining possession of carts at a	all times.			
	Item #2 Dietary Sani	tation							
					Person Responsible:				
	Based on observatio	n, the hospital failed to			Plant Operations Director				
	implement policies a	nd procedures to ensu	Θ						
	compliance with the	Washington State Reta	ll Less d						
	Food Code (246-215	WAC) and the Federa	1 L00a						
	and Drug Administra	tion.							
I									

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C ND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504011		B, WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP GODE			
CASCADE	BEHAVIORAL HOSP	ITAL	12844 MI	44 MILITARY ROAD SOUTH				
	•		TUKWILA	A, WA 981	68			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOUL	I	COMPLETION DATE	
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TRAIE	1	
	·				A			
A 749	, ,		.		Monitoring			
		food practices places			The Plant Operations Director will pe	I		
		sitors at risk for foodbo	rne		monthly environmental rounds of th	-		
	iliness.	,			care units to monitor contact times,		ĺ	
	Findings:	,			of cleaning brushes and dusting, and			
	radings.				maintenance of cleaning carts. Any own will be promptly addressed during the company of the comp			
	1. On 12/12/2016 bet	ween 11:00 AM and 1	2:15		environmental round. Results of the	1		
		d a chlorine indicator te			environmental rounds will be report	1	İ	
		chlorine concentration			monthly to EOC and PI committees			
		t for in-use wiping cloth			quarterly MEC meetings.	1110	i	
		ed the tolerance limit of	200		quarterty with modernings.			
	parts-per-million (ppn	n) for sanitizer.						
	Defenses Machines	on State Retail Food C	odo					
		(2) (2009 FDA Food C					1	
	3-304.14)	(2) (2003 I DA I 000 C						
	0.004.14)							
	2. On 12/12/2016 bet	tween 11:00 AM and 1:	2:15					
		erved signs of algae gr						
	-	panel of the ice machi	ne		,	Ì		
	located in the main ki	itchen.						
İ	Deference: Weekings	ton State Retail Food C	eho:				:	
	WAC 246-215-04605		ouc,					
	VINO E-10 E 10 0 (000)	(0)(4)(1)						
	Item #3 Housekeepir	ng Cleaning						
		n, review of hospital's p	oolicy					
		nstructions for use, the						
l		o follow procedures wh	en					
	cleaning patient roon	lio,						
	 Failure to follow man	ufacturer's instructions	for					
	use and hospital poli		-					
		infection/illness to patie	ents,					
	staff and visitors.							
		56 Diversey: "Apply us						
		-porous environmental s must remain wet for '				•		
	autiaces, All Suriace:	o must remain wet M						
	i .		t t				i	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		504011		B. WING	`	12/21	/2016		
		Name of the last o	STIPPET ADD	DDRESS, CITY, STATE, ZIP CODE					
	OVIDER OR SUPPLIER	ATT A I		4 MILITARY ROAD SOUTH					
CASCADE	BEHAVIORAL HOSP	TIAL		LA, WA 981		a.			
044.10	TZ VSAMMI 19	TATEMENT OF DEFICIENCIES	1	ID ·	PROVIDER'S PLAN OF CORRECT	ON	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE		
A 749	Continued From pag	e 51		A 749	Addendum 2/1/2017: Daily au	dits are			
,,,,,	minutes, Wipe surfac				being conducted in the kitchen.	The policy			
					is under revision and will be pres				
	Findings:				the PI Committee for approval on				
					17, 2017. Staff education is in pr				
		al's policy and procedu			The dietary manager will be resp				
	titled: "Daily Cleaning	of Patient Area" (Revi	sed		monitoring real-time compliance	related to			
	8/2016) stated in part	t ⊞, "Take cart with you	ı into		proper sanitation throughout the department. The COO/CNO will	daubla			
		art should be within eye	esight		check staff's compliance related	to the use			
÷	at all times."				of chlorine solution, on a weekly				
	0.0	5-20 AM Commune #4			make sure staff are complying wi				
	2. On 12/13/2016 at 8	eper (Staff Member #21	n l		standards. The results of those	audits first			
	during a daily class o	of a patient room, applie	ed		go to the weekly PI Committee of				
	"Virey 256 disinfector	nt solution" on a patient	ts I		Wednesday, February 8, 2017.	Γhe target 🛭			
	hand sink then proce	eded to wipe it off with	a dry		compliance is 90%. Any score b	elow 90%			
	cloth. The housekeep	oer did not allow 10-mir	iute		will require remediation with the	affected			
	contact time as requi	red per manufacturer's			employee and/or further analysis	of			
	instruction for use.				possible system issues.	*			
	3, On 12/13/2016 at 9	9:38 AM Surveyor #1			 Additionally, daily audits are bein				
	observed a housekee	eper (Staff Member #22	2)		conducted throughout the hospita				
	during a daily clean o	of a patient room. The			observing housekeepers in their				
	surveyor observed th	ie housekeeper use a b	orush		routines. Staff education is in pro-				
		or after cleaning a toile	t with		facilities director will be responsil				
	the same brush.	•			monitoring real-time compliance				
	4 05 40/40/0046 =14	ONE AM CHRISTIAN #4			procedures when cleaning patier The Infection Control nurse will d				
	4. On 12/13/2016 at 1	9:45 AM Surveyor#1 eper (Staff Member#2:	»		check, on a weekly basis, to make				
	during a dally class of	of a patient room. The	-/		staff are complying with standard	ls The			
	control of the street the	ne housekeeper dusting	าล		results of those audits first go to				
ļ	light fixture over the	patient's head while a p	patient		Pl Committee on Wednesday, Fe				
	was sleeping, potent	ially exposing the patie	nt to		2017. The target compliance is				
	dust particles.				score below 90% will require ren				
			,		with the affected employee and/o	r further			
	5. On 12/13/2016 at	9:50 AM Surveyor #1	1		analysis of possible system issue	es.			
	observed housekeep	er (Staff Member #21)	enter		·				
	a patient room at the	end of the hallway lea	ving						
	the housekeeping ca	art in the hallway unatte	nded.						
	6. On 12/15/2016 at	4:00 PM, Surveyor #1							

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GL AND PLAN OF CORRECTION UMBER IDENTIFICATION NUMBER		LIA :R:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
•		- 504011		B. WING		12/2	1/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE					
CASCADE	BEHAVIORAL HOSF	PITAL		ILITARY RO A, WA 9816				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T 8E PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X6) COMPLETION DATE	
A 749	reviewed a facility do Prevention" the docu indicators for 2016. O identified was Patien "Target" of success of	cument titled, "Infection ment provides a line lis One of the Indicators t Room Cleaning with a of 95% or better. For the January through Noven	et of	A 749				
				·				

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			l' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	;	504011		B. WING	444 - 3444	12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	DRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL		12844 MILITARY ROAD SOUTH					
			TUKWILA	, WA 981	68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE- ENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D86	(X5) COMPLETION DATE		
A 000	INITIAL COMMENTS	<u>. </u>		A 000	Submission of this plan of correction	is not an	2/10/17		
11005	MITTINE COMMITTEE	•			admission that the citations are true				
i	MEDICADE LIGORIT	AL COMPLAINT CHEA	/EV		hospital violated the rules.				
	WEDICARE HUSPIN	AL COMPLAINT SURV	E 1		,				
	conducted on the folloand 12/19-21/2016 by Department of Health RN, MN, MHA; Elizaby Valerie Walsh RN, M3 and Joy Williams, RN. The Fire Life Safety (I conducted on 12/14/2 Patrol Deputy Fire Ma F/L/S inspection reports Surveyors assessed if following MEDICARE #69393; #70129; #70	n surveyors: Paul Kondroeth Gordon, RN, MN; S; Alex Giel, REHS, PH, BSN. F/L/S) inspection was 2016 by Washington Starshal Donald West (Sert).	2016 rat, fA ate		A 000: Response to Medicare Hospit Complaint Survey As noted, an action plan was submit accepted in response to the immedication of overrides and reduction of overrides medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for owarder of overrides or owarder. -Two nurse verification for overrides or owarder. -After-hour pharmacist verification prevision; -Pharmacy policy revision relative to and home medications.	ted and ate included: in the verrides; orocess			
	of serious harm, injurextent of deficiencies of IMMEDIATE JEOP Fallure to provide sufservices to meet the sneeds of the patients The hospital initiated 12/20/2016 but surve the plan's implementate hospital for the IMME state of IMMEDIATE place at the time of si	I that there was a high by, and death due to the This resulted in one fir ARDY in the following a ficient pharmaceutical scope, complexity, and served. Corrective actions on eyors were unable to vereith to vereith developed by the EDIATE JEOPARDY and JEOPARDY remained urvey team exit.	rify d the in						
		OF IMMEDIATE JEOPA	<u> </u>		TITLE		(X6) DATE		

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguerds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

1.20.2017

CENTERS FOR MEDICARE & M	MEDICAID SERVICES				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011		B. WING		12/21/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STATE	E, ZIP CODE	
CASCADE BEHAVIORAL HOSE	PITAL		LITARY ROA 4, WA 98168		
				mmas (Immens to) ALL AC	OCCUPATION /YEL

CMGCMDE	BEHAVIORAL HOSPITAL	TUKWILA, WA 98168					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REC OR LSC IDENTIFYING INFORMATION)	GULATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Cond of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.25 Pharmaceutical Services 42 CFR 482.41 Physical Environment						
A 043	Shell # 27QV11 482.12 GOVERNING BODY There must be an effective governing body t legally responsible for the conduct of the hos if a hospital does not have an organized governing body, the persons legally respons for the conduct of the hospital must carry our functions specified in this part that pertain to governing body This Condition is not met as evidenced by: Based on observation, interviews, and docur reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body. Failure to meet patient rights, quality assess and performance improvement, pharmaceut services and physical environment requirements.	spital. sible t the t the ment f	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring systems to the Governing Board. See A0115, A0263, A0490, A0700	2/10/17			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
		504011		B. WING	<u>-</u>	12	/21/2016	
• •	ROVIDER OR SUPPLIER E BEHAVIORAL HO	SPITAL	12844 N	TADDRESS, CITY, STATE, ZIP CODE 844 MILITARY ROAD SOUTH IKWILA, WA 98168				
(X4) 1D PREFIX TAG	(EACH DEFICIENCY N	Y STATEMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL RE DIDENTIFYING INFORMATION)	GULATORY	ULATORY PREFIX (EACH CORRECTIVE ACTION SITES OF CROSS-REFERENCED TO THE AP		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 043	risks an unsafe he patients, visitors, a Findings: 1. The Governing manage the function patients from harm IMMEDIATE JEOF 12/20/2016 for fail pharmaceutical secomplexity, and new complexity, and new complexity and new complexity. 2. Failure to provious Improvement Prog Staff. 3. Failure to protect rights. 4. Failure to maint plant and the over care. Due to the scope and detailed under 42 Participation for Participation for Participation of	althcare environment for and staff. Body failed to effectively pring of the hospital to property as evidenced by the PARDY condition identified ure to provide sufficient evices to meet the scope, seeds of the patients served to eversight of the Performan delegated to the Medical and promote each patient ain the condition of the phall hospital environment of attent Rights; 42 CFR 482 cipation for Quality Assess Improvement; 42 CFR 482 cipation for Physical Condition of Participation	d on d. nance dical nt 's ysical f ss.2.21 sment 2.25 41 for	A 043				
A 084		TRACTED SERVICES		A 084				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		504011		B. WING _	•	12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	T ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL	12844 N	12844 MILITARY ROAD SOUTH					
				TUKWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	(X5) COMPLETION DATE		
					DEFICIENCY)				
A 084	Continued From pag	e 3	Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Marie Ma	A 084	A084 Corrective Actions:		2/10/17		
	services performed u	nder a contract are pro	vided		 The department heads respon 	,			
	in a safe and effective	e manner.			contracts evaluated all contracts				
					care services and submitted the evaluations to the Medical Exc				
	This Standard is not met as evidenced by: Based on interview and review of hospital				Committee for review and app	1			
					2. The PI/RM Director revised the				
					process for contract evaluatio	I			
		ital failed to ensure tha			a. The PI/RM Director	I			
		d performance improve			review dates to ensu	ıre			
	(QAPI) processes included a systematic re- contracted patient care services.		lew of		timeliness.				
	contracted patient cal	re services.			b. The Department He				
	Egilura ta davalan a r	process to oversee the	1		responsible for over		•		
	performance of all co				contracted clinical s				
		nts at risk for provision	of		review the contract				
		ite care and adverse pa			complete the evalua				
	outcomes.	to outo and advoide pr	4,10,11		c. If there are service of Department Head w				
	Octonios.				those concerns with				
	Findings:				contracted service a				
	. Minning-				plan of Improvemen				
	On 12/20/2016 at 9:0	0 AM, during a discuss	on of		ensure patient care				
		program with Director o			met.				
		ff Member #12), Surve			d. Annualiy, all evaluat	lons for			
	#2 reviewed the hosp	oital's process for evalu	ating		contracted clinical s				
	the performance of co	ontracted health servic	es. In		be forwarded to the				
ļ		sted services document			Executive Committe	e for review.			
		ere was no evidence th							
		services had ever been			Responsible Person:				
		part of the QAPI progra	am for		PI/RM Director				
	quality of services pro	ovided:			Monitor				
					On an annual basis, the PI/RM Director	will present			
	-Universal Hospital -				the list of contracted patient care service	-			
		eutical - Pharmacy Ser	vices		completed evaluations by the assigned				
	-Dietician Services		union di		head in the MEC meeting. The evaluation				
		nerapy - Physical Thera	hì		include any service concerns with relate	ed plan of			
	-Northwest Healthcar	re - cinen pervices			Improvement. Committee minutes will				
	•				review and any actions taken on patien	t care			
A 115	482.13 PATIENT RIC	SHT\$		A 115	contracts.				
	A hospital must prote patient's rights.	ect and promote each							

OPIAIPI/C	TON WEDION INC. O. II	1 may 1 mm 3 mm 1 mm 1 mm 1 mm 1 mm 1 mm 1 m		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR' COMPLETE			
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE				
	BEHAVIORAL HOSP	ITAL.	12844 M	MILITARY ROAD SOUTH					
UNCONDE			TUKWIL	A, WA 9810	38				
24.41.15 I	CHAMAND VO	ATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	Y BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE				
A 115	Continued From pag	e 4		A 115	See A 0123, A 0129, A 0164, A 01	.74			
	This Condition is not met as evidenced by:								
	. Resed on observation interview document				·				
	Based on observation, interview, document review, and review of hospital policies and								
	procedures, the hospital falled to protect and promote patient rights.								
	Esilves to protect and	promoto poch notionth							
	Failure to protect and promote each patient's rights risk the patient's loss of personal freedom, privacy, dignity, and psychological harm.				•				
	Findings:								
	Tailure to allow pat their rights to privacy	ients the right to exercinand refuse treatment.	se .		: \		9		
	. 2. Failure to utilize the to the use of seclusio	e least restrictive alterna n and restraints.	ative						
		he patient from seclusi ime when documentati t risk ofdanger.							
	4. Failure to investiga closure of the compla	te patient complaints p int.	rior to						
	The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights. Due to the scope and severity of deficiencies under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET.			•					
					·				
	Cross Reference: Tags A0123, A0129, A0164, A0174								
A 123	482.13(a)(2)(iii) PATI GRIEVANCE DECISI	ENT RIGHTS: NOTICE ON	E OF	A 123					

		(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE	WATER		X2) MULTIPLE CONSTRUCTION A, BUILDING		/EY D	
	504011			B. WING 12			21/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL			OAD SOUTH			
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X5) COMPLETION DATE		
A 123	Continued From page 5			A 123	A 0123 Corrective Actions		2/10/17	
	At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance.				The Patient Advocate reviewed the I Grievance Policy on the requirement providing a written response to a gri The Clinical Educator reeducated the staff on the grievance process with versponses provided to the patient. E was provided in staff meetings through the communication. Persons Responsible: Patient Advocate PI/RM Director	t of levance, e clinical written iducation		
					Monitoring: The Patient Advocate will present the Patient Advocate will present the log and grievance responses to the Pand Quarterly MEC and Governing Benetings. Any issues requiring Immetantion will be addressed by the adepartment head.	monthly PI oard ediate		
	Findings: 1. The hospital's policy and procedure titled "Patlent Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation Complete a written report on the Grievance Resolution Form Give written report to patient for review, comments and signature."							
	2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with					v		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HO	SPITAL	12844 N	ADDRESS, CITY, STATE, ZIP CODE 44 MILITARY ROAD SOUTH KWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES UST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETION	
A 123	the patient who file 3. Patient #2 filed on 6/3/2016 makin cleaning of the pat area, shower and it grievance log indic 4. On 12/15/2016 a interviewed the Pa #7) about the hosp reviewing the comp action was docume concern had been Member #7 confirm	a patient concern notifically allegations of inadequalient rooms, patient kitches bathrooms. A review of the teated the complaint was cast 2:30 PM, Surveyor #3 tient Advocate (Staff Meroital grievance process. We plaint log for Patient #2, rented indicating the patient addressed or resolved. Since this observation.	nte en elosed, mber /hile no nts	A 123	A 129 Corrective Actions	2/10	417	
A 129	RIGHTS Patient Rights: Exe This Standard is not. Based on observareview, and review procedures, the horights. Failure to allow paskin/clothing check personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity, posterior in the hospital's personal dignity and dignity and dignity and dignity and dignity and dignity and dignity and dignity an	T RIGHTS: EXERCISE Concrete of Rights of met as evidenced by: tion, interviews, document of hospital policy and ospital failed to protect partients the right to refuse its risks patient's loss of rivacy, and respect. The section "Purpose" patient is informed of his sibilities upon receiving calcade Behavioral Hose	at tient s and y # " read; or her are		The Clinical Educator reeducated the n staff on the policy titled Skin/Clothing Education included an emphasis on the procedure for assessing patients and p for patient's refusal. Education was produring staff meetings through verbal a written communication with competer testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perfole least 30 random audits per month to ecompliance of 90% or above for at least consecutive months. Audit results will reported in the monthly PI and quarte and Governing Board meetings.	check. e proper procedure rovided nd ncy orm at ensure st 3 be	, st. 7	

27QV11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE			
504011 NAME OF PROVIDER OR SUPPLIER			B. WING		12/	21/2016			
NAME OF PROVIDER OR SUPPLIER STREET		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE	,				
CASCADE	BEHAVIORAL HOSP	ITAL.		4 MILITARY ROAD SOUTH WILA, WA 98168					
	010000000000000000000000000000000000000	AND ACLU OF BERNIEL OF		1	PROVIDER'S PLAN OF C	OPPECTION	(×5)		
(X4) ID PREF\X TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETION DATE		
A 129	Continued From pag	e 7	·	A 129					
	and to assure that these rights are known by hospital staff, physicians and other health care providers."								
	not limited to the follo personal privacy, and invasion of privacy, P searches may be con to detect and prevent possessed or used or right to care that is co your personal culture	e treated in a manner	o nable s used g The						
	2. The hospitat's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital."		ho	in the second se					
	3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and								

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	504011			B. WING		12/2	12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
	The state of the s				DAD SOUTH			
ONOONDE				A, WA 9816			j	
,		·			PROVIDER'S PLAN OF CO	PRECTION	(X5)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE	
A 129	Continued From pag	e 8	-	A 129				
	coughing is no longer							
	4. On 12/14/2016 at interviewed a register about the skin/clothin Staff Member #3 comprocess included have cough and then chec contraband. Surveyor understanding of the two other registered in Staff Member #5) on and rehabilitative unit. 5. On 12/12/2016 at 2 interviewed the Clinic Psychiatric Services skin/clothing check power with the patient to about a month ago. Trequired the patient to allowed the patient to surveyor asked Staff the current policy directly discharge voluntary pskin/clothing check poing unaware of the Member #6 stated the responsible for disserinformation to their responsible for disserinformation	1:37 PM, Surveyor #2 red nurse (Staff Member g check done at admis firmed that part of the ing the patient squat at king for any visible r #2 found similar process while interview nurses (Staff Member # the chemical dependents. 2:30 PM, Surveyor #2 ral Director of Adult (Staff Member #6) about rocedure process. Staff the hospital had receive skin/clothing check recently changed their particular that and cough and refuse the skin check. Member #6 to explain receive staff to administrate ratients who refused the rocess. S/he acknowled at each clinical director minating the new policy respective clinical staff. 1:50 PM, Surveyor #3	sion. nd ving 44, nov ut the f ved olicy er now The why stively e dged Staff was					
	6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, #4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/O AND PLAN OF CORRECTION IDENTIFICATION NUMBER		-IA		LE CONSTRUCTION	(X3) DATE SURV COMPLETE		
	504011			B. WING 12/21			/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL			OAD SOUTH		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEOED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
A 164 A 164	164 482.13(e)(2) PATIENT RIGHTS: RESTRAINT			A 164	A 0164 Corrective Actions		
A 164	Restraint or seclusion less restrictive interved determined to be ined a staff member, or of this Standard is not in the standard is not in the staff failed to consider restrictive intervention restraints and seclus (Patients #4, #6). Failure to utilize less using both restraints simultaneously puts personal freedom and Findings: 1. The hospital policy "Seclusion and Physical section "Policy" read be used for the mana self-destructive behaving member or others affinterventions are interventions are interventions are interventions seclusion.	n may only be used who entions have been fective to protect the pathers fromharm. met as evidenced by: ew, interview, and revie procedures, the hospital or the effectiveness of lens before applying both ion for 2 of 6 patients restrictive alternatives franciscular section patients at risk for loss of dignity. y and procedure titled licel & Mechanical Restrictly # PC.R.100) under in part: "Restraints may agement of violent or violent or violent or that jeopardizes the afety of the patient, a ster less-restrictive ffective or ruled-out	en tient, ew of all ses		The Clinical Educator reeducated nu on the requirement of using less resinterventions prior to restraint and sprotecting patients, staff, and/or otherm. The education included an ende-escalation techniques as well as a therapeutic interventions. The Clinic provided the education during staff through the use of verbal and writte communication with return demonstration Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will aurestraints and seclusions to determing appropriateness of use with less resinterventions. Any clinical Issues recorrective actions will be promptly a by the COO/CNO. The PI/RM Director report audit results in the monthly inquarterly MEC and Governing Board	trictive seclusion in ners from uphasis on other sal Educator meetings n tration. dit all ne trictive quiring addressed or will el and	2/10/17
	less restrictive interv determined to be ine or others from harm.		atient				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL		
		504011		B. WING		1.2	/21/2016
NAME OF PROVIDER OR SUPPLIER STREET			STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	l.	IILITARY RO .A, WA 9816	DAD SOUTH 8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	'ATEMENT OF DEFICIENCIES I' BE PRECEDED BY FULL RE INTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 164	intervention that will I patient, a staff memb. 2. On 12/12/2016 at 2 reviewed the hospital seclusion order sheet that under the section labeled "Mechanical chest)" does not specto be applied by the harmonic of the section of the	be effective to protect ther, or others from harm 2:30 PM, Surveyor #3 is pre-printed restraint to for Patient #5 observing titled "Type", the box Restraints (wrist, ankledify how many restraint nospital staff. 2:00 PM, Surveyor #3 ital is primary restraint per #7) about how many sed when physical rest is sician. Staff Member # istered nurse determinare initially used. The start is primary used. The start is primary used.	and ng , s are y raints 7 es staff	A 164			
A 174	4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. No documentation indicating that a less restrictive alternative had been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found. 482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION		d add he	A 174			
	Restraint or seclusio the earliest possible	n must be discontinued time, regardless of the l	l at length				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		VEY D	
	504011			B. WING 12/21/2018				
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	DRESS, CITY, STATE, ZIP GODE				
CASCADE	BEHAVIORAL HOSP	ITAL		ILITARY R A, WA 981	OAD SOUTH			
			IOMANIC	M, WM 001	and the second s		(X6)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 174	4 Continued From page 11			A 174	A D174 Corrective Actions			
, , , , ,	of time identified in the order.						2/10/17	
	This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital				The Clinical Educator reeducated nu on the requirement of releasing pat seclusion and restraint at the earlies time. The education included an em	lents from it possible ophasis on		
					de-escalation techniques as well as			
		patients were released est possible time for 3 o			therapeutic interventions, The Clinic			
		atients #3, #4 and #5).	31.0		provided the education during Nursimeetings through the use of written	- 1		
	,	.,,.			communication and return demonst			
		tients from seclusion at						
		puts patients at risk fo			Person Responsible:			
	' '	oss of dignity, and pers	sonai		PI/RM Director			
	freedom.				COO/CNO			
	Findings: 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the				Monitoring: The PI/RM Director/designee will aurestraints and seclusions for release earlies possible time. Any clinical iss to length of use requiring corrective be addressed by the COO/CNO. Res	at the sues related actions will		
	earliest possible time), ^{II}			audit will be reported by the PI/RM			
		a am eska ös. — uo			the monthly PI and quarterly MEC a			
	2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. 3. On 12/13/2016 at 11:30 AM in the adult				Governing Board meetings.			
	3. On 12/13/2016 at	11:30 AM in the adult						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION (DENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
	504011			B. WING		12/2	21/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL	12844 N	4 MILITARY ROAD SOUTH					
			TUKWIL	(WILA, 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	(EACH CORRECTIVE ACTION SI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 174	A 174 Continued From page 12			Δ 174		Caralle Strategy of the Strate	· · · · · · · · · · · · · · · · · · ·		
A 174	psychiatric unit (2 We the medical record of into seclusion on 12/1 released from seclusion was placed in seclusion as placed in seclusion on the grabbing a food cart a repeatedly striking the Documentation on the indicated the patient's "resting" or "sleeping" AM, a period of 90 mi written at 10:30 AM in resting on the bed with verbalized understand seclusion. "Will discorstaffing allows for 1 to 4. On 12/14/2016 and reviewed seclusion/re Patients #4 and #5 and a. Hospital staff place and restraint on 9/29//him/her from seclusion of 28 hours. Surveyor observed documented resting for the following period of 2 hours and the seclusion of 2 hours and 2 hours and 2 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 2 hours and 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours are seclusion of 3 hours a	est), Surveyor #3 review Patient #3 who was pl 1/2016 at 8:30 AM and on at 11:30 AM. The property of the patient was played by the patient was a cart against the wall. It is esclusion flow sheet is observable behavior at from 9:00 AM to 10:30 mutes. A progress note adicated the patient was heyes closed and ding for the need for at inue seclusion when a 1 support." In 12/15/2016, Surveyor astraint flowsheet recond noted the following: In 12/15/2016, Surveyor at the patient #4 in seclusion when a 1 support." In 12/15/2016, Surveyor at the patient #4 in seclusion when a 1 support. It is a period to the patient was a period periods: In 12/15/2016, a period the patient was a period the patient was a period to the patient was	aced atient d liway as) s #3 ds of on se riod or	A 174	DEI ISLENOT)				
	From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours.		5 AM,						
	From 9/30/2016 a period of 3 hours.	3 at 12:30 PM until 3:30	PM,						

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPLE			
	504011 E OF PROVIDER OR SUPPLIER STR			B. WING		12/	21/2016		
NAME OF PR	OVIDER OR SUPPLIER	A PARAMETER PARA	STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSE	PITAL		4 MILITARY ROAD SOUTH					
			LOKWIL	.A, WA 9816					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENGED TO THE DEFICIENCY)	(X5) COMPLETION DATE			
A 174	Continued From pag	ge 13		A 174					
		ed Patient#5 in seclusi				•			
		PM and was released f							
	seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period		OF#3	,					
			eriod				}		
		nutes. The surveyor for							
		eclusion documentation							
	the patient from seclu	staff considered remov usion early.	ing						
		,							
,	5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.								
	•								
A 263	482.21 QAPI			A 263	See A0273, A0286, A0309, A	0490,			
					A0700				
		evelop, implement and	_		,				
		e, ongoing, hospital-wide ssessment and perform							
•	improvement program								
•		ning body must ensure	that						
		the complexity of the on and services; involve	ls all						
		s and services (includin							
	those services furnis	hed under contract or							
		ocuses on indicators re							
	to improved health o and reduction of med	utcomes and the preve	ntion						
	and reduction of med	dical entits.							
		aintain and demonstrat							
÷	evidence of its QAPI	program for review by	CMS.						
	This Condition is not	t met as evidenced by:		:					
	ļ.	·			•		ļ		
		on, interview, record rev					!		
		spital's quality program on, the hospital failed to	and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C NDD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C NDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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	OVIDER OR SUPPLIER E BEHAVIORAL HOSP	PITAL	12844 N	EET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH FUKWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X6) COMPLETION DATE		
A 263	develop and implemed data-driven quality as improvement (QAPI) Failure to systematica hospital-wide performaction plans to improvement data limited the horoblems and formula findings: Failure to identify phasufficient personnel to complexity, and need failure to provide over Improvement Program Failure to collect and performance measure Governing Body, Performance measure, a patient events; Failure to measure, a patient events; Failure to develop a previewing reportable and the Magnetic failure to ensure complexity of the provider of the failure to ensure complexity of the failure to ensure complexity of the failure to ensure and environment was mail	ent a hospital-wide, seessment and perform program. ally collect and analyze nance data and to deve we performance based nospitals ability to identiate action plans. armaceutical services late action plans. armaceutical services late of the patients served ersight of the Performance; analyze data for ses assigned by the formance Improvement ledical Staff for the year analyze and track advertionally and track advertionally and track advertises.	lop on ify acking d. nce	A 263					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL				ET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH				
TUKWILA, WA 98168 PROVIDER'S PLAN OF CORRECTION (X6)								
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE		
A 273	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY		A 273	A 0273 Corrective Actions The PI Director reviewed the list of performance indicators, assigned b Governing Body, PI Committee, and Staff for 2016. Of note, the followind data was aggregated, analyzed, and to the PI and MEC committees for a of patient care processes. -Grievances -Anticoagulation therapy and medication upon admission and Restraint/Seclusion -Elopement rates and medication version of the Medical consultations/treatment contracted Services -Pharmacy and Therapeutics (drug medication variances, adverse drug antibiotic usage, and nursing unit/schecks)	d Medical ag clinical ag clinical ag clinical ag clinical agreement assessment action agreement ariances at lilization, agreactions,	2/10/17		

	ENT' OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. IN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
	504011			B, WING _		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER	The state of the s	STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		
CASCADE	E BEHAVIORAL HOSE	PITAL	12844 M TUKWIL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
A 273				A 273	Persons Responsible: PI Director COO/CNO		2/10/17
	Based on interview a quality program and a hospital failed to colle performance measur Governing Body, Per Committee and the M 2016. Failure to measure, a related to performance leaves the hospital unconcern that may required.	formance Improvement fedical Staff for the yea malyze and track data se measures as assigne nable to identify areas c	r od if		Monitoring On a monthly basis, the PI/RM Dire facilitate the tracking and analysis of performance measures for presenting in the process of the presenting minutes. Negative or underwill be discussed by the committee of performance improvement action needed. The Medical Staff and Govwill be informed of data analysis an initiatives on a quarterly basis to enimplementation of the quality and pimprovement program.	of ation to the s will nted in stred trends for initiation ns as erning Board d PI sure	
	(Approved 12/2015) a Performance Databashospital was to collect different performance performance measure person for data collect reporting frequency was to review to a quarterly basis. 2. Surveyor #2 intervi Services (Staff Memb Measure data collection 12/16/2016 at 1:48 revealed the following a. The Performance Mights and Grievance	and a document titled " se - 2016 " revealed that and analyze data for 1 measures. Each was assigned to a spection and analysis, and to was defined. The Govern the performance measures weed the Director of Clin per #13) about Performa on, analysis and reports 5 PM. The interview or	at the 16 secific the ning tres				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	504011			B. WING		12/	21/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STAT	E, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	PITAL.		I4 MILITARY ROAD SOUTH WILA, WA 98168					
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A 273	grievances. The informand analyzed by the Director and the Patie to the Performance In monthly. There was minformation presented Director stated that the not been meeting and collected or analyzed b. The Performance In Patient Safety Goals hospital was to collected were reviewed by Sulikelihood of patient hanticoagulant therapy Medication Reconcilied discharge. The Chier Risk Manager were recollection and analys Committee and the Goald There was no report presented for surveyor c. The Performance In "Restraint/Seclusion" documentation of responsible for the day and for reporting more and Governing Board patients placed in response to the Goald There was incompleted by the Performance of the Goald There was incompleted in response to the Goald There are ported by the Performance of the Goald The Performance of the Goald The Performance of the Goald The Performance of the Perf	mation was to be collected and report containing this distribution of the transfer of the tran	nent orted es s he had being It two and he he were ysis, he he as no	A 273					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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and patient set. Chief Nursing collection and to the Perform Governing Bo review the da medication values and medication values and medication containing an e. The Perform Consultations medical consultations medical consultations medical consultations medical consultations medical consultations medical consultations medical consultations medical consultations and for report Performance Medical Execute port contain surveyor revies f. The Perform Services" refeservice and quand Chief Executive and quand Chief Executive Concontaining this review. Cross-referent g. The Performand Therapet.	ariances atisfacti officers analys analys analys analys analys analys analys of a collection varial alysis of a collection warial alysis of a collection was to the ager arible for a collection was to the ager arible for a collection and analys of a collection and analys anal	is, elopements, contrabation. The Risk Manager at were responsible for dis, and for reporting momprovement Committee e surveyor requested to ction and analysis for and elopement. While to the surveyor for elopement, there was no report the data. Measure titled "Medical ment" was to measure for timeliness and the patient's individual near the patient's individual near the contraction and analysis for the committee and the ment Committee and the minimum presented for surveyors, and for reporting to the Performance tree and the Medical at There was no report atlon presented for surveyors.	end ata anthly e and o there ement ort eeds, flysis, the he o for ed pe of lager e for g this	A 273					

A 273 Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. A 286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. A 286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce					B. WING		12/21	2016	
TUKWILA, WA 98168 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee. There was no report containing this information presented for surveyor review. A 286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	DRESS, CITY, STATE, ZIP CODE				
PREFIX TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. A 286 482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICION SHOULD BE CROSS-REFERENCE TO NIE APPROPRIATE DEFICIENCY) A 273 A 273 A 286 Corrective Actions A 286 Corrective Actions A 286 Corrective Actions A 286 Landard: Program Scope (1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance improvement Committee (1/11/17) and the Medical Stoff corrective Actions	CASCADE	BEHAVIORAL HOSF	ITAL						
reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. A 286 Corrective Actions A 286 Corrective Actions A 286 Corrective Actions A 286 Corrective Actions A 286 Corrective Actions A 286 I) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance improvement Committee (1/11/17) and the Medical Stoff committee (1/11/17) and the	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION	
(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will identify and reduce Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance improvement Committee (1/11/17) and the	A 273	reactions, antibiotic un room checks. The Pinger for data collection and this information quart Improvement Committee containing this information of the containing this information.	sage and nursing unit/ harmacist was respons d analysis, and for repo erly to the Performanc ttee and the Medical b. There was no report	sible orting e		A 286 Corrective Actions			
(2) The hospital must measure, analyze, and trackadverse patient events (b) Program Activities (c) Program Activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsible and accountable for ensuring the following: (3) That clear expectations for safety are established. This Standard is not met as evidenced by: 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis and tracking includin	A 286	(a) Standard: Progra (1) The program mus to, an ongoing progra improvement in indice evidence that it will medical errors. (2) The hospital must trackadverse patie (c) Program Activities (2) Performance impl track medical errors a analyze their causes actions and mechani and learning through (e) Executive Respon governing body (or o who assumes full leg responsibility for ope medical staff, and ad responsible and acco following: (3) That clear expect established.	m Scope t include, but not be lim am that shows measure ators for which there is identify and reduce measure, analyze, and at events s rovement activities must and adverse patient ev , and implement prever sms that include feedb out the hospital. nsibilities, The hospital rganized group or indivial authority and rations of the hospital) ministrative officials ar buntable for ensuring the	able st ents, ntive ack 's vidual	A 286	Events All elements of the PI plan and 2016 performance improvement activities reviewed by senior leadership, the Pi improvement Committee (1/11/17) Medical Staff committees (1/10/17 1/11/17). The processes for advers analysis and tracking including the Pi Analysis process was highlighted. 2: analysis and recommendations for a reviewed by PI and MEC committee Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director facilitate the tracking and analysis of measures for adverse events for protothe PI and MEC committees. Neg undesired trends will be discussed if committee for initiation of perform improvement actions as needed. The Staff and Governing Board will be in adverse event data analysis and tra quarterly basis to ensure implement	s were Performance and the and se event Root Cause 016 data action were s. ctor will of Pl esentation sative or by the ance ne Medical nformed of cking on a station of the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDF	ET ADDRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	ITAL	12844 N	12844 MILITARY ROAD SOUTH					
		i	TUKWII	.A, WA 981	68				
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A 286	Continued From pag	e 20		A 286					
	ITEM #1 - Analysis ar Patient Events	nd Tracking of Adverse							
	Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment.						-		
	Findings:								
	1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending.								
	12/2015) revealed that the Medical Executive Performance Improversisk management active results of incident repatient complaints to patient care occurrent	olicy #RM.300; Approv at it was the responsibil a Committee and the ament Committee to re- ivitles by analyzing the ports, patient surveys and determine patterns of	lity of view nd						
·	Quality (Staff Member PM and 12/20/2016 a of Clinical Services (S	he Manager of Risk and r#12) on 12/14/2016 al at 1:20 PM, and the Dir Staff Member #13) on M revealed the following	t 1:04 ector		·				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
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NAME OF PR	OF PROVIDER OR SUPPLIER STREET A			RESS, CITY, STA	TE, ZIP CODE	<u> </u>	
CASCADE	BEHAVIORAL HOSP	ITAL		JILITARY RO LA, WA 9810	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T SE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PRÒVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	(X6) COMPLETION DATE
A 286	a. Incident reports we the Risk Manager and but the data was not looking for patterns, t improvement. b. Patient grievances individually but the data aggregate looking for opportunities for improvement. c. The number of patitransfer were reported quarterly but the data aggregate looking for opportunities for improvement.	ere reviewed individually of other managers as ne reviewed in aggregate rends and opportunities were logged and review at a was not analyzed in patterns, trends and overnent. The control of the Governing Boars was not analyzed in patterns, trends and overnent. Was not being collecte ose of looking for patterns.	eded s for wed al rd	A 286			
	ITEM #2 - Reportable Based on interview, r hospital policies and failed to develop a pr reviewing reportable Fallure to recognize r inhibits the hospitals review of the events This failure places pa unsafe environment. Reference: WAC 246 "Adverse health event the list of twenty-nine	e Adverse Events ecord review and revie procedures, the hospits ocess for identifying an adverse events. reportable adverse eve ability to perform in-de and develop action pla tients at risk for care in	al nd onts opth uns. oan		ITEM #2 – Reportable Adverse Ever The COO/CNO has educated the P Director on the requirements of WAC246-302-010. All reportable outlined in the NQF list of reporta adverse events, the requirement f reporting adverse events and elen of submitting a root cause analysis discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	events ble or nents s were	2/10/17

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER E BEHAVIORAL HOSP	TAL .			OAD SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X6) COMPLETION DATE	
A 286	Forum in 2011, in its reportable events in fappendices. WAC 246-302-020 H. (1) Notify the departmevent has occurred woonfirmation of the acti	consensus report on senealth care including allow and When to Report on the that an adverse he within forty-eight hours of the department within confirmation of the adverse health event If the department within confirmation of the adverse include a root prective action plan In all Quality Forum (NG) twenty-nine serious he twenty-nine adverse ing but not limited to: events: Injury of a patient or start a physical assault (i It within or on the grounds of a patient or start a physical assault (i It titled "Incident Report or oved 12/2013) stated facility is required to rents to the State, it must requirements and within to Corporate Risk incal Services Department of the that "All Level I and lisk Manager investigation Chronol	t alth of erse If) Iff e., s of a ing" that port t be rents."		Persons Responsible: Pi Director COO/CNO Monitoring On a monthly basis, the PI/RM Director report all adverse events reported p WAC 246-302-020 to the PI committed MEC and Governing Board quarterly	er ee and		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		504011		8. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
·	BEHAVIORAL HOSP	ITAL	12844 M	844 MILITARY ROAD SOUTH					
			TUKWIL	A, WA 981	68				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID.	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION		
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TAG	OK LOG IDI	ENTIF TING INFORMATION)		IAG	DEFICIENCY)	137.52			
A 286	Continued From page	0.73		A 286			·		
A 200	, ,				A 286 Item #3- Completion of Action	Plans	2/10/17		
	The policy did not inc		tha		A 280 Reni #5- Completion of Accidi	11 Ialis	2, 20, 2,		
		vents nor did it include			 The COO/CNO and PI Director were	trained on	ì		
		ting adverse events ar	id						
	submitting a root cau	se analysis.			analysis of adverse events and credi				
	G Cummune #2 roules	ved a report of a patier	st to		cause analysis elements by the Regi				
		ng in a serious patient			Director. Adverse reportable event	1			
		sferred to the emergen			reviewed with credible action plans				
		quired follow-up specia			and implemented in a timely manne	er,			
	health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for								
					Persons Responsible:				
					PI Director		-		
			p was						
					Monitoring				
	improvement based of				On a monthly basis, the PI/RM Direct	ctor will			
	, , , , , , , , , , , , , , , , , , ,				present action plans based on analy	sis of			
	3. An interview with t	he Manager of Risk an	d		adverse events to the PI committee	. Action			
·		er #12) by Surveyor #2			plans will include date/s actions tak	en and	ļ		
		M about the patient to			persons responsible for action. The				
	patient assault revea	led that Staff Member:	#12		Staff and Governing Board will be in				
	was unaware that thi	s particular incident wa	ıs		actions taken in response to advers				
	considered an adver-	se event by NQF. Staff			a quarterly basis to ensure impleme				
		hat a root cause analy			the analysis and actions taken in re-				
		eted nor had the incide			adverse events.	.,,,,,,,			
	been reported to the	State as required by he	ospital			1			
	policy.								
			Ì		· ·				
	TTTM #0 Complete	w of Antion Dione							
	ITEM #3 - Completio	III DI ACIION FIANS			1				
	 Based on interview a	and document review, t	he						
		ure completion of action				*	į		
		ing review of adverse							
	L. With The Park May	•			· ·		[
[Failure to ensure cor	mpletion of action plans	s limits						
	the hospitals ability t	o correct systemic prol	blems				1		
	placing patients at ri								
1									
	Findings:								

	INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	VVIVI					12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	4 MILITARY ROAD SOUTH				
			TUKWIL	VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X6) COMPLETION DATE	
A 286	Continued From pag	e 24		A 286				
A 200	1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been		A ZOO		Construction of the Constr			
	done.							
A 309	482.21(e)(1), (e)(2), (RESPONSIBILITIES	e)(5) QAPI EXECUTIV	E	A 309	A 309 Corrective Actions The PI Director and Medical Director	revlewed	2/10/17	
	group or individual will authority and responsible hospital), medical state officials are responsible ensuring the following: 1) That an ongoing primprovement and pate reduction of medical implemented, and mate (2) That the hospital-and performance improvements improvements improvements and performance improvements improvements.	ole and accountable for g: rogram for quality tient safety, including the errors, is defined,	the ne		all elements of the PI plan and 2016 performance improvement activities Medical Staff and MEC committees (1 and 1/11/17). The processes for clin non-clinical analysis and tracking wer highlighted. 2016 data analysis and recommendations for action were rethe MEC. The Medical Staff assigned representation to the infection Contr Pharmacy & Therapeutics, EOC, Safet Performance improvement committee committee participants will report co activities to the MEC at least quarterl	l/10/17 ical and e viewed by physician ol, cy and ees. These		

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH VILA, WA 98168				
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A 309	safety and that all impevaluated. (5) That the determination of the content of th	provement actions are nation of the number of projects is conducted met as evidenced by: Index as evi	al's l's to fully t e as and d that e tablish ving ad s.		The MEC reviewed the 2017 PI Plan recommended priorities for quality a performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Directal facilitate the tracking and analysis of measures for presentation to the PI committees. Negative or undesired to be discussed by the committee for in performance improvement actions at The Medical Staff and Governing Bo informed of data analysis and PI init quarterly basis to ensure implement quality and performance improvement.	and tor will f Pl and MEC trends will nitiation of as needed, ard will be latives on a cation of the	2/10/17	
		ommittee and Perform						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLL/AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1, ,	E CONSTRUCTION	(X3) DATE SUF COMPLET				
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CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY RO LA, WA 9816					
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A 309	Continued From pag			A 309					
	the Authority and Accidelivery and assessment contribute to the previous appropriateness and outcomes. Medical Exesponsibilities, duty a performance improve in the Medical Staff B. The hospital's Medical 12/1/2013) under the Executive Committee Management: (a) The overseeing quality as improvement are to a evaluation of the qual assure its comprehent and document improvipatient outcome studies.	efficiency of patient car xecutive Committee and authority for ment activities are defi ylaws." al Staff Bylaws (dated section titled "Medical" read in part 11.4.1 Que duties involved in sessment and perform perform at least an an lity management progra siveness and effective yement in patient care a	or the at the at the at the at the at the at the at the ance and am to ness, and						
	Quality (Staff Member Clinical Services (Stathat the Medical Director Performance Improved not participate in performation of the credentialing and privipate of Risk and Performance Improved been formally evalual Medical Staff Bylaws		of ed loes ith						
	Cross Reference: A-6	0273, A-0286	·						

	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY ROAD SOUTH ILA, WA 98168				
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A 405				A 405	A 0405 Corrective Actions			
A 405	,		and d e as nd ners tate al d		The Clinical Educator reeducated th staff on the requirement of administ medications as ordered for the treat alcohol withdrawal. The Clinical Education during Nursing s meetings through verbal and writter communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perandom audit of at least 30 records to ensure compliance of 90% or aboconsecutive months. Any deficiencies promptly addressed. Audit results we presented to the monthly PI and qual and Governing Board meetings.	rating ment of cator taff of cator taff of cator taff of cator taff of cator taff of cator tage of c	2/10/17	
	Based on record revi- policy and procedure that nursing staff folio treatment of alcohol v reviewed (Patlent #7) Failure to follow such	orders risks patients or improper treatment,	ensure for Itients					

PREFIX TAG SUMMARY STATEMENT OF DEFICIENCISTORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 405 Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved		T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:			1	E CONSTRUCTION	(X3) DATE SI COMPLE		
CASCADE BEHAVIORAL HOSPITAL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (PREFIX TAG) PREFIX OR LSC IDENTIFYING INFORMATION) A 405 Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved [CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved			504011		B, WING	A STATE OF THE STA	12/	21/2016	
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1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETION DATE	
be assessed for symptoms of alcohol withdrawal; how the patient's symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 51/6/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal rotool Initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam ahould have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405	1. The hospital's pol "CIWA" [Clinical Insti Assessment] (Policy 12/2013) established be assessed for sym how the patient's syn using a withdrawal a: medications were to the patient's score. T pre-printed order set Alcohol Withdrawal" physicians to order s medications to be ad patient's withdrawal a 2. Review of the me patients who experie withdrawal during the following: a. Patient #7 was a 5 admitted on 12/10/20 withdrawal. On 12/10 patient's physician of Withdrawal Protocol alcohol withdrawalsy Review of the medic for Patient #7 reveal patient received 1 m and 1 mg of Lorazep An interview by Surv Nurse (Staff Member patients alcohol with administered medica the score assigned a patient's dose of Lor	icy and procedure titled flute Withdrawal #AR.C.210; Approved I how often a patient was ptoms of alcohol withdrawals were to be score seessment scale and he be administered accord he policy included a titled "Lorazepam Orde (dated 5/15/2014) used pecific dosages of Iministered based on the assessment score. dical records of three enced symptoms of alcohol hospital stay revealed by year-old patient who policy for treatment of alcohol hintiating treatment for amptoms. ation administration reced that on 12/10/2016 to g of Lorazepam at 9:40 warm at 2:20 PM. reyor #2 with a Register of the according review of the drawal scores and ations revealed that based 9:00 AM and 2:00 PM azepam should have be a series of the according to the period of the perio	as to rawal; red ow ing to ers for I by e was chol drie AM	A 405				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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NAME OF PR	OVIDER OR SUPPLIER	:	STREET ADDR	RESS, CITY, STA	TE, ZIP GODE		
CASCADE	BEHAVIORAL HOSP	ITAL		MLITARY RO LA, WA 9810	DAD SOUTH 88		
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A 405	Continued From pag	e 29		A 405			
	Member #4 did not kr administered the high	now why nursing staff	i.				
A 490	482.25 PHARMACEL	ITICAL SERVICES		A 490	See Tags A0491, A0493, A0500		
	that meet the needs of institution must have registered pharmacist under competent sup is responsible for dev procedures that mininfunction may be delegorganized pharmaceu. This Condition is not in Based on observation review, the hospital fapharmaceutical service.	a pharmacy directed by tor a drug storage area ervision. The medical seloping policies and nize drug errors. This gated to the hospital's utical service.	y a a staff ment nt				
	· ·	equate pharmacy serviced safe medication					
	Findings:						
	prior to pharmacy ver	administered to patien ification of orders resul omatic dispensing mac	ting				
	. 2. Patient home medi a pharmacist prior to t	cations not being verificeing administered.	edby				
		esulting from medication natic dispensing machi					
	4. Expansion of hospi	tal services, clinical uni	its,				

Printed: 01/09/2017 FORM APPROVED OMB NO 0938-0391

CENTERS	FOR MEDICARE & I	MEDICAID SERVICES				OWR NO	. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C (DENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF DO	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
	BEHAVIORAL HOSI	PITAL	12844		OAD SOUTH		
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A 490	Continued From page	ge 30		A 490			
, ,		vithout a comparable					
		y services coverage.	:				
	The cumulative effect	t of these systemic pro	blems				
	resulted in the hospi	tal's inability to provide	or a				
		and administration, an of medications.	u				
tracking and control of medications. Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was							
		rmaceutical Services w	98				
	NOT MET.						
	Cross Reference: Ta	ags A0491, A0493, A05	00				
				3 404	A 0491 Corrective Actions The Clinical Educator reeducated th	o nuecina	2/10/17
A 491	482.25(a) PHARMACY ADMINISTRATION			A 491	staff on policy titled "Medications Br	rought in	2/10/17
	The pharmacy or dru	ug storage area must be)		with Patients." Education was provid		
		ordance with accepted			Nursing staff meetings through verb		
•	professional princip!	es.		ŧ	written communication. Education - -Use of home medications only after		
	This Standard is not	met as evidenced by:			verification process is complete.		
	Based on observation	on, interview, and review	v of		-Proper labeling and initialing of the process on home medication bottles		
	policy and procedure	e, the hospital failed to	ensure		14		
	that hospital staff fol	lowed hospital procedu	res for		-Physician orders needed for use of	nome	
	use of a patient's ov	n medications.			medications.		
	Eailure of staff to fol	low procedures for use	of a		The medical staff were educated or	ı the	
	patient's own medic	ations places patients a	t risk		requirement of documenting dosage		•
	for harm due to med		•		medication administration and orde		
					allowance of patient home medicati		
	Findings:				Education was provided through wr verbal communication.	itten and	
	1. The hospital police	y and procedure titled					
	"Medications Broug	ht in with Patients" (Pol	cy#		Persons Responsible		
	PHR-118; Revised	4/2014) read as follows:	! !		Medical Director		
					Pharmacy Director		

COO/CNO

"...for those medications that will be used by the patient during their admission at the facility, the

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
	504011			B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST/	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	'ITAL	12844 M	ILITARY R	OAD SOUTH		
			TUKWIL	A, WA 981	68		}
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TAG	ON LOO ID	THE THOUGH ORMATION		IAG	DEFICIENCY)	NINIE	
A 491	Continued From pag	e 31		A 491	Monitoring		
	medications will be in			7 . 10 .	The PI/RM Director/designee will pe	rform a	
		g, and visual evaluation	ı as		random audit of at least 30 patient's		
		st verification process. (medication orders to ensure complia	I	
	a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's				the verification process. Any deficier	I	
					addressed promptly. Audit results w	1	
	initials and date the medication as evidence the medication has been verified"		the		reported in the monthly PI and guar		
					and Governing Board meetings.	,	
	PThe ander for a contra	t to toleo bis/bases			_ ~		
			İ				
	"The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form."						
	2. A tour of the medication room of three patient		ient				
		ch, Rehab and Detox) o					
	12/19/2016 between	2:00 PM and 3:00 PM					
	revealed the following	j :					
	a. One hattle of home	e medication, Latuda 12)C ma				
		r Patient #8 in the patie					
		Rehab unit medication					
		st attached a white print					·
		on bottle with "verified"					
:	written on the label a						
	(12/17/2016) and initi	ials of the pharmacist.	Staff				
		dication at 9:00 PM on			•	ļ	
		6/2016 prior to pharma	cist			İ	,
	verification.						
	h Two hottles of hom	ne medications, Provas	tatin				
		s and Dilt [Diltiazem] X					
		ere found for Patient #9					
		tray in the Rehab medi					
		st verified and labeled t					
		"date opened/expiration					
		in the pharmacy medici	ation				
	verification label. Sta						
		8/2016 at 9:00 AM. The		÷ ,			
		ler for the patient to tak	ke				
	his/her own medication	ons.					
						•	

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SUR' COMPLETE			
		ER OR SUPPLIER STE			- M-MY	12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE				
	BEHAVIORAL HOSP	ΙΤΔΙ	12844 M	4 MILITARY ROAD SOUTH					
CHOCHDL	BELIAVIORAE HOOF			A, WA 9816			;		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EAGH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE JBC	(X5) COMPLETION DATE		
A 491	Continued From pag	e 32		A 491					
A 491	c. Three bottles of ho 300 mg capsules, No Truvada 200 mg table #10 in the patient's m medication room. The written directly on the the Rayataz and Truvunable to tell if the initevidence of pharmac no pharmacist verificamedication bottles. The label with date and si pharmacist verification were in a plastic bag medication tray. Two one stated that the pland the other note staverified Norvir. The nany way to the bottler at 9:00 AM. There was administered all three at 4:00 AM. There was administration of the but the order did not	me medications, Rayal rivir 100 mg tablets and ets, were found for Patie edication tray in the Representation tray in the Representation bottle laber and but the surveyor strains and dates were list verification. There we attend habels on the two he Norvir medication had gnature indicating in. All of these medication placed in the patient's notes were found in the narmacist verified Truval attend the pharmacist had otes were not attached as of medications on 12/19 as a physician order for patient's own medication include specific dosage include specific dosage include specific dosage in the patient's own medication include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include specific dosage include include include specific dosage include	ent ent ehab ate I (for was ere ad no ons e bag, ada d in /2016 ons es.	. 701					
A 493	d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and tabeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication. 482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.		unit nd ne re e	A 493					

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA . N OF CORRECTION UMBER:				LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		504011		B. WING	- -	12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER	L	STREET ADDR	DDRESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	4 MILITARY ROAD SOUTH				
			TUKWIL	ILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES TBE PRECEDED 8Y FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			
A 493	Continued From pag	e 33		A 493	A 0493 Corrective Actions		2/10/17	
	This Standard is not i							
	hospital failed to ensustaffed with sufficient provide quality pharm to meet the needs of providing care. Failure to provide sufprovide accurate and medication delivery pharm due to medication. The hospital expaniby 42 beds within the period, two additional (2 North - 18 beds; 2 the expansion, the hocensus (ADC) was 66 current ADC is 104.4 increase or an additional	nded its overall bed cap past 12 months. During I nursing units were op West - 24 beds). Prior ospital's average daily 5.58 patients. This year 1 which represents a 6 onal 37.58 patients per cy staffing or coverage	o order aff o g and f pacity g that ened r to r's		Upon completion of the survey, the COO/CNO, Pharmacy Director, and it Clinical Director reviewed pharmacy order to ensure a sufficient number personnel. Effective 12/20/16, the PDirector increased pharmacy staffing two (2) additional evening hours, seeper week. The increase in pharmacy prioritized on verification of new order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track additional staffing hours and report in the monthly PI and quarterly MEG Governing Board meetings for a permonths. Any related deficiencies will addressed promptly.	Regional staffing in of charmacy g hours by ven days hours are ders and use of the utilization c and iod of 3		
·	pharmacy document key quality workload noted that the average doses administered r 12,000 doses since to The total number of r performed by nurses or nearly 87 per day, count off" in the autor monthly totals reflect	arveyor #3 reviewed a which captures a varied elements. The surveyonge number of medication monthly increased by on the beginning of the year medication overrides averaged 2,593 per medication, the "inventormatic dispensing machinon-controlled substant creased to a monthly	or on over ar. onth ry ines					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			RVEY (ED
		504011			Almaha (Figure 1)	12/2	1/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 W	ESS, CITY, STA IILITARY RC .A, WA 9816	OAD SOUTH		""
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RÉ ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULDBE	(X5) COMPLETION DATE
A 493	average of 685 items 3. On 12/14/2016 at interviewed a pharma about the adequacy compared to the curn #9 acknowledged the substantially increasistated that since star almost a year ago, the more inpatient clinical corresponding increasions or personnel. It that the average turn medication orders with delayed up to an hounew admissions. 4. On 12/19/2016 at interviewed the Direct Member #8) about the overrides occurring with Member #8 stated the member of the hospi month but acknowledge pharmacy is only onhours. Surveyor #3 s/he had sufficient pl Member #8 stated the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the process of the conexcept for the first with the process of the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the process of the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked over the conexcept for the first with the pharmacy staff to do director of pharmacy worked the pharmacy staff to do director of pharmacy worked the pharmacy staff	11:30 AM, Surveyor #3 acist (Staff Member #9) of pharmacy staffing ent workload. Staff Me e pharmacy workload h ed within the past year. ting work at this facility he hospital had added to al units without a ase in pharmacy operate Staff Member #9 indicate haround time for verifying as 30 minutes but may ar depending on volume 2:30 PM, Surveyor #3 ctor of Pharmacy (Staff he high number of medicate within the hospital. Staff hat he/she had only bee tal staff for "less than a	ember ad S/he wo ing ted g new be a of cation in a hat t iff in ad ek n.	A 493			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURY COMPLETE		
		504011		B. WING		12/21	/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	MTAL	12844 N	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID. PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
A 500	that medication over think medication over think medication over staff member acknow overriding because of the verified in the staff member acknow overriding because of the verified in the staff member and they medications in the aumachines on the week Monday mornings" research for medication 482.25(b) DELIVERY In order to provide particular to provide particular to provide particular to provide particular to provide particular to have a dequal distributed in acceptant and distributed in acceptant and medication orders to in a safe and timely mand medication error. Findings: 1. The hospital policy "After-Hour Medication Findings: 1. The hospital policy "After-Hour Medication Pharmacy Review" (IPHR-169I) under the Policy" read "The faction portance of pharmary acceptance of pharmary members and medication or pharmary read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction portance of pharmary particular to the policy" read "The faction po	ides is a "problem" staterides are dangerous." yledged that nurses were f how long it takes for a ystem. Staff nurses have frequently run out of attending the state of the ystem. Staff nurses have frequently run out of attending the state of the ystem. Staff nurses have frequently run out of attending nursing staff to a con other clinical units of DRUGS attent safety, drugs and controlled and distribute licable standards of pra aral and State law. met as evidenced by: are drugs were controlled cordance with applicable cordance with applicable attending the processes in place be received and disper manner risks patient safes. and procedure titled on Stock with or without Revised 4/2014; Policy section titled "Stateme	The Tre Tre Tre Tre Tre Tre Tre Tre Tre Tr	A 493	A 0500 Corrective Actions The Pharmacy Director, COO/CNO, a Director reviewed the process of me overrides in the automated dispensis To ensure safe delivery of medication following system revisions were made. Reasons for overrides -Reasons for overrides -Two nurse witness system when owneeded -Weekly review of overrides to assest trends, rationale, and any needed sylmprovements The Clinical Educator educated the medical staff on the revised system. Ediprovided during Nursing and Medical provided during Nursing and Medical meetings through verbal and writter communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	dication ng system. ns, the de: errides are as for estem nursing and changes for ucation was al Staff	2/10/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED				
		504011		B. WING	12/21/2016				
NAME OF PR	OVIDER OR SUPPLIER	S	STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	ITAL	12844 N	ILITARY R	OAD SOUTH				
U 112 - 11 - 1				.A, WA 9810					
	ALIENAL DV OT	ATEMENT OF DECIMENATION		In	PROVIDER'S PLAN OF CORRECTION	nn I	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE		
A 500	D Continued From page 36			A 500	Monitoring				
	to decrease medication errors associated with the				The Pharmacy Director/designee wil	report on			
	medication-use processThe hospital allows for				the total number of overrides with a	ggregated			
	an exception to pharmacist review of the				trends, analysis, and system improve				
	an exception to pharmacist review of the				the monthly PI and quarterly Pharma				
	medication order for certain situations when time does not permit pharmacist review. This often				Therapeutics committees. Findings,	,			
		or 'emergency' situation			recommendations and actions will b	e reviewed			
		tion is allowed becaus			and reported at quarterly MEC and G				
		m could result in the d			Board meetings. Committee minutes				
	involved for a pharma	clst review of the			data reporting, analysis, and system				
		i the potential harm wo			uata reporting, arrarysis, and system	CITALING CO.			
	outweigh the benefits of a pharmacist review."						***************************************		
	2. On 12/20/2016, Su	rveyor #3 reviewed a			•				
		which captured a varie	ty of				•		
		indicators that included					·		
		and medication overri			7				
	The surveyor noted th	ne hospital had a total	of		•				
	23,348 medication ov	errides performed by r	nurses						
		is of 2016. Prior to the	·						
	expansion of the hosp		ŀ						
		21 medication override:							
		ing of the two addition							
		nber of medication ove	rrides						
	had risen to a monthly		,						
		ncrease or 479 addition		:					
		he surveyor noted that]			
		n variances (potential e							
		reased by four fold sin	CO IIIC	:	•				
	beginning of the year	•							
	.2. On 12/10/2018 at 1	3:00 PM, Surveyor #3	ļ						
		medication override lis	st for						
	the period 12/16/2016								
		M (the weekend) in wh	ich						
		se coverage is only 6 h							
	day. During this time	period, the hospital							
	admitted 14 patients	and there was a total o	f 236						
	medication overrides	initiated by the nursing	staff.				1		
	Of the 236 medication	n overrides which occi	ırred						
		of the overrides listed							
	'								

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVI COMPLETED		
			8. WING		12/21/2	2016		
	CASCADE BEHAVIORAL HOSPITAL 1284			DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH //LA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ETION SHOULD BE THE APPROPRIATE	(X5) COMPLETI ON DATE	
A 500	"First Dose Needed" pharmacy had not ye order in the automate 11 medication overrid as the reason for the 4. On 12/19/2016 at 2 interviewed the Direct Member #8) about th overrides occurring w Member #8 indicated override and obtain a hospital's automated He/she acknowledge formulary was access any restriction. 5. On 12/20/2016 at 2 interviewed the Direct Nursing Services (Ste high number of medic within the hospital. S	as the reason indicatin t verified the medicatio d dispensing system. (des listed "Emergency	n Only Use" cation I can in the tire out	A 500				
A 700	problem. The staff memors processing "too incident reports. Staff member of the Pharm Committee to see if sprogress could be macknowledged discuss meetings with the professing with the professing Member #10) of (Staff Member #11) of (Staff Member #12) of to continue to monitor. 482.41 PHYSICAL E	ember confirmed that a many medication error of Member #6 asked to hacy & Therapeutics come improvement or hade on this issue. He/s asing medication overries evious pharmacy direct former chief nursing offi and the quality risk man and the decision was mand the situation.	/he be a he des in or icer hager hade	A 700	See Tags A0701, A0710,	A0724, A0726		

	OF DEFICIENCIES CORRECTION			1 -	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		. 504011		B, WING_		12/21	/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	PITAL	12844 M	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH NILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PRE FIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
A 700	and to provide facilities treatment and for speappropriate to the new This Condition is not. Based on observation staff interviews, the hondition of the physical environment manner that the safet was protected. Failure to maintain the facility plumbing and Failure to follow man maintenance activities areas. Failure to monitor and temperature devices are maintained at the Due to the scope and cited under 42 CFR 4 Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Participation for Physical Physical Participation for Physical Participation for Physical Physica	es for diagnosis and ecial hospital services eds of the community. met as evidenced by: ns, document review, a cospital failed to ensure cal plant and the overa was maintained in sucity and well-being of pattern and schedule. estructural integrity of ventilation system. ufacturer-recommenders and schedule. ature risks in patient call disprovide appropriate for to ensure food temperates.	the all h a ients the d re cod atures s f NOT	A 700					
A 701	PLANT The condition of the hospital environment	ANCE OF PHYSICAL / physical plant and the dimust be developed and manner that the safety	ıd	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reedu on environmental factors contributing and self-harm risks particularly related and handles. Training included mitige strategies such as patient observation	g to ligature d to doors ition	2/10/17		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			PLE CONSTRUCTION	(X3) DATE SUR' COMPLETE		
		504011		B. WING 12/21/2			/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH			
			TUKWIL	KWILA, WA 98168				
0/4) (b)	CIRMANDV CT	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTE	301	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	COMPLETION DATE	
A 701	Continued From pag	e 39		A 701	A 0701 Corrective Action			
	well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care.				Increased monitoring of high risk par Staff required to successfully complet training test. 3. Bathroom flooring was repaired (contractor) on 1-12-17. 4. Ceiling links were repaired by (co 1-12-17.	ete post by		
, , , , , , , , , , , , , , , , , , , ,		to maintain the physical plant increases of infection to patients, staff and visitors.			5. Occluded pipes were repaired by 1-12-17 6. Ceiling tiles were changed 1-16-1			
	Findings:			Maintenance staff 7. Burnt outlet was replaced by Mai	ntenance			
	1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in gerlatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What				staff by 12/23/16 8. Shower mold was remediated, ol removed and the area cleaned and rby Maintenance staff (1/9/17) 9. Oscillating fans have been installe PHP patient care areas. Permanent systems are being evaluated.	e-caulked ed in all		
	Action", "Time Frame Mediation Needed" fo information provided	or this item had limited	or no		Persons Responsible: Plant Operations Director CEO			
	observed that the har	10:00 AM Surveyor #1 Idles on the small in the sunroom posed	small Monitoring:					
	observed that the floo adult psychiatric unit underneath the vinyl and not smooth. The to 3 showers on 3 We 4. On 12/13/2016 at	and that vinyl was ripp bathroom was located	led next		flooring/walls/ceilings, furnishings, t cleanliness and structures. Any defi be promptly addressed during the environmental round. Results of the environmental rounds will be report monthly PI committee and quarterly meetings.	iinishes, ciencies will : ted in the		

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE S COMPLI			
		504011		B. WING 12/21/2016					
NAME OF PROVIDER OR CASCADE BEHAV		ITAL.	12844 №	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH WILA, WA 98168					
(X4) IO PREFIX (EACH DI TAG	EFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
psychiat ceiling, to exposed done. On PM and soaked is seclusion actively see what found the above with the survive was in um some solutions. On 12 AM Survive survive and pullidid a visible flashlight. 6. On 12 and 11:00 All the paties a potent survive survive was in um survive surviv	the crack appled by wall when 12/14/2016 3:00 PM Surviveyor #1 observed to the limit of the limi	est) a large crack in the eared to be wet with are work had previously between the hours of veyor #1 observed town in the same West where the ceiling eyor #1 went to 3 West the seclusion room and howers previously state above the seclusion rood that one of the shown incident. It ween 9:00 AM and 10:2 erved flooding over the loor on 3 West next to ent, the surveyor obsermber #17) "snake" the mounts of hair. Surveyor of the pipes were occluded to the pipes were occluded to the pipes were occluded to the hours of 10:2 for #1 observed water the hours of 10:2 for #1 observed a burnt out the in the Rehab unit, the surveyor are in the Rehab unit, the surveyor water the hours of 10:2 for #1 observed a burnt out the file in the Rehab unit, the same work in the Rehab unit, the same water the hours of 10:2 for #1 observed a burnt out the file in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the Rehab unit, the same work in the sam	been 2:00 els was t to d ed om, ers 00 rim of room rved drain r #1 d. 5:5 AM b unit 1:5 and tlet in his is 25 and rneath o unit. 0) PM	A 701					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SI COMPLE		
		50401 1		B, WING		12/	21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		<u> </u>	
CASCADE	E BEHAVIORAL HOSF	PITAL		4 MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 701	fire. Surveyor #1 obs used for group session did not have any wind	d not been replaced af erved 2 large rooms the ons for patients, one roo lows and the other roor open creating no mear	at are om n had	A 701	·			
A 710	(1) Except as otherw (i) The hospital me provisions of the Life Fire Protection Association of the Federal NFPA 101 2000 editions and January 14, 2 reference in accordant CFR Part 51. A copinspection at the CMS Center, 7500 Security or at the National Arc Administration (NAR/availability of this mat 202-741-6030, or go http://www.archives.g_federal_regulations/Copies may be obtain Protection Association Quincy, MA 02269. If of the Code are incorwill publish notice in the adopted edition of the hospitals. (2) After consideration findings, CMS may withe Life Safety Code	A). For information on the real at NARA, call for the call stored at NARA, call stored at NARA, call stored at NARA, call stored at NARA, call stored at NARA, call stored from the National Fig. 1 Batterymarch Park any changes in this exporated by reference, other Federal Register to	tion- tional the the ode, oy a) and ole for the the che che the the the the the the the the the t	A 710	A 0710 Corrective Actions The hospital will not require a way comply with 482.41(b)(1)(2)(3).	vaiver to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	504011		B. WING		12/21	/2016		
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
CASCADE BEHAVIORAL HOSP	ITAL		IILITARY R .A, WA 981	OAD SOUTH 68				
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE		
affect the health and (3) The provisions of apply in a State wher safety code imposed protects patients in he This Standard is not used to be a supplied to the Least of the	waiver does not adversafety of the patients. the Life Safety Code doe CMS finds that a fire by State law adequate ospitals. met as evidenced by: n, interview, and documated to meet the life Safety Code of the lon Association (NFPA) sies written on the Acut CARE Life Safety inspectives. TIES, SUPPLIES, ENANCE and equipment must be an acceptable level of met as evidenced by: plies n, interview, and reconfailed to ensure that pat exceed the manufacture.	o not and ly nent , 2012 e ction dient iren's		A 0724 Corrective Actions #1- Medical Supplies The COO/CNO directed/delegated monthly inspec Materials Department staff, Nursing Pharmacy staff to ensure that all su medications are not expired and wi specified on the manufacturers labe Expired/nearing expiration product properly disposed of timely. All ex supplies and medications were rem discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will environmental rounds of the patier to monitor integrity of products, su medications. Any deficiencies will addressed during the environment Results of the environmental round reported in the monthly PI commit quarterly MEC meetings.	tions by the g staff and pplies and thin date eling. s will be pired loved and perform at care areas pplies and be promptly al round.	2/10/17		

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SU COMPLET	
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TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO 1 DEFICIENC		
A 724				A 724			
	Findings:						
	On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet:						
	a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016.						
	b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016.			:	,		
	- ,						
	with an expiration date	cotton-tipped applicator e of 2/2016.	8				
	d. One box of sterile of with an expiration date	cotton-tipped applicator e of 9/2016.	s				
	e. One box of povidor expiration date of 10/2	ne-todine swabsticks wi 2016,	th an				
	f. One 14 french Fole expiration date of 7/20	y urethral catheter with 016,	an				
	2. On 12/12/2016 at 1 inspected the 3 West the following:	1:00 PM, Surveyor #3 emergency cart and fo	ound				
,	a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016.			-			
	b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016.		ed				
	c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016.						
	3. On 12/13/2016 at	1:35 PM Surveyor #4					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE S COMPLE	
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A 724	inspected the gero-premergency cart and to a. Two 1000 ml 0.9% Intravenous fluids wit 5/2016. b. Nine 10 ml 0.9% S syringes with an expiration dates of 11 4. On 12/13/2016 at the medication room three 10 ml 0.9% So syringes with an expiration date 4/201 a. On 12/14/2016 betand 2:25 PM Surveys (transparent adhesive expiration date 4/201 on the Detox unit. 5. On 12/13/2016 at inspected the emergand found the following.	sychiatric unit (4 West) found the following: Sodium Chloride han expiration date of odium Chloride pre-filleration date of 5/2016. ravenous site dressings 1/2015 and 4/2016. 1:11 PM Surveyor #2 to on the Detox Unit and idium Chloride pre-filled ration date of 5/2016. It ween the hours of 1:00 or #1 found Tegaderm e film dressing) with an id in the crash cart local 1:30 PM Surveyor #2 ency cart on the Rehabng:	s with bured found PM ated	A 724	DEFICIEN		
	syringes with an expl 6. On 12/14/2016 be 2:25 PM Surveyor #' staff (Staff Member #	odium Chloride pre-fille ration date of 5/2016. htween the hours of 1:00 1 interviewed central su #18). During the course	0 and upply of		·		
	the interview Survey	or #1 asked how often carts are checked. The	the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL			OAD SOUTH			
			TUKWIL	A, WA 981	88			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 724	Continued From pag	e 45		A 724				
	central supply person part of his/her respon carts monthly. He/she checked the crash ca	was unaware that it w sibilities to check the c stated that he/she had rts 4 months previously	rash d		A724 #2 Ice Machines			
	Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and				The Plant Operations Director has of certified contractor to perform the manufacturer recommended mainte cleaning for the Ice machines. All mawere serviced during the week of 1/1/20/17. This certified contractor will Plant Operations Staff on proper cleatechniques.	enance and achines 16/17 to I also train	2/10/17	
	installation, promotes				Person Responsible; Director of Plant Operations Monitoring: The Plant Operations	:		
	Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed:		Serial		Director/designee will perform mon inspections of all ice machines to mo cleanliness and operations. Any def will be promptly addressed during the environmental round. Results of the environmental rounds will be report	onitor iciencies he		
	Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the		• 4 the		monthly PI committee and quarterly meetings,	/ MEC		
	following was noted: recommended within Drain to be hard-pipe		er. ain					
	l ' '	e machine 400 Series a Machine Manual state						

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A 724	following cleaning fre page 14 and 17: "the	quency for both models frequency in cleaning e according to the sche ntive maintenance	and	A 724			
	Findings:						
	and 1:45PM Surveyor from a Follett Ice Mad to the floor drain. The the patient kitchen ar preventive maintenal	tween the hours of 1:00 or #1 observed a drain-lehine was not slope to go ice machine was located on the Rehab unit. Ince sticker was past during on the drip pan had re	ine grade ed in The e	1			
	and 10:00 AM, Surve hospital plant manag Member #19 stated i maintenance was be a company to get the how often they get phe/she said, annually from the company, "I several machines remaintenance between September but the which machines wer included in the prevent addition, Surveyor # generated from the is a "Follett" ice machines cheduled for prevent 2/11/2015, was cross	tween the hours of 8:30 ayor #1 interviewed the er (Staff Member #19). In part that the ice machind so they contracted am caught up. When as reventive maintenance, In review of work ord MacDonald-Miller" it should be done and what was entive maintenance. In 1 reviewed a work order to 3-North unit was native maintenance on sed out and a hand wriprovided to indicate who reviewed to indicate who revided to indicate who reviewed to indicate who r	Staff nine i with ked ers cwed arough ate				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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A 724	work was done. 3. On 12/14/2016 bet and 2:45 PM Surveyo	tween the hours of 1:00 or #1 observed soil buil train line of the ice mad	dup	A 724			
A 726	temperature controls preparation, and other This Standard is not in Based on observation implement policies ar with the Washington WAC 246-215 and Fe Administration. Failure to follow the firstaff, and visitors at refindings: 1. On 12/12/2016 bef PM, Surveyor #1 observations greater than 2 refrigerator. For food 2 inches, staff must of and times to ensure first cooling time-frame as State Retail Food Condocument cooling time. Reference: Washingt WAC 246-215-03518	r ventilation, light, and in pharmaceutical, fooder appropriate areas. The hospital staff falled procedures consistered and procedures consistered and procedures consistered and procedures patients for foodborne illness for foodborne illness for the walk-in color with a depth greater document temperature foods cool within the reasons specified by Washing Ide, The hospital did not the specified foods cool within the reasons for the pasta.	ed to ent e, nts, s. 2:15 of polling than dates quired ton et		A 0726 Corrective Actions The Dietary Manager purchased new thermometers and provided training the new thermometers. The Dietary reeducated all dietary staff on the pritechniques and requirements of obtaitemperatures and maintaining refriging freezer temperatures. All required temperature requirements will be logarized temperature requirements will be logarized temperature requirements will be logarized temperature requirements will be logarized temperature requirements will be logarized freezer temperature. Director of Dietary Monitoring: The Dietary Director/desperform weekly inspections of all foor refrigerator, and freezer temperature monitor adherence to the WAC 246-and FDA3-501.14 codes. The Dietary Director/designee will perform weekly observation monitors of staff perform temperature checks. Any deficience promptly addressed during the monit of the both monitors will be reported monthly PI committee and quarterly meetings.	on use of Manager coper aining food erator and gged daily. signee will od, es logs to 215-03515 y dy random ming les will be ltor. Results d in the	2/10/17
		tween 11:00 AM and 1: erved dietary staff (Stat					

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH	STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		N- 1.7 / - 1 - 1 - 1 - 1 - 1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
TAG Continued From page 48 A 726 Member #20 using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer used by the staff was not designed to thermometers in a cice-bath registered at 20 degrees Fahrenheit. The thermometers and toe-bath registered at 20 degrees Fahrenheit. The thermometers in a cice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 32 degrees Fahrenheit. The thermometer used to temp (1, 20 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04350 A 749 A 7			504011		B. WING		12/21	/2016	
GACH DEPRETATION AT THE PRECEDED BY FILL REGULATORY TAG Continued From page 49 Member #220) using a food probe thermometer inaccurately when taking the femperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stern; the staff inserted only the ligh into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patities, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer accuracy by placing the thermometer was to see the thermometer accuracy by placing the thermometer society by the staff was not designed to temp thin food items. In addition, Surveyor #1 checked to see the thermometer was to temp the "Ruben Sandwich" registered at 22 degrees Fahrenhelt. The thermometer was to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer was to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer was to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer was to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The thermometer was to temp the "Ruben Sandwich" registered at 20 degrees Fahrenhelt. The description of the provided during staff on the Importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. A 749 482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communication. Fersons Responsible: infection Control Practitioner Monitoring On a monthly basis, the infection Control Practitioner designee will monitor hand hygiere during medication adminis			PITAL	12844 N	844 MILITARY ROAD SOUTH				
Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the fighton the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as most patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer's accuracy by placing the thermometer and to elempth in food such as most patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer used to temp the "Ruben Sandwich" registered at 22 degrees Fahrenhelt, 12 degrees of calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580 A 749 Corrective Actions 1) The infection Control Practitioner reeducated the nursing staff on the Importance of hand hygiene per policy during medication administration. Education was provided during administration. Education was provided during the rection Control Practitioner of hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be medication pass. Monitoring results will be defeated to be addressed during the medication pass.	PREFIX	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.DBE	COMPLETION	
policy and procedure, staff failed to perform hand MEC meetings.		Member #20) using inaccurately when ta "Ruben Sandwich". temperature indicate stem; the staff insert sandwich thereby pereading. The type of staff was not designed meat patties, fish filled in addition, Surveyor thermometer's accurate thermometer with 2 dice-bath registered at thermometer used to registered at 20 deg off calibration. Dietar confirmed this. Reference: Washing WAC 246-215-0433. Reference: Washing WAC 246-215-0458. 482,42(a)(1) INFECT The Infection control develop a system for investigating, and communicable disease personnel. This Standard is not learn #1 Hand Hygie Based on observation.	a food probe thermome aking the temperature of The thermometer or is located half way up ted only the tip Into the otentially giving an inaccife thermometer used by the defence of the problem of the pr	the curate ne ch as lems. In it. The dwich" grees 20) Code, Code, Code,		1) The Infection Control Practitione reeducated the nursing staff on the of hand hygiene per policy during madministration. Education was provistaff meetings through verbal and wcommunication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner during medication administ a minimum of 10 medication passes Any deficiencies will be addressed deficiencies will be addressed deficiencies will be monthly Pi and	Importance edication ded during ritten ontrol hand ration with per unit. luring the will be	2/10/17	

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A 749	Continued From pag	A 40		A 749	2) The Dietary Manager obtained n	ew			
A 140	medications	G 40			thermometers designed to measure				
	medications				temperatures properly. The Dietary				
	Failure to perform hand hygiene puts patients an				educated the dietary staff on the pr		l		
	staff at risk for infection.				the food thermometers with an em		ľ		
	Findings:				accurate insertion. The education w				
					during staff meetings with the use o		1		
					written communications	, verburario	- [
	1. Facility policy titled "Hand Hygiene",						1		
	#IC.HH.100, reviewed 10/2016 read in part: "				Person Responsible:				
:	III. INDICATIONS FOR HANDWASHING AND				Dietary Manager				
	ANTISEPSIS C. Decontaminate hands before				Diecal y Ivianagei				
		ect contact with patient	s F.		 Monitoring				
	Decontaminate hands		_		The Dietary Manager will perform a	minimum	1		
		G. Decontaminate har	nds		of 30 random audits per month x 3		}		
		ly fluids or excretions,			ensure proper temperature monito				
	mucous membranes.	••"			deficiency will be promptly address				
	2. On 12/13/2016 at 9	OOO AM Currencer #f4	1		of the audit will be reported in the				
		d nurse (Staff Member	#14)		and quarterly MEC meetings.	noneny ri			
		cations to a patient. S/r			and quarterly wide meetings.				
		jiene (HH) before prep			3) The Infection Control Practitions	ا			
		though s/he came in o			reeducated the housekeeping staff				
	with the patient's oral	secretions during			following procedures for proper cle				
		nt perform HH afterwar	d.		patient care areas:	aning Oi			
					-Allowing for a 10-minute contact t	ima whon			
	3. On 12/13/2016 at 9				using Virex 256 disinfectant solution				
		d nurse (Staff Member			-Avoidance of cross-contamination				
	1	cations to a patient. S/h	ne did		cleaning brushes.	Much dame			
	not perform HH prior		- 341-		Proper dusting procedures to avoid	ł nationt			
		te numerous contacts	with		exposure.	patient			
	the patient's skin.				-Maintaining possession of carts at	all times	,		
	Item #2 Dietary Sanit	tation			Mantenning possession of cares at	un unita			
	Remark Dietary Sant	GUOTE			Person Responsible:				
	Based on observation	n, the hospital failed to	,		Plant Operations Director				
		nd procedures to ensu			Thank Operations of color				
		Washington State Reta							
		WAC) and the Federa							
	and Drug Administra								

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AVA 10	CI DANADV CT	ATEMENT OF DEFICIENCIES		ΙĐ	ON	(X5)	
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A 749	Continued From pag	e 50		A 749	Monitoring		
	-	food practices places			The Plant Operations Director will pe		
		sitors at risk for foodbo	rne		monthly environmental rounds of th	e patient	
	illness.				care units to monitor contact times,	proper use	
					of cleaning brushes and dusting, and	1	
i	Findings:		j		maintenance of cleaning carts. Any o		
					will be promptly addressed during th		1
		ween 11:00 AM and 12	J		environmental round. Results of the	I	l
		d a chlorine indicator te			environmental rounds will be report	I .	
	paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths.				monthly to EOC and PI committees a	and	
					quarterlγ MEC meetings.		i
	The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer.						
	Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14)						
	PM Surveyor #1 obse	tween 11:00 AM and 12 erved signs of algae gro panel of the ice machi itchen.	owth				
	Reference: Washingt WAC 246-215-04605	ton State Retail Food C (5)(d)(li)	ode,				
	Item #3 Housekeepin	ng Cleaning					
	and manufacturer's in	n, review of hospital's postructions for use, the office of the office o					
	use and hospital poli-	ufacturer's instructions ces and procedures infection/illness to patic				į	
	solution to hard, non-	56 Diversey: "Apply us -porous environmental s must remain wet for 1				AMERICAN.	

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A 749	Continued From pag	e 51		A 749			
	minutes. Wipe surfac	es and let air dry."		İ			
	Findings:						
	1. In review of hospital's policy and procedure titled: "Dally Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times."						
	2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use.						
	during a daily clean of surveyor observed the	eper (Staff Member #22	orush				
	during a daily clean of surveyor observed the light fixture over the p	9:45 AM Surveyor #1 eper (Staff Member #22 of a patient room. The le housekeeper dusting batient's head while a p ially exposing the patie	a atient				
	observed housekeep a patient room at the	9:50 AM Surveyor#1 er (Staff Member#21) end of the hallway lea rt in the hallway unatte	ving				
	6, On 12/15/2016 at	4:00 PM, Surveyor #1					

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET	RVEY 'ED
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CASCADE	BEHAVIORAL HOSP	ITAL		ILITARY RO A, WA 9816	DAD SOUTH S8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEF(CIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 749	reviewed a facility do Prevention" the docu indicators for 2016. C identified was Patient "Target" of success of	cument titled, "Infection ment provides a line lis one of the indicators : Room Cleaning with a of 95% or better. For the anuary through Novem	t of	A 749			
,							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED; 12/21/2016 FORM APPROVED OMB NO. 0938-0391

GENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M). 0938-0391
	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENT/FIGATION NUMBER:		LE CONSTRUCTION 6 62 - FEDERAL LSC E)	KISITING		SURVEY PLETED
		504011	B. WNG	-		12/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE		
CASCADI	E BEHAVIORAL HOSPITA	#		12044 MILITARY ROAI	n south		
VAQUAD:	- HEIMIOIGE HOOF IN	3-1		TUKWILA, WA 9816	88		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTJFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	BE	OATE COMPLETION OATE
K 000	This report is the res and Life Safety re-cer at Cascade Behavior a representative of the Fire Protection Burea conducted in concert Department of Health teams. The facility has a tota of this survey the cen The existing section of was used in accordant the facility is a 4 story construction with exite protected by a Type 1 throughout and an au with corridor smoke described.	ult of an unannounced Fire diffication survey conducted al Hospital on 12/14/2-16 by e Washington State Patrol, u. The survey was with the Washington State o (DOH) health survey of 135 beds and at the time	K 00	COO/CNO, Pl/ Operations Di and immediat action plan. A implemented	etion of the survey, in PRM Director, and Plirector reviewed the tely formulated a co a monitoring plan wa in order to ensure with the corrective an	ant findings rrective as	
	way.	ompliance with the 2012 Life ed by the Centers for		,			
	The surveyor was:				•		
K 161	Donald L West Deputy State Fire Mar NFPA 101 Building Co	shal onstruction Type and Height	K 16	1			
İ	Building Construction	Type and Height					
ABORATORY C	DIRECTOR'S OR PROVIDER/8	UPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>	TI	TLE		(X6) DAYE

Any deficiency statement ending with an esterick (*) denotes a deticiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If delictencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2867(02-99) Previous Versions Obsolate

Event ID:27QV21

Facility ID; 60429197

600

If continuation sheet Page 1 of 5

1.20.2017

PRINTED: .12/21/2016 FORM APPROVED OMB NO. 0938-0391

	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 2 - FEDERAL LSC EXISITING		e Survey Pleted
		504011	B, WING _			12	/14/2016
	ROVIDER OR SUPPLIER EBEHAVIORAL HOSPITA	ıL.		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 2844 MILITARY ROAD SOUTH UKWILA, WA 98168		,
(X4) ID PREFIX 1749	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING (NFORMATION)	ID PREFIX TAG	۲	PROVIDER'S PLAN OF GORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE COMPLETION (X5)
K 161	2012 EXISTING Building construction Table 19.1.6.1, unless 19.1.6.2 through 19.1 19.1.6.4, 19.1.6.5 Construction 1 (442), (33) stories sprinklered 2 II (111) non-sprinklered 3 II (000) non-sprinklered 4 III (211) sprinklered 5 IV (2HH) 6 V (111) 7 III (200) non-sprinklered 8 V (000) sprinklered Sprinklered stories muthroughout by an appr system in accordance 19.3.5) Give a brief description construction, the numinal basements, floors on viocation of smoke or fi approval. Complete si- plan of the building as	type and storles meets otherwise permitted by .6.7 Type 2), If (222) Any number of non-sprinklered and One story Maximum 3 stories Not allowed Maximum 2 stories Not allowed Maximum 1 story	K	[61	K 161 Corrective Actions The Plant Operations Director repliance the noted ceiling tile in the Two Wisoiled linen room. Person Responsible: Plant Operations Director Monitoring On the monthly basis, the Plant Operations Director/designee will conduct monthly environmental roto assess for intact ceiling tiles. Any damaged ceiling tiles will be prompremedied. Results of the environmental will be reported in the mon Safety/EOC and PI committee meet	unds / titly thly	1/12/17
	This STANDARD is n	of met as evidenced by:					

PRINTED: 12/21/2016 FORM APPROVED OMB NO. 0938-0391

		MEDICAID SERVICES	7		<u> </u>	<u>MB NC</u>), 0938-0 <u>3</u> :	
	ÓF DEFICIENCIES FCORRECTIΩN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			e construction () 02 - Féderal. Lec exisiting		SURVEY LETED	
	•	564611	B, WING		·	121	14/2016	
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		1	STREET ADDRESS, CITY, STATE, ZIP CODE	121	17/2010	
				١,	12844 MILITARY ROAD SOUTH			
UASCADE	E BEHAVIORAL HOSPITA	\L -		.	ľUKWILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCES Y MUST HE PRECEDED BY FULL SC (DENTIFYING INFORMATION))D PREF TAG	İΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE OROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	i	COMPLETION COMPLETION	
V 4G4	Confirmal Constitution	•	4.					
K 161			K	161	ļ			
		tions and staff interviews on						
,		approximately 0800 and	1					
		has falled to maintain fire						
		of the building capable of						
		of smoke and fire into other ould allow the toxic product						
ĺ	of combustion to move	e out of a room and into the				1	:	
		nd the smoke compartment						
	which would endange	r the residents, staff and/or	,		1 .			
	visitors within the facil							
	The findings include, i	out are not limited to:			• .			
	1. On Two west by the a celling tile in the con	e soiled linen room there is ridor with a large hole in it.						
1	The above was discus	seed and acknowledged by						
ĺ	the Facilities director.	- •			K 291 Corrective Actions			
K 291	NFPA 101 Emergency	Lighting	K:	291				
ĺ	Emergency Lighting				The Plant Operations Director installe	ed	1/11/1	
		at least 1-1/2-hour duration			new batteries for the emergency			
ļ		ally in accordance with 7.9.			lighting. In addition, the Plant	1		
	18.2.9.1, 19.2.9.1	at according attitude			Operations Director tested the			
ŀ		ot met as evidenced by:			emergency egress lighting with			
}	Based upon observat	lons and staff interviews on			satisfactory performance documented	d.		
		pproximately 0800 and	1		, and a supplied the supplied t			
l	1115 hours the facility				Person Responsible	!		
	records of testing for the		Į		Plant Operations Director	i		
ľ	packup lighting. This	could result in the failure of						
	the pattery powered by	ackup lighting in the event			Monitoring			
ļ	of a power outage and	i render the means of d result in tripping and fall					•	
	egress dark, This cour injuries to residents, st				On a monthly and annual basis, the Pl	ant		
	militarios to residentes! Si	idii atid/of visitojs,	1		Operations Director/designee will			
Ì	The findings include, b	eut are not limited to			monitor the testing of emergency egr	ess !		
1	manage metadel b	and the many of the			lighting. Monitor results will be report	ted		
	1. The emergency egi	ress light in the Fire alarm			in the monthly Safety/EOC and PI			
1	<u> </u>				committees.	1		

PRINTED: 12/21/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	WEDICAID SERVICES				72012 115	<u> </u>
ITATEMENT O ND PLAN OF	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:			Construction - Federal LSC exisiting		Survey Pleted
		504011	B. WING _		Application report of the state	12	/14/2016
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	mellaramat Hadriff	NI	1	12	844 MILITARY ROAD SOUTH		
CASCADE	BEHAVIORAL HOSPITA	iL .		Τŧ	IKWILA, WA 98168		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECECED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X6) COMPLETIC DATE
						•	
K 291	Continued From page		K 2	191			
-		unotion on battery back-up					
	power, .		,				ļ
	The above was discu	ssed and acknowledged by			K 311 Corrective Actions	!	
K 311	NFPA 101 Vertical Op	noninas - Englastire	K3	111	The Director of Plant Operations		
7017	THE COLOUR VIOLENCE OF	Antitian . milatorana	''`	· '	submitted a capital equipment rec	uest to	'
}	Vertical Openings - E	nolosure			replace the stairwell door. The car	•	
	2012 EXISTING				request was approved and sent to		
ļ	Stalrways, elevator st	hafts, light and ventilation			contractor on 1/17/2017. Door	LITE	1/17/1
	shafts, chutes, and of	ther vertical openings			replacement is scheduled for 2/17	/17	2/17/1
-	between floors are er	iclosed with construction			· · · · · · · · · · · · · · · · · · ·	/ 3. / 4	2/1//
	having a tire resistant	ce rating of at least 1 hour. ed in accordance with 8.6.			The Plant Operations Director trai	nod	
	19.3.1.1 through 19.3				hospital staff on the proper latching		
		are properly enclosed with			the door. A positive closure test w		
		g at least a-2-hour fire					
ĺ	resistance rating, also	check this			performed weekly until door is rep		Ì
	box.			ļ	If any issues are identified during t	-,	
		of met as evidenced by:			interim life safety measures will be	e	
		tions and staff interviews on approximately 0800 and			immediately implemented.	į	
		hes failed to maintain			Dames Descendibles	ļ	
]	vertical openings bety			İ	Person Responsible: Plant Operations Director		}
1	construction having a	fire resistive rating of at		٠	Plant Operations Director		1
	least one hour. This	could result in the passage			B. 4		ļ
.		ombustion from one floor to			Monitor	., !	
		endanger the residents, staff			In addition to the above monitorin		
Į	and/or visitors within t	ure racinty.	1	j	Plant Operations Director/designe		
	The findings include	but are not limited to:			test all rated doors for proper clos	ure and	1
	CITO HINGHISO HORACO	And the second s			damage on a semi-annual basis.	. !	
[1. The door to the sta	alrwell by room #361 has			Monitoring results will be reported	i semi-	
[been damaged and d	oes not seal tight to the			annually to the Safety/EOC and PI		
	frame.	<u>-</u>			meetings. If any interim life safety	ļ	
ļ					measures are used, the measures		
]		ssed and acknowledged by			reported monthly to the Safety/EC	C and	
	the facilities director.				PI meetings until resolved.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DÁTE SURVEY COMPLETED A. BUILDING 02 - FEDERAL LSC EXISITING 504011 B, WING 12/14/2016 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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (D (X6) COMPLETION (EACH DEFIDIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE

PRINTED: 12/21/2016

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/S IDENTIFICATION NUMBE		` '	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B, WING		12/21	/2016
	014000 40 ALIAN ISA		STREET ADDRE	SS CITY ST	ATE ZIP CODE		
	OVIDER OR SUPPLIER						
CASCADE	BEHAVIORAL HOSP	TAL		MILITARY ROAD SOUTH LA, WA 98168			
WALID	SHIMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X6)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	28E	COMPLETION DATE
A 000	INITIAL COMMENTS			A 000	Submission of this plan of correction	is not an	2/10/17
					admission that the citations are true	or that the	
		AL COMPLAINT OUR	/E\/		hospital violated the rules.		
	MEDICARE HOSPITA	AL COMPLAINT SURV	'EY				
	This Madicare bosnits	al complaint survey wa					
		owing dates: 12/12-16/			A 000: Response to Medicare Hospit	tal	
1	and 12/19-21/2016 by				Complaint Survey		
	Department of Health	surveyors: Paul Kondi	at,		-		
		eth Gordon, RN, MN;	·		As noted, an action plan was submit	ted and	
		S; Alex Giel, REHS, Ph	IA AI		accepted in response to the immedia		•
	and Joy Williams, RN				jeopardy finding. Corrective actions i		
	•				Analysis and reduction of overrides		-
	The Fire Life Safety (F/L/S) inspection was			medication dispensing devices;		
ļ		2016 by Washington St			Pharmacy staffing increases;		
		arshal Donald West (Se	90		Physician order requirements for ov	errides:	
	F/L/S inspection repo	rt).			Two nurse verification for overrides		
					After-hour pharmacist verification p		
	Surveyors assessed i				revision;		
	following MEDICARE		a.m.al		Pharmacy policy revision relative to	overrides	·
	#70136.	130; #70131; #70133;	ariu		and home medications.		
	#10150.						*
	During the course of t	this survey, the DOH			•		
		that there was a high	risk				
		y, and death due to the			· .		
	extent of deficiencies.	. This resulted in one fir	iding				
	of IMMEDIATE JEOP	ARDY in the following a	rea:				
	Callega to consider and	fisiont pharmacoutical					•
		ficient pharmaceutical scope, complexity, and					
	needs of the patients					•	
	neads of the barraurs	φοιγου.					
	The hospital initiated						
		yors were unable to ve	rity				
		ation developed by the					
,		DIATE JEOPARDY an					
		JEOPARDY remained	B1 ■				
	place at the time of su	urvey team exit.	,				
	Removal of the state	of IMMEDIATE JEOPA	RDY				
				···			IVAL DATE
LABORATOR'		VSUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(XB) DATE 2. 2017

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseble 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are discloseble 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		504011		B. WING	TARREST AND THE PARTY OF THE PA	12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER	·	STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
CASCADE	E BEHAVIORAL HOSP	PITAL		ILITARY RO A, WA 9810	OAD SOUTH 88		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
A 000	was verified on a revi PM by Paul Kondrat, Williams, RN, BSN. Cascade Behavloral	Isit on 12/29/2016 at 12 RN, MN, MHA and Joy Hospital is NOT IN Medicare Hospital Condensity Body and Rights lity Assessment and ement maceutical Services	,	A 000			
A 043	There must be an eff legally responsible for If a hospital does not governing body, the process for the conduct of the functions specified in governing body This Condition is not be a market by the hospital requirements at 42 C Participation for Governing body	fective governing body to the conduct of the home an organized persons legally response hospital must carry out this part that pertain to met as evidenced by: n, interviews, and docu failed to meet the EFR 482.12 Condition of	spital. sible It the It		Upon completion of the survey, the Medical Director, COO/CNO, Governmembers, and PI/RM Director revie findings and began formulation of t Correction. The Governing Board deresponsibility of ensuring completic corrective actions to the CEO. The Cresponsible for reporting the results corrective actions and use of monit systems to the Governing Board. See A0115, A0263, A0490, A07	ning Board wed the he Plan of elegated in of all EO is s of the	2/10/17

	•• •	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SU COMPLET	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBE					
		504011	•	B. WING		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDS	RESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	PITAL .			DAD SOUTH		
			TOKWIL	LA, WA 9816			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
A 043		hcare environment for		A 043			
	Findings:	•					
	manage the functioning patients from harm as IMMEDIATE JEOPAI 12/20/2016 for failure pharmaceutical services.	dy failed to effectively ng of the hospital to pro s evidenced by the RDY condition identified to provide sufficient ces to meet the scope, s of the patients served	d on				
	2. Failure to provide of Improvement Program Staff.	oversight of the Perform m delegated to the Med	nance dical				
	3. Failure to protect a rights.	nd promote each patie	nt's				
		the condition of thephy hospital environment o					
	detailed under 42 CF Participation for Paticipal Condition of Participal and Performance Imp Pharmaceutical Serv Condition of Participal Environment, the Condition Body was	ndition of Participation NOT MET.	2.21 sment 2.25 41		· .		
	Cross-Reference: Ta A0700	gs A0115, A0263, A04	90,				
A 084	482.12(e)(1) CONTR	ACTED SERVICES		A 084			
	The governing body	must ensure that the				•	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION		(X3) DATE SUR COMPLETE	
		504011		B. WING	The state of the s	· · · · · · · · · · · · · · · · · · ·	12/21	/2016
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH			
			TUKWIL	A, WA 981	68			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID.	PROVID	ER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		T BE PRECEDED BY FULL RE	GULATORY	PREFIX		RECTIVE ACTION SHOUL		COMPLETION DATE
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	GROSS-REFE	RENCED TO THE APPRO DEFICIENCY)	PRIATE	
					1004 C			D /4 D /4 "7
A 084	Continued From pag			A 084	A084 Corrective A	ictions: artment heads respon	slhie for	2/10/17
		nder a contract are pro	vided			s evaluated all contra		1
	in a safe and effective	e manner.				vices and submitted th		
ŀ	This Standard is not a	met as evidenced by:	1		evaluati	ons to the Medical Exe	cutive	
	THIS Statigate is not i	illet as evidenced by.			Commit	tee for review and app	oroval.	
	Based on interview a	nd review of hospital			1	IM Director revised th		
		ital failed to ensure tha	t its			for contract evaluatio		
	•	d performance improve	1		a.	The PI/RM Director		
		cluded a systematic rev				review dates to ense timeliness,	are	
	contracted patient ca				h	The Department He	he	
					i	responsible for over		
		process to oversee the				contracted clinical s		
	performance of all co					review the contract	and	·
		nts at risk for provision				complete the evalua	ition.	
	• •	ate care and adverse pa	atient		C.	If there are service of		
	outcomes.					Department Head w		
	Cindings					those concerns with		
	Findings:					contracted service a plan of improvemer		
	On 12/20/2016 at 9:0	0 AM, during a discuss	ion of			ensure patient care		
		program with Director				met.	110040 410	
' <u> </u>		ff Member #12), Surve			d.	Annually, all evaluat	ions for	
		oital's process for evalu				contracted clinical s	ervices will	
		ontracted health servic				be forwarded to the		
		cled services document				Executive Committe	e for review.	
		ere was no evidence th			Dana ibia Dava			
	•	services had ever been			Responsible Person PI/RM Director	aus:		
		part of the QAPI progra	am for		TOTAL DIRECTOR			
	quality of services pro	oyjaeu:			Monitor			
•	-Universal Hospital -	R&M Faulin Blomed				s, the PI/RM Director		
		eutical - Pharmacy Ser	vices			ted patient care service		
	-Dietician Services	, ,,				tions by the assigned		
		erapy - Physical Thera	ру			neeting, The evaluation e concerns with relate		
	-Northwest Healthcar		-			e concerns with relate mmittee minutes will		
	•				1 '	tions taken on patien		
A 115	482.13 PATIENT RIG	BHTS		A 1 1 5	contracts,		. — .	
	A hospital must prote patient's rights.	ect and promote each						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE S COMPU	
		504011		B, WING		12	/21/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HO	SPITAL	12844 N	RESS, CITY, STA MILITARY R LA, WA 981	OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	Y STATEMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL RE IDENTIFYING INFORMATION)	3 EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X8) COMPLETION DATE
A 115	Continued From p	age 4		A 115	See A 0123, A 0129, A 016	54, A 0174	
	Based on observa review, and review	not met as evidenced by: tion, interview, document of hospital policies and ospital falled to protect an ghts.	٠				
	rights risk the patie	and promote each patient ent's loss of personal free ad psychological harm.	's dom,				
	Findings:						
		patients the right to exercing and refusetreatment.	ise				
		the least restrictive altern sion and restraints.	ative		,		
		se the patient from seclus le time when documentat ent risk ofdanger.		·			·
	4. Failure to invest closure of the com	igate patient complaints p plaint.	orior to				
	resulted in the hos	fect of these systemic pro pital's inability to provide protect patient rights.	blems				
	under 42 CFR 482	and severity of deficiencie 2.13, the Condition of atient Rights was NOT Mi					
	Cross Reference: A0174	Tags A0123, A0129, A01	64,				
A 123	3 482.13(a)(2)(iii) P/ GRIEVANCE DEC	ATIENT RIGHTS: NOTIC	E OF	A 123			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1'''	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		504011		B. WING	. Lastin and Adapting y	12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
	BEHAVIORAL HOSP	ITAI	12844 M	III ITARY R	OAD SOUTH		ļ
GABOADE	DLIMATORAL HOU			A, WA 981			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X6) COMPLETION DATE
A 123	Continued From pag	e 5		A 123	A 0123 Corrective Actions		2/10/17
-	must provide the path decision that contains contact person, the significant to investigate the grievance process completion. This Standard is not a second to the significant policies are failed to ensure that puritten response to the grievances reviewed to their grievance vio	met as evidenced by: document review, and a nd procedures, the hos patients were provided neir grievances for 1 of (Patients #2). dients with a written res lates their right to be nospital investigated ar	of its ital it the uits of review pital with a 4		The Patient Advocate reviewed the Grievance Policy on the requirement providing a written response to a grithe Clinical Educator reeducated the staff on the grievance process with versponses provided to the patient. Ewas provided in staff meetings through verbal communication. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present the gand grievance responses to the land quarterly MEC and Governing Benetings. Any issues requiring Immetation will be addressed by the addressed by the addressed by the addressed by the addressed in the land generating in the patient head.	t of levance. e clinical written iducation ugh written monthly Pi oard ediate	
	Findings:						
	"Patient Grievance P Policy # G.1001) read Advocate will: Review investigation Com Grievance Resolution	cy and procedure titled officy" (Revised 10/201) d in part: "The Patient v results of the preliming plete a written report on Form Give written eview, comments and	5; nary n the				
	review of process an included the patient of reviewed for evidence investigation, findings	laints were selected for d resolution. Sources complaint log. Each wa e of receipt, hospital re s, and resolution of the the findings reviewed w	s view,		·		

	OF DEFICIENCIES . F CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE				ATE SURVEY OMPLETED
		504011		B. WING		12/21/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST/	TE, ZIP CODE	
CASCADE	BEHAVIORAL HOSP	ITAL		IILITARY R .A, WA 981	OAD SOUTH 68	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 123	the patient who filed to the patient #2 filed a property on 6/3/2016 making a cleaning of the patient area, shower and bat grievance log indicates 4. On 12/15/2016 at 2 interviewed the Patie #7) about the hospital reviewing the compla action was document	the grievance. catient concern notifical allegations of inadequal it rooms, patient kitcher throoms. A review of the dthe complaint was clearly and Advocate (Staff Menul grievance process. Whint log for Patient #2, noted indicating the patient dressed or resolved.	te n e losed. nber /hile o	A 123		
A 129	RIGHTS	RIGHTS: EXERCISE O	F .	A 129	A 129 Corrective Actions The Clinical Educator reeducated the nur	2/10/17
	Based on observation review, and review of	met as evidenced by: n, interviews, documen			staff on the policy titled Skin/Clothing Che Education included an emphasis on the p procedure for assessing patients and pro- for patient's refusal. Education was providuring staff meetings through verbal and written communication with competency testing.	roper cedure ided
	skin/clothing checks personal dignity, priva . Findings: . 1. The hospital's polic Responsibilities" (Re ADM.P.300) under th "To assure that a pat rights and responsible	nts the right to refuse risks patient's loss of acy, and respect. cy titled "Patient Rights viewed 10/2016; Policy as section "PURPOSE" tient is informed of his collection receiving cascade Rehavioral Hosp	r# read: or her re		Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perforn least 30 random audits per month to ens compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly and Governing Board meetings.	ure . B

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SI COMPLE			
	504011			B. WING 12/21/2016					
NAME OF PR	OVIDER OR SUPPLIER			DRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL	, .	LITARY RO A, WA 9816					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
A 129				A 129	•••				
	and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: 4. The right to		are						
	"B. The list of patient rights shall include but are not limited to the following: 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and		nable s used g The						
	your personal culture	e, values, beliefs, and e treated in a manner	ιμι οι						
	Check" (Reviewed 16 "Voluntary psychiatric voicing or exhibiting	c patients who are not self-harm behaviors, w ng check, will be given nd administratively							
	observed Patient #1 hospital. During the s Patient #1 was asked gown and hand his d supervisor (Staff Mei	12:00 PM, Surveyor #3 being admitted to the skin/clothing check pro- d to change into a hosp lothing over to a nursir mber #1) to be checked	cess, oital ng d for						
	agreed but stated, I a off, I am here volunts that. The other regist (Staff Member #2) in acceptable. After Pa searched for contrabthe patient to squat a check further for con	prohibited items). Pati am not taking my unde arily and am not going t tered nurse in attendar formed Patient #1 that tient #1's clothing had b and, Staff Member #1 and cough so they coul traband. Staff Member ter #1 that squatting ar	rwear to do ace was been asked d						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION UMBER:				E CONSTRUCTION	(X3) DATE SUI COMPLET		
		504011		B. WING 12/21/2016				
NAME OF PR	PROVIDER OR SUPPLIER STREET		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
			12844 M	IILITARY RO	OAD SOUTH			
0,100,122			TUKWIL	A, WA 9816	88			
					PROVIDER'S PLAN OF C	CORRECTION	(X6)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
A 129	. 129 Continued From page 8			A 129				
7 120	coughing is no longer part of the process.							
				-				
	4. On 12/14/2016 at 1:37 PM, Surveyor #2							
!	interviewed a registered nurse (Staff Member #3)		er #3)	-			1	
	about the skin/clothing check done at admission.		sion.	Ì			 	
	about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the				_			
	process included hav	ing the patient squat a	nd		·			
	cough and then chec	king for any visible			-			
	contraband. Surveyor #2 found similar understanding of the process while interviewing			- 1	•		1	
	two other registered r	nurses (Staff Member #	1 4,					
		the chemical depender	ncy					
	and rehabilitative unit	ls.	1					
	interviewed the Clinic Psychiatric Services skin/clothing check procedure and had reabout a month ago. Trequired the patient to allowed the patient to surveyor asked Staff the current policy discharge voluntary pskin/clothing check pbeing unaware of the Member #6 stated the responsible for dissenting their responsible for dissen	(Staff Member #6) aborocedure process. Stafed the hospital had received skin/clothing check exently changed their power and cough and or refuse the skin check. Member #6 to explain extend staff to administrate the staff to administrate the skin check of the policy. State each clinical director minating the new policy expective clinical staff.	fived colicy er now The why atively e dged Staff					
	conducted a review of resource training files staff members (Staff reviewed had no reco	1:50 PM, Surveyor #3 of the hospital's human e. Three of the four nur- Members #1, #3, # 4) ord of completing the no Competency as require	ew					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	504011			8. WING 12/21/2016				
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL			OAD SOUTH	***		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ATORY PREFIX (EACH CORRECTIVE ACTION SHI TAG CROSS-REFERENCED TO THE APP			(X5) COMPLETION DATE	
A 164	Continued From pag	ne 9		A 164	A 0164 Corrective Actions			
A 164 A 164	482.13(e)(2) PATIENT SECLUSION Restraint or seclusion less restrictive intervedetermined to be ined a staff member, or of this Standard is not. Based on record revinospital policies and staff falled to considerestrictive intervention restraints and seclus (Patients #4, #6). Failure to utilize less using both restraints simultaneously puts personal freedom and Findings: 1. The hospital policy "Seclusion and Physical Section "Policy" read be used for the manself-destructive behaving member or others af interventions are ine "Restraint or seclusion".	IT RIGHTS: RESTRAIN In may only be used whentions have been ffective to protect the pathers fromharm. In met as evidenced by: I iew, interview, and review, interview, and review procedures, the hospiter the effectiveness of lons before applying botton for 2 of 6 patients I restrictive alternatives and seclusion patients at risk for loss and dignity. I y and procedure titled sical & Mechanical Resisticy # PC.R.100) under I in part: "Restraints magement of violent or avior that jeopardizes the safety of the patient, a ster less-restrictive attent Rights" read on may only be used we	en alient, ew of al ess n to of traint" the ay only ne staff	A 164	The Clinical Educator reeducated nu on the requirement of using less resinterventions prior to restraint and sprotecting patients, staff, and/or otherm. The education included an ende-escalation techniques as well as therapeutic interventions. The Clinic provided the education during staff through the use of verbal and writte communication with return demonstration Person Responsible: P!/RM Director COO/CNO Monitoring: The P!/RM Director/designee will aurestraints and seclusions to determing appropriateness of use with less resinterventions. Any clinical issues recorrective actions will be promptly by the COO/CNO. The P!/RM Director eport audit results in the monthly quarterly MEC and Governing Board	trictive seclusion in hers from hphasis on other cal Educator meetings in stration. dit all ine strictive quiring addressed or will Pl and	2/10/17	
	less restrictive intervioletermined to be ine or others from harm.	rentions have been offective to protect the parties. The type of technique to be the least restrictive	patient or					

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504011			1''	E CONSTRUCTION	(X3) DATE SU COMPLET			
				B. WING		12/2	1/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL		MILITARY ROAD SOUTH LA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(XB) COMPLETION DATE		
A 164	intervention that will to patient, a staff member. 2. On 12/12/2016 at 2 reviewed the hospital seclusion order sheet that under the section labeled "Mechanical chest)" does not spectobe applied by the hospital seclusion order sheet to be applied by the hospital seclusion (Staff Memberstraints are to be used are ordered by a physiciated that the regulation member acknowledging generally start with relegs. The chest restraints are to be used to be applied to be used ordered by a physician seclusion. 4. On 12/14/2016 and reviewed the seclusion and physician ordered patients #4 and #6 in placed Patients #4 are restraints and seclusion applysician ordered indicating that a less	ce effective to protect ther, or others from harm 2:30 PM, Surveyor #3 I's pre-printed restraint t for Patient #5 observin titled "Type", the box Restraints (wrist, ankle cify how many restraint nospital staff. 2:00 PM, Surveyor #3 ital 's primary restraint per #7) about how man sed when physical rest sician. Staff Member # istered nurse determin are initially used. The sed that hospital staff estraining both the arms aint is only used in rare and 12/15/2016, Surveyor con/restraint records of othing that hospital staff and #6 in both physical ion simultaneously on 2016 respectively based er. No documentation restrictive alternative h attempted first prior to th tion of both physical	and ng , s are y raints 7 es staff s and	A 164					
A 174	482.13(e)(9) PATIEN SECLUSION	T RIGHTS: RESTRAIN	IT OR	A 174					
		n must be discontinued							

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	504011			B. WING 12/21/2			/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	PITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH //LA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	ON DBE PRIATE	(X5) COMPLETION DATE			
A 174	of time identified in the This Standard is not a Based on record revision and failed to ensure that seclusion at the earling patients reviewed (Properties of the earliest possible time psychological harm, freedom. Findings: 1. The hospital's policy section "PATIENT Rigure to remove participation and Phys (Revised 2/2016; Polsection "PATIENT Rigure to reclusion and Phys (Revised 2/2016; Polsection "PATIENT Rigure to reclusion and restraints or section and restraints (Staff asked Staff Member released from sections acknowledged that the physician would revise the earlies of the determination of the discontinue surveyor what should behavior was described indicated the door should released from the earliest released	met as evidenced by: ew, interview, and revie procedures, the hospit patients were released est possible time for 3 e atlents #3, #4 and #5). tients from seclusion at puts patients at risk fo loss of dignity, and pers cy and procedure titled ical & Mechanical Rest licy # PC.R. 100) under licy # PC.R. 100) under licy # PC.R. 100 under licy	al from of 6 I the or sonal raint" r the asion eyor uld be urse or ent's nts ented		A 0174 Corrective Actions The Clinical Educator reeducated nu on the requirement of releasing pat seclusion and restraint at the earlies time. The education included an ende-escalation techniques as well as therapeutic interventions. The Clinic provided the education during Nurs meetings through the use of writter communication and return demonst Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will at restraints and seclusions for release earlies possible time. Any clinical issto length of use requiring corrective be addressed by the COO/CNO. Resaudit will be reported by the PI/RM the monthly PI and quarterly MEC a Governing Board meetings.	lents from st possible uphasis on other cal Educator ing staff tration. uidit all e at the sues related e actions will uits of the Director in	2/10/17		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		504011	, ,	B. WING 12/21/2016			1/2016		
NAME OF PR	ÖVIDER ÖR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL	12844 N	44 MILITARY ROAD SOUTH					
			TUKWIL	/ILA, WA 98168					
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		OII	PROVIDER'S PLAN OF CO	RRECTION	(X6)		
PREFIX		T BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETION DATE		
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	DEFICIENCY)	APPROPRIATE			
				A 477.4					
A 174			_	A 174					
		est), Surveyor #3 revieu							
		Patient #3 who was pl	aced						
,		1/2016 at 8:30 AM and Ion at 11:30 AM. The p	ationt						
		ion after being observe							
	grabbing a food cart and running down a hallway repeatedly striking the cart against the wall.								
	Documentation on the seclusion flow sheet								
	Documentation on the seclusion flow sheet indicated the patient's observable behavior as		as						
	"resting" or "sleeping" from 9:00 AM to 10:30								
	AM, a period of 90 minutes. A progress note			•					
	written at 10:30 AM indicated the patient was		8						
	resting on the bed with eyes closed and								
	verbalized understand		ļ						
		ntinue seclusion when							
	staffing allows for 1 to) i support.	-						
	.4. On 12/14/2016 and	d 12/15/2016, Surveyor	#3						
		estraint flowsheet recor							
		nd noted the following:							
	•								
		nd Patient #4 in seclusion							
		2016 and did not relea				ę			
		on until 9/30/2016, a pe							
-		r#3 noted the patient's d behavior of sleeping			,				
	resting for the following								
		ig porioue.			•				
	From 9/29/2016	6 at 6:45 PM until 9:30	PM, a						
	period of 2 hours and		1						
			,						
		3 at 10:45 PM until 9/30)/2016						
	at 7:45 AM, a period of	of 9 hours.							
	F 010010041	5 AL GLAZ ABA LIMIN AM. 42							
		3 at 8:45 AM until 10:48	AIVI,			•			
	a period of 2 hours.								
}	From 9/30/2016	3 at 12:30 PM until 3:30	PM. I						
	a period of 3 hours.								
	•								
I			i i				ı i		

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SU COMPLE		
	504011			8. WING 12/21/201				
	OVIDER OR SUPPLIER BEHAVIORAL HO	SPITAL	12844 1	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	Y STATEMENT OF DEFICIENCIE: MUST BE PRECEDED BY FULL RI CIDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE	
A 174	b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.		from yor #3 period und 1 to	A 174				
				,	•			
A 263	The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.			A 263	See A0273, A0286, A0309 A0700), A0490,		
	the program reflect hospital's organizathospital departmenthose services fur arrangement); and	rerning body must ensure tis the complexity of the ation and services; involvents and services (includin nished under contract or d focuses on indicators re n outcomes and the preventedical errors.	es all Ig Iated					
	The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.							
	This Condition is not met as evidenced by:		•					
	and review of the	ition, interview, record rev hospital's quality program ition, the hospital failed to	and					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION . (X			(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/2	1/2016		
NAME OF PR	OVIDER OR SUPPLIER	A STATE OF THE PARTY OF THE PAR	STREET ADDR	REET ADDRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	IATI	12844 M	12844 MILITARY ROAD SOUTH					
ONOUNDE	PENAMONALINOO	1071111		A, WA 9816			•		
					PROVIDER'S PLAN OF	CORRECTION	(X6)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	COMPLETION		
A 263	Continued From pag	e 14		A 263					
, (2 55	develop and impleme data-driven quality as improvement (QAPI) Failure to systematics hospital-wide perform	ent a hospital-wide, ssessment and perform	ilop						
	that data limited the h problems and formula	nospitals ability to identi	ify	•					
:	Findings:						į		
	Faiture to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served.								
	Failure to provide ove Improvement Program	ersight of the Performar m;	nce						
	Failure to collect and performance measure Governing Body, Per Committee and the M 2016;		t ır						
	Failure to measure, a patient events;	analyze and track adver	rse						
	Failure to develop a previewing reportable	process for identifying a adverse events;	and						
		npletion of action plans riew of adverse events;							
	environment was ma	d monitor the overall ho intained in such a mani ell being of patients wa	ner						

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SUR' COMPLETE	
	504011			B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER STREE			ESS, CITY, STA	ATE, ZIP GODE		ļ
CASCADE			12844 M	ILITARY R	OAD SOUTH		
			TUKWIL	A, WA 981	68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
A 263	Continued From pag	e 15		A 263			
	The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies						
	cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET.						
	Cross Reference: A-0273, A-0286, A-0309, A0490, A0700						
A 273	482.21(a), (b)(1),(b)(3) COLLECTION & ANA (a) Program Scope (1) The program musto, an ongoing progratimprovement in indiction evidence that it will in (2) The hospital must track quality indicator performance that asshospital service and (b)Program Data (1) The program must indicator data including other relevant data, for submitted to, or received quality improvement (2) The hospital mustor (1) Monitor the efficiency (3) The frequency	t include, but not be limer that shows measure ators for which there is approve health outcomes measure, analyze, and other aspects ess processes of care operations. It incorporate quality ap patient care data, and or example, informatically of generation. The corporate quality are data, and or example, informatically or example, informatically or example, incorporate quality or example, informatically or example, informatically or example, informatically or example, incorporate quality or example, informatically or example, i	able s d of n s to of ection		A 0273 Corrective Actions The PI Director reviewed the list of performance indicators, assigned by Governing Body, Pl Committee, and Staff for 2016. Of note, the following data was aggregated, analyzed, and to the Pl and MEC committees for as of patient care processes. -Grievances -Anticoagulation therapy and medic reconciliation upon admission and decentrication and decentrication and decentrication reconciliation of the processes. -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug upon admission and decentrication variances, adverse drug antibiotic usage, and nursing unit/methecks)	Medical g clinical presented ssessment ation lischarge arlances utilization, reactions,	2/10/17

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
	504011			B, WING		12/21	/2016
~ ~~			STREET ADDR	COO CITY RT	TE ZIR CODE		
7,0 11.1.2 - 1 - 1 - 1	OVIDER OR SUPPLIER						
CASCADE	CASCADE BEHAVIORAL HOSPITAL 128				OAD SOUTH 68		
4441.173	O IMMADV ST	ATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETION DATE
A 273	Continued From page	e 16			Persons Responsible: PI Director COO/CNO		2/10/17
	This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital felled to collect and analyze data for		al's		Monitoring On a monthly basis, the PI/RM Direc facilitate the tracking and analysis o	f	,
	quality program and quality documents, the				performance measures for presenta		
	hospital failed to collect and analyze data for		r		PI committee. Committee members	will	
	performance measures assigned by the Governing Body, Performance Improvement				implement action plans as documen	ted in	
	Governing Body, Performance Improvement Committee and the Medical Staff for the year		_		meeting minutes. Negative or undes	ired trends	
	Committee and the Medical Staff for the year 2016.		1		will be discussed by the committee t		
	2016.				of performance improvement action		
	Enllure to messure a	nalyze and track data			needed. The Medical Staff and Gove	rning Board	
		e measures as assign	∍d		will be informed of data analysis and	l Pi	
		nable to identify areas			initiatives on a quarterly basis to en		
	concern that may req				implementation of the quality and p improvement program.	erformance	;
	Findings:						
	Review of the Performance Improvement Plan (Approved 12/2015) and a document titled "Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis.		at the 16 ecific the ning				
	2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following:		ance				
	Rights and Grievance	Measure titled "Patient es" was to measure impliance and number o	of				

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCIES (CA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 17 grievences. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the gitevance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure tilled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Wardarin), and 2) Medication Reconcillation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Coverning Board monthly. There was no report containing this information presented for surveyor review.	STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION							RVEY 'ED
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 CX4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 17 grievances. The Information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient herm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and report containing this information 1284 MILITARY ROAD SOUTH TUKWILA, WA 98168 PROVIDER'S PLAN OF CORRECTION (CACH PROPORIATE DEPRETAT		504011			B. WING		12/21/2016	
TUKWILA, WA 98168 (X4) ID PREPIX TAGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) A 273 Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the galevance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconcillation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information	NAME OF PROVIDER OR SU	UPPLIER						
REFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 273 Continued From page 17 grievances. The Information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been maeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge, The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information	CASCADE BEHAVIO	DRAL HOSP	PITAL					
grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconcillation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information	PREFIX (EACH DEF	FICIENCY MUS	TBE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint and seclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suickles/suicide attempts, falls,	grievances and analyz Director ar to the Perf monthly. T information Director st not been in collected of the perfect of the p	es. The inforvized by the and the Patik formance in There was in the presented or analyzed erformance is a fety Goals' was to collect ewed by Suit of patient had analys as and analys as and analys as and analys as no report of for surveyerformance is the Goald for the deporting more pring Board in results of the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for restation of results and the Goaldable for re	mation was to be collected was to measure titled "Nursing Officer and the sponsible for data is, and for reportation upon admission at Nursing Officer and the sponsible for data is, and for reporting to the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible for data is, and the sponsible	nent orted e s s The e had being al two and ne the PI diy, tion er he were ysis, ee as no	A 273			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
	BEHAVIORAL HOSP	PITAL	12844 N	MLITARY RO	AD SOUTH		
			TUKWII	LA, WA 98168	}		
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A 273	medication variances and patient satisfaction. Chief Nursing Officer collection and analysis to the Performance in Governing Board. The review the data collection wariances was data presented to and medication variances was data presented to and medication variance in Consultations/Treatmedical consultations/Treatmedical consultation appropriateness to the The Risk Manager and were responsible for and for reporting the in Performance Improve Medical Executive Coreport containing this surveyor review. f. The Performance Medical Executive Coreport containing this surveyor review. f. The Performance Medical Executive Coreport containing this surveyor review. Cross-reference: Tag g. The Performance Medical Executive Committee containing this information information annually the containing this information information.	is, elopements, contrabation. The Risk Manager is were responsible for dis, and for reporting monprovement Committed e surveyor requested totion and analysis for and elopement. While to the surveyor for elopement, there was no report in the data. Measure titled "Medical and the patient's individual not contract of timeliness and the patient's individual not contract of the Committee and the mainformation quarterly to the ment Committee and the minformation presented feasure titled "Contract the Contract log for scale as the Contract log for scale as the Performance the and the Medical and the Medic	and lata porthly e and o there ement ort l eeds. r lysis, the the o for ted ppe of pager le for g this	A 273			
	and Therapeutics" wa utilization, medication	as to measure drug variances, adverse dru	19 [.]				

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A 286	room checks. The P for data collection an this information quari Improvement Commit Executive Committee containing this inform review. 482.21(a), (c)(2), (e)(a) (a) Standard: Program to, an ongoing program improvement in indicevidence that it will a medical errors. (2) The hospital must track andverse patient (c) Program Activitient (2) Performance importack medical errors analyze their causes actions and mechanical dearning through (e) Executive Responsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical staff, and additional exponsibility for open medical exponsibility for open	sage and nursing unit/ harmacist was respons d analysis, and for report terly to the Performance terly to the Performance terly to the Performance terly to the Performance terly to the Performance terly to the Performance terly to the Performance the and the Medical and There was no report nation presented for sur (3) PATIENT SAFETY and Scope at include, but not be lime and that shows measure actors for which there is actors for which there is actors for which there is actors for which there is actors for which there is actors for which there is actors for which there that shows measure actors for which there are surre, analyze, and actors for which there is such that include feedb out the hospital actors of the hospital parations of the hospital actors of the hospital a	sible orting e rveyor sited steple d steple ents, ntive ack	A 286	A 286 Corrective Actions 1) Analysis and Tracking of Adverse Events All elements of the PI plan and 2016 performance improvement activities reviewed by senior leadership, the Pimprovement Committee (1/11/17) Medical Staff committees (1/10/17 1/11/17). The processes for adversanalysis and tracking including the Pimprovement Commendations for a reviewed by PI and MEC committee Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director the PI and MEC committees. Negundesired trends will be discussed to the PI and MEC committees. Negundesired trends will be discussed to the PI and MEC committees as needed. The Staff and Governing Board will be in adverse event data analysis and tra	s were Performance and the and se event Root Cause 016 data action were ss. ctor will of PI esentation sative or by the ance he Medical aformed of cking on a	2/10/17
	This Standard is not	met as evidenced by:			quarterly basis to ensure implemen	tation of the	

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			TUKWII	LA, WA 98168			
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A 286	Continued From page 20			A 286			
	Patient Events Based on interview, r quality documents, th	nd Tracking of Adverse record review and revie te hospital failed to me-	w of				
	analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment.					· .	
	Findings:						
,	1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending.						
· · · · · · · · · · · · · · · · · · ·	12/2015) revealed the the Medical Executive Performance Improve risk management act results of incident repatient complaints to patient care occurrent	rolicy #RM.300; Approvatilit was the responsible Committee and the ement Committee to relivities by analyzing the ports, patient surveys a determine patterns of	lity of view nd				
	Quality (Staff Membe PM and 12/20/2016 a of Clinical Services (he Manager of Risk an or #12) on 12/14/2016 a at 1:20 PM, and the Dir Staff Member #13) on M revealed the followin	t 1:04 ector				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE SURVEY COMPLETED					
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A 286	a. Incident reports we the Risk Manager are but the data was not looking for patterns, improvement. b. Patient grievance individually but the data ggregate looking for opportunities for impor	vere reviewed individual and other managers as not reviewed in aggregate trends and opportunities were logged and reviewed at a was not analyzed in or patterns, trends and provement. Attents requiring a medicate to the Governing Boats was not analyzed in or patterns, trends and provement.	eeded s for wed 1 eat	A 286						
	analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Fallure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality			TEM #2 – Reportable Adverse Ever The COO/CNO has educated the P Director on the requirements of WAC246-302-010. All reportable outlined in the NQF list of reportal adverse events, the requirement freporting adverse events and elen of submitting a root cause analysis discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	events ble for nents s were	2/10/17				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED			
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A 286	Continued From page 22			A 286	ITEM #2 continued			
	reportable events in frappendices. WAC 246-302-020 He (1) Notify the department has occurred we confirmation of the additional to the second	the department within confirmation of the adve- ort must include a root prrective action plan anal Quality Forum (NQ twenty-nine serious e twenty-nine adverse ag but not limited to:	t alth of erse F)		Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Direc report all adverse events reported p WAC 246-302-020 to the PI committ MEC and Governing Board quarterly	er ee and		
	health care setting.							
	Findings:							
	(Policy #RM.200; App "In States where the tragic/Serious incide done within the State notification of comple	r titled "Incident Reportion proved 12/2013) stated facility is required to reports to the State, it must requirements and tion to Corporate Risk nical Services Departm	that port t be	·				
	The same policy stated that "All Level I and II incidents require a Risk Manager Investigation and completion of the Investigation Chronology and Incident Recap Analysis."							

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE				(X3) DATE SURVEY COMPLETED	
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A 286	Continued From pag	e 23		A 286			Padda
	The policy did not inc		ļ		A 286 Item #3- Completion of Action	n Plans	2/10/17
		vents nor did it include	the		·		
		rting adverse events ar			The COO/CNO and Pl Director were	trained on	
	submitting a root cau				analysis of adverse events and cred	Ible root	
	_	•			cause analysis elements by the Regi		
		wed a report of a patier			Director. Adverse reportable even		
	patient assault resulti	ing in a serious patient	injury.		reviewed with credible action plans	I	
		sferred to the emergen			and implemented in a timely manne		
		quired follow-up specia					
		ents for his/her injuries			Persons Responsible:		
	incident was reviewed by the Manager of Risk				PI Director		
	and Quality (Staff Me				, , 24, 00401		
		logy and Incident Rece	ip was		Monitoring		
	completed with recor				On a monthly basis, the PI/RM Dire	ctor will	
	improvement based of	on the myestigation.			present action plans based on analy		
	2 An intorviou with t	he Manager of Risk an	d		adverse events to the PI committee		
		er #12) by Surveyor #2			plans will include date/s actions tak		
		M about the patient to	"		persons responsible for action. The		
		led that Staff Member:	#12		Staff and Governing Board will be in		
		s particular incident wa	l.		actions taken in response to advers		
		se event by NQF. Staff			a quarterly basis to ensure implement		
		hat a root cause analy:			the analysis and actions taken in re		
		eted nor had the incide		•	adverse events.	sponse to	
	been reported to the	State as required by ho	ospital _.		davetse events.		
	policy.						
		•			'	l	
	ITEM #3 - Completio	n of Action Plans					
		ind document review, t					
		ure completion of actio					
	plans developed duri	ing review of adverse e	events.				
	 Failure to ensure cor	npletion of action plans	imits				
		o correct systemic prot					
	placing patients at ris						
	harman hamanna ar th	12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
	Findings:					e e	
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1 -	EE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
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for 3 adverse events Services (Staff Mem 1:25 PM and with th Quality (Staff Memb AM. Review of the a correct identified iss a. For the elopemer change the policy "0 staff of a patient wh the nursing unit) to "1 completed although E was being used by b. For the sexual as items was a change followed by audits to were properly condi- reduction precaution Member #12 stated done. A 309 482,21(e)(1), (e)(2), RESPONSIBILITIES The hospital's gove group or individual valuationity and respo- hospital), medical si officials are response ensuring the followi 1) That an ongoing improvement and p reduction of medical implemented, and re (2) That the hospital and performance in	ewed the root cause and a with the Director of Clinber #13) on 12/16/2016 are Manager of Risk and er #12) on 12/20/2016 are cation plans developed to use revealed the following tissue, the action item Code Amber" (used to a consumer to has wandered away for 'Code E" had not been staff were trained and Coy the hospital. Sault issue, one of the are to an assessment form to ensure that assessment form	nical S at 19:20 o ng: to lert rom Code ction nts I risk staff been /E	A 286	A 309 Corrective Actions The PI Director and Medical Director re all elements of the PI plan and 2016 performance improvement activities w Medical Staff and MEC committees (1/2 and 1/11/17). The processes for clinic non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviethe MEC. The Medical Staff assigned pirepresentation to the Infection Control Pharmacy & Therapeutics, EOC, Safety Performance Improvement committees committees participants will report com activities to the MEC at least quarterly.	ith the 10/17 al and ewed by hysician i, and s. These	17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
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A 309	Continued From pag	e 25		A 309	The MEC reviewed the 2017 Pl Plan	and	2/10/17
7 000	safety and that all im evaluated. (5) That the determined distinct improvement	provement actions are nation of the number of projects is conducted			recommended priorities for quality performance improvement activitie	and	
	annually.				Persons Responsible: Medical Director President of the Medical Staff		
	This Standard is not met as evidenced by: Based on Interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Fallure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings:				Monitoring On a monthly basis, the PI/RM Direc	ctor will	
					facilitate the tracking and analysis of measures for presentation to the Pleonmittees. Negative or undesired be discussed by the committee for it performance improvement actions. The Medical Staff and Governing Boinformed of data analysis and Plinit quarterly basis to ensure implement quality and performance improvem	f PI and MEC trends will nitiation of as needed, eard will be tiatives on a tation of the	
	1. The hospital's Per (Policy #RM. 300; Ar "Medical staff and medical staff and medical staff and medical for and acceptance improved criteria for measuring organization perform non-clinical processes. They assure implemeduality assessment and report the results.	ement activities and est g, assessing and Impro lance of both clinical ar es and patient outcome entation of appropriate and improvement activities to the Board through committee and Performa	d that tablish ving nd s. ties				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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					PROVIDER'S PLAN OF C	ADDECTION .	(X5)
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A 309	Continued From pag	e 26		A 309			
	the Authority and Acc delivery and assessment contribute to the prevent continual improvement appropriateness and outcomes. Medical Eresponsibilities, duty performance improve in the Medical Staff B. The hospital's Medical 12/1/2013) under the Executive Committee Management: (a) The overseeing quality as improvement are to evaluation of the quality as improvement are to patient outcome studies.	efficiency of patient ca xecutive Committee and authority for ement activities are defi- tylaws." al Staff Bylaws (dated section titled "Medical read in part 11.4.1 Que duties involved in sessment and perform perform at least an an ilty management prograsiveness and effective vement in patient care	or the at the at the at the at the at the at the at the at the ance ance and to ance and and and and and and and and and and				
	2. An interview with the Quality (Staff Member Clinical Services (Stathat the Medical Director Performance Improve not participate in perfactivities other than the credentialing and priving manager of Risk and Performance Improve		of ed loes lith			·	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(X3) DATE SUR' COMPLETE		
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, ST	ATE, ZIP CODE	4. ••• • • • • • • • • • • • • • • • • •		
CASCADE	BEHAVIORAL HOSP	PITAL	ì	LITARY R A, WA 981	OAD SOUTH 68			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFIGIENCY)	(X5) COMPLETION DATE		
A 405	Continued From page 27			A 405	A 0405 Corrective Actions			
A 405	482.23(c)(1), (c)(1)(i) OF DRUGS (1) Drugs and biological administered in accordance of the control of the con	& (c)(2) ADMINISTRA cals must be prepared rdance with Federal an s of the practitioner or ible for the patient's can .12(c), and accepted cals may be prepared a orders of other practition (482.12(c) only if such ng in accordance with S of practice laws, hospit I staff bylaws, rules, an ogicals must be under supervision of, nu accordance with Fede egulations, including requirements, and in approved medical staff	and id re as and ners state tal d		The Clinical Educator reeducated the staff on the requirement of administ medications as ordered for the treat alcohol withdrawal. The Clinical Eduprovided education during Nursing semeetings through verbal and writter communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perandom audit of at least 30 records to ensure compliance of 90% or aborded to the monthly PI and quand Governing Board meetings.	erform a per month ove for four es will be	2/10/17	
	This Standard is not	met as evidenced by:						
	policy and procedure that nursing staff folk	iew, interview, and revi e, the hospital failed to owed physician orders withdrawal for 1 of 3 pa).	ensure for					
-	Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm.							
	Findings:							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		504011		B, WING		12	/21/2016
	ON HOUSE AN OLIOMA (FFD		STREET ADDE	RESS, CITY, STA	TE, ZIP CODE		
	OVIDER OR SUPPLIER			ILITARY RO			
CASCADE	E BEHAVIORAL HOSP	TIAL		.A, WA 9816			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS'	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X6) COMPLETION DATE
A 405	Continued From pag	e 28		A 405			
	"CIWA" [Clinical Instit Assessment] (Policy: 12/2013) established be assessed for symphow the patient's symusing a withdrawal as medications were to be the patient's score. The pre-printed order set Alcohol Withdrawal" (physicians to order symedications to be adaptient's withdrawal at 2. Review of the medications who experients	#AR.C.210; Approved how often a patient was of alcohol withdraptoms were to be score seesment scale and hose administered according to policy included a titled "Lorazepam Orde (dated 5/15/2014) used beclfic dosages of ministered based on the seessment score.	as to awal; red ow ing to ers for I by				
	admitted on 12/10/20 withdrawal. On 12/10 patient's physician or Withdrawal Protocol i alcohol withdrawal syn Review of the medica for Patient #7 reveale patient received 1 mg and 1 mg of Lorazepa An interview by Surve Nurse (Staff Member patients alcohol withdadministered medical the score assigned all patient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's patient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's patient's dose of Lorazepatient's dose of Lorazepatient's dose of Lorazepatient's patient pat	dered the Alcohol nitiating treatment for mptoms. Ition administration rec d that on 12/10/2016 to g of Lorazepam at 9:40 am at 2:20 PM. Eyor #2 with a Register #4) during review of the	ord he AM ed lee ed on the leen				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		504011		B, WING		12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY RO	OAD SOUTH		
			TUKWIL	A, WA 9816	38		
2111 15	OLIMIA DV CT	ATEMENT OF DEFICIENCIES		1	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLÉTION DATE
A 405	Continued From pag	e 29		A 405			
	Member #4 did not know why nursing staff administered the higher doses.						
A 490	482.25 PHARMACEUTICAL SERVICES			A 490	See Tags A0491, A0493, A0500		
	that meet the needs of institution must have registered pharmacis under competent sup is responsible for dev procedures that minimulation may be delegorganized pharmace. This Condition is not Based on observation review, the hospital fapharmaceutical service.	a pharmacy directed b t or a drug storage are ervision. The medical s reloping policies and nize drug errors. This gated to the hospital's	y a a staff ment nt				
	Failure to provide ade risks patient safety ar administration practice		ces			·	
	Findings:						
	prior to pharmacy ver	administered to patier ification of orders resu omatic dispensing mac	lting				
	2. Patient home medi a pharmacist prior to l	ications not being verifi being administered.	edby				
		resulting from medicationatic dispensing machi					
	4. Expansion of hospi	ital services, clinical un	its,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING	· · · · · · · · · · · · · · · · · · ·	12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N	RESS, CITY, STA MILITARY R .A, WA 981	OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X6) COMPLETION DATE
A 490	and patient census wincrease in pharmacy. The cumulative effect resulted in the hospit safe dispensing, use tracking and control of the scope and under 42 CFR 482.22 Participation for Pharmot MET. Cross Reference: Tate 482.26(a) PHARMACO The pharmacy or dru administered in accoprofessional principle. This Standard is not Based on observation policy and procedure that hospital staff follows of a patient's own medicator harm due to medications. 1. The hospital policy "Medications Brough"	without a comparable y services coverage. It of these systemic prolai's inability to provide and administration, and of medications. It severity of deficiencies, the Condition of maceutical Services with acceptation of the Condition of maceutical Services with acceptations are an acceptations. It is evidence with accepted as a evidence with accepted as a evidence with accepted as a evidence of the hospital failed to evide the hospital procedure medications.	for d s as 00 for d for		A 0491 Corrective Actions The Clinical Educator reeducated the staff on policy titled "Medications Brwith Patients." Education was provid Nursing staff meetings through verbawritten communication. Education lugarity erification process is complete. Proper labeling and initialing of the process on home medication bottles. Physician orders needed for use of hemedications. The medical staff were educated on requirement of documenting dosage medication administration and order allowance of patient home medication Education was provided through writh verbal communication. Persons Responsible Medical Director	ought in ed during al and ncluded: the verification nome the s for home ring ons.	2/10/17
	"for those medication patient during their a	ons that will be used by dmission at the facility,	the the		Pharmacy Director COO/CNO		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C (DENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURV COMPLETED		
		504011		B. WING		12/21/	2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL			DAD SOUTH			
	•		TUKWIL	UKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(X6) COMPLETION DATE			
A 491	Continued From pag	e 31			Monitoring			
A 491	medications will be in identification, labeling part of the pharmacis a medication is verifical a sticker on the packer initials and date the medication has been "The order for a patient medication must be weared to the medication must be weared to the medication on the Phy 2. A tour of the medicate units (Gero-psyon 12/19/2016 between revealed the following a. One bottle of home tablets, was found for medication tray in the room. The pharmacis label to the medication written on the label at (12/17/2016) and initial administered the medication. b. Two bottles of home sodium 40 mg tablet 180 mg capsules, we patient's medication room. The pharmacis room. The pharmacis	aspected for proper g, and visual evaluation of verification process. Ged, the pharmacist will aging with the pharmacinedication as evidence verified" ent to take his/her own written by the attending sician's Order form." eation room of three patch, Rehab and Detox) General endication, Latuda 12 relation #8 in the patic endication #8 in the patic endication at tached a white prinon bottle with "verified"	Once place clast's othe dent on 20 mg ent's n ster Staff acist cR SR in the cation the		Monitoring The PI/RM Director/designee will perandom audit of at least 30 patient's medication orders to ensure complithe verification process. Any deficient addressed promptly. Audit results were ported in the monthly PI and quarant Governing Board meetings.	s own ance with ncies will be vill be		
	verification label, Sta medications on 12/18	8/2016 at 9:00 AM. The ler for the patient to tak	ere	·				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE S COMPLI				
		504011		B. WING		12	21/2016			
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	STREET ADDR	ADDRESS, CITY, STATE, ZIP CODE						
	BEHAVIORAL HOSP	нτΔι	12844 N	844 MILITARY ROAD SOUTH						
CMOCMDI				WILA, WA 98168						
							(X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETION DATE			
A 491	Continued From pag	g 32		A 491						
M 401		me medications, Raya	las	7, 701						
		rvir 100 mg tablets and								
		ets, were found for Pati								
		edication tray in the Re								
		ere was an initial and d								
		medication bottle labe rada) but the surveyor								
	unable to tell if the ini		was		•		1			
		itals and dates were ist verification. There w	wra							
		ation labels on the two	eie							
		he Norvir medication h	ad no							
	label with date and sign		34110							
		n. All of these medicati	ons							
		placed in the patient's	.,,,							
		notes were found in the	e bag.							
	one stated that the ph	narmacist verified Truva	ada							
		ated the pharmacist ha								
		otes were not attached								
	any way to the bottles					•				
		medications on 12/19	/2016							
	at 9:00 AM. There wa	ıs a physician order for								
	administration of the	patient's own medication	ons							
	but the order did not i	include specific dosage	s.							
		medication, Dilantin 3	0 mg	•						
	capsules, was found									
		ray in the Gero-psych (
		pharmacist verified ar								
		n. Staff administered ti								
		2016 at 9:00 AM. Thei					1			
		er for the patient to tak	₽		•					
	his/her own medication	on.								
	•									
A 493	482.25(a)(2) PHARM	ACY PERSONNEL		A 493						
	The shame and the le	ondos must hava co								
	The pharmaceutical s		ality							
		personnel to ensure qu		İ						
	•	ces, including emergen	∨y							
	services.									
							ı l			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1.	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE			
		504011		B. WING	TOTAL TO THE TOTAL TO A SAME AND	12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY ROAD SOUTH					
			TUKWIL	A, WA 981	68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE		
A 493	Continued From pag	e 33		A 493	A 0493 Corrective Actions		2/10/17		
A 493	This Standard is not in Based on document hospital failed to ensistaffed with sufficient provide quality pharm to meet the needs of providing care. Failure to provide sufprovide accurate and medication delivery pharm due to medication delivery pharm due to medication. Findings: 1. The hospital expands by 42 beds within the period, two additional (2 North - 18 beds; 2 the expansion, the hocensus (ADC) was 6 current ADC is 104.4 increase or an additional increase or an additional increase dworkload. 2. On 12/20/2016, Sipharmacy document key quality workload noted that the average doses administered in 12,000 doses since to The total number of inperformed by nurses or nearly 87 per day, count off" in the autorical in the autor	met as evidenced by: review and interview, the pharmacy was anumber of personnel to accutical services in on the patients and the state of the patients and the state of the patients at risk of the patients at risk of the patients at risk of the patients at risk of the patients at risk of the patients at risk of the past 12 months. During a past 12 months. During units were on West - 24 beds). Priorespital's average daily 6.68 patients. This years which represents a 5 mail 37.58 patients per cy staffing or coverage ondingly despite the curveyor #3 reviewed a which captures a varied elements. The surveyor genumber of medication monthly increased by of the beginning of the year medication overrides averaged 2,593 per medication dispensing mach	o order aff to g and f pacity g that ened r to r's 67% day. did ty of or on over ar. enth ry ines		Upon completion of the survey, the COO/CNO, Pharmacy Director, and it Clinical Director reviewed pharmacy order to ensure a sufficient number personnel. Effective 12/20/16, the PDirector increased pharmacy staffin two (2) additional evening hours, seper week. The increase in pharmacy prioritized on verification of new order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track additional staffing hours and report in the monthly PI and quarterly MEG Governing Board meetings for a permonths. Any related deficiencies will addressed promptly.	Regional y staffing in of Pharmacy g hours by ven days y hours are ders and use of the utilization C and iod of 3	2/10/17		
		non-controlled substar ncreased to a monthly	rces						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ITED
	•	504011				12/	21/2016
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA	TE, ZIP CODE		
	BEHAVIORAL HOSP			IILITARY RO	DAD SOUTH		
0,1001.52		TU		_A, WA 9816	88		1
	OLIMANA DV CT	TATEMENT OF DEFICIENCIES		iD	PROVIDER'S PLAN OF	CORRECTION	(X5)
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TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENC		
A 493	Continued From pag	e 34		A 493			
	average of 685 items	4					
	•						
		11:30 AM, Surveyor #3					
		acist (Staff Member #9)	' .				
	about the adequacy of	of pharmacy statting					
	compared to the curr	ent workload. Staff Me	mber		•		
	#9 acknowledged the	pharmacy workload hed within the past year.	S/he	•	•		
		ting work at this facility	Onio				
		e hospital had added t	wo				1
	more inpatient clinica	units without a					
	corresponding increa	se in pharmacy operat	Ing				
	hours or personnel. S	Staff Member #9 indica	ted				
		around time for verifyin					
	medication orders wa	as 30 minutes but may	be				
		r depending on volume	of				
	new admissions.				<u>.</u>		
	. 0- 40/40/0040 at 6	24 TOWNSHIP ME ASS					
		2:30 PM, Surveyor#3 tor of Pharmacy (Staff					
	Mambar #8) shout th	e high number of medi	cation				
}	overrides occurring w	vithin the hospital. Staf	:				1
	Member #8 stated the	at he/she had only bee	na			*	
		tal staff for "less than a			·		
	month" but acknowle						
		was "high" indicating t					
!	pharmacy is only on-	site during the day shif	t		•		
		asked Staff Member #8					
		narmacy resources. Sta					
		at "I don't have enough what we should." The	1				
	director of pharmacy	indicated that he/she	nad				
	worked over the cont	tracted hours every we	ek				
		ek when on orientation					ļ [
l .					•		
l .		11:00 AM, Surveyor#3			·	-	
	interviewed the Direct	ctor of Adult Psychiatric					
1	Nursing Services (St	aff Member #6) about t	he				
	high number of medi	cation overrides occurr	ing				
	within the hospital. S	taff Member #6 Indicat	9a				

STATEMENT OF		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1''	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PRO	VIDER OR SUPPLIER		STREET ADDRE	ess, city, st/	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL		LITARY R A, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D8E	(X5) COMPLETION DATE
	think medication over staff member acknow overriding because or to be verified in the stall also complained they medications in the au machines on the wee Monday mornings" re	ides is a "problem" stat rides are dangerous." riedged that nurses we f how long it takes for c ystem. Staff nurses hav r frequently run out of	The re orders ve	A 493			
	biologicals must be c accordance with appl consistent with Feder This Standard is not a Based on document a review of hospital pol hospital failed to enst and distributed in acc standards of practice Fallure to have adequent medication orders to in a safe and timely mand medication errors. Findings: 1. The hospital policy "After-Hour Medicatic Pharmacy Review" (F PHR-1691) under the Policy" read "The fac	atient safety, drugs and controlled and distribute licable standards of presal and State law. The as evidenced by: The reviews, interviews, and icies and procedures, the cordance with applicable and processes in place be received and dispensanner risks patient satisfies. The and procedure titled on Stock with or without section titled "Stateme"	d in actice, d the ed e for assed fety t # nt of		A 0500 Corrective Actions The Pharmacy Director, COO/CNO, Director reviewed the process of me overrides in the automated dispensi To ensure safe delivery of medicatio following system revisions were made a compared to the system revisions were made as a compared to the system of overrides. Two nurse witness system when owneeded and any needed and any needed system and any needed system articolar Educator educated the system oversight of the override system oversight of the override system. Educations and Medical provided during Nursing and Medical provided during nursing and meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	edication ing system. ons, the de: errides are ss for ystem nursing and changes for lucation was al Staff	2/10/17

Printed: 01/09/2017 FORM APPROVED OMB NO, 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SUR COMPLETI	
ANDPLANO	F CORRECTION		111				
		504011		B, WING		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER		1		ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	PITAL			OAD SOUTH		
				_A, WA 981		A A PARTICIAN I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
A 500	to decrease medication medication-use proces an exception to pharm medication order for does not permit pharmoccurs in 'first doses' such cases, an excepsignificant patient had involved for a pharmocutweigh the benefits. 2. On 12/20/2016, Supharmacy document key quality workload medication variances. The surveyor noted the 23,348 medication of the first nine month expansion of the hos hospital average 2,22 month. With the opernursing units, the numbar risen to a month representing a 22% in overrides. Similarly, the number of medication by physicians had incoverrides. Similarly, the period 12/19/2016 at 3. On 12/19/2016 at 3. On 12/19/2016 at 7:00 A the pharmacy in-hous day. During this time admitted 14 patients medication overrides. Of the 236 medication of t	on errors associated witersThe hospital allow macist review of the certain situations when macist review. This offer or 'emergency' situation is allowed because the could result in the deacts review of the design of a pharmacist review arreyor #3 reviewed a which captured a varied indicators that included a macing of the two additions of 2016. Prior to the pital bed capacity, the 21 medication overrides in the two additions of the two additions of medication over in sof 2016. Prior to the pital bed capacity, the 21 medication overrides in the surveyor noted that in variances (potential expressed by four fold sing 3:00 PM, Surveyor #3 I medication override is 6 at 4:00 PM until M (the weekend) in whise coverage is only 6 here.	time en ins. In e elay ould ty of i des. of nurses al rrides nat the rrors) ce the et for ich ours a staff.		Monitoring The Pharmacy Director/desi the total number of override trends, analysis, and system the monthly PI and quarterl Therapeutics committees. F recommendations and actio and reported at quarterly M Board meetings. Committee data reporting, analysis, and	es with aggregated improvements to y Pharmacy and Findings, ons will be reviewed lEC and Governing amoutes will reflect	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/G	LIA	1	LE CONSTRUCTION	(X3) DATE SU	
AND PLAN OF	F CORRECTION	IDENTIFICATION NUMBE	:R:	A. BUILDING	torprec 1/1	COMPLET	ED
		504011		B. WING		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE	ι.	
	BEHAVIORAL HOSF	PITA!	12844 N	MLITARY RO	DAD SOUTH		
OMOGRAP	. primingine ileoi	11,75	1	_A, WA 9816			
	ALUMATY 6	TATEMENT OF DEFICIENCIES	<u> </u>		PROVIDER'S PLAN O	E CORRECTION	(XE)
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A 500	Continued From pag	ne 37		A 500			
7 300	, -	as the reason indicatin	ig the				
		et verified the medication					
		ed dispensing system.				•	
		des listed "Emergency	Use"				
	as the reason for the	override.					
	•			-			
		2:30 PM, Surveyor #3					
		ctor of Pharmacy (Staff					<i>'</i>
		e high number of medi					
		within the hospital. Staff					
		that nursing personne					
		any and all medications I dispensing machines.	III KIC				
		ed that the hospital's en	itire				
		sible to all nurses with					
	any restriction.	oldio to all marous man					
		•					
	5. On 12/20/2016 at	2:30 AM, Surveyor #3					
		ctor of Adult Psychiatric	}				
	Nursing Services (St	laff Member #6) about t	ihe				
	high number of medi	ication overrides occuri	ing				1
	within the hospital. S	Staff Member #6 Indica	ted				
		rides is a long standing					
		ember confirmed that					
		many medication error					
		ff Member #6 asked to	pe a				
	I .	macy & Therapeutics					}
		some improvement or lade on this issue, He/s	ho				
		ssing medication overri			,		
		evious pharmacy direct		,			
	(Staff Member #10)	former chief nursing off	icer				
		and the quality risk mar					
		and the decision was m					
	to continue to monito						
A 700	482,41 PHYSICAL E	ENVIRONMENT	*	A 700	See Tags A0701, A0710,	A0724, A0726	
,,,,,,						•	
		e constructed, arranged					1
		e the safety of the patie					İ

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1'''	RIPLE CONSTRUCTION (X3) DATE COMI	SURVEY PLETED
		504011		B. WING		2/21/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N		STATE, ZIP CODE ROAD SOUTH 3168	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PRE FIX TAG	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X8) COMPLETION DATE
A 700	and to provide facilitic treatment and for spot appropriate to the new This Condition is not Based on observation staff interviews, the incondition of the physical environment manner that the safe was protected. Failure to maintain the facility plumbing and Failure to follow man maintenance activities Failure to remove light areas. Failure to monitor and temperature devices are maintained at the Due to the scope and cited under 42 CFR 4 Participation for PhysimeT.	es for diagnosis and ecial hospital services eds of the community. met as evidenced by: ns, document review, a nospital failed to ensure ical plant and the oversity and well-being of particular particular integrity of ventilation system. suffacturer-recommenders and schedule. ature risks in patient cand provide appropriate for to ensure food temper.	the all the al	A 700		
A 701	PLANT The condition of the hospital environment	ANCE OF PHYSICAL / physical plant and the of the set of the property and the set of the	rd i	Α	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated st on environmental factors contributing to ligat and self-harm risks particularly related to doo and handles. Training included mitigation	ure

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	'ITAL	12844 N	IILITARY R	OAD SOUTH		
			TUKWIL	.A, WA 981	68		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID .	ID PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	.D BE PRIATE	COMPLETION DATE	
A 701	Continued From pag	e 39		A 701	A 0701 Corrective Action	1	
	well-being of patients	are assured.					·
	This Standard is not met as evidenced by:				Increased monitoring of high risk pa Staff required to successfully compl training test.	ete post	
		n, interview and record			3. Bathroom flooring was repaired	bγ	4
		illed to maintain the co			(contractor) on 1-12-17.		
	environment of care.	and the overall hospital			4. Ceiling links were repaired by (co	ontractor) on	
	CHAUGIHIGH OF COLO.				1-12-17.		
	Failure to maintain th	e physical plant increa	ses		5. Occluded pipes were repaired by	contractor	
		patients, staff and visi			1-12-17		
		, ,			6. Ceiling tiles were changed 1-16-1	L/ by	
	Findings:				Maintenance staff		
	_	7. Burnt outlet was replaced by Maintenance staff by 12/23/16					
		10:00 AM Surveyor #1					
	observed the door in		_		ld caulk was		
		had a closure mechan	ism		removed and the area cleaned and	re-cauikea	
	that posed a ligature		1016		by Maintenance staff (1/9/17)	الممالما	
		ssment dated August 2 fled door risks in geriati			9. Oscillating fans have been install		
		High" or "Severe Risk".			PHP patient care areas. Permanent	vennauon	
		olumns labeled "What	',,,,		systems are being evaluated.		
	Action", "Time Frame				Persons Responsible:		
		or this item had limited	or no		Plant Operations Director		
	information provided	in these columns.			CEO		
		_					•
		10:00 AM Surveyor #1			Monitoring:		
	observed that the har				The Plant Operations Director/design	nee will	
	_	in the sunroom posed	a		perform environmental rounds of t	-	
	ligature risk				care areas to monitor ligature risks,		
	3 On 12/13/2016 of	10:10 AM Surveyor #1			flooring/walls/ceilings, furnishings,		
		oring in the bathroom o	n the		cleanliness and structures. Any def		
	adult psychiatric unit				be promptly addressed during the	,	
		and that vinyl was ripp	led		environmental round. Results of the	e	
		bathroom was located			environmental rounds will be repor		
	to 3 showers on 3 W				monthly PI committee and quarter		
					meetings.	• *** •	
		10:25 AM Surveyor #1 usion room on the adult			The second secon		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE S COMPLE			
		504011		B. WING		12/	21/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 M	ADDRESS, CITY, STATE, ZIP CODE 44 MILITARY ROAD SOUTH (WILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	'ION SHOULD BE I'HE APPROPRIATE	(X5) COMPLETION DATE		
A 701	psychiatric unit (2 We ceiling, the crack apprexposed dry wall whe done. On 12/14/2016 PM and 3:00 PM Sur soaked in water on the seclusion room on 2 actively leaking. Surveye what was above found that the three sabove were located at the surveyor observe was in use during the 5. On 12/15/2016 be AM Surveyor #1 obset the shower onto the 303. During the incide facility staff (Staff Me and pull out small arridid a visual inspection flashlight and found to	est) a large crack in the peared to be wet with per work had previously between the hours of veyor #1 observed towne floor in the same West where the celling reyor #1 went to 3 West the seclusion room and showers previously state above the seclusion room and that one of the shown incident. Itween 9:00 AM and 10: erved flooding over the floor on 3 West next to ent, the surveyor obsermber #17) "snake" the nounts of hair. Surveyor of the pipes using a he pipes were occluded.	been 2:00 els was t to d ed om, ers :00 rim of room rved drain r #1	A 701					
	and 11:00 AM Survey damage on a celling laundry room. 7. On 12/13/2016 bet 11:00 AM Surveyor # the patient kitchen ar a potential fire hazard 8. On 12/13/2016 bet 11:00 AM Surveyor # the caulking in the shand 3:00 PM Surveyor and 3:00 PM Surveyor # the caulking in the shand 3:00 PM Surveyo	tween the hours of 10:2 tobserved mold under lower room in the rehal tween the hours of 1:30	b unit 5 and let in his is 25 and meath b unit.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE S COMPLI	
		504011		B, WING		12	21/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL.	12844 N	RESS, CITY, STA MILITARY RO LA, WA 9810	DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
A 701	ventilation system ha fire. Surveyor #1 obs used for group sessi- did not have any wind skylights that did not ventilate in both roon	d not been replaced at erved 2 large rooms th ons for patients, one ro dows and the other roo open creating no mean ns.	at are om m had ns to	A 710			
A 710	(1) Except as otherw (i) The hospital m provisions of the Life Fire Protection Asso Office of the Federal NFPA 101 2000 editi Issued January 14, 2 reference in accorda 1 CFR Part 51. A cop inspection at the CM Center, 7500 Securit or at the National Ara Administration (NAR availability of this ma 202-741-6030, or go http://www.archives.gederal_regulations Copies may be obtai Protection Associatio Quincy, MA 02269. I of the Code are inco will publish notice in announce the chang (ii) Chapter 19.3.6 the adopted edition of hospitals.	A). For information on terial at NARA, call to: gov/federal_register/co /ibr_locations.html ined from the National lon, 1 Batterymarch Par f any changes in this e- rporated by reference, the Federal Register to es. 3.3.2, exception number of the LSC does not ap	ction- chitional the dithe de, by a) and ble for e c, MD the de_of Fire k, dition CMS or 2 of ply to	A 710	A 0710 Corrective Actions The hospital will not require a watcomply with 482.41(b)(1)(2)(3).	alver to	
	findings, CMS may very the Life Safety Code	on of State survey age vaive specific provision which, if rigidly applied sonable hardship upon	s of J,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETI			
		504011		B. WING		12/2	1/2016		
NAME OF PR	OVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL	12844 N	844 MILITARY ROAD SOUTH					
			TŲKWII	_A, WA 981	68				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION 8HOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
A 710	Continued From pag	e 42		A 710					
ATIO	facility, but only if the waiver does not adversely affect the health and safety of the patients. (3) The provisions of the Life Safety Code do not			11110					
	(3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports.		and						
					:				
					A 0724 Corrective Actions #1- Medical Supplies The COO/CNC directed/delegated monthly inspect Materials Department staff, Nursing Pharmacy staff to ensure that all su	ions by the staff and	2/10/17		
A 724	482.41(c)(2) FACILIT EQUIPMENT MAINT			A 724	medications are not expired and will specified on the manufacturers laborated in the manufacturers laborated in the manufacturers laborated in the manufacturers are secured in the manufacturers and the manufacturers laborated in the manufacturers are secured in the manufacturers and the manufacturers are secured in the manufacturers are secured in the manufacturers and the manufacturers are secured in the manufacturers and the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and will be secured in the manufacturers are not expired and the manufacturers are not expired and the manufacturers are not expired and the manufacturers are not expired and the manufacturers are not expired in the manufacturers are not expire	thin date			
		nd equipment must be an acceptable level of met as evidenced by:			Expired/nearing expiration products properly disposed of timely. All exp supplies and medications were rem discarded on 12/21/16.	pired			
	item #1 Medical Supp	olies			Person Responsible: COO/CNO				
	Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date.		ient		Monitoring: The COO/designee will environmental rounds of the patien to monitor integrity of products, sumedications. Any deficiencies will be addressed during the environmental	t care areas oplies and e promptly			
	exceed their expiration	ent care supplies do no n dates risks deteriora pplies being available f	ted		Results of the environmental round reported in the monthly PI committ quarterly MEC meetings.	s will be			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE SI COMPLE		
		504011		B. WING		12/	21/2016
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
	BEHAVIORAL HOSP	PITAL	12844 N	MILITARY RO	AD SOUTH		
			TUKWII	LA, WA 9816	8 .		
04045	CUMMACV	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE AC	TION SHOULD BE	COMPLETION DATE
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO DEFICIEN		
	Continued From page 43				·		
A 724	Continued From page 43			A 724			
	Findings:						
	Findings:	•					
	1. On 12/12/2016 at 11:00 AM during a tour of 3						
	West adult psychiatric unit, Surveyor #3 found the						
	following items in the wound supplies cabinet:		et:				1
			, , , , ,				
		of 0.9% Sodium Chloric iration date of 4/2016.	ge tot				
	iirigation with an expi	nation date of 4/2010.					
	b. One 500 ml bottle	of 0.9% Sodium Chloric	de for				
		iration date of 9/2016.					
		cotton-tipped applicator	rs		•		
	with an expiration dat	te of 2/2016.					
	d. One how of sterile	cotton-tipped applicato	rs.				
	with an expiration dat						-
	•						
		ne-lodine swabsticks w	ith an				
	expiration date of 10/	2016.					
	f One 14 french Fole	ey urethral catheter with	n an			• .	
	expiration date of 7/2						
	•						
		1:00 PM, Surveyor #3					
		t emergency cart and f	ound				
,	the following:						
,	a. Two 1000 ml 0.9%	6 Sodium Chloride					}
·		th an expiration date of					
	5/2016.						
	 	Saultania Obtantala mas est	l				
		Sodium Chloride pre-fill iration date of 5/2016.	ea				-
	ayınıgas wıtırı an expi	nation date of orzo to.					
	c. One 60 ml bottle o	f povidone-iodine solut	ion				
	with an expiration da						
		4 or man m					
	3. On 12/13/2016 at	1:35 PM Surveyor #4			,	•	

27QV11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	504011			B. WING	n braidein haift h a 17 fe y ac tarr an c eirige y y an ceirige y	. 12	/21/2016
***************************************	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N	RESS, CITY, STATE MILITARY ROA LA, WA 98168	AD SOUTH	and the second s	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE DIENCY)	(X6) COMPLETION DATE
A 724	inspected the gero-p emergency cart and a. Two 1000 ml 0.9% intravenous fluids wit 5/2016. b. Nine 10 ml 0.9% S syringes with an expi	sychiatric unit (4 West) found the following: Sodium Chloride han expiration date of codium Chloride pre-fille ration date of 5/2016.	ed	A 724			
	4. On 12/13/2016 at the medication room three 10 ml 0.9% So syringes with an expi	1:11 PM Surveyor #2 to on the Detox Unit and to dium Chloride pre-filled ration date of 5/2016. tween the hours of 1:00	ound			·.	
	and 2:25 PM Survey (transparent adhesiv expiration date 4/201 on the Detox unit. 5. On 12/13/2016 at inspected the emerg	or #1 found Tegaderm e film dressing) with an l6 in the crash cart loca 1:30 PM Surveyor #2 ency cart on the Rehab	ited				
	and found the following a. Two 1000 ml 0.9% intravenous fluids wit 5/2016.						
	syringes with an expi 6. On 12/14/2016 be 2:25 PM Surveyor #7 staff (Staff Member # the interview Survey	codium Chloride pre-fille ration date of 5/2016. tween the hours of 1:00 I interviewed central su f18). During the course or #1 asked how often to carts are checked. The) and pply of the				

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
		604011 B. WING 12/21/				/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL		4 MILITARY ROAD SOUTH NILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
A 724	central supply person part of his/her respondents monthly. He/she checked the crash call tem #2 Ice Machines Based on observation interview the hospital manufacturer's instrumaintenance, installatistic machine. Failure to follow manupreventive maintenar installation, promotes microorganisms, which risk. Reference: Follett Serence: Follett Serence: Follett Serence above D254 provided a diagram of Information on incommodification in the serence of the serence in the	was unaware that it was biblities to check the constitute to the constitute that he stated that he she had attended to follow comment review and failed to follow comment review and failed to follow comment review and failed to follow comment review and failed to follow comment review and routine cleaning and the growth of the places patients health of the places patients health ries/W, MCD400A/W, W, D400A/W Ice Macin and Service Manual Service Manual Service Manual Service installation as follow atter can collect that restricts ice flow the results in wet ice and problems remphony Plus: On page "Water shut-off 10 ft. (3 m) of dispensed and insulated. Maintafoot (20 mm per 1 m) remachine 400 Series at machine 400 Series 40 Series 40 Series 40 Series 40 Series 4	rash d y. d ing of or nd th at hines Serial ved:		#2 Ice Machines The Plant Operations Director has of certified contractor to perform the manufacturer recommended mainted cleaning for the Ice machines. All may were serviced during the week of 1/1/20/17. This certified contractor will Plant Operations Staff on proper cleatechniques. Person Responsible: Director of Plant Operations Director/designee will perform more inspections of all ice machines to make to make the machines and operations. Any definition will be promptly addressed during the environmental round. Results of the environmental rounds will be report monthly PI committee and quarterly meetings.	enance and achines /16/17 to Il also train eaning onitor ficiencies the e	2/10/17	
		Machine Manual state			j 1	:		

		VAL DE OVAD CONTROL IEDA	11A	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE 8	URVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING		COMPLE	
		504011		B. WING		12/	21/2016
NAME OF PR	OVIDER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,	STREET ADDI	RESS, CITY, STATE	, ZIP CODE		****
,	BEHAVIORAL HOSF	PITAL .	12844 N	MILITARY ROA	ND SOUTH		
ONGONDE			TUKWII	LA, WA 98168			
(X4) ID PREFIX	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE	<u> </u>	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	(X6) COMPLETION DATE
TAG	OR LSC ID	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	
A 724	Continued From pag	je 46		A 724			
		quency for both model	s on				
	page 14 and 17: "the	frequency in cleaning	and		V.		
-	sanitizing ice machin	e according to the sche	edule		•		
	below:"				•		
			ŀ	,			İ
	Semi-annually preven	ntive maintenance					
	Drain Line - weekly			1			
	Drain Pan/Drip Pan -	weekly		,			
	Findings:						
							,
		tween the hours of 1:00					
		or #1 observed a drain-l					
		chine was not slope to (e ice machine was locat					
		rea on the Rehab unit.					
		nce sticker was past du					
		on the drip pan had re					
	build-up.	the alle bally some		-			
	waita spr						
	2. On 12/14/2016 bet	tween the hours of 8:30	MA C	1			
		eyor #1 interviewed the					
	hospital plant manag	er (Staff Member #19).	Staff]			
	Member #19 stated it	n part that the ice mach	nine				
	maintenance was be	hind so they contracted	d with	Ì			
	a company to get the	m caught up. When as	iked			•	
		reventive maintenance,			`		
		y. In review of work ord MacDonald-Miller" it sh					
	several machines rec		Owed				
		n the months of July th	rough				
	Sentember but the w	ork order did not indica	ate .	Ì			
		e done and what was					
		entive maintenance. In	j				
		1 reviewed a work orde	r				
		ospital system that ind					
	a "Follett" ice machin	ne on 3-North unit was					
	scheduled for prever	itive maintenance on					
		sed out and a hand writ					
	date of 8/10/16 was p	provided to indicate whe	en the	ļ			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C		1,,	LE CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF	FORRECTION	IDENTIFICATION NUMBE	:R;	A, BUILDING	<u>, , , , , , , , , , , , , , , , , , , </u>	COMPLETE	D
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER	<u></u>	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	· ·	-000
CASCADE	BEHAVIORAL HOSE	PITAL	12844 [WILITARY R	OAD SOUTH		
			TUKWI	LA, WA 981	68		
W 45 100	S ADVINATIO	TATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	COMPLETION DATE
A 724	Continued From pag	ne 47		A 724			
	work was done.)					

	3. On 12/14/2016 be	tween the hours of 1:00	D PM				
		or #1 observed soil buil				:	
		drain line of the ice mad					
	located in the Detox						
	•						
A 726	482.41(c)(4) VENTIL	ATION, LIGHT,		A 726	A 0726 Corrective Actions		2/10/17
,,,до	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS				The Dietary Manager purcha	acad naw digital	2/10/1/
					thermometers and provided	_	
	There must be prope	er ventilation, light, and			the new thermometers. Th		
		in pharmaceutical, foo		,	reeducated all dietary staff		
		er appropriate areas.		1		, ,	
		met as evidenced by:			techniques and requirement		
		n, the hospital staff fail			temperatures and maintaini		
		nd procedures consiste			freezer temperatures. All re		
		State Retail Food Cod	е,		temperature requirements	will be logged daily.	
		ederal Food and Drug			Davis an Bananasibles		
	Administration.				Person Responsible: Director of Dietary		
-	Enilure to follow the	food code places patie	nte		Director of Dietary	-	
		risk for foodborne illnes			 Monitoring: The Dietary Dire	actor/docimon will	
	stan, and visitors at	TOR TOT TOO BOTTO THE TO			perform weekly inspections		
	Findings:		•		refrigerator, and freezer ter		
					monitor adherence to the V	•	
	1. On 12/12/2016 be	tween 11:00 AM and 1	2:15		and FDA3-501.14 codes. Th		
		served two containers o			Director/designee will perfo	•	
		inches in the walk-in o			observation monitors of sta	•	
		ds with a depth greater			temperature checks. Any	•	
		document temperature			promptly addressed during		
		foods cool within the re			of the both monitors will be		
		s specified by Washing			monthly PI committee and		
		ode. The hospital did no	Ж		meetings.	qualitariy iviet	
	document cooling tin	nes for the pasta.			meenigs.		
	 Reference: Washing	ton State Retail Food (Code				-
		5. FDA Food Code 3-5					
	2. On 12/12/2016 be	etween 11:00 AM and 1	2:15				
		erved dietary staff (Sta					1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	1/2016
NAME OF PR	OVIDER OR SUPPLIER	<u> </u>	STREET ADDI	RESS, CITY, ST.	ATE, ZIP CODE		
	BEHAVIORAL HOSP	ντΔι	12844 N	IILITARY R	OAD SOUTH		
CAGCADE	DEIMMONALING	1772		.A, WA 981			
						r)kl	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	COMPLETION DATE
A 726	Continued From pag	e 48		A 726			
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ler				
	Member #20) using a food probe thermometer Inaccurately when taking the temperature of a						
	"Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the		~				
ļ			the				
		em; the staff inserted only the tip into the induction induction induction in the induction induction in the induction induction in the induction induction in the induction induction in the induction induction in the induction induction in the induction induction induction in the induction induction in the induction induction induction induction in the induction i					
	reading. The type of t	thermometer used by the	ne		,		
	etaffwae not designe	d to temp thin foods su	ch as		·		
		ts, and other thin food it					
	mod pattoo, non mo	(O) Color Color Color	,				
	In addition Surveyor	#1 checked to see the					
	thermometer's accura						
		ther thermometers in a	n I				
1		32 degrees Fahrenhei					
		temp the "Ruben Sand					
		ees Fahrenheit, 12 deg					
		y staff (Staff Member#					
	confirmed this.	,					:
					A 0749 Corrective Actions		
	Reference: Washingt	on State Retail Food C	ode,				
	WAC 246-215-04335				1) The Infection Control Practitione		2/10/17
	Reference: Washingt	on State Retail Food C	ode,		reeducated the nursing staff on the	*	
	WAC 246-215-04580				of hand hygiene per policy during m	edication	
	•				administration. Education was provi	ded during	
A 740	482 42/a)/4) INFECT	ION CONTROL PROG	RAM	A 749	staff meetings through verbal and w	ritten	
A 749	402,42(a)(1) IN LOT	ION CONTINOET NOC		71110	communication.		
	The infection control	officer or officers must					
		identifying, reporting,			Persons Responsible:	-	
		ntrolling infections and		•	Infection Control Practitioner		
	communicable diseas		,				
	personnel.	see or patiente and			Monitoring		
	регоотител				On a monthly basis, the Infection Co	ntrol ·	
					Practitioner/designee will monitor h		
	This Standard is not	met as evidenced by:					
	THE OWNER IS NOT	no, ao oriadiloos sy			hygiene during medication administ		
	Item #1 Hand Hygien	ne.			a minimum of 10 medication passes		
	Itom or Francis Tygich				Any deficiencies will be addressed d		
	Resed on observation	n and review of hospita	,		medication pass. Monitoring results		
		, staff failed to perform			reported during the monthly PI and	quarterly	
	business procedure				MEC meetings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		504011		B. WING		12/21/	/2016			
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDR	ET ADDRESS, CITY, STATE, ZIP CODE						
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	12844 MILITARY ROAD SOUTH						
				TUKWILA, WA 98168						
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		al	PROVIDER'S PLAN OF CORRECTI					
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE			
A 749	Continued From page 49			A 749	2) The Dietary Manager obtained n	ew	ļ.			
	medications				thermometers designed to measure					
					temperatures properly. The Dietary	Manager				
1	Failure to perform ha	nd hygiene puts patien	ts and		educated the dietary staff on the pr	oper use of				
	staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: " III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS C. Decontaminate hands before having direct or indirect contact with patients F. Decontaminate hands after contact with a				the food thermometers with an em	phasis on	İ			
					accurate insertion. The education w	as provided				
					during staff meetings with the use of	of verbal and				
					written communications	l	ļ			
			VD vfore		Person Responsible: Dietary Manager Monitoring					
		G. Decontaminate har	nds		The Dietary Manager will perform a	minimum	`			
	•	dy fluids or excretions,			of 30 random audits per month x 3	months to	Į			
	muçous membranos.				ensure proper temperature monito	ring. Any				
					deficiency will be promptly address	ed. Results				
	2. On 12/13/2016 at	9:00 AM Surveyor #4			of the audit will be reported in the	monthly PI	1			
	observed a registere	d nurse (Staff Member	#14)		and quarterly MEC meetings.					
	administer oral medic	cations to a patient. S/h	ie did							
:		giene (HH) before prep			3) The Infection Control Practitions	er				
		though s/he came in c	ontact		reeducated the housekeeping staff	on the				
	with the patient's ora				following procedures for proper cle		ĺ			
	administration, did no	ot perform HH afterwar	d.		patient care areas:	-	Ì			
	3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did		#15) ne did		-Allowing for a 10-minute contact tusing Virex 256 disinfectant solution-Avoidance of cross-contamination	n,				
	not perform HH prior				cleaning brushes.	d nationt				
		te numerous contacts	with		-Proper dusting procedures to avoid	u patient				
	the patient's skin.				exposure.	all times				
					-Maintaining possession of carts at	an times.				
	Item #2 Dietary Sani	tation								
	Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.		re nil		Person Responsible: Plant Operations Director					

NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG A 749 Continued From page 50 STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 749 Monitoring		TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 749 Continued From page 50 A 749 Monitoring	,		504011		B, WING				
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 749 Continued From page 50 A 749 Monitoring				OTRETT ADDIT	APPT APPOINED ONLY STATE AID CODE				
TUKWILA, WA 98168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 749 Continued From page 50 A 749 Monitoring			ALCONOMI A SECTION AND A SECTION ASSESSMENT						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL REGULATORY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) A 749 Continued From page 50 A 749 Monitoring	CASCADE	E BEHAVIORAL HOSF	PITAL						
	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTUAL OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO				TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE		
Failure to follow best food practices places patients, staff, and visitors at risk for foodborne Illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanilizer bucket for in-use whiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanilizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 266 Diversey: "Apply use solution to hard, non-prorus environmental and maintenance of cleaning patient or on."	A 749	Failure to follow best patients, staff, and vi illness. Findings: 1. On 12/12/2016 bei PM Surveyor #1 used paper to evaluate the in the sanitizer bucket The chlorine exceede parts-per-million (ppr Reference: Washingt WAC 246-215-033393-304.14) 2. On 12/12/2016 bei PM Surveyor #1 obset on the interior plastic located in the main kind Reference: Washingt WAC 246-215-04605 Item #3 Housekeepir Based on observation and manufacturer's in hospital staff failed to cleaning patient room. Fallure to follow manuse and hospital poli increases the risk of staff and visitors. Reference: Virex II 2 solution to hard, non-	food practices places sitors at risk for foodbo tween 11:00 AM and 12 d a chlorine indicator te chlorine concentration of for in-use wiping clotted the tolerance limit of m) for sanitizer. Iton State Retail Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (2009 FDA Food Co (20) (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) FDA Food Co (20) (20) (20) FDA Food Co (20) (20) (20) FDA Food Co (20) (20) (20) (20) FDA Food Co (20) (20) (20) (20) (20) (20) (20) (20)	2:15 st level ns. 200 code, ode 2:15 owth ne code, office ents,	A 749	The Plant Operations Direct monthly environmental rocare units to monitor control of cleaning brushes and dumaintenance of cleaning could be promptly addressed environmental round. Resignification and the control of the condition of the control of the condition	unds of the patient act times, proper use isting, and arts. Any deficiencies during the lits of the be reported in the		

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DE CORRECTION IDENTIFICATION NUMBER;				E CONSTRUCTION	(X3) DATE SU COMPLE		
	504011			B. WING		12/:	21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	PITAL	12844 M	MILITARY ROAD SOUTH				
	•		TUKWIL	A, WA 9816				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES I' BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO ' DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE	
A 749	, ,			A 749				
	minutes. Wipe surfaces and let air dry."						ļ	
	Findings:							
	In review of hospital's policy and procedure titled: "Dally Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times."				·			
5 5 5 5	2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use.							
	3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush.		orush					
	4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles.		a patient					
	observed housekeep a patient room at the	9:50 AM Surveyor #1 er (Staff Member #21) end of the hallway lea rt in the hallway unatte	ving					
	6. On 12/15/2016 at	4:00 PM, Surveyor #1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SU COMPLE			
	504011			B. WING		12/3	21/2016	
NAME OF DR	OVIDER OR SUPPLIER	<u>!</u>	STREET ADDR	DDRESS, CITY, STATE, ZIP CODE				
	BEHAVIORAL HOSF	нтлі		44 MILITARY ROAD SOUTH				
CASCADE	E BEHAVIORAL HOSP	TEAL		.A, WA 9816	8			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 749	reviewed a facility do Prevention" the docu indicators for 2016. O identified was Patien "Target" of success of	cument titled, "Infection ment provides a line list one of the indicators to Room Cleaning with a sof 95% or better. For the tanuary through Novem	et of	A 749				

Cascade Behavioral Health Hospital Plan of Correction Review 2nd Revision

A0500 – The plan does not address the deficiency (uncontrolled distribution of medications in accordance with applicable standards of practice, consistent with Federal and State law). Current plan of correction is incongruent with state WAC 246-873-080 (6) which states ". . . A pharmacist shall review the original order or direct copy thereof, prior to dispensing any drug, except for emergency use". Upon approval of the override list, will the automated dispensing machine (ADM) restrict access to nursing personnel to medications that have not had a prospective pharmacy review? If not, what is the plan to ensure pharmacy review of provider orders prior to medication administration?

A0701 – The plan of correction does not address the second room with skylights. Will the second room continue to be utilized as an outpatient room? If the vented windows cannot be completed by day 45 (exceeds required date of compliance), then a extension waiver will need to be submitted. A process and or a policy needs to be developed to guide staff when classes need to be relocated.

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	VT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:			į.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		504011		B, WING			/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	DDRESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSE	PITAL		12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	ON .D BE PRIATE	(X5) COMPLETION DATE		
TAG	INITIAL COMMENTS MEDICARE HOSPIT This Medicare hospit conducted on the foll and 12/19-21/2016 b Department of Health RN, MN, MHA; Elizal Valerie Walsh RN, M and Joy Williams, RN The Fire Life Safety (conducted on 12/14// Patrol Deputy Fire M F/L/S inspection report Surveyors assessed following MEDICARE #69393; #70129; #70 #70136. During the course of surveyors determined of serious harm, injur extent of deficiencies of IMMEDIATE JEOF	AL COMPLAINT SURVal complaint survey was owing dates: 12/12-16/2 y Washington State a surveyors: Paul Kondo peth Gordon, RN, MN; S; Alex Giel, REHS, Plus BSN. [F/L/S) inspection was 2016 by Washington Starshal Donald West (Sept.).	/EY s 2016 rat,	TAG A 000	CROSS-REFERENCED TO THE APPRODEFICIENCY) Submission of this plan of correction admission that the citations are true hospital violated the rules. A 000: Response to Medicare Hosp Complaint Survey As noted, an action plan was submit accepted in response to the immed jeopardy finding. Corrective actions—Analysis and reduction of overrides medication dispensing devices;—Pharmacy staffing increases;—Physician order requirements for one-Two nurse verification for override—After-hour pharmacist verification revision;—Pharmacy policy revision relative to and home medications.	r is not an is not an is not an is not an is not an is not an ital ital ital ital included: in the verrides; s; process	2/10/17	
	The hospital initiated 12/20/2016 but surve the plan's implementationspital for the IMME		rify			·		
	place at the time of s			hunael	the, ceo 2/1/	2.017		

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

TITLE

(X0) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14

days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			1	CE CONSTRUCTION ((X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH IILA, WA 98168				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
A 000	was verified on a rev PM by Paul Kondrat, Williams, RN, BSN. Cascade Behavioral	isit on 12/29/2016 at 12 RN, MN, MHA and Joy Hospital is NOT IN Medicare Hospital Concerning Body ant Rights lity Assessment and ement maceutical Services	'	A 000				
A 043	legally responsible for if a hospital does not governing body, the properties of the functions specified in governing body This Condition is not based on observation reviews, the hospital requirements at 42 C Participation for Governing body	ective governing body or the conduct of the hosens have an organized persons legally response hospital must carry out this part that pertain to met as evidenced by: n, interviews, and docutation of the first pertain to the first pertain to the first pertain to the first pertain to the first pertain to the first pertain to the first pertain to the first pertain to the first pertain the first pertain to the first pertain th	spital. sible if the the the ment f		Upon completion of the survey, the Omedical Director, COO/CNO, Governing members, and PI/RM Director review findings and began formulation of the Correction. The Governing Board deletes actions to the CEO. The CE responsible for reporting the results of corrective actions and use of monitor Systems to the Governing Board. See A0115, A0263, A0490, A0700	ng Board ed the e Plan of egated of all O is of the	2/10/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504011		B. WING		12/21/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL	12844 MI	oress, city, state, zip code MILITARY ROAD SOUTH ILA, 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 CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	TON SHOULD BE COMPLET THE APPROPRIATE DATE		
A 043	CORRECTION IDENTIFICATION NUMBER: 504011 STREET ADD 12844 TUKWI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY)		d on I. nance dical nt's ysical f s 1.21 ment 2.25 41		Amendment 2/1/2017: The CEO weekly reports to the Governing E related to the hospital's ongoing e toward compliance for all citations Conference calls will be held as no dialogue. The target compliance all standards cited. Any score be will require remediation with the a employee and/or further analysis possible system issues.	Roard offorts s. eeded for is 90% for low 90%		
A 084				A 084				
	The governing body r	nust ensure that the						

			(1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	(X8) DATE SURVEY COMPLETED		
		504011		B, WING	B, WING		/2016	
NAME OF BO	OVIDER OR SUPPLIER	<u> </u>	STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
	BEHAVIORAL HOSP	OTA!						
CHOCHDE	BEHAVIORAL HOOF	· ·		MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID Prefix Tag	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
A 084	Continued From pag	e 3		A 084	A084 Corrective Actions:		2/10/17	
,		nder a contract are pro	vided		 The department heads respon. 			
ļ	in a safe and effective manner.				contracts evaluated all contrac	ted patient		
	THE COLO CITE CITED				care services and submitted th	ose		
	This Standard is not met as evidenced by: . Based on interview and review of hospital		1		evaluations to the Medical Exe			
					Committee for review and app			
					2. The PI/RM Director revised the			
		ital failed to ensure tha	t its		process for contract evaluation			
		d performance improve			a. The PI/RM Director v review dates to ensu			
	(QAPI) processes inc	duded a systematic rev	iew of		timeliness.	ii e		
	contracted patient ca	re services.			b. The Department Hea	ad		
	Failure to develop a process to oversee the				responsible for overs			
			İ		contracted clinical se	-		
	performance of all co				review the contract a	and		
		nts at risk for provision			complete the evalua	tion.		
		ate care and adverse pa	atient		c. If there are service o	oncerns, the		
	outcomes.				Department Head w			
					those concerns with			
	Findings:				contracted service a		i	
	D.: 1070010010 -10.0	0 4 4 4			plan of improvemen			
		0 AM, during a discuss			ensure patient care	needs are		
		program with Director (met. d. Annually, all evaluat	ione for		
		iff Member #12), Surve pital's process for evalu			contracted clinical se			
		ontracted health servic			be forwarded to the			
		ontracted nearin services document			Executive Committee			
	~	ere was no evidence th						
		services had ever beer			Responsible Person:			
		part of the QAPI progra			PI/RM Director			
	quality of services pro	, , ,						
	dament, an annuar but				Monitor			
	-Universal Hospital - I	R&M Equip, Biomed			On an annual basis, the PI/RM Director			
}		eutical - Pharmacy Ser	vices		the list of contracted patient care service			
į	-Dietician Services	•			completed evaluations by the assigned of			
İ	-Highline Physical Th	erapy - Physical Thera	ру		head in the MEC meeting. The evaluatio Include any service concerns with relate			
	-Northwest Healthcar				Improvement, Committee minutes will r			
	-				review and any actions taken on patient			
A 115	482.13 PATIENT RIG	HTS			contracts.	. var. w		
	A hospital must prote patient's rights.	ct and promote each			·			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			A, BUILDING		(X3) DATE S COMPL		
		504011		B. WING		12	/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSE	PITAL			OAD SOUTH			
			TUKWIL	.A, WA 981	38			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		id Prefix Tag	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE		
A 115	Continued From pag	je 4		A 115	See A 0123, A 0129, A 016	4, A 0174		
	This Condition is not	met as evidenced by:						
	review, and review o	n, interview, document f hospital policles and bital failed to protect and s.	d ,					
	Failure to protect and promote each patient's rights risk the patient's loss of personal freedom, privacy, dignity, and psychological harm. Findings:							
					**			
		tients the right to exerci and refusetreatment.	se					
	2. Failure to utilize the to the use of seclusion	e least restrictive alterna on and restraints.	ative		,			
		the patient from seclusi time when documentati it risk ofdanger.						
	4. Failure to investigate closure of the compla	ate patient complaints p aint.	rior to					
		t of these systemic prol al's inability to provide to tect patlent rights,					į	
	under 42 CFR 482.13	d severity of deficiencie 3, the Condition of ent Rights was NOT ME						
	Cross Reference: Ta A0174	gs A0123, A0129, A016	34,					
A 123	482.13(a)(2)(iii) PATI GRIEVANCE DECISI	ENT RIGHTS: NOTICE	OF	A 123				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
AND PLAN O	P CORRECTION	IDENTIFICATION NUMBER				OOW CEN	40
		504011		B, WING			/2016
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	PITAL			OAD SOUTH		
				.A, WA 981	88	CARAMIE ENGRA VIENINE VAN VIEN	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 123	Continued From pag	je 5		A 123	A 0123 Corrective Actions		2/10/17
	must provide the patidecision that contains contact person, the spatient to investigate the grievance process completion. This Standard is not a Based on interview, of hospital policies are failed to ensure that puritten response to the grievances reviewed a Failure to provide part to their grievance vio	met as evidenced by: document review, and red procedures, the hose patients were provided neir grievances for 1 of (Patients #2). tients with a written reseates their right to be nospital investigated ar	of its ital ithe uits of eview pital with a 4		The Patient Advocate reviewed Grievance Policy on the requirer providing a written response to The Clinical Educator reeducate staff on the grievance process wresponses provided to the patiewas provided in staff meetings that and verbal communication. Amendment 2/1/2017: The higrievance policy, log for grieval letters that are to be mailed to all been revised and will be pweekly PI Committee on Thu February 9, 2017 for approvatiney will go the Medical Exect Committee on February 9, 20 Governing Board at its next in the new processes is 90%.	ment of a grievance, d the clinical i/th written nt. Education chrough written ospital's ances, and o patients have resented at the rsday, il. From there, utive 17 and neeting ird compliance Any score	
	"Patient Grievance P Policy # G.1001) rea Advocate will: Review Investigation Com Grievance Resolution report to patient for re signature." 2. Four patient compleview of process and included the patient of reviewed for evidence investigation, findings	cy and procedure titled olicy" (Revised 10/201: d in part: "The Patient w results of the prelimin plete a written report or Form Give written eview, comments and laints were selected for d resolution. Sources complaint log. Each was of receipt, hospital revis, and resolution of the the findings reviewed w	5; nary n the s s view,		below 90% will require remedaffected employee and/or fur possible system issues. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will prese the grievance log and grievance the monthly PI and quarterly M meeting is Feb 9, 2017) and Governmentings. Any issues requiring in attention will be addressed by the department head.	nt an analysis of responses to EC (next verning Board mmediate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		604011		B. WING		12/21/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE				
	BEHAVIORAL HOSP	PITAL	12844 N	MILITARY ROAD SOUTH				
0.10 -71-				A, WA 981				
	0114144.007.00	FATERICAL OF DECIDIONOLES		,	PROVIDER'S PLAN OF CORRECTION	361	(X6)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL, RE ENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	E ACTION SHOULD BE O TO THE APPROPRIATE		
A 123	Continued From pag	e 6		A 123				
	the patient who filed the grievance. 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed.							
	4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation.							
A 129	482.13(b) PATIENT I RIGHTS	RIGHTS: EXERCISE O	F	A 129	A 129 Corrective Actions		2/10/17	
	Patient Rights: Exerc	sise of Rights			The Clinical Educator reeducated the staff on the policy titled Skin/Clothir Education included an emphasis on	ng Check.		
i	This Standard is not	met as evidenced by:			procedure for assessing patients and			
	Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights.				for patient's refusal. Education was during staff meetings through verba written communication with compe testing,	provided I and		
	Failure to allow paties skin/clothing checks personal dignity, private	risks patient's loss of			Person Responsible: COO/CNO Patlent Advocate			
	Responsibilities" (Re ADM.P.300) under th "To assure that a pat rights and responsibi	cy titled "Patient Rights viewed 10/2016; Policy le section "PURPOSE" ient is informed of his d litles upon receiving ca scade Behavioral Hospi	# read: or her re		Monitoring: The PI/RM Director/designee will pe least 30 random audits per month to compliance of 90% or above for at le consecutive months. Audit results w reported in the monthly PI and quar and Governing Board meetings.	o ensure east 3 vill be		

	/IDER/SUPPLIER/CLIA [[FIGATION NUMBER:	I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	504011			12/21/2016			
NAME OF PROVIDER OR SUPPLIER	i	•	RESS, CITY, STATE, ZIP CODE				
CASCADE BEHAVIORAL HOSPITAL			MILITARY ROAD SOUTH /ILA, WA 98168				
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST BE PREC TAG OR LSC IDENTIFYING	EDED BY FULL REGULATORY	TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION PRIATE DATE			
A 129 Continued From page 7 and to assure that these right hospital staff, physicians and providers." "B. The list of patient rights a not limited to the following: personal privacy, and to be pinvasion of privacy, PROVIDI searches may be conducted to detect and prevent contrat possessed or used on the pright to care that is consideral your personal culture, values preferences and to be treated promoting dignity and self-rest. 2. The hospital's policy titled Check" (Reviewed 10/2016) "Voluntary psychiatric patient voicing or exhibiting self-harm refuse the skin/clothing check referral information and admit discharged from the hospital. 3. On 12/14/2016 at 12:00 Plobserved Patient #1 being admission and hand his clothing composition and hand his clothing contraband (hospital prohibits agreed but stated, I am not to off, I am here voluntarily and that. The other registered num (Staff Member #2) informed I acceptable. After Patient #1's searched for contraband, Stathe patient to squat and cougheck further for contraband, informed Staff Member #1 the	cother health care thall include but are 4. The right to rotected from ED, that reasonable or other means used and from being emises 13. The te and respectful of beliefs, and in a manner spect." "Skin/Clothing read in part: s who are not behaviors, who k, will be given mistratively " M, Surveyor #3 Imitted to the ming check process, may into a hospital over to a nursing to be checked for ed items). Patient #1 aking my underwear am not going to do se in attendance Patient #1 that was a clothing had been ff Member #1 asked h so they could Staff Member #2	A 129	Amendment 2/1/2017: The hosp check/contraband policy has bee to remove the administrative disc patients who refuse the skin check Staff education has been conducted to this change. Daily audits are a progress and the results of which shared at the weekly PI Committed Wednesday, February 1, 20 the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the amployee and/or further analysis possible system issues.	n revised harge for ck process. ted related already in will be ee to be 17 and to e on e target elow 90% affected			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
,		504011		B. WING	<u>,</u>	12/	21/2016	
	OVIDER OR SUPPLIER E BEHAVIORAL HO	SPITAL	12844 N	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 129	4. On 12/14/2016 a interviewed a regis about the skin/clott Staff Member #3 c process included h cough and then ch contraband. Surve understanding of the two other registere Staff Member #5 and rehabilitative understanding of the contraband of the contraband of the contraband of the contraband of the contraband of the complaints about the Cli Psychiatric Service skin/clothing check Member #6 explain complaints about the patient allowed the patient surveyor asked State of the current policy of discharge voluntar skin/clothing check being unaware of the current policy	ger part of the process. at 1:37 PM, Surveyor #2 stered nurse (Staff Memb hing check done at admit onfirmed that part of the naving the patient squat a ecking for any visible yor #2 found similar he process while interview d nurses (Staff Member a on the chemical depende	ssion. wing #4, ncy ut the ff ived holicy er I now The why atively he dged Staff r was y	A 129				

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011	B. WING			12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		
CASCADE	E BEHAVIORAL HOS	SPITAL		IILITARY R .A, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST 8E PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
A 164	Continued From page 9			A 164	A 0164 Corrective Actions		
A 164	A 164 482.13(e)(2) PATIENT RIGHTS: RESTRAIN SECLUSION Restraint or seclusion may only be used whe			A 164	The Clinical Educator reeducated n on the requirement of using less re Interventions prior to restraint and	strictive	2/10/17
		ventions have been	٧		protecting patients, staff, and/or o	1	
		effective to protect the pa	atlent.		harm. The education included an e	ì	
	a staff member, or				de-escalation techniques as well as	•	
					therapeutic interventions. The Clin		
	This Standard is no	t met as evidenced by:			provided the education during staf		
			.		through the use of verbal and writi	ren	
	hospital policies an	view, interview, and revi d procedures, the hospit	al		communication with return demor	istration.	·
	1	der the effectiveness of l			Person Responsible:		
	restrictive interventions before applying both restraints and seclusion for 2 of 6 patients		•		PI/RM Director		
	(Patients #4, #6).	ision for 2 or 0 patients			COO/CNO		
	Failure to utilize les using both restraint	s restrictive alternatives	to		Monitoring: The PI/RM Director/designee will a	uudit all	
		s and seclusion s patients at risk for loss	of I		restraints and seclusions to determ		
	personal freedom a				appropriateness of use with less re interventions. Any clinical issues re	strictive	
	Findings:				corrective actions will be promptly by the COO/CNO. The PI/RM Direct	addressed	
	1. The hospital police	cy and procedure titled			report audit results in the monthly		
	"Seclusion and Phy	sical & Mechanical Rest	raint"		quarterly MEC and Governing Boar		
		olicy # PC.R.100) under			quarterly MEC and Coverning Doan	u meetings.	
4	l •	d in part: "Restraints ma				ĺ	
		nagement of violent or				ĺ	
		avior that jeopardizes th			·		
		safety of the patient, a s	tan			l	
	member or others a interventions are in-	effective or ruled-out	11				
		Patient Rights" read					
		ion may only be used wi	nen				
	\	ventions have been	_414				
		effective to protect the p					
		n. The type of technique of the the least restrictive	UI ·				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
	504011			B. WING		12/21/2016			
NAME OF PR	OVIDER OR SUPPLIER	,	STREET ADDRE	RESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL	12844 M	MILITARY ROAD SOUTH					
			TUKWIL	A, WA 981	68		ļ		
(X4) ID		TATEMENT OF DEFICIENCIES		ID					
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETION DATE		
(7.0				,,,,	DEFICIENCY)				
A 164	Continued From page 10			A 164	Amendment 2/1/2017: Seclusion	&			
		be effective to protect to	he		restraint forms were changed to o				
		er, or others from harm			with standards and staff were edu				
	•				those changes. Audits are alread				
		2:30 PM, Surveyor #3			progress and the results of which shared at the weekly PI Committe				
		l's pre-printed restraint t for Patient #5 observi			held Wednesday, February 1, 20				
		n titled "Type", the box	, ia		the Medical Executive Committee				
		Restraints (wrist, ankle	,		Thursday, February 9, 2017. The				
		cify how many restraint	s are		compliance is 90%. Any score be				
	to be applied by the h	nospital staff.			will require remediation with the a employee and/or further analysis				
	2 On 42/15/2046 at 2:00 PM Curroup #2				possible system issues. 100% of				
	3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital 's primary restraint				restraint charts are being audited				
		ber #7) about how man							
		sed when physical rest							
		sician, Staff Member#							
		istered nurse determin are initially used. The s							
	member acknowledg		otan						
		estraining both the arm	s and						
		aint is only used in rare							
	occasions.								
	4 On 40/44/0040 and	d 4014E/0048 . O	- 40						
		d 12/15/2016, Surveyor on/restraint records of	7#3						
		oting that hospital staff							
		nd #6 in both physical				ļ			
		ion simultaneously on							
		2016 respectively based	d						
		er. No documentation restrictive alternative h	امما						
	_	restrictive alternative in attempted first prior to the							
	simultaneous applica								
	restraints and seclusi								
	•								
A 174	482.13(e)(9) PATIEN SECLUSION	IT RIGHTS: RESTRAIN	IT OR	A 174					
	Restraint or secturior	n must be discontinued	af						
ļ		ime, regardless of the l							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/OUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		504011		B. WING 12/2		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY ROAD SOUTH ILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES F BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	ON D BE PRIATE	(X6) COMPLETION DATE		
A 174	Continued From page 11			A 174				
A 174	of time identified in the This Standard is not read to the Standard is not read to the Standard is not read to the Standard is not read to the Standard is not read to the Standard in the earliest possible time psychological harm, Infreedom. The hospital's policies and Physical (Revised 2/2016; Policies to "PATIENT Rie" (Restraints or seclusical earliest possible time 2. On 12/15/2016 at a interviewed the hospitrainer/educator for standard restraints (Staff Masked Staff Member a released from seclusical acknowledged that the physician would revisible havior to determine could be discontinued.	e order. met as evidenced by: ew, interview, and revie procedures, the hospita patients were released est possible time for 3 of atients #3, #4 and #5). Idents from seclusion at puts patients at risk for oss of dignity, and pers ey and procedure titled cal & Mechanical Rest icy # PC.R. 100) under GHTS" read in part: on shall be ended at the " 1:15 PM, Surveyor #3 tal's principal taff on the use of seclut Member #7). The surve #7 when a patient should ion. Staff Member #7 the trained registered nut ew and assess the patic et if seclusion or restrain the When asked by the inappen if the docume	al from of 6 the r sonal raint" the ne sion oyor uld be arse or ant's onts		The Clinical Educator reeducated nu on the requirement of releasing patiseclusion and restraint at the earlies time. The education included an emde-escalation techniques as well as of the the rapeutic interventions. The Clinic provided the education during Nursimeetings through the use of written communication and return demonst Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will aurestraints and seclusions for release earlies possible time. Any clinical iss to length of use requiring corrective be addressed by the COO/CNO. Restaudit will be reported by the PI/RM the monthly PI and quarterly MEC at Governing Board meetings.	ients from it possible inphasis on other cal Educator ing staff cration. dit all at the ues related actions will ults of the Director in	2/10/17	
	indicated the door she patient released from 3. On 12/13/2016 at 1		he					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		604011		B. WING		12/21	/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
CASCAD	E BEHAVIORAL HOSP	PITAL		MILITARY ROAD SOUTH /ILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
A 174	psychiatric unit (2 We the medical record of into seclusion on 12/released from seclus was placed in seclusigrabbing a food cart repeatedly striking the Documentation on the indicated the patient's "resting" or "sleeping AM, a period of 90 m written at 10:30 AM in resting on the bed with verbalized understant seclusion. "Will discost affing allows for 1 to 4. On 12/14/2016 and reviewed seclusion/re Patients #4 and #5 and a. Hospital staff place and restraint on 9/29/him/her from seclusion of 28 hours. Surveyor observed documente resting for the following restriction of 2 hours andFrom 9/29/2016 at 7:45 AM, a period of 2 hours.	est), Surveyor #3 review Patient #3 who was play 1/2016 at 8:30 AM and ion at 11:30 AM. The play ion after being observe and running down a hase cart against the wall. It is esclusion flow sheets observable behavior: from 9:00 AM to 10:30 inutes. A progress note indicated the patient wath eyes closed and ding for the need for intinue seclusion when to 1 support." If 12/15/2016, Surveyor estraint flowsheet record noted the following: and noted the patient's department #4 in seclusion which are until 9/30/2016, a per #3 noted the patient's department in the patient in the	aced atient d llway as 0 as 0 as or FM, a 0/2016 5 AM,	.,,	Amendment 2/1/2017: Seclusion restraint forms were changed to with standards and staff were edithose changes. Audits are alreal progress and the results of which shared at the weekly PI Committed Wednesday, February 1, 20 the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the amployee and/or further analysis possible system issues. 100% or restraint charts are being audited.	comply ucated on dy in will be ee to be 17 and to o on e target elow 90% affected of f all		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1' '	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		504011		B, WING		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET AODR	ESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSE	PITAL	1	IILITARY RO .A, WA 9810	DAD SOUTH 38		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		(D PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULO BE	(X5) COMPLETION DATE
A 174	b. Hospital staff place 12/11/2016 at 10:30 seclusion on 12/12/20 noted the patient's of behavior on the section "sleeping" from 11:35 of 7 hours and 40 min no evidence in the second indicate the hospital of the patient from section.	ed Patient #5 in seclusi PM and was released to 016 at 7:15 AM. Survey oserved documented usion flow sheet as 5 PM until 7:15 AM, a p nutes. The surveyor for eclusion documentation staff considered remov	from for #3 eriod und to ing	A 174	Con 20272 A0286 A0209 A048	on.	
A 203	The hospital must de maintain an effective data-driven quality as improvement program. The hospital's govern the program reflects hospital's organizatio hospital departments those services furnish arrangement); and for to improved health or and reduction of med. The hospital must may evidence of its QAPI.	ning body must ensure the complexity of the on and services; involved and services (including hed under contract or ocuses on indicators rel utcomes and the preve- lical errors. aintain and demonstrate program for review by:	that s all g ated intion e CMS.	A 2003	See A0273, A0286, A0309, A049	iO,	
	and review of the hos	n, interview, record rev spital's quality program n, the hospital failed to					

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1	E CONSTRUCTION	(X3) DATE SI COMPLE	
		504011		B. WING	(198 -11) - J. J. H. Million (1980) - Market (12/	21/2016
	OVIDER OR SUPPLIER			ESS, CITY, STA	TE, ZIP CODE DAD SOUTH		
CASCADE	BEHAVIORAL HOSF	TIAL		A, WA 9816			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
A 263	Improvement (QAPI) Failure to systematic hospital-wide perform action plans to improthat data limited the ilproblems and formula Findings: Failure to identify plasufficient personnel tromplexity, and need improvement Program Failure to collect and performance measur Governing Body, Per Committee and the Macondition of the control of t	ent a hospital-wide, ssessment and perform program. ally collect and analyzed ance data and to develope performance based hospitals ability to identiate action plans. armaceutical services less of the patients serve ersight of the Performance; analyze data for reseassigned by the rformance Improvement dedical Staff for the year analyze and track advernancess for identifying a process for identifying analyze and track advernancess for identifying analyze and track advernancess for identifying analyze and track advernances for identifying analyze and track advernances for identifying analyze and track advernances for identifying analyze and track advernances for identifying analyze and track advernances for identifying analyze and track advernances for identifying analyze and track advernances.	elop on on diffy acking d. nce	A 263			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	1/2016
	ROVIDER OR SUPPLIER		STREET ADDRE			I	
CASCADI	E BEHAVIORAL HOSF	PITAL	1	LITARY R 4, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X6) COMPLETION DATE
A 263	The cumulative effect resulted in the hospit opportunities to improut outcomes of care. Due to the scope and cited under 42 CFR 4 Participation for Qual Performance Improve MET. Cross Reference: A-(A0490, A0700 482.21(a), (b)(1), (b)(1) (c)(1) (d)(1) (t of these systemic pro- al's inability to identify ove patient care, safety diseverity of deficiencies 82.21, the Condition of ity Assurance and ement Program was No 0273, A-0286, A-0309, 0273, A-0	d and description of to-		A 0273 Corrective Actions The PI Director reviewed the list of performance indicators, assigned by Governing Body, PI Committee, and Staff for 2016. Of note, the following data was aggregated, analyzed, and to the PI and MEC committees for as of patient care processes. Grievances -Anticoagulation therapy and medicate reconciliation upon admission and descraint/Seclusion -Elopement rates and medication valued and consultations/treatment contracted Services -Pharmacy and Therapeutics (drug umedication variances, adverse drug antibiotic usage, and nursing unit/michecks)	Medical g clinical presented ssessment ation lischarge criances	2/10/17

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE			
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	OVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	ITAL		4 MILITARY ROAD SOUTH					
			IUKWIL	.A, WA 981	98				
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A 273	Continued From pag	e 16			Persons Responsible: Pi Director COO/CNO		2/10/17		
	quality program and of hospital falled to colles performance measure. Governing Body, Performance and the M 2016. Failure to measure, a related to performance leaves the hospital ur concern that may require findings: 1. Review of the Performance Database hospital was to collect different performance performance measure person for data collection a quarterly basis. 2. Surveyor #2 intervises (Staff Memb Measure data collection 12/16/2016 at 1:45 revealed the following a. The Performance Measure Action 12/16/2016 at 1:45 revealed the following a.	nd review of the hospitiquality documents, the set and analyze data forces assigned by the formance Improvement ledical Staff for the year analyze and track data se measures as assignmable to identify areas ouire improvement. Dormance Improvement and a document titled "se - 2016" revealed that and analyze data for a measures. Each se was assigned to a specifion and analysis, and was defined. The Gover the performance measures are defined to a specifion and analysis, and was defined. The Gover the performance measures and reports on, analysis and reports on, analysis and reports of PM. The interview of the performance	r t ar ed of Plan at the 16 ecific the ming ures inical ance		Monitoring On a monthly basis, the PI/RM Direct facilitate the tracking and analysis of performance measures for presenta PI committee. Committee members implement action plans as document meeting minutes. Negative or undeswill be discussed by the committee of performance improvement action needed. The Medical Staff and Gove will be informed of data analysis and initiatives on a quarterly basis to enimplementation of the quality and pimprovement program.	f tion to the will ited in Sired trends for initiation as as erning Board I Pl sure			
	Rights and Grievance		of						

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			TUKWIL	WILA, WA 98168					
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Δ 273	Continued From page	e 17		A 273	Amendment 2/1/2017: The 2016	data for			
A 273	grievances. The infor and analyzed by the Director and the Patie to the Performance In monthly. There was r information presented Director stated that the not been meeting and collected or analyzed b. The Performance I Patient Safety Goals' hospital was to collect were reviewed by Sulikelihood of patient hanticoagulant therapy Medication Reconciliadischarge. The Chier Risk Manager were recollection and analys Committee and the Gommittee and the Gommittee and the Gommittee and the Gommittee and the Gommittee and for reporting morand Governing Board patients placed in respected by the Performance of the Performance of the Gommittee to the Gommitt	mation was to be colled Performance Improvement Advocate, and reported performance Improvement Advocate, and reported performance Improvement Committed for surveyor review. The grievance committed that the data was not at the data was not an analyze data for, received that the data was not an analyze data for, received with a (Warfarin), and 2) atton upon admission a for Nursing Officer and the esponsible for data is, and for reporting to the containing this information review. Measure titled was to measure proper traint and seclusion. The and the Risk Manager was to measure proper traint and seclusion we are improvement werning Board, there was eview related to proper	nent orted o		Amendment 2/1/2017: The 2016 grievances, anticoagulants, restra seclusions, elopements, medicaticonsultations, Pharmacy & Thera indicators, and contracted service been abstracted and analyzed and the PI Committee on or before The February 9, 2017 and then to the Executive Committee on Thursda February 9, 2017 and Governing thereafter. The target compliance Any score below 90% will require remediation with the affected empand/or further analysis of possible issues.	aints & on peutics es have d will go aursday, Medical y, Board e is 90%.			
	d. The Performance I	Measure titled "Risk Safety/Quality" was to							

NAME OF PROVIDER OR SUPPLER CASCADE BEHAVIORAL HOSPITAL SUMMARY STATEMENT OF DEFICIENCY TAG POPULO REACH DEPOCEPTIVE MAST BE PRECEDED BY PLUE REPORT TAG CONTINUED From page 13 A 273 CONTINUED From page 13 Chief Nursing Officer were responsible for data collection and analysis, and for reporting the middle and appriatements of the patient's individual needs. The Performance Measure titled "Medical Consultations of the patient's individual needs. The Risk Manager and Chief Nursing Officer and analysis, and for reporting the middle not need and patient seatures. The Risk Manager and approximate the patient's individual needs. The Performance Measure titled "Medical Consultations for time flowers to the Department and medicalion variances, there was no report containing analysis of the data. a. The Performance Measure titled "Medical Consultations for time flowers to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. 1. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Committee and the Medical Executive Committee. There was no report containing this Information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapoulics" was to measure drug		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	E CONSTRUCTION	(X3) DATE SU COMPLET	RVEY I'ED
A 273 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES GRAPH DEFICIENCY MAY THE PRECEDED BY PILL REGULATORY TAG PROVIDENS PLAN OF CORRECTION PROPERTY OF DESTREYING INFORMATION			504011		B. WNG	·	12/2	1/2016
CA9 ID SUMMANY STATEMENT OF DEFICIENCES PARTICIPATION PRETX TAB PROVIDER'S PLAN OF CORRECTION CRUSHOWN MUST BE PRECEDED BY PILL RESULATORY PRETX TAB PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES AND MUST BE PRECEDED BY PILL RESULATORY PRETX TAB PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES PLAN OF CROSS-REFERENCES PLA	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
A 273 A 273 Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer was to report containing analysis of the data. a. The Performance Measure titled "Medical Consultation for reporting the information quarterly to the Performance Improvement Committee and appropriateness to the patient's individual needs. The Risk Manager and the Medical Consultation for Implement of variances and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer was to measure medication variances, there was no report containing the information quarterly to the Performance Improvement Committee and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer was compared to fast collection and analysis, and for reporting the information presented for surveyor review. 1. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure littled "Pharmacy and Therapeutics" was to measure littled "Pharmacy and Therapeutics" was to measure drug	CASCADE	BEHAVIORAL HOSP	PITAL					
PREFIX TAG ROLS DEPICIENCY MUST BE PROCEDED BY MILL RESULATORY CALL RESULATORY CAS SAFEFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE REGISTANCE OF THE PROPRIATE OF THE PROPRI				TUKWIL	.A, WA 9816	8		
medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract tog for scope of service and quality measures. The Risk Manager and Chief Executive Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug	PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP	OULD BE	COMPLETION
utilization, medication variances, adverse drug	A 273	medication variances and patient satisfactic Chief Nursing Officer collection and analys to the Performance Ir Governing Board. The review the data collection variances was data presented the and medication variances was data presented the and medication variances. The Performance Ir Consultations/Treatmedical consultation appropriateness to the The Risk Manager ar were responsible for and for reporting the Performance Improve Medical Executive Coreport containing this surveyor review. f. The Performance In Services and quality mand Chief Executive Coreport containing this surveyor review. f. The Performance Ir service and quality mand Chief Executive Committee containing this information annually improvement Committee containing this information. Gross-reference: Tag. The Performance Ir and Therapeutics was and T	s, elopements, contrabation. The Risk Manager were responsible for dis, and for reporting momprovement Committee e surveyor requested totion and analysis for and elopement. While to the surveyor for elopences, there was no report the data. Measure titled "Medical ment" was to measure for timeliness and the patient's individual ment Committee and information quarterly to mement Committee and information presented malysis, and for reporting to the Performance tree and the Medical and the Me	and lata porthly e and c there ement ort l eeds. r llysis, b the the c for ted ope of nager le for g this	A 273			

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A 273	reactions, antibiotic union checks. The Properties of the Properti	pe 19 Isage and nursing unit/ harmacist was responsed analysis, and for repoterly to the Performancities and the Medical There was no report nation presented for sur	sible orting e	A 273	A 286 Corrective Actions		
A 200	(a) Standard: Program (1) The program mus to, an ongoing progra improvement in indicevidence that it will medical errors. (2) The hospital must trackadverse patie (c) Program Activities (2) Performance impitrack medical errors analyze their causes, actions and mechaniand learning through (e) Executive Resporgoverning body (or owho assumes full leg responsibility for opermedical staff, and ad-	am Scope at Include, but not be lime am that shows measure ators for which there is ators for which there is ators for which there is ators for which there is ators for which there is and reduce t measure, analyze, and at events s rovement activities must and adverse patient events and implement prever sms that include feedbout the hospital. nsibilities, The hospital' rganized group or indivial authority and rations of the hospital), ministrative officials are buntable for ensuring the	able d at ents, ntive ack s idual	A 200	1) Analysis and Tracking of Adverse Events All elements of the PI plan and 2016 performance improvement activities reviewed by senior leadership, the FI improvement Committee (1/11/17) Medical Staff committees (1/10/17) 1/11/17). The processes for advers analysis and tracking including the R Analysis process was highlighted. 26 analysis and recommendations for a reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director amonthly basis, the PI/RM Director the PI and MEC committees. Neglighted the PI and MEC committees. Neglighted trends will be discussed by committee for initiation of performal improvement actions as needed. The Staff and Governing Board will be in adverse event data analysis and traced.	s were Performance and the and e event toot Cause 016 data action were s. ctor will f Pl esentation ative or by the ance e Medical formed of	2/10/17
	This Standard is not I	met as evidenced by:			quarterly basis to ensure implement performance improvement program	tation of the	

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A 286	ITEM #1 - Analysis at Patient Events Based on Interview, requality documents, the analyze and track additional analyze agadverse patient evento identify root cause and may contribute to environment. Findings: 1. Review of the hospitaled "Incident Report (Policy #RM.200; Appithat the hospital's Risfor collecting incident analysis and trending Review of the hospital improvement Plan (P12/2015) revealed that the Medical Executive Performance Improverisk management act results of incident reppatient complaints to patient care occurrent corrective action is or extent possible. 2. An interview with the Quality (Staff Membe PM and 12/20/2016 a of Clinical Services (Staff Colinical Services)	ecord review and review to hospital falled to meaverse patient events. gregate data related to its risks the hospital's as and develop action properties and proceduring an unsafe patient care for the provided that it was the responsible Committee and the ement Committee to relivities by analyzing the ports, patient surveys a determine patterns of	ew of asure, bility lans e led hibble cal view and dt 1:04 ector		Amendment 2/1/2017: Going for Pi Committee will receive action each Root Cause Analysis condution at time frame for the complet those action items. The Pi Committee and receive action items and received action items are resolved. Action items typically be resolved within 90 dassooner, depending on the urgent associated with that action item. compliance is 90% of all items of with 90 days. Any score below 9 require remediation with the afferemployee and/or further analysis possible system issues	plans for ucted along ion of mittee will receive until all will ays, some by The target ompleted 10% will oted	

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A 286	Continued From pag	e 21		A 286			
	a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patlent grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement.						
	c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement.						
		was not being collecte ose of looking for patte les for improvement.		·	•		
	ITEM #2 - Reportable	Adverse Events			ITEM #2 – Reportable Adverse Even The COO/CNO has educated the Pl	ts	2/10/17
	hospital policies and	ecord review and revie procedures, the hospita ocess for identifying an adverse events.	al 🐪		Director on the requirements of WAC246-302-010. All reportable e outlined in the NQF list of reportable adverse events, the requirement for	l e or	
	Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment.		pth ns.		reporting adverse events and elem of submitting a root cause analysis discussed. All reportable adverse events will be reported in a timely manner in accordance with		
	the list of twenty-nine	-302-010 Definitions t" or "adverse event" m serious reportable eve by the National Quality	nts		WAC246-302-010,		

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED			
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A 286	Forum in 2011, in its reportable events in appendices. WAC 246-302-020 H (1) Notify the department of the account of the acco	consensus report on senealth care including all low and When to Report nent that an adverse he within forty-eight hours of diverse health event of the department within confirmation of the adverse health event must include a root orrective action plan on all Quality Forum (NCs twenty-nine serious ne twenty-nine adverse ng but not limited to: events: (injury of a patient or starm a physical assault (i) within or on the grounds or the state, it must be requirements and stion to Corporate Risk nical Services Departments and eight and sisk Manager investigation Chronolies.	It alth of erse EF) aff e., s of a ing" I that port t be ments."	A 286	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Dire report all adverse events reported WAC 246-302-020 to the PI commit MEC and Governing Board quarter!	oer tee and			

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			TUKWIL	WILA, WA 98168			
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A 286	Continued From pag	e 23		A 286			
	The policy did not inc				A 286 Item #3- Completion of Action	Plans	2/10/17
		vents nor did it include	the				
	requirement for repor	ting adverse events an	d		The COO/CNO and PI Director were t	trained on	
	submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury.				analysis of adverse events and credil	ole root	
				,	cause analysis elements by the Regio	nal Clinical	
					Director. Adverse reportable event	s will be	
					reviewed with credible action plans	formulated	
		sferred to the emergence			and implemented in a timely manne	r.	
		quired follow-up special					
					Persons Responsible:		
	health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the		"		PI Director		
		logy and Incident Reca	p was				
	completed with recon		• • • •		Monitoring		
:	improvement based o				On a monthly basis, the PI/RM Direc present action plans based on analys		
	3. An interview with the	he Manager of Risk and	d		adverse events to the PI committee.	Action	
		r #12) by Surveyor #2	on		plans will include date/s actions take	en and	
		M about the patient to			persons responsible for action. The	Medical	
	•	led that Staff Member#	I		Staff and Governing Board will be in	formed of	
		s particular incident wa			actions taken in response to adverse	events on	
		se event by NQF. Staff			a quarterly basis to ensure impleme	ntation of	
		hat a root cause analys ted nor had the inciden			the analysis and actions taken in res	ponse to	
		State as required by ho			adverse events.		
	policy.	diate as required by no	apitai				·
	- Laurah						
	ITEM #3 - Completion	n of Action Plans					
	Based on interview a	nd document review, th	1 0 -				
		ure completion of action			-		
	plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm.						
	Findings:						

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A 286	1. Surveyor #2 revise for 3 adverse events for 3 adverse events. Services (Staff Men 1:25 PM and with the Quality (Staff Memb AM, Review of the accorrect identified issen. For the elopemer change the policy "C staff of a patient when the nursing unit) to completed although E was being used by b. For the sexual as items was a change followed by audits to were properly conditionally in the property conditional precaution for the sexual as items was a change followed by audits to were properly conditional services.	ewed the root cause and a with the Director of Climber #13) on 12/16/2016 we Manager of Risk and wer #12) on 12/20/2016 a action plans developed to ues revealed the following issue, the action item to Code Amber" (used to also has wandered away frode E" had not been staff were trained and C	nical at t 9:20 o ng: to ert om code ction nts risk taff	A 286				
A 309	The hospital's gover group or individual value authority and responsionally, medical strong the following the foll	rning body (or organized who assumes full legal naibility for operations of taff, and administrative sible and accountable for org: program for quality atient safety, including the orgen of the organization of the	the r ne nt		A 309 Corrective Actions The PI Director and Medical Director all elements of the PI plan and 2016 performance improvement activities Medical Staff and MEC committees (and 1/11/17). The processes for clir non-clinical analysis and tracking wellighted. 2016 data analysis and recommendations for action were rethe MEC. The Medical Staff assigned representation to the Infection Contipharmacy & Therapeutics, EOC, Safe Performance improvement committee participants will report coactivities to the MEC at least quarter	s with the 1/10/17 nical and re eviewed by d physician rol, ety and ees. These	2/10/17	

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A 309	Continued From pag	e 25		A 309	The MEC reviewed the 2017 Pl Plan		2/10/17	
	evaluated. (5) That the determin	provement actions are nation of the number of projects is conducted			recommended priorities for quality a performance improvement activities Persons Responsible: Medical Director President of the Medical Staff			
	Based on interview a performance improve Governing Body faile ensure that the qualit performance improve implemented. Failure to provide over Assessment and Perprogram to ensure ful performance Improve hospital's ability to ide	ment (QAPI) plan was	fully		Monitoring On a monthly basis, the PI/RM Direct facilitate the tracking and analysis of measures for presentation to the PI committees. Negative or undesired to be discussed by the committee for in performance improvement actions at The Medical Staff and Governing Bolinformed of data analysis and PI init quarterly basis to ensure implement quality and performance improvement	f PI and MEC trends will nitiation of as needed. ard will be latives on a cation of the		
	1. The hospital's Perf (Policy #RM. 300; Ap "Medical staff and ma leadership for and ac performance improve criteria for measuring organization performance-clinical processe They assure implementality assessment a and report the results	ement activities and est ance of both clinical an s and patient outcomes entation of appropriate and improvement activity to the Board through to committee and Performa	d that e ablish ring d s.					

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AS CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE			
A 309	Continued From pag	e 26		A 309						
	The Medical Executive the Authority and Accidelivery and assessment contribute to the preventional improvement appropriateness and outcomes. Medical Exesponsibilities, duty performance improvement the Medical Staff B. The hospital's Medical 2/1/2013) under the Executive Committee Management: (a) The overseeing quality as improvement are to evaluation of the quality as improvement are to evaluation of the quality comment improvement outcome studing performance of this formation of the quality (Staff Member Clinical Services (Staff Member Clinical Services (Staff and Performance Improvement participate in performance Improvement activities other than the credentialing and privalent formally evaluated Medical Staff Bylaws	ve Committee is delegated ountability necessary for the first of all processes the rention of problems and the first of the quality, efficiency of patient can executive Committee and authority for ement activities are deficiency. It is a section titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "Medical exection titled "medical exection at least an an allity management program is exected in patient care execution in a report on a section in a report on a first Member #13) reveal exector is a member of the execution of the ex	or the at at at at at at at at at at at at at							
	Cross Reference: A-0	0273, A-0286								

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			TE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B, WING		12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL			OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 405	Continued From pag	ge 27		A 405	A 0405 Corrective Actions		
A 405	482.23(c)(1), (c)(1)(f) OF DRUGS (1) Drugs and biolog administered in accostate laws, the order practitioners respons specified under §482 standards of practice (i) Drugs and biological administered on the not specified under § practitioners are actiliaw, including scope policies, and medical regulations. (2) All drugs and biological administered by, or corother personnel in and State laws and rapplicable licensing	icals must be prepared ordance with Federal and is of the practitioner or sible for the patient's care 2.12(c), and accepted a corders of other practitions 482.12(c) only if suching in accordance with S of practice laws, hospital staff bylaws, rules, and accordance with Federegulations, including requirements, and in approved medical staff	and d e as nd ners tate al d rsing	A 405	The Clinical Educator reeducated th staff on the requirement of administ medications as ordered for the treat alcohol withdrawal. The Clinical Edu provided education during Nursing s meetings through verbal and writter communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will per random audit of at least 30 records to ensure compliance of 90% or aboconsecutive months. Any deficiencie promptly addressed. Audit results we presented to the monthly PI and quand Governing Board meetings.	erform a per month ve for four es will be	2/10/17
	Based on record revipolicy and procedure that nursing staff foliatreatment of alcohol reviewed (Patient #7 Failure to follow such receiving inadequate which may result in process.	n orders risks patients e or improper treatment,	ensure for tlents				
	Findings:						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE			
		504011		B. WING 12/21/2			/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	ITAL		DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH					
			TUKWILA	ILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE		
A 405	1. The hospital's poli "CIWA" [Clinical Instit Assessment] (Policy: 12/2013) established be assessed for symphow the patient's symusing a withdrawal as medications were to be the patient's score. The pre-printed order set Alcohol Withdrawal" (physicians to order set Medications to be adepatient's withdrawal at 2. Review of the medications who experient withdrawal during the following: a. Patient #7 was a 56 admitted on 12/10/20 withdrawal, On 12/10/20 withdrawal, On 12/10 patient's physician or Withdrawal Protocol is alcohol withdrawal sympatient #7 revealed patient #7 revealed patient #7 revealed and 1 mg of Lorazepatients alcohol withdrawal withdrawal sympatients alcohol withdrawal the score assigned at patient's dose of Lora	cy and procedure titled tute Withdrawal #AR.C.210; Approved how often a patient was atoms of alcohol withdraptoms were to be score sessment scale and hose administered according policy included a titled "Lorazepam Ordedated 5/15/2014") used decific dosages of ministered based on the sessment score. Itical records of three inced symptoms of alcohol in hospital stay revealed by year-old patient who was at 9:30 PM the dered the Alcohol initiating treatment for mptoms. Ition administration recided that on 12/10/2016 to 12/10/2016	as to awal; ed ow ing to ors for by e hol d the was chol ord ne AM ed ed ed on the en		Amendment 2/1/2017: CIWA pro- currently being audited daily by the Director of CD Services. Analysis audits will go to the PI Committee weekly PI Committee starting We February 1, 2017. The target con 90%. Any score below 90% will remediation with the affected empand/or further analysis of possible issues. Once several weeks of cois achieved, monitoring will become with the same targets.	e Nursing s of the at each dnesday, npliance is equire bloyee s system compliance			

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DE CORRECTION IDENTIFICATION NUMBER:					(X3) DATE S COMPLE	
		504011		B. WING		12/	21/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE				
CASCADE	BEHAVIORAL HOSE	PITAL		LITARY RO A, WA 9816	DAD SOUTH S8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	Offed BE	(X5) COMPLETION DATE
A 405		now why nursing staff		A 405			
A 490	that meet the needs institution must have registered pharmacis under competent sup is responsible for deprocedures that minifunction may be deletered pharmace. This Condition is not. Based on observation review, the hospital of pharmaceutical servicemplexity, and need in the provide administration practicular. Failure to provide administration practicular. Findings: 1. Medications being prior to pharmacy ve	ave pharmaceutical service of the patients. The a pharmacy directed best or a drug storage are pervision. The medical eveloping policies and mize drug errors. This agated to the hospital's autical service. The met as evidenced by: In, interviews, and docurate to provide sufficient to provide sufficient to meet the scope, do of the patients served equate pharmacy serviced safe medication	y a a staff ment nt d. ces	A 490	See Tags A0491, A0493, A0500		
	overrides. 2. Patient home med a pharmacist prior to 3. Medication errors overrides of the auto	lications not being verif	iedby on nes.				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		1''	EE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	504011			B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSE	PITAL		LITARY RO A, WA 9810	DAD SOUTH 88		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
A 490	Continued From pag	je 30		A 490			7.411
7 490	and patient census wincrease in pharmacy. The cumulative effect resulted in the hospit safe dispensing, use tracking and control of the scope and under 42 CFR 482.2: Participation for Pharmot MET.	vithout a comparable y services coverage. It of these systemic pro- ial's inability to provide and administration, an of medications.	for d ss as				
A 491	The pharmacy or dru administered in acco professional principle. This Standard is not Based on observatio policy and procedure that hospital staff foliuse of a patient's own Failure of staff to foliopatient's own medicator harm due to medications. 1. The hospital policy "Medications Brough	met as evidenced by: n, Interview, and review the hospital failed to cowed hospital procedu n medications. ow procedures for use tions places patients a	v of ensure res for of a t risk		A 0491 Corrective Actions The Clinical Educator reeducated th staff on policy titled "Medications Brown with Patients." Education was provided for the process of home medications. Education—Use of home medications only after verification process is complete.—Proper labeling and initialing of the process on home medication bottles—Physician orders needed for use of medications. The medical staff were educated or requirement of documenting dosage medication administration and order allowance of patient home medication decent the process of t	rought in ded during hal and included: r the verification home the es for home ering ons.	2/10/17
		ons that will be used by dmission at the facility,			Pharmacy Director COO/CNO		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE		
		504011		8, WING_	1.04	12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSF	PITAL	12844 M	IILITARY R	OAD SOUTH			
			TUKWIL	UKWILA, WA 98168				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	! }	lD .	PROVIDER'S PLAN OF CORRECTION	ON	(XB)	
PRÉFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE	
TAG	OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	-KWIE		
0.404		04		A 404	Monitoring	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
A 491	Continued From page 31 medications will be inspected for proper			A 491	The PI/RM Director/designee will pe	rform a	Į	
	identification, labeling, and visual evaluation as				random audit of at least 30 patient's			
					medication orders to ensure compli		1	
	part of the pharmacist verification process. Once a medication is verified, the pharmacist will place				the verification process. Any deficie			
•	a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's				addressed promptly. Audit results w			
	a sticker on the packaging with the pharmacist's initials and date the medication as evidence the				reported in the monthly PI and quar	1		
	medication has been				and Governing Board meetings.	terry wile		
					and doverning board meetings.			
		ent to take his/her own	٠.		Amendment 2/1/2017: The pharm	acv		
					director is auditing 100% of home			
	medication must be written by the attending physician on the Physician's Order form."				medications and will first report h		ŀ	
	- 14 44 11				to the weekly PI Committee on W		i	
		cation room of three pai			February 1, 2017, to the Medical			
		ch, Rehab and Detox) (2:00 PM and 3:00 PM	on		Committee on February 9, 2017			
	revealed the following				Governing Board thereafter. Auc			
	Tevealed the lollowing	9•			continue until several weeks of c		ļ	
	a. One bottle of home	e medication, Latuda 13	20 ma		at or greater than 90% has been		ŀ	
		r Patient #8 in the patie			and sustained. The target compl			
		e Rehab unit medicatio			90%. Any score below 90% will			
		st attached a white prin	ter		remediation with the affected em and/or further analysis of possible			
		on bottle with "verified"			issues.	a ayatam	1	
	written on the label a				laguea.			
		ials of the pharmacist.	Staff				İ	
		dication at 9:00 PM on	alas			i		
	verification.	6/2016 prior to pharma	CISI					
	vermeation.	•					ŀ	
	b. Two bottles of hom	ne medications, Provas	tatin					
		s and Dllt [Diltiazem] X			·	ļ		
		ere found for Patient #9			! !			
	patient's medication	tray in the Rehab medi	cation					
		st verified and labeled t						
		"date opened/expiratio						
		n the pharmacy medic	ation					
	verification label. Sta		NA .					
		8/2016 at 9:00 AM. The ler for the patient to tak						
	hls/her own medication							
	Inditor Own moderate	,						
					1	ļ		

	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DE CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	RESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL		12844 MILITARY ROAD SOUTH TUKWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
A 491	300 mg capsules, No Truvada 200 mg table #10 in the patient's m medication room. The written directly on the the Rayataz and Trus unable to tell if the inite evidence of pharmac no pharmacist verification bottles. The label with date and sipharmacist verification were in a plastic bag medication tray. Two one stated that the pland the other note stated way to the bottles administered all three at 9:00 AM. There was administration of the but the order did not d. One bottle of home capsules, was found patient's medication to medication room. The labeled the medication on 12/19/	ome medications, Raya prvir 100 mg tablets and ets, were found for Patinedication tray in the Regional and demodication tray in the Regional and demodication bottle laber and but the surveyor itials and dates were list verification. There wation labels on the two he Norvir medication higharture indicating on. All of these medication placed in the patient's notes were found in the narmacist verified Truvated the pharmacist had one were not attached so for medications on 12/19 as a physician order for patient's own medication patient's own medication. Staff a medication, Dilantin 3 for Patient #11 in the gray in the Gero-psychical pharmacist verified a on. Staff administered to 2016 at 9:00 AM. Their for the patient to take	ent ent ehab ate al (for was vere ad no ions e bag, ada id in v/2016 ons es. 0 mg unit nd he re	A 491					
A 493	adequate number of	IACY PERSONNEL service must have an personnel to ensure qu ces, including emerger		A 493					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SURV COMPLETE			
		504011		B, WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOSP	PITAL	12844 M	4 MILITARY ROAD SOUTH					
			TUKWIL	NILA, WA 98168					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION		
PREFIX TAG		T BE PRECEDED BY FULL RE ENTIFYING (NFORMATION)	GULATORY	PREFIX TAG			DATE		
*NO	\$1, 200 12.			,,,,-	DEFICIENCY)				
A 493	Continued From pag	ne 33		A 493	A 0493 Corrective Actions		2/10/17		
71 100		met as evidenced by:							
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		Upon completion of the survey, the	CEO,			
	Based on document	review and interview, th	ne	COO/CNO, Pharmacy Director, and Regional					
	hospital falled to ensure the pharmacy was staffed with sufficient number of personnel to				Clinical Director reviewed pharmacy				
					order to ensure a sufficient number				
	provide quality pharmaceutical services in order				personnel. Effective 12/20/16, the P	harmacy			
		the patients and the st	aff		Director increased pharmacy staffing	g hours by			
	providing care.				two (2) additional evening hours, se	ven days			
	Enilura ta provida cut	fficient pharmacy staff t	_		per week. The increase in pharmacy				
		timely order processing			prioritized on verification of new ord	ders and			
		places patients at risk o							
	harm due to medicati								
	•		1		Persons Responsible:	}			
	Findings:				Pharmacy Director				
	•				CEO				
		nded its overall bed cap							
		past 12 months. Durin			Monitoring	6.1			
		l nursing units were op West - 24 beds). Prior			The Director of Pharmacy will track				
		ospital's average daily	10		additional staffing hours and report				
		6.58 patients. This yea	r's		In the monthly PI and quarterly MEC				
		1 which represents a 5			Governing Board meetings for a per				
		onal 37.58 patients per			months. Any related deficiencies will	i de			
		cy staffing or coverage	did		addressed promptly,				
	not increase correspo	ondingly despite the			<u>,</u>				
	increased workload.								
					-				
		urveyor #3 reviewed a							
		which captures a variet elements. The surveyor							
		ge number of medicatio							
		monthly increased by o							
-		he beginning of the yea							
	The total number of r								
	performed by nurses	averaged 2,593 per mo	onth	,	,				
		Similarly, the "inventor							
		matic dispensing machi							
		non-controlled substan	ces						
	discrepancies have ir	ncreased to a monthly							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENT/FICATION NUMBE		Γ΄	E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSE	PITAL	12844 M	ILITARY R	DAD SOUTH		
			TUKWIL.	A, WA 9810	38		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID .	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		IT BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPERTY (CONTROL OF THE APPROPROPERTY)		COMPLETION DATE
TAG	OR LSC ID	ENTIFYING INFORMATION)		TAG	DEFICIENCY)	TRINIL	
A 400	0	0.4		V 403	Addendum 2/1/2017: Pharmac	w hae	
A 493	, ,				Increased its hours of coverage in		
	average of 685 items			evening hours. Overrides are be			
	3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing				daily and analyzed for time of day		
					drug, and reason for the override		
					Director and Pharmacy Director v		
		ent workload. Staff Me	mber		present their findings at the week	ly PI	
		e pharmacy workload h			Committee meeting beginning W		
		ed within the past year.			February 1, 2017. Pharmacy hou		
		ting work at this facility			continue to be adjusted as neces		
		no hospital had added t	wo		minimize the use of the override		
	more inpatient clinics				The facility will continue to evalua		
		ase in pharmacy operat			needed by the pharmacy through		
		Staff Member #9 indica paround time for verifyir			recommendations by the contrac provider, number of over-rides du		
		as 30 minutes but may	-		of pharmacist to conduct the first		
		ar depending on volume			review, and medication errors rel		
	new admissions.	i sopononia on raimin			overrides.		
	•						
	4, On 12/19/2016 at	2:30 PM, Surveyor #3					
		ctor of Pharmacy (Staff					
		e high number of medi				·	
		vithin the hospital. Staf					
		at he/she had only bee					
	member of the nospi month" but acknowle	tal staff for "less than a					
:		was "high" indicating t	hat				
		site during the day shif					
		asked Staff Member #8					
	_	harmacy resources. Sta	I				
	Member #8 stated th	at "I don't have enough	ı				
		what we should." The					
		indicated that he/she h					
		tracted hours every we					
	except for the first we	eek when on orientation) .				
	5 On 12/16/2016 of	11:00 AM, Surveyor#3					
		ctor of Adult Psychiatric					
		aff Member #6) about t					
		cation overrides occurr					
		taff Member #6 indicat					
	-		1]

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1''	LE GONSTRUCTION	(X3) DATE SURV COMPLETED	
		504011		8. WING		12/21/	2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		i
CASCADE	BEHAVIORAL HOSE	PITAL	12844 MI	LITARY R	OAD SOUTH		
	·		TUKWILA	A, WA 9810	68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
A 493	Continued From page	e 35		A 493	•		1
A 100	that medication over think medication ove staff member acknow overriding because of to be verified in the s also complained they medications in the au machines on the weat Monday mornings" of	ides is a "problem" sta rrides are dangerous." vledged that nurses we if how long it takes for o ystem. Staff nurses ha if frequently run out of	The re orders ve	,,,,,			
A 500	482,25(b) DELIVER	OF DRUGS		A 500	A 0500 Corrective Actions		2/10/17
7,000	In order to provide position biologicals must be deaccordance with approper consistent with Fede. This Standard is not be assed on document review of hospital position biological failed to ensigned.	atient safety, drugs and controlled and distribute licable standards of praral and State law. met as evidenced by: reviews, interviews, and licies and procedures, ure drugs were control cordance with applicab	ed in actice, ad the		The Pharmacy Director, COO/CNO, Director reviewed the process of moverrides in the automated dispension of the consure safe delivery of medication following system revisions were marked as a system when or needed weekly review of overrides to asset trends, rationale, and any needed improvements	edication ling system. ons, the ide: verrides are	
	medication orders to in a safe and timely and medication error Findings: 1. The hospital police "After-Hour Medicati Pharmacy Review" (PHR-169I) under the Policy" read "The facimportance of pharm	y and procedure titled on Stock with or withou Revised 4/2014; Policy section titled "Stateme	nsed ifety if # ent of		The Clinical Educator educated the medical staff on the revised system oversight of the override system. Exprovided during Nursing and Medical meetings through verbal and writte communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	changes for ducation was al Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	DRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY R	OAD SOUTH				
5,155.12				ILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
A 500	Continued From page 36			A 500	Monitoring				
	to decrease medication errors associated with the				The Pharmacy Director/designee wil	I report on			
	medication-use processThe hospital allows for		I		the total number of overrides with aggregated				
	an exception to pharmacist review of the				trends, analysis, and system improve	ements to			
	medication order for certain situations when time		time		the monthly PI and quarterly Pharm				
	does not permit phan	macist review. This offe	en		Therapeutics committees. Findings,	•			
	does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In				recommendations and actions will b	e reviewed	1		
	such cases, an exception is allowed because				and reported at quarterly MEC and				
·	significant patient harm could result in the delay		elay		Board meetings. Committee minute		,		
	involved for a pharmaclst review of the				data reporting, analysis, and system				
	medication order, and the potential harm would				.				
	outweigh the benefits of a pharmacist review."								
		ırveyor #3 revlewed a							
		which captured a varie		•		· i			
		indicators that included							
		and medication overri	I .						
		he hospital had a total							
		verrides performed by t	nurses						
		ns of 2016. Prior to the							
		pital bed capacity, the 21 medication override	e a						
		ning of the two addition							
		mber of medication over							
	had risen to a monthl								
		ncrease or 479 addition	nal			İ			
		he surveyor noted that							
	number of medication	n variances (potential e	errors)						
	by physicians had inc	creased by four fold sin	ice the						
	beginning of the year	•							
	i. 3. On 12/19/2016 at 3	3:00 PM, Surveyor#3							
		l medication override li	st for						
	the period 12/16/2010								
		M (the weekend) in wh							
		se coverage is only 6 h	ours a						
	day. During this time								
		and there was a total o		-					
'		initiated by the nursing							
		n overrides which occu i of the overrides listed	area						
	over the weekend, 60	O THE CAPITIOES HEIGH							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		Y		
		504011		B. WING		12/21/2	016		
VIVIE OF 000	OVIDER OR SUPPLIER		STREET ADDI	DRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	UTAI		MILITARY ROAD SOUTH					
CASCADE	BEHAVIORAL HOSE	IIOF		LA, WA 9816					
		·			PROVIDER'S PLAN OF CORRECT	TION	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
A 500	Continued From pag	e 37			Amendment 2/1/2017: The m				
, , , , ,		as the reason indicatin	a the	1	will develop a list of medications	which may			
		t verified the medicatio			be overridden. That list is due to	the the	_		
	order in the automated dispensing system. Only		Only		COO/CNO by Tuesday, Februar		į		
	11 medication overrides listed "Emergency Use"				which time an educational event		l		
	as the reason for the				for nursing staff. Overrides will o				
	•		1		monitored daily and trended we				
	4. On 12/19/2016 at 2	2:30 PM, Surveyor #3			presented to the PI Committee v				
		tor of Pharmacy (Staff			quarterly P&T Committee, quart				
	Member #8) about th	e high number of medi	cation		Executive Committee (next mee		ŧ		
		vithin the hospital. Staff			9, 2017) & Governing Board the				
		i that nursing personne			target compliance is 90% of all r				
		any and all medications			overridden will be from the appr				
	hospital's automated	dispensing machines.			incident report will be written by				
	He/she acknowledge	ed that the hospital's en	itire		pharmacist for any meds remov		1		
		sible to all nurses witho	out		not from the approved override	ist and the			
	any restriction.				Nursing Director will follow up w	nn me			
		0.00 414 0			employee and medical provider	as mulcaleu. o romodiation			
		2:30 AM, Surveyor #3	_		Any score below 90% will require with the affected employee and				
		ctor of Adult Psychiatric			analysis of possible system issu		1		
		aff Member #6) about t			care will not be restricted becau				
		cation overrides occurr Staff Member #6 Indica			imposition. It is expected to see				
		rides is a long standing			decline of medication overrides				
		ember confirmed that			week.	week by			
		many medication error		ļ	Wook.				
		ff Member #6 asked to							
		nacy & Therapeutics							
		some improvement or							
		ade on this issue. He/s	he	•					
	acknowledged discu-	ssing medication overri	des in						
ļ Ē		evious pharmacy direct							
	(Staff Member #10) f	former chief nursing off	licer						
		and the quality risk mar							
		and the decision was n	nade						
	to continue to monito	or the situation.		1			[
A 700	482.41 PHYSICAL E	ENVIRONMENT		A 700					
	The hospital must be	e constructed, arranged	i, and	,					
		e the safety of the patie							

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1, ,		DATE SURVEY COMPLETED	_
		504011		B. WING		12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, 8	STATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	TAL	12844 M TUKWIL		ROAD SOUTH 1168		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PRE FIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETI DATE	ON
A 700	and to provide facilities treatment and for spe appropriate to the ne This Condition is not	es for diagnosis and ecial hospital services eds of the community. met as evidenced by:		A 700			
	staff interviews, the h condition of the physi hospital environment manner that the safet was protected.	ns, document review, a ospital failed to ensure cal plant and the overs was maintained in suct by and well-being of part e structural integrity of	the all th a tients				
	maintenance activitie	ufacturer-recommende					
	temperature devices are maintained at the Due to the scope and cited under 42 CFR 4	severity of deficiencie 82.41, the Condition o	atures es f				
	MET.	ical Environment was gs A0701, A0710, A07					
A 701	PLANT The condition of the phospital environment	NCE OF PHYSICAL ohysical plant and the omust be developed an manner that the safety	d	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducate on environmental factors contributing to land self-harm risks particularly related to and handles. Training included mitigation strategies such as patient observation and	igature doors	7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		VEY :D		
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE		····		
	BEHAVIORAL HOSP	OTA!		ADDRESS, CITY, STATE, ZIP CODE 44 MILLITARY ROAD SOUTH					
CASCADE	: BEHAVIORAL HOUP	IIAL .		.A, WA 981					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	(X6) COMPLETION DATE			
A 701	Continued From pag	e 39		A 701	A 0701 Corrective Action		CALLED THE THE CALLED		
,,,,,,	well-being of patients		1						
	This Standard is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors.				Increased monitoring of high risk par Staff required to successfully completering test. 3. Bathroom flooring was repaired	ete post			
					(contractor) on 1-12-17. 4. Ceiling links were repaired by (co 1-12-17. 5. Occluded pipes were repaired by				
					1-12-17 6. Ceiling tiles were changed 1-16-1	:			
	Findings:				Maintenance staff 7. Burnt outlet was replaced by Mai	intenance			
	observed the door in	10:00 AM Surveyor #1 the sunroom in the had a closure mechan	iem		staff by 12/23/16 8. Shower mold was remediated, of removed and the area cleaned and i				
	that posed a ligature				by Maintenance staff (1/9/17)				
		ssment dated August 2	2016.		9. Oscillating fans have been installed	ed in all			
	the facility had identife and assessed it as "I	iled door risks in geriati High" or "Severe Risk". Diumns labeled "What	ic unit		PHP patient care areas. Permanent systems are being evaluated.				
	Action", "Time Frame				Persons Responsible:				
	Mediation Needed" for information provided	or this item had limited in these columns.	or no		Plant Operations Director CEO				
,	2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult		a		Monitoring: The Plant Operations Director/desig perform environmental rounds of th care areas to monitor ligature risks,	ne patient integrity of			
			ed next		flooring/walls/ceilings, furnishings, t cleanliness and structures. Any defi be promptly addressed during the environmental round. Results of the environmental rounds will be report monthly PI committee and quarterly meetings.	ciencles will : ted in the			
	observed in the seclu	ision room on the adult		•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
							,	
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, ST	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL			OAD SOUTH			
			TUKWIL	A, WA 981	68			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
A 701	21 Continued From page 40			A 701	Amendment 2/1/2017: The pir	oes were		
A 701	psychiatric unit (2 We ceiling, the crack app exposed dry wall whe done. On 12/14/2016 PM and 3:00 PM Sun soaked in water on the seclusion room on 2 vactively leaking. Survice what was above found that the three's above were located at the surveyor observed was in use during the 5. On 12/15/2016 betted AM Surveyor #1 obsetthe shower onto the fill 303. During the incide facility staff (Staff Merand pull out small amdid a visual inspection flashlight and found the fill 1:00 AM Surveyor #1 and 11:00 AM Surveyor #1	est) a large crack in the eared to be wet with re work had previously between the hours of a veyor #1 observed towe of floor in the same. West where the ceiling eyor #1 went to 3 West the seclusion room and howers previously state bove the seclusion rood that one of the shower incident. I ween 9:00 AM and 10: eved flooding over the loor on 3 West next to be ent, the surveyor obsermber #17) "snake" the counts of hair. Surveyor of the pipes using a me pipes were occluded ween the hours of 10:20 or #1 observed water ite located in the Rehability of	been 2:00 els was t to 1 ed im, ers 00 nim of room ved drain #1 d. 5 AM D unit		Amendment 2/1/2017: The pip occluded by temporary obstruct have been assessed by an independent, professional plur. The pipes have no on-going nexcept routine cleaning and maintenance. To improve cleamaintenance, the hospital pure distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour the distinct brushes to scour monthly an needed and has been added the and housekeeping rounds. The hospital has switched to psychospital has switched to psychospital has switched to psychospital has switched to psychospital has switched to psychospital will install vented windows in the outpatient group by the processed as possible. The work is expected completed within the next 60 of depending on vendor availability worst-case scenario, the outpatient be installed in the outpatient department, alerting staff if the temperature is excessive. On day basis, these services can	ctions and mber. eeds aning and chased rain pipes s. This das of acility ie in-safe en wet to skylight ip room. being se soon as d to be lays, ity. In a atient her areas r will also a day-by-		
	8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit.		neath	•	relocated to another area in th that is air conditioned.			
	and 3:00 PM Surveyo	veen the hours of 1:30 r #1 entered into an IP Building), the buildir						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		1'	E CONSTRUCTION	(X3) DATE SI COMPLE	
		504011		B. WING		42/	21/2016
							21/2010
	OVIDER OR SUPPLIER			RESS, CITY, STA			
CASCADE	E BEHAVIORAL HOSP	ITAL	•	MLITARY RO LA, WA 9816	DAD SOUTH 38		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	<u> </u>	[D	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
A 701	Continued From pag	e 41		A 701			
	ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.						
A 710	(1) Except as otherw (i) The hospital must provisions of the Life Fire Protection Association of the Federal NFPA 101 2000 editions and January 14, 20 reference in accordant CFR Part 51. A copinspection at the CMS Center, 7500 Security or at the National Arc Administration (NAR/availability of this mat 202-741-6030, or go http://www.archives.cg_federal_regulations/Copies may be obtain Protection Association Quincy, MA 02269. If of the Code are incorwill publish notice in the adopted edition of hospitals.	A). For information on the control of the control o	tion- tional the the the ode, oy a) and ole for the the the the the the the the the the	A 710	A 0710 Corrective Actions The hospital will not require a comply with 482.41(b)(1)(2)(3)		
	findings, CMS may w the Life Safety Code	on of State survey ager aive specific provisions which, if rigidly applied sonable hardship upon	s of				

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C	(X1) PROVIDER/SUPPLIER/GLIA		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 12/21/2016			
	50401			B, WING					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	STREET ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	E BEHAVIORAL HOS	PITAL	l	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE		
A 710	facility, but only if the affect the health and (3) The provisions of apply in a State who safety code Impose protects patients in This Standard is not. Based on observation of the National Fire Protect edition. Findings: Refer to the deficient Care Hospital MEDI reports. 482.41(c)(2) FACILI EQUIPMENT MAIN Facilities, supplies, maintained to ensure safety and quality. This Standard is not litem #1 Medical Supplies of the proview, the hospital care supplies did not designated expiration of the sure patrone of the sure	e waiver does not adver disafety of the patients. If the Life Safety Code dere CMS finds that a fire diby State law adequate hospitals. If met as evidenced by: on, interview, and docum failed to meet the Life Safety Code of the stion Association (NFPA) incies written on the Acut ICARE Life Safety inspections. TENANCE and equipment must be the an acceptable level of the time as evidenced by: on, interview, and recording the safety inspection in the safety code of the time and equipment must be the anacceptable level of the safety inspection, interview, and recording the safety in t	o not and ly nent ction	A 724	A 0724 Corrective Actions #1- Medical Supplies The COO/CNO directed/delegated monthly inspecti Materials Department staff, Nursing Pharmacy staff to ensure that all sup medications are not expired and with specified on the manufacturers label Expired/nearing expiration products properly disposed of timely. All exp supplies and medications were remodiscarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will personnental rounds of the patient to monitor integrity of products, sup medications. Any deficiencies will be addressed during the environmental Results of the environmental rounds reported in the monthly PI committed quarterly MEC meetings.	ions by the staff and oplies and hin date ling. will be direct oved and operform the care areas oplies and e promptly I round.	2/10/17		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CU IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED				
	504011			B. WING 12/2			/2016		
NAME OF PR	OF PROVIDER OR SUPPLIER STI			ADDRESS, CITY, STATE, ZIP CODE					
CASCADE	BEHAVIORAL HOS	PITAL		12844 MILITARY ROAD SOUTH TUKWILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ACTION SHOULD BE COMPLETION DATE			
A 724	OR LSC IDENTIFYING INFORMATION)		nd the et: de for de for s s an	A 724		udits are units. Unit necking the weekly. o to the sday, mpliance is 0% will cted			
	inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4								

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			1'''	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
-		504011		B. WING	. A. A. A. A.	12/2	21/2016		
	OVIDER OR SUPPLIER BEHAVIORAL HOS	PITAL	12844 N	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH WILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE		
A 724	inspected the gero- emergency cart and a. Two 1000 ml 0.99 intravenous fluids w 5/2016. b. Nine 10 ml 0.9% syringes with an experiment of the medication roor three 10 ml 0.9% Syringes with an experiment and 2:25 PM Surve (transparent adhesis	psychiatric unit (4 West) I found the following:	ed s with oured found d	A 724					
	inspected the emer and found the follov a. Two 1000 ml 0.9	t 1:30 PM Surveyor #2 gency cart on the Rehal wing: % Sodium Chloride vith an expiration date of							
	6. On 12/14/2016 b 2:25 PM Surveyor staff (Staff Member the interview Surve	Sodium Chloride pre-fille piration date of 5/2016. Setween the hours of 1:0 #1 interviewed central standard #18). During the course yor #1 asked how often the carts are checked. The	0 and upply e of the						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		ı	LE CONSTRUCTION	(X3) DATE SUR COMPLETE			
		504011		B. WING		12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	PITAL.	12844 M	ILITARY R	OAD SOUTH				
			TUKWIL	VILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	(X5) COMPLETION DATE		
,,,,	***	•		DEFICIENCY)			1		
A 724	Continued From pag	e 45		A 724					
	central supply person was unaware that it was		as						
	part of his/her responsibilities to check the crash								
	carts monthly. He/she stated that he/she had								
	checked the crash carts 4 months previously.			certified contractor to perform the manufacturer recommended maintenance and					
		,	´	cleaning for the Ice machines. All machines					
	Item #2 Ice Machines	\$			were serviced during the week of 1/		2/10/17		
					1/20/17.This certified contractor will		2/10/17		
	Based on observation	n, document review an	d		Plant Operations Staff on proper cle				
	interview the hospital	failed to follow			techniques.	dim'ig			
	manufacturer's instru				ceciniques.				
	maintenance, installa	ition and routine cleani	ng of		Person Responsible:				
	its ice machine.				Director of Plant Operations				
					Director of Plant Operations				
		ufacturer's instruction f			Monitoring: The Plant Operations				
		nce, routine cleaning a	nd		Director/designee will perform mon	thle			
	installation, promotes		W4			-			
		ch places patients heal	ith at		inspections of all ice machines to me				
	risk.				cleanliness and operations. Any def				
	Boforonno: Eallatt Sa	ries/W, MCD400A/W,			will be promptly addressed during the				
		./W, D400A/W Ice Mac	hines		environmental round. Results of the				
		n and Service Manual			environmental rounds will be report				
		455 stated on page 15	00,,6,1		monthly PI committee and quarterly	VIVIEC			
		of incorrect installation.			meetings.				
		ect installation as follo	wed:						
			1						
	Dips in tube where w	ater can collect							
	Splice or tight bend the								
		t results in wet ice and							
	potential dispensing p	problems							
		mphony Plus: On page	e 4 the						
	following was noted:		ł						
		10 ft. (3 m) of dispens							
		ed and insulated. Maint							
	that at least 1/4" per foot (20 mm per 1 m) run of slope."		un of						
	D-fourmet: F7-H-44.1	. manahina 400 Canta -							
	I *	e machine 400 Series a Machine Manual state							

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING		(X3) DATE SURVEY COMPLETED				
		504011		B. WING		12/2	1/2016			
NAME OF PR	OVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE						
CASCADE	BEHAVIORAL HOSF	PITAL.	1	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE			
A 724	following cleaning fre page 14 and 17: "the sanitizing ice machin below:" Semi-annually preve Drain Line - weekly Drain Pan/Drip Pan - Findings: 1. On 12/13/2016 be and 1:45PM Surveyor from a Follett Ice Marto the floor drain. The the patient kitchen as preventive maintenant 9/2016 and the grate build-up. 2. On 12/14/2016 be and 10:00 AM, Surveyor hospital plant manage Member #19 stated is maintenance was be a company to get the how often they get publishe said, annually	equency for both models frequency in cleaning e according to the scheen tive maintenance weekly tween the hours of 1:00 or #1 observed a drainchine was not slope to go ice machine was located on the Rehab unit. Ince sticker was past due on the drip pan had restricted the ice machine was the ice machine was the ice machine was the ice machine was the ice machine so they contracted in caught up. When as reventive maintenance, y. In review of work ord MacDonald-Miller" it should be according to the intervence of work ord MacDonald-Miller" it should be according to the intervence of work ord MacDonald-Miller" it should be according to the intervence of work ord MacDonald-Miller" it should be according to the intervence of work ord MacDonald-Miller" it should be according to the scheen can be accord	and edule DPM line grade ded in The sidue D AM Staff nine d with sked	A 724						
	maintenance betwee September but the w which machines were included in the preveraddition, Surveyor # generated from the ha "Follett" ice machinescheduled for prever 2/11/2015, was cross	on the months of July the rork order did not indicate done and what was entive maintenance. In a reviewed a work ordenospital system that indicate on 3-North unit was notive maintenance on sed out and a hand write provided to Indicate who	r icated iten							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY COMPLETED		
,		504011		B. WING	Action to the state of the stat	12/21	/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
	BEHAVIORAL HOSP	ΙΤΔΙ	12844 M	4 MILITARY ROAD SOUTH					
O'UOO'U	, pulling out and indeed	,,,,,		WILA, WA 98168					
			· .	**************************************	PROVIDER'S PLAN OF CORRECTION	ON T	(X6)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
A 724	Continued From pag	e 47		A 724	,	ļ			
	work was done.		ŀ			į			
. 1	Work Had donor		,			1			
	and 2:45 PM Surveyo	tween the hours of 1:00 or #1 observed soil buil Irain line of the ice mad unit.	dup						
A 726	482.41(c)(4) VENTIL	ATION, LIGHT,		A 726	A 0726 Corrective Actions		2/10/17		
	TEMPERATURE COL				The Dietary Manager purchased nev	w digital	2/10/1/		
					thermometers and provided training				
-		r ventilation, light, and			the new thermometers. The Dietar				
		in pharmaceutical, foo	d		reeducated all dietary staff on the p	, -			
	preparation, and other				techniques and requirements of obt				
		met as evidenced by:			temperatures and maintaining refrig				
		n, the hospital staff faile				gerator and			
		nd procedures consiste			freezer temperatures. All required	aggad daibe			
		State Retail Food Code			temperature requirements will be lo	ogged daily.			
		ederal Food and Drug			B	1			
	Administration.				Person Responsible:				
	Callena ta fallano tha f	land and a plane and a			Director of Dietary				
		ood code places patier isk for foodborne illnes			and the second of the second o	1			
	Stan, and visitors at i	ISK IOI IOOGDOINE IIIIES	3,		Monitoring: The Dietary Director/de				
	Findings:				perform weekly inspections of all fo refrigerator, and freezer temperatu monitor adherence to the WAC 246	res logs to			
	1. On 12/12/2016 bet	lween 11:00 AM and 12	2:15			1			
		erved two containers o			and FDA3-501.14 codes. The Dietar	- 1	,		
		inches in the walk-in co			Director/designee will perform wee				
		is with a depth greater			observation monitors of staff perfor	_			
		locument temperature			temperature checks. Any deficience				
		oods cool within the rec			promptly addressed during the mor				
		s specified by Washing			of the both monitors will be reported				
		de. The hospital did no	t		monthly Pi committee and quarterly	A IMEC			
	document cooling tim	nes for thepasta.			meetings.				
	D 6 144	lan Olaka Batak Es / 10							
		ton State Retail Food C 5. FDA Food Code 3-50							
	VVAG 240-215-03515 	i. MDA LOOG COOR 3401	71.14						
	l	tween 11:00 AM and 1 erved dietary staff (Stat							

		(X1) PROVIDER/SUPPLIER/CLIA		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETE	D				
		504011		8. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL	12844 N	MLITARY R	OAD SOUTH			
			TUKWII	LA, WA 981	68			
(X4) (D	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	NC	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)		COMPLETION DATE	
A 726	Continued From pag	e 48		A 726	Amendment 2/1/2017: Daily at	udits are		
	, ,	food probe thermome	ter		being conducted in the kitchen. I			
		king the temperature of			is under revision. Staff education			
	"Ruben Sandwich". T	he thermometer			process. The dietary manager w			
		r is located half way up	the		responsible for monitoring real-tir			
		ed only the tip into the			compliance related to food tempe			
		tentially giving an inacc			throughout the department. The		-	
		thermometer used by t			Control nurse will double check, o			
		d to temp thin foods su			weekly basis, to make sure staff a complying with standards. The re			
	meat patties, fish title	ts, and other thin food i	terns.		those audits first go to the weekly			
	In addition Suprover	#11 chacked to see the			Committee on Wednesday, Febru			
		Surveyor #1 checked to see the Committee on Wednesday, February 1, ar's accuracy by placing the 2017. The target compliance is 90%. Any						
		other thermometers in a	ın İ		score below 90% will require rem			
		l 32 degrees Fahrenhe			with the affected employee and/o			
	Ū	temp the "Ruben Sand			analysis of possible system issue			
		ees Fahrenheit, 12 deg						
	off calibration. Dietar	y staff (Staff Member#	20)				-	
	confirmed this.							
					A 0749 Corrective Actions			
		ion State Retail Food C	ode,			3	2/10/17	
•	WAC 246-215-04335		han al ac		1) The Infection Control Practitione	r	2/10/17	
	WAC 246-215-04580	ton State Retail Food C	oae,		reeducated the nursing staff on the			
	VV/IC 240-210-04000	,			of hand hygiene per policy during m	edication		
	•				administration. Education was provi	ded during	-	
A 749	482.42(a)(1) INFECT	TION CONTROL PROC	RAM	A 749	staff meetings through verbal and w	ritten -		
	The infection control	afficar or afficare much			communication.			
		officer or officers must identifying, reporting,						
		ntrolling infections and			Persons Responsible:			
	communicable disease				Infection Control Practitioner			
	personnel.	and at harrentes miss						
	Process measures?				Monitoring			
					On a monthly basis, the Infection Co			
	This Standard is not	met as evidenced by:			Practitioner/designee will monitor h			
	•				hygiene during medication administ			
	Item #1 Hand Hygien	10			a minimum of 10 medication passes			
					Any deficiencies will be addressed d	-		
		n and review of hospita			medication pass. Monitoring results			
		, staff failed to perform	nand		reported during the monthly PI and	quarterly		
	hygiene prior to and	aner administering			MEC meetings.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		604011 B. WING 12/21/2					/2016		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE	<u> </u>			
	BEHAVIORAL HOSP	ITAL.	12844 N	ILITARY R	OAD SOUTH				
			TUKWII	A, WA 981	68				
(X4) ID	STAMMARY	ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON T	(X6)		
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	COMPLETION DATE			
A 749	Continued From pag	e 49		A 749	2) The Dietary Manager obtained n	ew			
	medications				thermometers designed to measure	food			
					temperatures properly. The Dietary	Manager	-		
	Failure to perform had	nd hygiene puts patien	ts and		educated the dietary staff on the pro-	-			
	staff at risk for infection				the food thermometers with an emp				
					accurate insertion. The education w				
	Findings:				during staff meetings with the use o				
					written communications				
	1. Facility policy titled								
		d 10/2016 read in part:			Person Responsible:				
		R HANDWASHING A	I		Dietary Manager				
		econtaminate hands be							
	Decontaminate hands	ect contact with patients	s F,		Monitoring				
			. Decontaminate hands The Dietary Manager will perform a minimum						
	7		ids or excretions, of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any						
	mucous membranes.								
					deficiency will be promptly addresse				
	2. On 12/13/2016 at 9	9:00 AM Surveyor #4			of the audit will be reported in the r				
	observed a registered	d nurse (Staff Member	#14)		and quarterly MEC meetings.	· I			
	administer oral medic	cations to a patient. S/h	e did		, .		İ		
		jiene (HH) before prepa			3) The Infection Control Practitione	r			
		though s/he came in c	ontact		reeducated the housekeeping staff of				
	with the patient's oral				following procedures for proper clea				
	administration, did no	ot perform HH afterward	ä.		patient care areas:	-			
		TAR AND COMPANION HAD			-Allowing for a 10-minute contact ti	ime when			
	3. On 12/13/2016 at 9	d nurse (Staff Member	#1E\		using Virex 256 disinfectant solution				
		ations to a patient. S/h			-Avoidance of cross-contamination	when using			
	not perform HH prior		io dia		cleaning brushes.				
i	,	te numerous contacts v	vith		Proper dusting procedures to avoid	patient			
	the patient's skin.		-,		exposure.	Ť			
					-Maintaining possession of carts at a	all times.			
	Item #2 Dietary Sanit	ation							
	-				Person Responsible:				
		n, the hospital failed to			Plant Operations Director				
		nd procedures to ensur							
		Washington State Reta							
		WAC) and the Federal	l Food						
	and Drug Administrat	IOD.							
				,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		504011		B, WING 12/21/2016					
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	ITAL	12844 MI	LITARY R	DAD SOUTH				
,,,,,		·	TUKWILA	A, WA 9810	68				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON ((X5)		
PRÉFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETION DATE		
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TRIATE			
	D . (1 . LE	- FO		A 740	Manitarios				
A 749					Monitoring The Plant Operations Director will pe	orform			
		food practices places	174 M. JO.		monthly environmental rounds of th				
	patients, starr, and vis liness.	sitors at risk for foodbo	IIIe		care units to monitor contact times,				
	uness.				of cleaning brushes and dusting, and				
	Findings:				maintenance of cleaning carts. Any o				
					will be promptly addressed during th				
	1, On 12/12/2016 bet	tween 11:00 AM and 12	2:15		environmental round. Results of the				
		d a chlorine indicator te			environmental rounds will be report				
		chlorine concentration			monthly to EOC and PI committees a				
		t for in-use wiping cloth			quarterly MEC meetings.				
		ed the tolerance limit of	200		4 may 1 a 7 m				
	parts-per-million (ppn	n) for sanitizer.				}			
	Reference: Machinat	on State Retail Food C	ade						
		(2) (2009 FDA Food C							
	3-304.14)	(-) (-300)							
	,		ŀ						
		ween 11:00 AM and 1	I				l		
		erved signs of algae gr							
		panel of the ice machi	ne						
	located in the main ki	itchen.	ŀ						
	Reference: Washingt	on State Retail Food C	ode.						
÷	WAC 246-215-04605								
	Item #3 Housekeepin	ng Cleaning							
į	 _{max}					1			
		n, review of hospital's p	olicy			-			
		nstructions for use, the							
	cleaning patient room	follow procedures whe	311	•					
	MANIEL PARTICITY TOOM	***			·				
	Failure to follow man	ufacturer's instructions	for						
	use and hospital polic						1		
		infection/illness to patie	ents,						
	staff and visitors.		1						
	Deference \ firev II 0	SS Divorcous "Apple con	,						
İ		56 Diversey: "Apply us porous environmental	7						
		s must remain wet for 1	0						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		504011		B. WING		12/21	/2016			
			OTDECT ADDE	RESS, CITY, STA	7/B CODE	COMMITTEE AND AND ADDRESS OF THE ADD				
	OVIDER OR SUPPLIER									
CASCADE	BEHAVIORAL HOSP	TAL		.A, WA 981	OAD SOUTH 68					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X COMPL DA DA					
A 749	Continued From pag	e 51		A 749	Addendum 2/1/2017: Daily aud	lits are				
·	minutes. Wipe surfac				being conducted in the kitchen. T	he policy				
					is under revision and will be prese					
	Findings:				the PI Committee for approval on	February				
					17, 2017. Staff education is in pro-	ocess.				
		al's policy and procedu			The dietary manager will be respond					
	titled: "Daily Cleaning	of Patient Area" (Revi	sed		monitoring real-time compliance r	elated to				
		l III, "Take cart with you			proper sanitation throughout the					
		art should be within eye	sight		department. The COO/CNO will					
	at all times."				check staff's compliance related t	}				
	0.0-40/40/0040 -14	DeGO ARE Commenced HE			of chlorine solution, on a weekly basis, to make sure staff are complying with					
	2, On 12/13/2016 at 8	s:30 AW Surveyor#1 eper (Staff Member#21			udits first					
		eper (Stail Member #2) of a patient room, applie								
		of a patient room, applied go to the weekly PI Committee on Wednesday, February 8, 2017. The target								
		eded to wipe it off with								
			ed to wipe it off with a dry compliance is 90%. Any score below 90% did not allow 10-minute will require remediation with the affected							
		red per manufacturer's			employee and/or further analysis					
	instruction for use.	·			possible system issues.					
	3. On 12/13/2016 at 9	9:38 AM Surveyor #1			Additionally, daily audits are being	a l				
		eper (Staff Member #22	2)		conducted throughout the hospital					
	during a daily clean o	of a patient room. The			observing housekeepers in their of	iaily				
		e housekeeper use a b			routines. Staff education is in pro					
		or after cleaning a toile	t with		facilities director will be responsib					
	the same brush.				monitoring real-time compliance i					
	A On Antionnaid at	20 A 6 A 8 A 6 C	ļ		procedures when cleaning patien					
	4, On 12/13/2016 at 9	∌:45 AM Surveyor #1 eper (Staff Member #22	,,		The Infection Control nurse will de					
	during a daily clean o		•		check, on a weekly basis, to mak					
		e housekeeper dusting			staff are complying with standard					
		e nousekeeper dusting patient's head while a p			results of those audits first go to t					
		ally exposing the patie			PI Committee on Wednesday, Fe 2017. The target compliance is 9					
	dust particles.	acheant Stub hours			score below 90% will require rem					
İ					with the affected employee and/o					
	5. On 12/13/2016 at 9	9:50 AM Surveyor #1			analysis of possible system issue					
ļ		er (Staff Member #21)	enter		mining at proposition of agold it to add					
		end of the hallway leav								
į	the housekeeping car	rt in the hallway unatte	nded.							
	6. On 12/15/2016 at 4	4:00 PM, Surveyor #1			· .					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		504011		B. WING		12/2	1/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE			
	BEHAVIORAL HOSP	PITAL			AD SOUTH	•		
ONDONDE				A, WA 9816				
(X4) ID PREFIX TAG	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			ID PREFIX TAG	OF CORRECTION CTION SHOULD BE D THE APPROPRIATE NCY)	(X6) COMPLETION DATE		
A 749	Prevention" the docu indicators for 2016. C identified was Patien: "Target" of success of	cument titled, "Infectior ment provides a line lis One of the indicators t Room Cleaning with a of 95% or better. For the lanuary through Noven	t of	A 749				

- Overricle Automatic Despensig Device

RECEIVED 12/20/2016 PRESONTOD BY "JOHN BOTHL, CAN, COO MILLE VRANGILICED

in call pharmacist

Date:

12/20/2016

To:

Paul Kondrat, RN, MN, Washington State Department of Health Survey Team Leader

From: John Beall, COO/CNO and Michael Uradnik, CEO, Cascade Behavioral Health

Re:

Response to NOTICE OF IMMEDIATE JEOPARDY

Finding	Response	Responsible Party
Medications being administered to patients prior to pharmacy verification of orders resulting in a high number of automatic dispensing machine overrides	 Cascade Behavioral Health (CBH) will increase pharmacy hours by two hours per day (in the evening) so that 	Dale Cary, Pharmacy Director John Beall, CNO & Swapna Vaidya, Medical Director
	medication which must be administered in a timely fashion in which case: Two nurses will verify medication dispensing machine overrides prior to administering the medication to the patient.	• John Beall, CNO

Cascade Behavioral Hospital www.Cascadebh.com 12844 Military Road South Tukwila, WA 98168 206.244.0180

Medication variances (errors) resulting from medication overrides.	Nursing will no longer override unless a physician has determined it is a critical medication. If/when that happens, two nurses will perform the override, verifying the 5 rights of medication. administration.
Patient home medications not being verified by a pharmacist prior to administering	 Home medications will no longer be administered until reviewed by a pharmacist unless a physician determines the medication to be critical in nature, in which case: A nursing supervisor, specifically trained in home medication review, will verify the accuracy of the critical home medication to be administered. John Beall, CNO John Beall, CNO John Beall, CNO John Beall, CNO John Beall, CNO
Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.	Two additional hours per day of Director pharmacist review of orders will be added immediately for increased evening-hour coverage based on admission trends. Dale Cary, Pharmacy Director Director Director Director Director Director Director

If we can be of any further assistance, please do not hesitate to contact us at 206-248-4550. Sincerely,

John Bealf, RN, DNP, NEA-BC Chief Operating Officer/Chief Nursing Officer

Michael Uradnik Chief Executive Officer

Nursing Supervisor Patient Home Medication Verification Competency

Purpose:

- To ensure that medications brought in by the patient are utilized during their stay, disposed of properly or stored properly in a manner consistent with State and Federal law, Joint Commission Standards, and professional practice.
- To ensure proper dispensing and administration, all medications brought in by patients will be examined by the Pharmacist for identification and labeling (when on duty)
- To contribute to the process of reconciliation of all medication across the continuum of care.
- Patient's own medications may be used during their stay in the facility for the following reasons:
 1) To avoid interruption in therapy,
 2) If the patient is taking a non-formulary medication, and
 3) If there is a lack of alternatives to a patient's personal medication. While the physician is required to write an order that a patient may use their own medications, facility policy states that patient's own medications may be used.

Procedure Requirement	Step completed yes/no	Pharmacist initials
The Nursing Supervisor has received an order from the		
physician stating the medication needs to be given to the		
patient prior to Pharmacys normal operating hours		
Nursing Supervisor has determined the patients home		
medication is not available in the Med Dispense (non-		
formulary).		
Name of the patient matches the name on the prescription		
bottle exactly.		
Check prescription label for description of medication		
(Small, white, oval #234 imprinted, etc). Does it match?		
If no descriptors on medication label go to		
www.drugs.com/imprints.php. Type in name & strength of		
medication. Check photos for exact match with what is in		
prescription bottle.		
If medication is verified, Nursing Supervisor signs		
Medication Verification Form, applies patients identification		
sticker on the form and faxes it to the pharmacy. Nursing		
Supervisor will file form in patients medical record.		
Nursing Supervisor has read Pharmacy policy # PHR-118		
Medications Brought In With Patients		

Nursing Supervisor Name (Print):	
Nursing Supervisor Signature:	
Pharmacist performing competency sign off (print):	
Pharmacist signature:	
Date Competency Performed:	

ADVANGED PHARMAGEUTICAL CONSULTA	NTS, INC.
MEDICATION MANAGEMENT.	
POLICY AND PROCEDURE MANUAL	PAGE: ONE OF TWO
POLICY NUMBER PHR:418 TJC:: MM:03:01:03 MM:05:01:13	Origination Date: 02/2014
CASCADE BEHAVIORAL HOSPITAL	Annual Review: 05/2015
TITLE: MEDICATIONS BROUGHT IN WITH PATIENTS	Revised/Effective: 04/2014

1.0 STATEMENT OF PURPOSE:

- 1.1 To ensure that medications brought in by the patient are utilized during their stay, disposed of properly or stored properly in a manner consistent with State and Federal law, Joint Commission Standards, and professional practice.
- 1.2 To ensure proper dispensing and administration, all medications brought in by patients will be examined by the Pharmacist for identification and labeling (when on duty)
- 1.3 To contribute to the process of reconciliation of all medication across the continuum of care.

2.0 STATEMENT OF POLICY:

- 2.1 Patient's own medications may be used during their stay in the facility for the following reasons: 1) To avoid interruption in therapy, 2) If the patient is taking a non-formulary medication, and 3) If there is a lack of alternatives to a patient's personal medication. While the physician is required to write an order that a patient may use their own medications, facility policy states that patient's own medications may be used. Patient's using their own medications will not be charged for medications. Medications will be returned to patient upon discharge if warranted by the physician.
- 2.2 Nonprescription nasal sprays and eye drops will not be used for patients on the Dual Diagnosis Program or Drug Detoxification programs except upon the order of a Facility Prescriber.
- 2.3 Herbal non-formulary medications may only be used if the patient has a new sealed bottle, the medication is in date, the herbal medication does not interact with any other medication the client is prescribed, and the physician writes an order to use their own herbal medication with the instructions for use.

3.0 SCOPE OF POLICY:

Admissions Clinical Staff Medical Staff Pharmacy POLICY AND PROCEDURE PHR-118
RE: MEDICATIONS BROUGHT IN WITH PATIENTS
MEDICATION MANAGEMENT
PAGE 2

4.0 PROCEDURE:

- 4.1 The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form.
- 4.2 The medication order will be reviewed by the pharmacist.
- 4.3 When the pharmacist is on duty, for those medications that will be used by the patient during their admission at the facility, the medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence that the medication has been verified. In addition pharmacy will notify the physician and patient (per MD approval) if the medications are not acceptable for use or it is recommended that they should not be returned. When the pharmacist is not on duty, but home medications are to be used, the nurse or physician is responsible for identifying the medication. This can be done by: (i) calling poison control (800-222-1222), (ii) comparing the medication to the identification label listed on the Rx bottle, (iii) calling the dispensing pharmacy for assistance or (iv) positive identification using drugs.com or epocrates.com to verify the tablet/capsule markings.
- 4.4 If the use of the medication is not warranted, then the following procedure should be used:
 - 4.4.1 All medications are given back to the patient's family to be taken home if possible.
 - 4.4.2 If the patient's family cannot be notified, then all medications are placed in a tamper resistant sealed bag. A list of the medications will be written on the approved inventory form by the Admissions staff or nurse in charge and will include the patient's name and list of medications. Controlled substances that cannot be returned to the family must be counted with the quantity noted on the inventory sheet. The patient and staff member receiving medications will sign the form. The entire bag with the inventory form will be secured under lock in the medication room on the unit where the patient is located or other designated area. Tamper resistant tape shall be used to seal the bag. If the pharmacy has to check a medication for use in house, the pharmacy will remove the medication and reseal the bag. No meds will be stored in the pharmacy dept. Copies of the inventory form are kept with the bag of medications and in the patient's record.
 - 4.4.3 When the patient is discharged, the medications will be returned as indicated by the physician. If a patient has controlled substances being returned at discharge, the quantity being returned to the patient must be noted by the nurse (and witness if available) on the Controlled Drug Record form. The patient or care giver must also verify that the count is correct.
 - 4.4.4 No medication will be returned which does not meet proper labeling requirements, is mixed with other tablets, or is adulterated in any way as defined in the Drug Product Defect Policy PHR-108.
 - 4.4.5 If the physician has agreed to release the medication to the patient and the patient does not pick them up at the time of discharge, the medications will be held for thirty (30) days post-discharge prior to destroying in accordance with DEA requirements. The pharmacy dept will be responsible for placing the meds in quarantine until removal from hospital by a licensed reverse drug distributor.

All medication documentation regarding disposition of medications must be clearly marked and maintained for a period of two years.



Nursing Supervisor Home Medication Verification Form

	Patient label here
Name of medication	verified:
Strength:	verified: Directions:
Name of medication	verified:
Strength:	verified:Directions:
Name of medication	verified:
Strength:	verified:Directions:
1. Medication or	er has been obtained by physician and is in the chart.
	ot on formulary (not in Med dispense)
	been determined by physician as a critical medication and
	prior to pharmacists regular hours of operation.
Name of Verifying N	ursing Supervisor:
	Signature:
Faxed to Pharmacy:	
Date:	Time:

Please place completed form in patients medical record.



NOTICE OF IMMEDIATE JEOPARDY

On 12/20/2016 at 10:30 AM, Washington State Department of Health surveyors determined that a condition existed at Cascade Behavioral Health Hospital that posed an immediate and serious threat to patient safety.

The facility failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served.

This posed a serious risk of harm due to:

- Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides risking patient safety
- Medication variances (errors) resulting from medication overrides
- Patient home medications not being verified by a pharmacist prior to administering
- Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.

Notice of a determination of Immediate Jeopardy was made on behalf of CMS to:

A state of Immediate Jeopardy will remain in effect until the corrections are completed and accepted by the Washington Department of Health.

Paul M Konduct en MWM 12/20/2016 1145 AM

Survey team leader

Date/Time

Facility representative Date/Time



NOTICE OF IMMEDIATE JEOPARDY

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- Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.

Notice of a determination of Immediate Jeopardy was made on behalf of CMS to:

Cascade Behavioral Health Hospital on December 20, 2016 at ______/PM. The facility needs to respond by developing an effective system-wide plan to remove the immediate risk of harm to patients.

A state of Immediate Jeopardy will remain in effect until the corrections are completed and accepted by the Washington Department of Health.

Survey team leader

Date/Time

Date/Time

Date/Time

Date/Time

Med-Dispense® -- APC Cascade Behavioral

PROFILE OVERRIDE HISTORY From: 12/20/2016 6:00:00 PM To: 12/21/2016 6:59:00 AM

	DSO		DSO		DSO		DSO		DSO		DSO		DSO	3 NORTH	Type
	_				_				_		>		_	RTH	Qua
Notes	2629	Notes	16759	Notes	142800	Notes	33653	Notes	68187	Notes	75251	Notes	16758	•	ntityltem N
Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	HYDROXYZINE 50 MG CAP VISTARIL CAP 50 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	CLONIDINE TAB 0.2 MG CATAPRES TAB 0.2 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	TRAZODONE TAB 50 MG DESYREL TAB 50 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	DIPHENHYDRAMINE 25 MG CAP BENADRYL CAP 25 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	HALOPERIDOL TAB 5 MG HALDOL TAB 5 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	DICYCLOMINE 20 MG TAB BENTYL TAB 20 MG	Override Reason: First dose needed. Verified no allergies/contraindications Nursing Notes:	CLONIDINE 0.1 MG TAB CATAPRES TAB 0.1 MG	Brand Name	QuantityItem Number Common Name
rgies/contraindications	KUNGU, HELEN	rgies/contraindications	KUNGU, HELEN	rgies/contraindications	HAY, THOMAS	rgies/contraindications	HAY, THOMAS	rgies/contraindications	HAY, THOMAS	rgies/contraindications	WSELASSIE, TIGIST	rgies/contraindications	WSELASSIE, TIGIST		Operator Name
															Witness Name
	GAYNOR, JULES		GARRIS, ISAAC		SNIDER, JEREMIAH		SNIDER, JEREMIAH		SNIDER, JEREMIAH		SNIDER, JEREMIAH		SNIDER, JEREMIAH		Patient Name
TranID 3229602	12/21/2016 2:29:07A	TranID 3229570	12/21/2016 2:00:01A	TranID 3229496	12/21/2016 12:03:17/	TranID 3229494	12/21/2016 12:03:02/	TranID 3229492	12/21/2016 12:02:54/	TranID 3229042	016	TranID 3229040	016		Entry Date



Approved Remaral plan
12/20/2016 455 Ay
Palar leador

Date: 12/20/2016

To: Paul Kondrat, RN, MN, Washington State Department of Health Survey Team Leader

From: John Beall, COO/CNO and Michael Uradnik, CEO, Cascade Behavioral Health

Re: Response to NOTICE OF IMMEDIATE JEOPARDY

Finding	Response	Responsible Party		
Medications being administered to patients prior to pharmacy verification of orderesulting in a high number of automa dispensing machine overrides	Cascade Behavioral Health (CBH) will increase pharmacy hours by two hours per day (in the evening) so that pharmacists can	Dale Cary, Pharmacy Director John Beall, CNO & Swapna Vaidya, Medical Director		
	pharmacy <u>unless</u> the medication has been identified by the physician as a critical medication which must be administered in a timely fashion in which case: Two nurses will verify	 John Beall, CNO 		
	medication dispensing machine overrides prior to administering the medication to the patient.			

Medication variances (errors) resulting from medication overides.	 Nursing will no longer override unless a physician has determined it is a critical medication. If/when that happens, two nurses will perform the override, verifying the 5 rights of medication administration. 	John Beall, CNO & Swapna Vaidya, Medical Director
Patient home medications not being verified by a pharmacist prior to administering.	 Home medications will no longer be administered until reviewed by a pharmacist. 	John Beall, CNO &Dale Cary, Pharmacy Director
Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.	 Two additional hours per day of pharmacist review of orders will be added immediately. Coverage is currently 70 hours/week and will be increased to 84 hours/week. An on-call pharmacist will be available 24 hours/day for consultation and/or to come to the hospital, should the need arise. 	Dale Cary, Pharmacy Director

If we can be of any further assistance, please do not hesitate to contact us at 206-248-4550. Sincerely,

John Beall, RN, DNP, NEA-BC

Chief Operating Officer/Chief Nursing Officer

Michael Uradnik Chief Executive Officer

Immediate Jeopardy

Removal Plan Verification Inspection

Clinical Units -

Interview 2 licensed nursing staff

Interview 1 medical staff provider

Nursing -

When retrieving medications for a patient, what do you do if recently ordered medications are not visible on the ADM for selection?

Under what circumstances, may a nursing staff member perform a medication override?

Describe the process of performing a medication override?

If you have pharmacy questions when the pharmacy is closed, what do you do?

What is the process for using a patient's home medications in the hospital? Can they be given without pharmacy verification?

Medical Staff -

What steps or process must be taken when pharmacy verification of provider orders has not taken place?

Printed: 01/09/2017 FORM APPROVED

				ı	PLE CONSTRUCTION	(X3) DATE SU	3VEV
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ED
		504011		B. WING	State of the state	12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST.	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL	12844 N		OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
A 000	MEDICARE HOSPITATHIS Medicare hospital conducted on the folloand 12/19-21/2016 by Department of Health RN, MN, MHA; Elizab Valerie Walsh RN, MS and Joy Williams, RN	AL COMPLAINT SURV al complaint survey was owing dates: 12/12-16/2 v Washington State surveyors: Paul Kondr eth Gordon, RN, MN; S; Alex Giel, REHS, PH , BSN.	s 2016 rat,		Submission of this plan of correction admission that the citations are true hospital violated the rules. A 000: Response to Medicare Hospi Complaint Survey As noted, an action plan was submit accepted in response to the immedice pardy finding. Corrective actions	e or that the Ital Ited and ate Included:	2/10/17
	The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #89393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH			-Analysis and reduction of overrides medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for or Two nurse verification for overrides -After-hour pharmacist verification prevision; -Pharmacy policy revision relative to and home medications.	ensing devices; ang increases; requirements for overrides; cation for overrides; macist verification process revision relative to overrides		
	surveyors determined of serious harm, injury extent of deficiencies. of IMMEDIATE JEOPA Failure to provide suffi services to meet the services to meet the services of the patients of 12/20/2016 but survey the plan's implementation hospital for the IMMEDIATE Jelace at the time of survey that of IMMEDIATE Jelace at the time of survey that the services is the time of survey that the services is the time of survey that the services is the time of survey that the services is the services in the	that there was a high read death due to the This resulted in one find RDY in the following a scient pharmaceutical cope, complexity, and served. corrective actions on ors were unable to verillon developed by the DIATE JEOPARDY and EOPARDY remained in	ding rea: ify I the	chael	Madre, CEO 211	8 17	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

TITLE

(X6) DATE

CENTERS FOR MEDICARE & N	MEDICAID SERVICES		OND 140, 0200-03.	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504011		LIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			B. WING	12/21/2016
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSE	ITAL	12844 MI	SS, CITY, STATE, ZIP CODE LITARY ROAD SOUTH A, WA 98168	(X5)

-,		TUKWILA, WA 9816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REI OR LSC IDENTIFYING INFORMATION)	GULATORY PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Cond of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.25 Pharmaceutical Services 42 CFR 482.41 Physical Environment			
A 043	Shell # 27QV11 482.12 GOVERNING BODY There must be an effective governing body legally responsible for the conduct of the hold is a hospital does not have an organized governing body, the persons legally respons for the conduct of the hospital must carry or functions specified in this part that pertain the governing body This Condition is not met as evidenced by: Based on observation, interviews, and docreviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition Participation for Governing Body. Failure to meet patient rights, quality assess and performance improvement, pharmacer services and physical environment requires	sible ut the o the ument of	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring Systems to the Governing Board. See A0115, A0263, A0490, A0700	2/10/17

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011		B. WING 12/21/			/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE	- <u>I.</u>	
CASCADE	BEHAVIORAL HOSP	PITAL		LITARY R A, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE
A 043	risks an unsafe health patients, visitors, and . Findings: 1. The Governing Bomanage the functioning patients from harm as IMMEDIATE JEOPAI 12/20/2016 for failure pharmaceutical service complexity, and need . 2. Failure to provide complexity, and need . 3. Failure to provide comprovement Programstaff. 4. Failure to maintain plant and the overall care. Due to the scope and detailed under 42 CF Participation for Patie Condition of Participation	dy failed to effectively ng of the hospital to prose evidenced by the RDY condition identified to provide sufficient ces to meet the scope, s of the patients served oversight of the Perform delegated to the Mediand promote each patient the condition of the physical to the R 482.13 Condition of the Rights; 42 CFR 482 ation for Quality Assess provement; 42 CFR 482.4 ation for Physical addition of Participation of the physical addition of Participation of	d on	, "	Amendment 2/1/2017: The CEO weekly reports to the Governing related to the hospital's ongoing of toward compliance for all citation Conference calls will be held as redialogue. The target compliance all standards cited. Any score be will require remediation with the employee and/or further analysis possible system issues.	Board efforts s. needed for is 90% for elow 90% affected	
A 084	482.12(e)(1) CONTR	0		A 084			
	The governing body r	nust ensure that the	1				ļ

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C (DENTIFICATION NUMBE		l'''	LE CONSTRUCTION	(X3) DATE SURY COMPLETE		
		504011		B. WING	IG12/21			
NAME OF RRO	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STATE, ZIP CODE				
	BEHAVIORAL HOSP	PITΔΙ	12844 MI	LITARY RO	DAD SOUTH			
CMOCADE	TL							
				·	PROVIDER'S PLAN OF CORRECTI	ON	(X6)	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG PROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		.D 8E	COMPLETION DATE	
4.004	Continued From page			A 084	A084 Corrective Actions:		2/10/17	
A 084	Continued From pag		wided	7,001	 The department heads resport 	isible for		
		inder a contract are pro	Mided		contracts evaluated all contra	cted patlent		
	in a safe and effective	e manner.			care services and submitted t			
	ent to Oscilland to make				evaluations to the Medical Ex			
	Inis Standard is fiber	met as evidenced by:			Committee for review and ap			
	Based on interview a	and routow of hospital			2. The PI/RM Director revised th			
		hital failed to ensure the	ıt its		process for contract evaluation			
	quality accurance an	d performance improve	ement		a. The PI/RM Director review dates to ens		-	
	(OAPI) moresses in	cluded a systematic rev	view of		timeliness.	nte		
1	contracted patient ca				b. The Department He	ad		
	Contractor political				responsible for over	sight of the		
	Failure to develop a	process to oversee the			contracted clinical s			
	performance of all contracted patient care				review the contract			
	services places patie	ents at risk for provision	of		complete the evaluation	atlon.		
	improper or inadequa	ate care and adverse p	atient		c. If there are service			
	outcomes.				Department Head v			
					those concerns with			
	Findings:		-		contracted service a			
					plan of improvemen			
	On 12/20/2016 at 9:0	00 AM, during a discuss	ion of		ensure patient care	needs are		
	the hospital's quality	program with Director	of		met. d. Annually, all evalua	tions for		
	Risk and Quality (Sta	aff Member #12), Surve	yor		contracted clinical s			
	#2 reviewed the hos	pital's process for evaluation	uating		be forwarded to the			
	the performance of c	contracted health service	ito		Executive Committee			
	reviewing the contra	cted services documer	hat the		· ·			
	Surveyor #2 found to	nere was no evidence t services had ever bee	nat til 🗸		Responsible Person:			
	formula contracted	part of the QAPI prog	ram for		PI/RM Director			
	quality of services pr	wiqeq,						
	drailing of services by	igriged.			Monitor			
	_I Injuersal Hospital -	R&M Equip, Biomed			On an annual basis, the PI/RM Director	will present		
	-Advanced Pharmac	coutical - Pharmacy Se	rvices		the list of contracted patient care servi	ces with		
	-Dietician Services				completed evaluations by the assigned head in the MEC meeting. The evaluati	one will		
		herapy - Physical Ther	ару		include any service concerns with relat	ed alan of		
	-Northwest Healthca	are - Linen Services			Improvement. Committee minutes will	reflect the		
		•			review and any actions taken on patier		.	
2 44-	482.13 PATIENT RI	GHTS	ļ	A 115	contracts.			
A 115	HOZ. TO MATIENT KI	GITTO	Ì	73 110				
	A hospital must prot patient's rights.	ect and promote each						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	604011			B. WING			12/21/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	DRESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSP	TAL		4 MILITARY ROAD SOUTH NILA, 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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X6) COMPLETION DATE	
A 115	Continued From pag	e 4		A 115	See A 0123, A 0129, A 0164, A 0174	4		
	This Condition is not met as evidenced by: . Based on observation, interview, document							
	review, and review of	f hospital policies and ital failed to protect and	i					
		I promote each patient's 's loss of personal freed osychological harm.						
	Findings:							
	Failure to allow patients the right to exercise their rights to privacy and refuse treatment.							
	Pailure to utilize the least restrictive alternative to the use of seclusion and restraints.		ative					
	3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk ofdanger.							
	Failure to investigate patient complaints prior to closure of the complaint.							
	The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights.							
	under 42 CFR 482.13	I severity of deficiencies 3, the Condition of ent Rights was NOT ME				,		
	Cross Reference: Tag A0174	gs A0123, A0129, A016	34,					
A 123	482.13(a)(2)(iii) PATI GRIEVANCE DECISIO	ENT RIGHTS: NOTICE ON	OF	A 123				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LIA :R:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE			
		504011 B. WING 12/21/2		/2016			
•	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 M	DRESS, CITY, STATE, ZIP CODE MILITARY ROAD SOUTH PLA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 123	Continued From pag	ge 5		A 123	A 0123 Corrective Actions		2/10/17
	must provide the pat decision that contain contact person, the spatient to investigate the grievance process completion. This Standard is not. Based on interview, of hospital policies a failed to ensure that written response to the grievances reviewed. Failure to provide pat to their grievance vice.	met as evidenced by: document review, and ind procedures, the hos patients were provided their grievances for 1 of i (Patients #2). Attents with a written resolates their right to be hospital investigated a	of its Ital If the Ults of review Spital with a If 4		The Patient Advocate reviewed Grievance Policy on the requirer providing a written response to The Clinical Educator reeducate staff on the grievance process we responses provided to the patie was provided in staff meetings and verbal communication. Amendment 2/1/2017: The higrievance policy, log for grievalletters that are to be mailed to all been revised and will be pweekly PI Committee on Thu February 9, 2017 for approvating will go the Medical Execution Committee on February 9, 20 Governing Board at its next of the new processes is 90% below 90% will require remedaffected employee and/or fur possible system issues.	ment of a grievance. d the clinical and the clinical and the clinical and the clinical and the compliance and compliance. Any score cliation with the clinical and the compliance and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and compliance clinical and c	
	"Patient Grievance I Policy # G.1001) rea Advocate will: Revie investigation Cor Grievance Resolution report to patient for signature." 2. Four patient compreview of process a included the patient reviewed for evident investigation, finding	licy and procedure titled Policy" (Revised 10/201 ad in part: "The Patient ew results of the preliminglete a written report on Form Give written review, comments and plaints were selected fond resolution. Sources a complaint log. Each with the findings reviewed to the findings reviewed to the process of the process o	nary on the or as eview,		Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will prese the grievance log and grievance the monthly PI and quarterly M meeting is Feb 9, 2017) and Go meetings. Any issues requiring attention will be addressed by department head.	e responses to IEC (next verning Board Immediate	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		504011		B. WING			1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	DDRESS, CITY, STATE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL			ROAD SOUTH		l
				LA, WA 981			İ
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	O BE	(X6) COMPLETION
	_	ENTIFYING INFORMATION)	- N	TAG 	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
A 123	1 1 - 0			A 123			
	the patient who filed t	he grievance.					
	0 B-0-100 #	at a same					
	3. Patient #2 filed a p	patient concern notifica	tion				-
	clashing of the notion	illegations of inadequal t rooms, patient kitchei	te				
	area shower and half	n rooms, patient kitchei hrooms. A review of thi	1				
i		ed the complaint was cl					
	4. On 12/15/2016 at 2:30 PM, Surveyor #3 Interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no						
	action was documents	ed indicating the patien	ts				
:	concern had been add	dressed or resolved. St	aff				
	Member #7 confirmed	I this observation.					
A 129	482.13(b) PATIENT R RIGHTS	IGHTS: EXERCISE O	-	A 129	A 129 Corrective Actions		2/10/17
	Patient Rights: Exercis	se of Rights			The Clinical Educator reeducated the staff on the policy titled Skin/Clothing	nursing Check	
ł	This Standard is not m	net as evidenced by:		-	Education included an emphasis on the	he proper	
	•	,			procedure for assessing patients and	procedure	
	Based on observation,	, interviews, document			for patient's refusal. Education was p	provided	
	review, and review of I	hospital policy and	_	•	during staff meetings through verbal	and	
	rights.	al failed to protect pation	ent		written communication with compete testing.	ency	
	Failure to allow patient	ts the right to refuse			Person Responsible:		
	skin/clothing checks ris personal dignity, privac				COO/CNO		İ
	, personal digitity, privac	sy, and respect.			Patient Advocate	İ	
	Findings:				Monitoring:		
1	1. The hospital's policy	titled "Patient Rights a	and		The PI/RM Director/designee will peri	form at	ł
	Responsibilities" (Revi	ewed 10/2016; Policy #	#		least 30 random audits per month to	ensure	
1.	ADM.P.300) under the	section "PURPOSE" r	ead:		compliance of 90% or above for at lea		ļ
	"To assure that a patie	nt is informed of his or	her		consecutive months. Audit results will		
	rights and responsibiliti				reported in the monthly PI and quarte	erly MEC	
ļ :	and service from Casca	ade Behavioral Hospita	al	į	and Governing Board meetings.	ļ	

27QV11

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE			
•		504011		B. WING		12/21/	2016
	CASCADE BEHAVIORAL HOSPITAL 1284 TUK						(VE)
(X4) ID PREFIX TAG	FACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL, RE ENTIFYING INFORMATION)	B EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE PRIATE	(X5) COMPLETION DATE
A 129	and to assure that the hospital staff, physic providers." "B. The list of patier not limited to the foll personal privacy, an invasion of privacy, searches may be conto detect and prever possessed or used right to care that is do your personal cultur preferences and to promoting dignity are. 2. The hospital's pool Check" (Reviewed "Voluntary psychiativolicing or exhibiting refuse the skin/cloth referral information discharged from the same as a contraband (hospital). During the Patient #1 was ask gown and hand his supervisor (Staff Member #2) acceptable. After Federical for contrabale. After Federical for contrabale to squacheck further for contrabale contrabale.	ese rights are known bians and other health of the rights shall include be owing: 4. The right of the protected from PROVIDED, that reasonducted or other means to contraband from being the premises 13. considerate and respect, values, beliefs, and be treated in a manner and self-respect." Iticy titled "Skin/Clothing 10/2016) read in part: ric patients who are not self-harm behaviors, whing check, will be give and administratively	t are to conable is used ing. The strul of the who in the strul of the who in the transfer of		Amendment 2/1/2017: The hosp check/contraband policy has been to remove the administrative disc patients who refuse the skin check staff education has been conducted to this change. Daily audits are a progress and the results of which shared at the weekly PI Committed Wednesday, February 1, 20 the Medical Executive Committee Thursday, February 9, 2017. The compliance is 90%. Any score to will require remediation with the employee and/or further analysis possible system issues.	charge for charge for ck process. In the charge for cha	

A 129 Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had received the policy about a month ago. The new policy no longer		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
A 129 Continued From page 8 Coughing is no longer part of the process. A. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a replatered varies (Staff Member #3, Staff Member #5) on the chemical dependency and rehabilitative units. S. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check process. Staff Member #8 explained the hospital had received complaints about the skin/clothing check procedure process. Staff Member #8 explained the hospital had received complaints about the skin/clothing check procedure process. Staff Member #8 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer			504011		8. WING		12/	21/2016	
TUKWILA, WA 98168 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) A 129 Continued From page 8 Coughing is no longer part of the process. A 129 Continued Regulation				i		·			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A 129 Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #8) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #8 explained the hospital had received complaints about the skin/clothing check procedure and had receitly changed their policy about a month ago. The new policy no longer	CASCADE	E BEHAVIORAL HOSP	PATE				•		
coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while Interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #8 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION	
required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff. 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, #4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.	A 129	4. On 12/14/2016 at interviewed a register about the skin/clothin Staff Member #3 comprocess included have cough and then check contraband. Surveyounderstanding of the two other registered in Staff Member #5) on and rehabilitative unit. 5. On 12/12/2016 at 2 interviewed the Clinic Psychiatric Services (skin/clothing check procedure and had reabout a month ago. Trequired the patient to surveyor asked Staff the current policy directly discharge voluntary pskin/clothing check probeing unaware of that Member #6 stated the responsible for disserinformation to their resource training files staff members (Staff Freviewed had no reco	r part of the process. 1:37 PM, Surveyor #2 red nurse (Staff Member g check done at admis firmed that part of the ring the patient squat ar king for any visible r #2 found similar process while interview nurses (Staff Member # the chemical dependents. 2:30 PM, Surveyor #2 cal Director of Adult (Staff Member #6) about recedure process. Staff d the hospital had receiv skin/clothing check recently changed their pr the new policy no longer to squat and cough and refuse the skin check. Member #6 to explain to rected staff to administrate retires who refused the recess. S/he acknowled to aspect of the policy. Set at each clinical director minating the new policy spective clinical staff. I:50 PM, Surveyor #3 f the hospital's human to Three of the four nurs Members #1, #3, #4) and of completing the new	sion. nd ving 44, ncy ut the f ved olicy er now The why atively e e dged Staff was ving	A 129				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	504011	•	B. WING		12/21	/2016
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	OVIDER OR SUPPLIER			RESS, CITY, STA			
CASCADE	BEHAVIORAL HOSF	PITAL	L.		OAD SOUTH		
			LOWANI	LA, WA 981		TION	(X6)
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A 464	Continued From 1990			A 164	A 0164 Corrective Actions		
A 164 A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when		A 164	The Clinical Educator reeducated on the regulrement of using less r interventions prior to restraint an	estrictive d seclusion in	2/10/17	
	less restrictive interv	entions have been			protecting patients, staff, and/or	Mileta Hour	
	determined to be ine	ffective to protect the p	atient,	ļ	harm. The education included an de-escalation techniques as well a	simpliasis uii s other	
	a staff member, or o	thers from harm.			therapeutic interventions. The Cli	s ouici sical Educator	
	This Observation not	met as evidenced by:		i	provided the education during sta	ff meetings	
	I his Standard is not	thet as evidenced by.			through the use of verbal and wri	ten	
	Based on record rev	iew, interview, and rev	iew of		communication with return demo	nstration.	
	hospital policies and	procedures, the hospi	tal		Communication		,
	staff falled to conside	er the effectiveness of	less	!	Person Responsible:		
	restrictive intervention	ons before applying bot	h		PI/RM Director		
•	(Patients #4, #6).	sion for 2 of 6 patients			COO/CNO		
	using both restraints simultaneously puts personal freedom an	patients at risk for loss			Monitoring: The PI/RM Director/designee will restraints and seclusions to deter appropriateness of use with less interventions. Any clinical issues in the property of the pro	mine estrictive equiring	
	Findings:				corrective actions will be prompt by the COO/CNO. The PI/RM Dire	rtor will	
	. 1 The bosnital police	v and procedure titled		İ	report audit results in the month	v Pl and	
	The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "Restraints may only			quarterly MEC and Governing Bo	ard meetings.		
	be used for the man	nagement of violent or	ho.] .		•	
	self-destructive beh	avior that jeopardizes t safety of the patient, a	staff				
	member or others a	ifter less-restrictive				• •	
!	interventions are inc	effective or ruled-out	, 11				
	"Restraint or seclus less restrictive inter determined to be in or others from harm	Patient Rights" read lon may only be used to ventions have been effective to protect the n. The type of technique to the least restrictive	patient e or				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
		504011		B. WING		12/21	/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 MI	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL RE			ATORY PREFIX (EACH CORRECTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X6) COMPLETION DATE	
	patient, a staff member. 2. On 12/12/2016 at reviewed the hospital seclusion order shee that under the section labeled "Mechanical chest)" does not specto be applied by the labeled that the section be applied by the labeled that the regulator (Staff Member acknowledge generally start with relegs. The chest restraints member acknowledge generally start with relegs. The chest restraints with relegs. The chest restraints and seclusive Patients #4 and #6 replaced Patients #4 and #6 replaced Patients #4 are restraints and seclusive security indicating that a less been considered or a simultaneous applical restraints and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security and seclusive security se	be effective to protect the effective to protect the per, or others from harm 2:30 PM, Surveyor #3 I's pre-printed restraint at for Patient #5 observing titled "Type", the box Restraints (wrist, ankle cify how many restraint thospital staff. 2:00 PM, Surveyor #3 Ital's primary restraint ber #7) about how many sed when physical restriction. Staff Member #1 istered nurse determinate initially used. The sed that hospital staff estraining both the arms aint is only used in rare of 12/15/2016, Surveyor on/restraint records of othing that hospital staff and #6 in both physical ion simultaneously on 2016 respectively based er. No documentation restrictive alternative hattempted first prior to the titon of both physical ion could be found.	and ng sare y raints y staff sand #3		Amendment 2/1/2017: Seclusion restraint forms were changed to dwith standards and staff were eduthose changes. Audits are alread progress and the results of which shared at the weekly PI Committed Held Wednesday, February 1, 200 the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the amployee and/or further analysis possible system issues. 100% of restraint charts are being audited.	comply scated on dy in will be se to be 17 and to so on starget selow 90% offected of all		
A 174	SECLUSION	T RIGHTS: RESTRAIN		A 174		·		
ļ		n must be discontinued ime, regardless of the le				,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LIA R:	1	E CONSTRUCTION	(X3) DATE SUR! COMPLETE	VEY D	
		504011		B. WING	-	12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE		12844 M TUKWIL	A, WA 981	DAD SOUTH	ORRECTION	(X5)
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A 174	This Standard is not Based on record rev hospital policies and failed to ensure that seclusion at the earl patients reviewed (F . Failure to remove pa earliest possible tim psychological harm, freedom Findings: . 1. The hospital's po "Seclusion and Phy (Revised 2/2016; Po section "PATIENT F "Restraints or seclu earliest possible tim . 2. On 12/15/2016 a interviewed the hos trainer/educator for and restraints (Staf asked Staff Member released from seclu acknowledged that physician would rev behavior to determit could be discontinual surveyor what shot behavior was described and released from surveyor what shot behavior was described and released from patient released from patient released from patient released from	met as evidenced by: riew, interview, and revidencedures, the hospit patients were released iest possible time for 3 Patients #3, #4 and #5). The street is a patient of the patients from seclusion are puts patients at risk for the second of the patient of the p	al from of 6 at the or resonal destraint" or the the or ould be nurse or tient's aints on the or the the or the the or the or the the or the ould be nurse or tient's aints on the ould be ould be on t	A 174	The Clinical Educator reeduce on the requirement of release seclusion and restraint at the time. The education include de-escalation techniques as therapeutic interventions. The provided the education during meetings through the use of communication and return of the communication and return of the communication and return of the pl/RM Director COO/CNO Monitoring: The Pl/RM Director/designer restraints and seclusions for earlies possible time. Any clot length of use requiring communication and quarterly addressed by the COO/C audit will be reported by the monthly Pl and quarterly Governing Board meetings.	sing patients from e earliest possible d an emphasis on well as other he Clinical Educator ng Nursing staff written demonstration. ee will audit all release at the inical issues related prective actions will NO. Results of the e PI/RM Director in y MEC and	
	2 On 12/13/2016 s	st 11:30 AM in the adult	ŀ				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 -	PLE CONSTRUCTION	(X3) DATE SUF COMPLETO	
	AND AND AND AND AND AND AND AND AND AND	504011		B. WING		12/2	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, ST	ATE, ZIP CODE		***
CASCADE BEHAVIORAL HOSPITAL				LITARY R 4, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG				ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
A 174	the medical record of into seclusion on 12/released from seclus was placed in seclusing grabbing a food cart repeatedly striking the Documentation on the indicated the patient's "resting" or "sleeping AM, a period of 90 m written at 10:30 AM in resting on the bed with verbalized understant seclusion. "Will disconstaffing allows for 1 to 4. On 12/14/2016 and reviewed seclusion/re Patients #4 and #5 and a. Hospital staff places and restraint on 9/29/him/her from seclusion of 28 hours. Surveyor observed documenter resting for the following remaining for the following at 7:45 AM, a period of 2 hours.	est), Surveyor #3 review Patient #3 who was placed at 8:30 AM and ion at 11:30 AM. The placed and running down a hase cart against the wall, esclusion flow sheets observable behavior at from 9:00 AM to 10:30 inutes. A progress note indicated the patient wat the eyes closed and ding for the need for intinue seclusion when to 1 support." If 12/15/2016, Surveyor estraint flowsheet recorned noted the following: If All 12/15/2016, a per #3 noted the patient's department of sleeping in periods: If at 6:45 PM until 9:30 at 6:45 PM until 9/30/2016.	aced atient d llway as) s #3 ds of or PM, a		Amendment 2/1/2017: Seclusion restraint forms were changed to continuous with standards and staff were eduthose changes. Audits are alread progress and the results of which shared at the weekly PI Committed held Wednesday, February 1, 20° the Medical Executive Committed Thursday, February 9, 2017. The compliance is 90%. Any score be will require remediation with the amployee and/or further analysis possible system issues. 100% of restraint charts are being audited	comply ucated on dy in will be ee to be 17 and to e on e target elow 90% offected of	

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		(X3) DATE SURVEY COMPLETED			
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CASCADE BEHAVIORAL HOSPITAL 128				DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH WILA, WA 98168				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FOLE REGOLATION)		GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X6) COMPLETION DATE	
A 174	b. Hospital staff place 12/11/2016 at 10:30 seclusion on 12/12/2 noted the patient's obehavior on the seclusion of 7 hours and 40 m no evidence in the sindicate the hospital the patient from seclusion. 5. The director of ad Member #6) confirm review.	ed Patient #5 in seclusi PM and was released 1016 at 7:15 AM. Survey bserved documented usion flow sheet as 5 PM until 7:15 AM, a prinutes. The surveyor foeclusion documentation staff considered removes.	from yor #3 period und n to ving (Staff	A 174	eno A0273 A0286 A0309.	A0490.		
A 263	maintain an effective data-driven quality a improvement progration the program reflects hospital's organization hospital department those services furniarrangement); and to improved health and reduction of me The hospital must revidence of its QAF.	rning body must ensure is the complexity of the ion and services; involv is and services (includi- ished under contract or focuses on indicators re outcomes and the prev	that tes all elated rention ate y CMS.	A 263	See A0273, A0286, A0309, A0700	. A0490,		
	and review of the h	ion, interview, record re ospital's quality prograr ion, the hospital failed to	m and					

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	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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CASCADE	BEHAVIORAL HOSP	ITAL		ILITARY RO A, WA 9816	DAD SOUTH 38			
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A 263	develop and implement data-driven quality as improvement (QAPI) Failure to systematica hospital-wide performaction plans to improve that data limited the horoblems and formula findings: Failure to identify phasufficient personnel to complexity, and need failure to provide overlimprovement Program Failure to collect and performance measure Governing Body, Perf Committee and the M 2016; Failure to measure, a patient events; Failure to develop a previewing reportable a failure to ensure complexity and environment was maithat the safety and well and the safety and the s	ent a hospital-wide, seessment and perform program. ally collect and analyze hance data and to deve be performance based hospitals ability to identiate action plans. Armaceutical services late of the scope, is of the patients served ersight of the Performann; analyze data for hes assigned by the formance Improvement idedical Staff for the year analyze and track advertises as a signed by the formance Improvement idedical Staff for the year analyze and track advertises.	lop on lify acking d. nce	A 263				
	protected.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	ECONSTRUCTION	(X3) DATE SURV	COMPLETED	
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PORSTY FACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X6) COMPLETION DATE	
resulted in the hosp opportunities to impoutcomes of care. Due to the scope at cited under 42 CFR Participation for Quarter Performance Improved MET. Cross Reference: A A0490, A0700 A 273 482.21(a), (b)(1), (b) COLLECTION & All (a) Program Scope (1) The program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, an ongoing program musto, and call the performance that a hospital service and (b) Program Data (1) The program musto indicator data inclusion of the relevant data submitted to, or requality Improvement (2) The hospital musto, and quality Improvement (2) The hospital musto, and quality Improvement (3) The frequer	act of these systemic problems inability to identify prove patient care, safety and severity of deficiencies 482.21, the Condition chality Assurance and everent Program was NA-0273, A-0286, A-0309 (2)(i), (b)(3) DATA NALYSIS ust include, but not be firgram that shows measure improve health outcome ust measure, analyze, and tors and other aspects assess processes of care doperations. ust incorporate quality adding patient care data, and, for example, informatic ceived from, the hospital ent Organization. ust use the data collecte effectiveness and safety	y and es of OT mited rable s es nd s of e, and ton l's d to y of	A 273	A 0273 Corrective Actions The PI Director reviewed the list of performance indicators, assigned b Governing Body, PI Committee, and Staff for 2016. Of note, the followindata was aggregated, analyzed, and to the PI and MEC committees for a of patient care processes. -Grievances -Anticoagulation therapy and medication upon admission and Restraint/Seclusion -Elopement rates and medication velopement rates and medication velopement consultations/treatment Contracted Services -Pharmacy and Therapeutics (drug medication variances, adverse drug antibiotic usage, and nursing unit/schecks)	d Medical ag clinical dipresented assessment cation discharge variances utilization, greactions,	2/10/17	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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CASCADE BEHAVIORAL HOSPITAL 1284					OAD SOUTH		
				LA, WA 981			
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A 273	This Standard is not Based on interview a quality program and a hospital failed to colle performance measur Governing Body, Per Committee and the M 2016. Failure to measure, a related to performance	met as evidenced by: Ind review of the hospita quality documents, the ect and analyze data for es assigned by the formance improvement fedical Staff for the yea analyze and track data be measures as assigned	r t ır		Persons Responsible: Pi Director COO/CNO Monitoring On a monthly basis, the PI/RM Director facilitate the tracking and analysis of performance measures for presental programment action plans as document meeting minutes. Negative or underwill be discussed by the committee of performance improvement action needed. The Medical Staff and Government introduced in the medical staff and some initiatives on a quarterly basis to entimplementation of the quality and provement program.	f ation to the will nted in sired trends for initiation as as erning Board d Pl sure	
	(Approved 12/2015) a Performance Databa: hospital was to collect different performance performance measure person for data collect reporting frequency w Board was to review on a quarterly basis. 2. Surveyor #2 intervi Services (Staff Memb	e was assigned to a spection and analysis, and was defined. The Gover the performance measurement of the Director of Cliper #13) about Performation, analysis and report 5 PM. The interview	at the 16 ecific the ning ures				
	Rights and Grievance	Measure titled "Patient es" was to measure mpliance and number o	f	ı			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		LIA		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		504011		B. WING		12/2	1/2016
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	OVIDER OR SUPPLIER	DITAI			OAD SOUTH		
CASCADE	BEHAVIORAL HOSE	TIAL		LA, WA 981			
		TATEMENT OF DEFINIONOIS		ID	PROVIDER'S PLAN OF C	CORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
A 273	Continued From page	ge 17		A 273	Amendment 2/1/2017: Th	le 2016 data for	
	grievances. The info and analyzed by the Director and the Pat to the Performance monthly. There was information presented Director stated that to not been meeting ar collected or analyze b. The Performance Patient Safety Goals hospital was to colle were reviewed by Silkelihood of patient anticoagulant theray Medication Reconcidischarge. The Chirick Manager were collection and analy Committee and the	rmation was to be colled. Performance Improver ient Advocate, and reposition of the provement Committee to report containing this of for surveyor review. The grievance committee that the data was not defend that the data was not defend analyze data for urveyor #2: 1) Reduce harm associated with by (Warfarin), and 2) liation upon admission of Nursing Officer and the responsible for data sis, and for reporting to Governing Board montit containing this informatical interest of the provention of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing this informatical interest of the containing the containing this informatical interest of the containing the	ment orted is The e had t being al t, two the P1 hly.		grievances, anticoagulant seclusions, elopements, no consultations, Pharmacy a indicators, and contracted been abstracted and analythe PI Committee on or be Executive Committee on February 9, 2017 and Gothereafter. The target cor Any score below 90% will remediation with the affect and/or further analysis of issues.	medication & Therapeutics I services have yzed and will go efore Thursday, n to the Medical Thursday, verning Board mpliance is 90%. I require cted employee	
	documentation of re Directors of Nursing responsible for the and for reporting mand Governing Boa patients placed in re reported by the Per Committee to the Government available for documentation of red d. The Performance Management/Pattle	e Measure titled n" was to measure propertraint and seclusion. It is and the Risk Manager data collection and and control to the PI Committed. While the number of estraint and seclusion of the property of	The r were lysis, ttee f were t were t was no				

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·				IILITARY ROA .A, WA 98168			
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A 273	medication variances and patient satisfaction. Chief Nursing Officer collection and analys to the Performance II Governing Board. The review the data collection variances was data presented the and medication variate containing analysis on the Performance II Consultations/Treatmedical consultation appropriateness to the The Risk Manager are were responsible for and for reporting the Performance Improved Medical Executive Coreport containing this surveyor review. In the Performance IV Services referred to service and quality mend Chief Executive Coreport containing this surveyor review. In the Performance IV Services and quality mend Chief Executive Containing this information annually the containing this information annually the containing this information. Cross-reference: Tag g. The Performance IV and Therapeutics wearenced.	s, elopements, contrabasion. The Risk Manager were responsible for colls, and for reporting manprovement Committee surveyor requested totion and analysis for and elopement. While to the surveyor for elopences, there was no report the data. Measure titled "Medical ment" was to measure for timeliness and the patient's individual near the Contract of the Committee and information quarterly to the contract log for scale asures. The Risk Man Officer were responsible the Performance the and the Medical and the	and data onthly e and to there ement cort l eeds. or slysis, o the the to for ted ppe of nager le for ng this	A 273			

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	4 4 . 4 . 7		·	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X6)
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A 273	reactions, antibiotic union checks. The Proof of data collection and this information quare Improvement Committee Committee containing this informations.	ge 19 usage and nursing unit/ harmacist was responsed analysis, and for reporterly to the Performance ittee and the Medical at There was no reported partion presented for su (3) PATIENT SAFETY	sible orting ee rveyor	A 273 A 286	A 286 Corrective Actions 1) Analysis and Tracking of Adverse 1	Patient	2/10/17
A 200	(a) Standard: Program (1) The program musto, an ongoing program provement in indicevidence that it will medical errors. (2) The hospital mustrackadverse patice (2) Performance imperack medical errors analyze their causes actions and mechan and learning through (e) Executive Responsibility for opmedical staff, and a responsible and according the control of the	am Scope st include, but not be lin am that shows measure actors for which there is identify and reduce st measure, analyze, an ent events es orovement activities mu and adverse patient ev is, and implement preve ilsms that include feedle mout the hospital. onsibilities, The hospital organized group or indi	nited rable s ad ust vents, entive back Vidual),		Events All elements of the PI plan and 2016 performance Improvement activities reviewed by senior leadership, the PI Improvement Committee (1/11/17) Medical Staff committees (1/10/17 analysis and tracking including the RI Analysis process was highlighted. 20 analysis and recommendations for a reviewed by PI and MEC committee. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director the PI and MEC committees. Neg undesired trends will be discussed is committee for initiation of perform improvement actions as needed. The	erformance and the and e event toot Cause 016 data action were s.	
	This Standard is no	t met as evidenced by:			adverse event data analysis and tra quarterly basis to ensure implemen performance improvement program	tation of the	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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A 286	ITEM #1 - Analysis a Patient Events Based on interview, r quality documents, the analyze and track additional analyze agadverse patient evento identify root causes and may contribute to environment. Findings: 1. Review of the hospitaled "Incident Report (Policy #RM.200; Appithat the hospital's Risfor collecting incident analysis and trending Review of the hospital improvement Plan (P 12/2015) revealed that the Medical Executive Performance Improverisk management active sults of incident reppatient complaints to patient care occurrence corrective action is or extent possible. 2. An interview with the Quality (Staff Member PM and 12/20/2016 and Clinical Services (Staff Clinical Services)	record review and review he hospital failed to meaverse patient events. gregate data related to the related to	ew of asure, bility lans e led hisble cal lity of view and det 1:04 ector		Amendment 2/1/2017: Going fo PI Committee will receive action each Root Cause Analysis cond with a time frame for the complethose action items. The PI Comadd those items to minutes and follow-up at each of its meetings items are resolved. Action items typically be resolved within 90 disconer, depending on the urgen associated with that action items. compliance is 90% of all items of with 90 days. Any score below strequire remediation with the affeemployee and/or further analysis possible system issues	plans for ucted along tion of mittee will receive until all s will ays, some cy The target ompleted 90% will octed	

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A 286	A 286 Continued From page 21			A 286				
	the Risk Manager and but the data was not looking for patterns, improvement. b. Patient grievances individually but the data gregate looking for opportunities for implementaries for i	tients requiring a mediced to the Governing Boa a was not analyzed in a patterns, trends and rovement. a was not being collecte pose of looking for patte ties for improvement.	eeded s for wed n cal eard ed or erns,		ITEM #2 Reportable Adverse I The COO/CNO has educated th Director on the requirements o WAC246-302-010. All reportal outlined in the NQF list of repo	ne PI of ble events	2/10/17	
	Failure to recognize inhibits the hospitals review of the events. This failure places punsafe environment. Reference: WAC 24 "Adverse health events the list of twenty-ning."	adverse events. reportable adverse events ability to perform in-deand develop action platients at risk for care i	ents epth ans. n an means rents		adverse events, the requirement reporting adverse events and of submitting a root cause and discussed. All reportable adverse events will be reported in a time manner in accordance with WAC246-302-010.	ent for elements Ilysis were erse		

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A 286				A 286	ITEM #2 continued				
	Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to:				Persons Responsible: Pl Director COO/CNO		·		
					Monitoring		1		
					On a monthly basis, the PI/RM Direc				
					report all adverse events reported p WAC 246-302-020 to the PI committ				
					WAC 246-302-020 to the PI committ MEC and Governing Board quarterly				
	member resulting from	events: njury of a patlent or sta n a physical assault (i.e lithin or on the grounds	e.,						
	Findings:								
	The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments."		that port be						
	The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."			·					

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A 286	The policy did not ind reportable adverse e requirement for reposubmitting a root cau. 2. Surveyor #2 reviet patient assault result The patient was tran room for care and rehealth care appoint incident was reviewed and Quality (Staff Melnvestigation Chronocompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted with recompleted an adverse unaware that the considered an adverse was unaware that the considered an adverse had not been completed had not been completed to the policy. ITEM #3 - Completion Based on interview hospital failed to enplans developed during the plans developed during the plans developed during the policy.	clude the NQF list of events nor did it include rting adverse events ar use analysis. wed a report of a patient ling in a serious patient effect to the emergen equired follow-up special nents for his/her injuries ed by the Manager of Rember #12), and the ology and incident Recammendations for on the investigation. the Manager of Risk ar er #12) by Surveyor #2 PM about the patient to aled that Staff Member its particular incident were event by NQF. Staff that a root cause analy letted nor had the incide estate as required by hon of Action Plans and document review, sure completion of action plant to correct systemic prompletion of action plant to correct systemic pro	nt to injury. cy alty s. The isk ap was as f rsls int ospital the on events. ss limits		A 286 Item #3- Completion The COO/CNO and PI Direct analysis of adverse events a cause analysis elements by Director. Adverse reportal reviewed with credible activand implemented in a time. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/ present action plans based adverse events to the Pi co plans will include date/s ac persons responsible for act Staff and Governing Board actions taken in response t a quarterly basis to ensure the analysis and actions tal adverse events.	cor were trained on and credible root the Regional Clinical ole events will be on plans formulated by manner. RM Director will on analysis of mmittee. Action tions taken and ion. The Medical will be informed of o adverse events on implementation of	2/10/17
	rindings:						

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AND PLAN C	F CORRECTION	IDENTIFICATION NUMBE	R:	A. BUILDING	<u> </u>	COMPLET	ED
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A 286	Continued From pag	e 24		A 286			
	1. Surveyor #2 review for 3 adverse events Services (Staff Member 1:25 PM and with the Quality (Staff Member AM. Review of the accorrect identified issue). a. For the elopement change the policy "Costaff of a patient who the nursing unit) to "Completed although sewas being used by the b. For the sexual assaitems was a change the followed by audits to were properly conducted and the property conducted the prop	wed the root cause and with the Director of Clir ber #13) on 12/16/2016 Manager of Risk and r#12) on 12/20/2016 at tion plans developed to es revealed the followings wandered away from the code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not been taff were trained and Code E" had not be taken the taff were trained and Code E" had not be taken t	nical at at 9:20 or g: ert om ode ation ats risk aff	7, 200			
A 309	RESPONSIBILITIES The hospital's govern group or individual whauthority and responsible hospital), medical state officials are responsible ensuring the following 1) That an ongoing primprovement and patireduction of medical eimplemented, and mad (2) That the hospital-vand performance implemented implemen	ibility for operations of ff, and administrative ble and accountable for p: ogram for quality ent safety, including the errors, is defined,	the e ss		A 309 Corrective Actions The PI Director and Medical Director all elements of the PI plan and 2016 performance improvement activities Medical Staff and MEC committees (and 1/11/17). The processes for clinon-clinical analysis and tracking we highlighted. 2016 data analysis and recommendations for action were rethe MEC. The Medical Staff assigned representation to the Infection Cont Pharmacy & Therapeutics, EOC, Safe Performance Improvement committee committee participants will report committee to the MEC at least quarter	s with the (1/10/17 nical and are eviewed by d physician arol, ety and ees. These ommittee	2/10/17

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safety and that all evaluated. (5) That the deter distinct improveme annually.	safety and that all im evaluated. (5) That the determi distinct improvement	ge 25 provement actions are nation of the number o t projects is conducted		A 309	The MEC reviewed the 201 recommended priorities fo performance improvement Persons Responsible: Medical Director President of the Medical St	r quality and activities.	2/10/17
	This Standard is not met as evidenced by: Based on interview and review of the hosp performance improvement plan, the hospit Governing Body failed to provide oversight ensure that the quality assessment and performance improvement (QAPI) plan wa implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic probled develop action plans to improve patient calendary.		al's to s fully nt ie ms and		Monitoring On a monthly basis, the Plana in a monthly basis, the Plana in a measures for presentation committees. Negative or use discussed by the commer performance improvemen the Medical Staff and Govinformed of data analysis a quarterly basis to ensure in quality and performance in	analysis of PI to the PI and MEC ndesired trends will ittee for initiation of t actions as needed. erning Board will be and PI initiation of the mplementation of the	
	(Policy #RM. 300; A "Medical staff and n leadership for and a performance improcriteria for measurir organization performan-clinical process. They assure impler quality assessment and report the resu	erformance Improvement Approved 12/2015) state management staff proving actively participate in vement activities and early, assessing and impromente of both clinical assess and patient outcommentation of appropriate and improvement activities to the Board through Committee and Performities.	ed that ide stablish oving and ies. e vities h the				

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			TUKWIL	.A, WA 9816	88		
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A 309	Continued From pag	e 26		A 309			
A 309	The Medical Executive the Authority and Accordelivery and assessment contribute to the preventional improvement appropriateness and outcomes. Medical Exceptorial Executives, duly aperformance improve in the Medical Staff B. The hospital's Medical 2/1/2013) under the Executive Committee Management: (a) The overseeing quality as improvement are to evaluation of the qual assure its comprehent and document improvement outcome studit performance of this further a quarterly basis. 2. An interview with the Quality (Staff Member Clinical Services (Stat that the Medical Direct Performance Improvement participate in performance in performance of Risk and	re Committee is delegated ountability necessary for the fall processes the ention of problems and not of the quality, efficiency of patient care executive Committee and authority for ment activities are defivored in the ention of the ention	or the at the at the re ned uality ance nual am to ness, and t least of ed oes th . The	A 309			
	Cross Reference: A-0	9273, A-0286					

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A 405	5 Continued From page 27			A 405	A 0405 Corrective Actions		
) & (c)(2) ADMINISTRA	TION	A 405			
7, 100	OF DRUGS	,			The Clinical Educator reeduc		2/10/17
					staff on the requirement of a	dministrating	
	(1) Drugs and biologi	icals must be prepared	and		medications as ordered for th		
		ordance with Federal ar	ıd		alcohol withdrawal. The Clinic		
	State laws, the order	rs of the practitioner or			provided education during N		
	practitioners respons	sible for the patient's ca	re as		meetings through verbal and	written	
•	specified under §482.12(c), and accepted standards of practice.				communication.		
			أسما		Person Responsible:		
	(I) Drugs and blologic	cals may be prepared a orders of other practitio	nere		COO/CNO		
		§482,12(c) only if such	10.0				
		ng in accordance with 8	State		Monitoring		
	law, including scope	of practice laws, hospi	tal		The PI/RM Director/designee	will perform a	
	policies, and medica	il staff bylaws, rules, ar	d		random audit of at least 30 re	acords per month	,
	regulations.				to ensure compliance of 90%		
					consecutive months. Any def		
	(2) All drugs and bio	logicals must be			promptly addressed. Audit re	Suits will be	ļ.
	administered by, or t	under supervision of, n	ursing		presented to the monthly Pi		
		n accordance with Fede regulations, including	i ai		and Governing Board meetin	gs,	
		requirements, and in					
	applicable licerality	approved medical stat	f				
	policies and procedu				·		
	pendict in it						
	This Standard is not	t met as evidenced by:		i			
	Based on record rev	iew, interview, and rev	iew of				
	policy and procedure	e, the hospital failed to	ensure				
	that nursing staff foll	lowed physician orders	TOF oficiate				
	reviewed (Patient #7	withdrawal for 1 of 3 p 7).	audilla				
	E-lloup to fallous area	ch orders risks patients					
		e or improper treatmen	ł.	1			
	which may result in	patient harm.	•1	1			
	Winost may robuit in	Pennin imili					
	Findings:						

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(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X6) COMPLETION DATE	
A 405	1. The hospital's poli "CIWA" [Clinical Instit Assessment] (Policy 12/2013) established be assessed for symphow the patient's symusing a withdrawal as medications were to a the patient's score. The pre-printed order set Alcohol Withdrawal" physicians to order set an edications to be ad patient's withdrawal at 2. Review of the medications who experies withdrawal during the following: a. Patient #7 was a 5 admitted on 12/10/20 withdrawal. On 12/10 patient's physician or Withdrawal Protocol alcohol withdrawal sy Review of the medication of the medi	cy and procedure titled interview Withdrawal #AR.C.210; Approved how often a patient was proms of alcohol withdraptoms were to be score sessment scale and hope administered according policy included a titled "Lorazepam Orde (dated 5/15/2014) used pecific dosages of ministered based on the assessment score. dical records of three inced symptoms of alcohol initiating treatment of alcohol initiating treatment for mptoms. ation administration reced that on 12/10/2016 to go forazepam at 9:40 am at 2:20 PM.	as to awal; ed cw ing to ers for by e hol d the was chol ord he AM ed e ed on i the een		Amendment 2/1/2017: CIWA procurrently being audited daily by the Director of CD Services. Analysis audits will go to the PI Committee weekly PI Committee starting We February 1, 2017. The target cor 90%. Any score below 90% will remediation with the affected empand/or further analysis of possible issues. Once several weeks of cois achieved, monitoring will become with the same targets.	e Nursing s of the at each dnesday, apliance is equire bloyee s system ampliance		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION (DENTIFICATION NUMBER AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER (X1) PROVIDER (X1) PROVI		Lja :R:	1, ,	LE CONSTRUCTION	(X3) DATE SI COMPLE			
		504011		B. WING	tion of the same o	12/	21/2016	
	OVIDER OR SUPPLIER BEHAVIORAL HOS	BPITAL	12844 M	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	'ION SHOULD BE THE APPROPRIATE	(X8) COMPLETION DATE	
A 405	Continued From pa	age 29		A 405	11			
,		know why nursing staff						
A 490	490 482.25 PHARMACEUTICAL SERVICES			A 490	See Tags A0491, A0493, A	A0500		
	that meet the need- institution must hav registered pharmac under competent st is responsible for d procedures that min function may be de organized pharmac This Condition is not Based on observat review, the hospita pharmaceutical ser complexity, and ne Failure to provide a	ot met as evidenced by: ion, interviews, and doct I failed to provide sufficie vices to meet the scope, eds of the patients serve adequate pharmacy serv and safe medication	y a a staff ument ent					
	Findings:							
	prior to pharmacy	ing administered to patie verification of orders rest automatic dispensing mad	alting					
		edications not being veri to being administered.	fiedby					
		rs resulting from medicat tomatic dispensing mach						
	4. Expansion of ho	spital services, clinical u	nits,					

Printed: 01/09/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIF	E CONSTRUCTION	(X3) DATE SURV COMPLETE		
		504011		B. WING		12/21	/2016	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDS	T ADDRESS, CITY, STATE, ZIP CODE				
CASCADE	BEHAVIORAL HOSF	PITAL	Į.	MLITARY R _A, WA 981	OAD SOUTH 68			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
A 490	and patient census wincrease in pharmacy. The cumulative effect resulted in the hospit safe dispensing, use tracking and control of the scope and under 42 CFR 482.28 Participation for Pharmot MET. Cross Reference: Ta	without a comparable viservices coverage. It of these systemic profal's inability to provide and administration, and medications. It severity of deficiencies, the Condition of maceutical Services with the condition of maceutical Services with the condition of maceutical Services with the condition of maceutical Services with the condition of maceutical Services with the condition of the condi	for d s as	A 490	A 0491 Corrective Actions			
A 491	The pharmacy or dru administered in accorprofessional principle. This Standard is not a Based on observation policy and procedure that hospital staff follouse of a patient's own Failure of staff to follopatient's own medica for harm due to medi. Findings: 1. The hospital policy "Medications Brough PHR-118; Revised 4/4"for those medicated.	met as evidenced by: n, interview, and review, the hospital failed to a wed hospital procedur medications. by procedures for use a tions places patients at cation errors.	of of ensure es for of a trisk	A 491	The Clinical Educator reeducated the staff on policy titled "Medications B with Patients," Education was provided in Patients, and in Patients, and in Patients, and in Patients, and in Patients on Process is complete. Proper labeling and initialing of the process on home medication bottled. Physician orders needed for use of medications. The medical staff were educated or requirement of documenting dosage medication administration and order allowance of patient home medication. Persons Responsible Medical Director Pharmacy Director COO/CNO	rought in ded during pal and included; r the verification s, home the es for home ions.	2/10/17	

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	OVIDER/SUPPLIER/CLI NTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVI COMPLETED	
	504011		B. WING		12/21/	2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDRE				
CASCADE BEHAVIORAL HOSPITAL				DAD SOUTH		
		TUKWILA	A, WA 9816		=	(X6)
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST BE PRE TAG OR LSC IDENTIFYIN	CEDED BY FULL REG	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	,DBE	COMPLETION DATE
A 491 Continued From page 31 medications will be inspecte identification, labeling, and water of the pharmacist verification is verified, the a sticker on the packaging winitials and date the medication has been verified. "The order for a patient to tamedication must be written physician on the Physician's 2. A tour of the medication recare units (Gero-psych, Ref 12/19/2016 between 2:00 Prevealed the following: a. One bottle of home medication tray in the Reharoom. The pharmacist attactablets, was found for Patienmedication tray in the Reharoom. The pharmacist attactable to the medication bottle written on the label along with (12/17/2016) and initials of administered the medication 12/15/2016 and 12/16/2016 verification. b. Two bottles of home medication. b. Two bottles of home medication. b. Two bottles of home medication. care units (gero-psych, Ref 12/19/2016) and 12/16/2016 and 12/16/2016 werification.	visual evaluation a cation process. O pharmacist will plain the pharmacist will provide the pharmacist will process. O the pharmacist will provide the pattern of the pattern of the pattern of the pattern of the pharmacist. So the pharmacist will be pened/expiration pharmacy medical and labeled the pharmacy medical at 9:00 AM. The so the pharmacy medical at 9:00 AM. The so the pharmacy of the pharmacy medical at 9:00 AM. The so the pharmacy of the pharmacy medical at 9:00 AM. The so the pharmacy of the phar	nce lace st's the sthe on the station the		Monitoring The PI/RM Director/designee will per random audit of at least 30 patient's medication orders to ensure complithe verification process. Any deficie addressed promptly. Audit results were ported in the monthly PI and quarant Governing Board meetings. Amendment 2/1/2017: The pharm director is auditing 100% of home medications and will first report have to the weekly PI Committee on Vierbruary 1, 2017, to the Medical Committee on February 9, 2017 Governing Board thereafter. Audit or greater than 90% has been and sustained. The target comp 90%. Any score below 90% will remediation with the affected emand/or further analysis of possiblissues.	s own ance with ncies will be vill be rterly MEC nacy e is findings Vednesday, Executive and to the dits will ompliance achieved liance is require uployee	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETS	
•		504011		B. WING		12/21	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL.	12844 N	IILITARY R	OAD SOUTH		
	•		TUKWIL	ILA, WA 98168			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING (NFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 491	Continued From pag	A 22		A 491	· · · · · · · · · · · · · · · · · · ·	4. E. Maria	
A 481			to-	A 481			
		ime medications, Raya rvir 100 mg tablets and					
		ets, were found for Pati					
		edication tray in the Re					
		ere was an initial and d					
		medication bottle labe			•		
		rada) but the surveyor					
	unable to tell if the ini	•	vvas				
		ist verification. There w	iere				
		ation labels on the two	0.0				
		he Norvir medication h	ad no				•
	label with date and si						
		n. All of these medicat	ions				
		placed in the patient's					
•	medication tray. Two	notes were found in the			,		
	one stated that the pl	harmacist verified Truva	ada				
		ated the pharmacist ha					
	verified Norvir. The ne	otes were not attached	in				
	any way to the bottles	s of medication. Staff					
		e medications on 12/19					- [
		as a physician order for					}
		patient's own medication					
	but the order did not i	include specific dosage	es.		·		
÷			_				ļ
		medication, Dilantin 3	0 mg				
	capsules, was found		.,				
		ray in the Gero-psych					İ
		e pharmacist verified a					
		on. Staff administered the					
		2016 at 9:00 AM. Ther					
	was no pnysician oro his/her own medicatio	er for the patient to tak	e				ĺ
	nismer own medicalic	ori.					
	٠						
A 493	482.25(a)(2) PHARM	ACY PERSONNEL		A 493	·		
	The pharmaceutical s		121				
		personnel to ensure qu			·	-	
	. •	ces, including emergen	су				
	services.				·		
							ı

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
WAD STAM OF	CORRECTION	504011		B. WING		12/2	1/2016
		504011	OTOMET ABOU	RESS, CITY, STA		12/2/	1/2010
	OVIDER OR SUPPLIER	MT ()			OAD SOUTH		
CASCADE	BEHAVIORAL HOSE	TIAL		A, WA 981			•
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
A 493	This Standard is not Based on document hospital failed to ens staffed with sufficient provide quality pharm to meet the needs of providing care. Failure to provide su provide accurate and medication delivery pharm due to medicat Findings: 1. The hospital expa by 42 beds within the period, two additions (2 North - 18 beds; 2 the expansion, the h census (ADC) was 6 current ADC is 104.4 increase or an additi The hospital pharma	met as evidenced by: review and interview, t ure the pharmacy was t number of personnel t naceutical services in c i the patients and the st fficient pharmacy staff I timely order processin places patients at risk of	to order taff to g and of pacity g that pened or to order	A 493	A 0493 Corrective Actions Upon completion of the survey, the COO/CNO, Pharmacy Director, and Clinical Director reviewed pharmacy order to ensure a sufficient number personnel. Effective 12/20/16, the Director increased pharmacy staffir two (2) additional evening hours, so per week. The increase in pharmacy prioritized on verification of new or order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track additional staffing hours and repor in the monthly Pl and quarterly ME Governing Board meetings for a permonths. Any related deficiencies waddressed promptly.	Regional y staffing in r of Pharmacy ng hours by even days y hours are rders and t use of the t utilization IC and riod of 3	2/10/17
	pharmacy document key quality workload noted that the avera doses administered 12,000 doses since The total number of performed by nurses or nearly 87 per day	urveyor #3 reviewed a twhich captures a varied lelements. The survey ge number of medication monthly increased by the beginning of the year medication overrides averaged 2,593 per magnification.	or on over aar. oonth				
	monthly totals reflec	omatic dispensing mach it non-controlled substa increased to a monthly	nces		·		

~	OI CITIBLE DIONITIE ON IN	HERITAL SILVERON				CIVID 14C	7. 0000-000 1
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	1/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	PITAL	12844 N	TILITARY R	OAD SOUTH		
			TUKWIL	.A, WA 981	68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETION DATE
A 493	average of 685 items 3. On 12/14/2016 at interviewed a pharma about the adequacy of compared to the curn #9 acknowledged the substantially increase stated that since star almost a year ago, the more inpatient clinical corresponding increase hours or personnel. Signification orders was delayed up to an hour medication orders was delayed up to an hour new admissions. 4. On 12/19/2016 at 2 interviewed the Direct Member #8 stated the overrides occurring with Member #8 stated the medication overrides pharmacy is only one-hours. Surveyor #3 a s/he had sufficient phember #8 stated the pharmacy staff to do director of pharmacy worked over the contribute of the contributed in	11:30 AM, Surveyor #3 acist (Staff Member #9) of pharmacy staffing ent workload. Staff Me e pharmacy workload h ed within the past year. ting work at this facility e hospital had added to al units without a use in pharmacy operate staff Member #9 indicate around time for verifying as 30 minutes but may ar depending on volume 2:30 PM, Surveyor #3 etor of Pharmacy (Staff e high number of medicate within the hospital, Staff at he/she had only bee tal staff for "less than a	ember ad S/he wo ing ted ing new be of cation n a hat t if if inad ek		Addendum 2/1/2017: Pincreased its hours of coverence of coverence of coverides daily and analyzed for time drug, and reason for the continue to meeting begin February 1, 2017. Pharm continue to be adjusted as minimize the use of the own The facility will continue to needed by the pharmacy frecommendations by the corovider, number of oversof pharmacist to conduct the review, and medication erroverides.	harmacy has erage in the are being tracked e of day, type of verride. The PI rector will formally e weekly PI ning Wednesday, acy hours will a necessary to verride process through contracted ides due to lack he first dose	
	interviewed the Direc Nursing Services (Sta high number of medic	11:00 AM, Surveyor #3 tor of Adult Psychlatric aff Member #6) about to cation overrides occurritated the second	he ing				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA R:		LE CONSTRUCTION (X3) DATE SU COMPLE	
		604011		B. WING	12/	21/2016
			OTDEET ADDE	ESS, CITY, STA	TE, ZIP CODE	
	OVIDER OR SUPPLIER	- 104 Å h			DAD SOUTH	
CASCADE	BEHAVIORAL HOSE	TIAL		.A, WA 9816		Ì
			<u></u>		PROVIDER'S PLAN OF CORRECTION	(X6)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTHYING INPORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
A 493	Continued From pag	ne 35		A 493		
A 493	that medication over think medication ove staff member acknow overriding because of to be verified in the s also complained the medications in the all machines on the weat Monday mornings" in	rides is a "problem" sta rrides are dangerous." wledged that nurses we of how long it takes for a system. Staff nurses ha y frequently run out of	The re orders ve			
					_	0/40/47
A 500	482.25(b) DELIVER	Y OF DRUGS		A 500	A 0500 Corrective Actions	2/10/17
	In order to provide p biologicals must be a accordance with app consistent with Fede This Standard is not Based on document review of hospital po hospital failed to ens	atient safety, drugs and controlled and distribute blicable standards of preral and State law. met as evidenced by: reviews, interviews, ar blicies and procedures, sure drugs were control	ed in actice, actice, actice, actice, actice the action ac		The Pharmacy Director, COO/CNO, and PI/RN Director reviewed the process of medication overrides in the automated dispensing system To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides ar needed -Weekly review of overrides to assess for	
	standards of practic				trends, rationale, and any needed system improvements	
	medication orders to in a safe and timely and medication erro Findings:	•	nsed		The Clinical Educator educated the nursing an medical staff on the revised system changes foversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication.	or
	"After-Hour Medicat Pharmacy Review" PHR-169I) under th Policy" read "The fa importance of phare	by and procedure titled tion Stock with or without (Revised 4/2014; Police e section titled "Statem will recognizes the macist review prior to ing. This review has been	y# ent of itiation		Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/C	LIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUR	VEY
	F CORRECTION	IDENTIFICATION NUMBE		A. BUILDING		COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	- I	(18/0 FW) - (1
	BEHAVIORAL HOSP	ΙΤΔΙ			OAD SOUTH		1
0,1007102	22,000,000,000			LA, WA 981			
	01101114 034 03	TARCAMAT OF BECINES (AITO				OM : 1	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFIGIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETION DATE
A 500	Continued From pag	e 36		A 500	Monitoring		
	, -	on errors associated wi	th the		The Pharmacy Director/designee wi	ll report on	
		essThe hospital allow			the total number of overrides with	, ,	
	an exception to phare				trends, analysis, and system improv		
		certain situations when	time		the monthly PI and quarterly Pharm		
	does not permit phan	macist review. This ofte	en		Therapeutics committees. Findings		
		or 'emergency' situation			recommendations and actions will be		
		otion is allowed becaus			and reported at quarterly MEC and		
		rm could result in the d	elay		Board meetings. Committee minute	- 1	
	involved for a pharma				data reporting, analysis, and system	,	
		d the potential harm wo				3.1.0.1.	
	outweigh the benefits	of a pharmacist review	<i>'</i> ,"		A500 Amendment 2/18/2017	.	
	, o. 4010010046 C.	managed to a continue of the		1	Cascade Behavioral Health was	cited for	
		rveyor #3 reviewed a which captured a varie	tu of		pharmaceutical services not med		
		indicators that included			needs of its patients. The cumul		
		and medication overri			of these systemic problems/findia		
		he hospital had a total			in the hospital's inability to provid	e for safe	
		verrides performed by r			dispensing, use and administration	on, and	
		ns of 2016. Prior to the			tracking and control of medicatio		
	expansion of the hos	pital bed capacity, the			Immediate response included inc		
		21 medication override:	sa		pharmacy hours by two (2) addit		
	month. With the oper	ning of the two addition	al		evening hours, seven (7) days po		
		mber of medication ove	rrides		That staffing enhancement resul		
	had risen to a month				overrides being reduced to appro	eximately	
		ncrease or 479 addition			10 per day. Since then, the medical staff con	eidored e	
		the surveyor noted that			night locker concept with a small		
		n variances (potential e creased by four fold sin			inventory of medications but ultir		
	beginning of the year		re ne		decided not to endorse this idea.		
	neaminity of the Jest	1 x			Collectively, these systemic issu		
	3. On 12/19/2016 at :	3:00 PM, Surveyor #3			additional time to implement prod		
		medication override lis	st for		change, arrange additional phar		
	the period 12/16/201				coverage, establish 24/7 coverage		
		M (the weekend) in wh	ich		to review all orders, and eliminat		
		se coverage is only 6 h			access and overrides.	-	
	day. During this time	period, the hospital	,				
		and there was a total of		,			
		initiated by the nursing					
		n overrides which occu	ırred				
	over the weekend, 85	of the overrides listed					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		, ,		(X3) DATE SURVE COMPLETED	Y
		504011		B, WING		12/21/2	016
	OVIDER OR SUPPLIER BEHAVIORAL HOS	PITAL			DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X6) COMPLETI ON DATE
A 500	"First Dose Needed' pharmacy had not your order in the automat 11 medication over as the reason for the 4. On 12/19/2016 at interviewed the Dire Member #8) about to overrides occurring Member #8 indicate override and obtain hospital's automated He/she acknowledg formulary was accessary restriction. 5. On 12/20/2016 at interviewed the Dire Nursing Services (Shigh number of med within the hospital, that medication over problem. The staff rowas processing "too incident reports. Stamember of the Phat Committee to see if progress could be racknowledged discurrentings with the period (Staff Member #10) (Staff Member #11) (Staff Member #12) to continue to monit	as the reason indicating et verified the medication ted dispensing system. It idea listed "Emergency e override. 12:30 PM, Surveyor #3 actor of Pharmacy (Staff he high number of medications of the high number of medications and all medications and all medications dispensing machines. It is a listed that the hospital's ensible to all nurses without the dispensing machines. It is a long standing member confirmed that the common medication error aff Member #6 asked to many medication error aff Member #6 asked to macy & Therapeutics is some improvement or made on this issue. He/sussing medication overriance in medication over the situation.	cation f cation f can in the dire but the lng ted f s/he des des in tor ficer hager		Proposed Interim Plan Temporary night and weeke provide additional coverage by February 24, 2017. The present in the pharmacy to all new orders during their s day-shift pharmacists curre nurses' ability to override m disabled permanently. All i will be verified by a pharma administration. Responsible Person Pharmacy Director (Pharm Proposed Long Term F On or about April 1, 2017, s transition pharmacist cover through a combination of p and remote order entry. Th Director, CEO and COO ar options to obtain the neces establish this service withir timeframe.	e will be in place by will physically be review and enter shift, just as the intly do. The nedications will be medication orders acist in Charge) lian the facility will rage to 24/7 harmacist on site ne Pharmacy re evaluating stary resources to	
A 700	482.41 PHYSICAL	ENVIRONMENT		A 700			
		be constructed, arranged re the safety of the pation				•	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE					
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, S	STATE, ZIP CODE	1	
CASCADE	BEHAVIORAL HOSP	ITAL	12844 M	ILITARY	ROAD SOUTH		
			TUKWIL	A, WA 98	3168		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID . PRE FIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
A 700	Continued From pag	e 38		Α	Mark Late Wild Late District Nation		
	and to provide facilities			700			
		ecial hospital services					
	appropriate to the ne	eds of the community.					
	This Condition is not	met as evidenced by:					
•	, B					ļ	
		ns, document review, a lospital failed to ensure			·		
		ical plant and the overs					1
		was maintained in suc					
		ty and well-being of pat					
	was protected.	•					
	Fallure to maintain th facility plumbing and	e structural integrity of ventilation system.	the				:
	Failure to follow man maintenance activitie	ufacturer-recommende s and schedule.	d				
	Failure to remove ligareas.	ature risks in patient ca	re				
		d provide appropriate for to ensure food tempera e required levels.					
	cited under 42 CFR 4	d severity of deficiencie 182.41, the Condition o sical Environment was	f				
	Cross Reference: Ta A0726	gs A0701, A0710, A07	24,				
A 701	PLANT	ANCE OF PHYSICAL		A	A 701 Corrective Actions 1. and 2. The Facilities Director reedu on environmental factors contributing		2/10/17
	hospital environment	physical plant and the o must be developed an manner that the safety	đ		and self-harm risks particularly related and handles. Training included mitiga strategies such as patient observation	d to doors tion	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1'''	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		504011		B. WING	(All Pilot P	12/21	/2016
MAKE OF DR	OVIDER OR SUPPLIER	<u></u>	STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE		
	BEHAVIORAL HOSF	ЭΙΤΔΙ	l		OAD SOUTH		
CHOCHDL	2 DEHAVIORAL HOUR	TIME	1	_A, WA 981			•
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULDBE	(X6) COMPLETION DATE
A 701	Continued From pag	ne 39		A 701	A 0701 Corrective Action		
71701	well-being of patients		•				
	West-being or patient	are aboutou.			increased monitoring of high risk	patients.	
	This Standard is not	met as evidenced by:			Staff required to successfully cor		
	THIS STAIRGARD IS NOT	includ dyladilodd by.			training test.	•	
	Based on observatio	n, interview and record			3. Bathroom flooring was repai	red by	
		ailed to maintain the co			(contractor) on 1-12-17.	,	
	of the physical plant	and the overall hospita	1	•	4. Ceiling links were repaired by	(contractor) on	
	environment of care.				1-12-17.	(20,111,121,1	
					5. Occluded pipes were repaired	hy contractor	
	Failure to maintain th	ne physical plant increa	ses		1-12-17	a by continuetor	
	the risk of infection to	patients, staff and vis	itors.		6. Ceiling tiles were changed 1-	16 17 hu	
		•				IO-TI DY	
	Findings:				Maintenance staff	*********	
			•		7. Burnt outlet was replaced by	waintenance	
	1, On 12/13/2016 at	10:00 AM Surveyor #1			staff by 12/23/16		
	observed the door in	the sunroom in the			8. Shower mold was remediated	i, old caulk was	
	Gero-psychiatric unit	t had a closure mechar	ism		removed and the area cleaned a	nd re-caulked	
	that posed a ligature	risk. In review of the			by Maintenance staff (1/9/17)		
	"Proactive Risk Asse	essment dated August :	2016,		9. Oscillating fans have been ins		
	the facility had identi	fied door risks in geriat	ric unit		PHP patient care areas. Perman	ent ventilation	
	and assessed it as "	High" or "Severe Risk".	The		systems are being evaluated.	:	
		olumns labeled "What					
		e", and "Intermediate			Persons Responsible:		
		or this item had limited	or no		Plant Operations Director	·	
	information provided	in these columns.			CEO		
	2 On 12/12/2016 of	10:00 AM Surveyor #1	,		•	•	
	observed that the ha				Monitoring:		
		in the sunroom posed	ន		The Plant Operations Director/d	esignee will	
	igature risk	illi ille sullisoni possa	4		perform environmental rounds	of the patient	
	iligature risk				care areas to monitor ligature ri		
	3 On 19/13/9018 of	10:10 AM Surveyor #1			flooring/walls/ceilings, furnishin		
		oring in the bathroom			cleanliness and structures. Any	deficiencies will	
	adult psychiatric unit				be promptly addressed during t		
	underneath the vinvi	and that vinyl was ripp	oled		environmental round. Results of		
	and not smooth. The	e bathroom was located	l next		environmental rounds will be re		
	to 3 showers on 3 W				monthly PI committee and quar		
	O O SHOWOLD ALL A AL	.004			,	FOLIA MIEC	
ı	4 On 12/13/2016 at	10:25 AM Surveyor #1			meetings.		
		ueion room on the aditi					

<u> </u>	ST OLYMEDION HAD ON H	PERSONAL OFFICERS	7007			OMID IAC	, 0000-000 I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, ST	ATE, ZIP CODE	14.	
CASCADE	BEHAVIORAL HOSP	PITAL	12844 M	LITARY R	OAD SOUTH		
			TUKWIL	A, WA 981	68		
844.15	O VERMANDAY O'	FATEMENT OF DEFICIENCIES				<u></u>	fVE\
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	OBE {	(X5) COMPLETION DATE
A 701	Continued From pag	e 40		A 701	Amendment 2/1/2017: The pi	oes were	
	psychiatric unit (2 We	est) a large crack in the	,		occluded by temporary obstru		
	ceiling, the crack app				have been assessed by an		
		ere work had previously	been		independent, professional plur	mher	
'	done. On 12/14/2016	between the hours of	2:00		The pipes have no on-going n		
	PM and 3:00 PM Sur	veyor #1 observed tow	els		except routine cleaning and	ceus	
	soaked in water on th		1			na aniaa	
		West where the ceiling			maintenance. To improve clear		
		eyor #1 went to 3 Wes			maintenance, the hospital pure		
		the seclusion room and	. ,		distinct brushes to scour the d		
		showers previously stat			to remove hair and other debr		
	i	above the seclusion roc	· ·		cleaning will occur monthly an		
		d that one of the show	ers		needed and has been added t		
	was in use during the	incident.			and housekeeping rounds. Th		•
	5 On 12/15/2018 hal	ween 9:00 AM and 10:	00		hospital has switched to psych		,
	1	erved flooding over the			paper towels that dissolve who		
		floor on 3 West next to			address drain clogging issues		
		ent, the surveyor obser					
		mber #17) "snake" the					
		ounts of hair. Surveyor			A701 Amendment 2/18/2017		
		n of the pipes using a			We propose to cool, circulate, an	d	
		he pipes were occluded	d.		dehumidify our outpatient/PHP ro	oms with	
					two portable air conditioners desi	gned for	
	6. On 12/13/2016 bet	ween the hours of 10:2	5 AM		that purpose, one in each room w	vhere	
		or#1 observed water			patient care is delivered.		
		ile located in the Rehat	o unit		The rooms measure:		
	laundry room.				1) 19 feet by 19 feet (361 square		
			_		2) 17 feet by 29 feet (493 square	re feet)	
		ween the hours of 10:2					
		1 observed a burnt out			Before the summer heat arrives,		
		ea in the Rehab unit, th	IIS IS		install two Honeywell model MM1		
	a potential fire hazard	lr.	1		similar, units which are designed		
	8 On 12/13/2018 hat	ween the hours of 10:2	5 and		500 square feet. These quiet unit		
•		1 observed mold under			14,000 BTU cooling. They can be		
		ower room in the rehab			cool or use the fan and dehumidi The units' venting kits would be in		
					the air conditioner to operate pro		
	9. On 12/15/2016 bet	ween the hours of 1:30	PM		ino an conditioner to operate proj	peny.	
	and 3:00 PM Surveyo						
		HP Building), the building	ngs				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		504011		B, WING		12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N	RESS, CITY, ST/ JILITARY R LA, WA 981	OAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE PRIATE	(X5) COMPLETION DATE
A 701	ventilation system ha fire. Surveyor #1 obs used for group sessi- did not have any wind skylights that did not ventilate in both room	nd not been replaced at served 2 large rooms th ons for patients, one ro dows and the other roo open creating no meal	at are om m had ns to	A 701	Between now and the installation units, ventilation of these patient rooms will be accomplished by the forced heaters currently in use at oscillating fans. No policy is nee staff to turn on the air conditionin be based on a consensus of the patients and staff at the time as a comfort.	care ne fan- nd ded for g. This will group of	,
	(i) The hospital m provisions of the Life Fire Protection Asso Office of the Federal NFPA 101 2000 edit issued January 14, 2 reference in accorda 1 CFR Part 51. A colinspection at the CM Center, 7500 Securi or at the National Ar Administration (NAR availability of this ma 202-741-6030, or go http://www.archivesfederal_regulations Copies may be obta Protection Associati Quincy, MA 02269. of the Code are incovill publish notice in announce the chang (ii) Chapter 19.3.	A). For information on aterial at NARA, call to to: gov/federal_register/cos/lbr_locations.html ined from the National on, 1 Batterymarch Par if any changes in this eprorated by reference, the Federal Register to	ational ational ational atine dithe ode, by (a) and ble for se e, MD the ode_of Fire rk, dition CMS o	A 710	A 0710 Corrective Actions The hospital will not require a waive comply with 482.41(b)(1)(2)(3).	er to	
	findings, CMS may the Life Safety Code	ilon of State survey age waive specific provision e which, if rigidly applie asonable hardship upor	ns of d,				- A A A A A A A A A A A A A A A A A A A

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B. WING		12/21	/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		TAIN MEDIAN
CASCADE	BEHAVIORAL HOSP	ITAL		MILITARY R LA, WA 981	OAD SOUTH 68		•
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X6) COMPLETION DATE
A 710	facility, but only if the affect the health and (3) The provisions of apply in a State wher safety code imposed protects patients in home the standard is not a sased on observation review, the hospital farequirements of the L National Fire Protectivedition.	waiver does not adver safety of the patients. the Life Safety Code d e CMS finds that a fire by State law adequate ospitals. met as evidenced by: n, interview, and docum	o not and ly	A 710			
A 724	Care Hospital MEDIC reports. 482.41(c)(2) FACILIT EQUIPMENT MAINT Facilities, supplies, a maintained to ensure safety and quality. This Standard is not a liem #1 Medical Supplier.	ENANCE nd equipment must be an acceptable level of met as evidenced by: blies	ction	A 724	A 0724 Corrective Actions #1- Medical Supplies The COO/CNC directed/delegated monthly inspect Materials Department staff, Nursing Pharmacy staff to ensure that all su medications are not expired and wit specified on the manufacturers labe Expired/nearing expiration products properly disposed of timely. All exp supplies and medications were rem discarded on 12/21/16. Person Responsible: COO/CNO	tions by the g staff and pplies and thin date eling, s will be pired oved and	2/10/17
	review, the hospital factories supplies did not designated expiration Failure to ensure pations exceed their expiration	n, interview, and recordailed to ensure that pat exceed the manufactured date. ent care supplies do no en dates risks deterioral	ient rer's ot ted		Monitoring: The COO/designee will environmental rounds of the patien to monitor integrity of products, sulmedications. Any deficiencies will baddressed during the environmental Results of the environmental round reported in the monthly PI committ quarterly MEC meetings.	t care areas oplies and e promptly if round.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		LIA III DINIG		E CONSTRUCTION	(X3) DATE SUR COMPLETE	VEY SO	
		504011		B, WING	-	12/21	/2016
	ROVIDER OR SUPPLIER E BEHAVIORAL HOSF	PITAL	12844 N	RESS, CITY, STA MILITARY RO LA, WA 981	DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RI ENTIFYING INFORMATION)	5 EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE S APPROPRIATE	(X5) COMPLETION DATE
A 724	Findings: 1. On 12/12/2016 at West adult psychiatr following items in the a. One 500 ml bottle Irrigation with an exp b. One 500 ml bottle Irrigation with an exp c. One box of sterile with an expiration date with an expiration date of 10 f. One 14 french Following: a. Two 1000 ml 0.99 intravenous fluids w 5/2016. b. Five 10 ml 0.9 % syringes with an expiration date with an expiration	t 11:00 AM during a toutic unit, Surveyor #3 for a wound supplies cabir of 0.9% Sodium Chlorioiration date of 4/2016. of 0.9% Sodium Chlorioiration date of 9/2016. cotton-tipped applicate ate of 2/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016. cotton-tipped applicate ate of 9/2016.	ind the net: de for de for ors with an h an found f		Amendment 2/1/2017: Deling conducted on each of champions are responsible ice machine logs to make so cleanings are happening at The results of those audits weekly PI Committee on Williams February 1, 2017. The targent power unit. Any score be require remediation with the employee and/or further are possible system issues.	of the units. Uniter for checking the sure the sure the sure the sure the sure the sure the sure to the sure the sure the sure the sure that t	

		(X1) PROVIDER/SUPPLIER/CI	ROVIDER/SUPPLIER/CL(A DENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLET			
	504011			B. WING		12/2	1/2016		
NAME OF DD	OVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
					DAD SOUTH				
CAGCADE	. DETATIONAL TICOP	110-		.A, WA 9816					
AINIL			***************************************				l age		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE- ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
A 724	Continued From pag	e 44		A 724		·			
	inspected the gero-psychiatric unit (4 West) emergency cart and found the following:								
	a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016.								
	b. Nine 10 ml 0.9% So syringes with an expir	odium Chloride pre-fille ation date of 5/2016.	d						
	c. Five Tegaderrm intr expiration dates of 11	avenous site dressings /2015 and 4/2016.	with						
	the medication room	I:11 PM Surveyor #2 to on the Detox Unit and fi lium Chloride pre-filled ation date of 5/2016.	ound						
	and 2:25 PM Surveyo (transparent adhesive	ween the hours of 1:00 or #1 found Tegaderm e film dressing) with an 6 in the crash cart loca							
	5. On 12/13/2016 at inspected the emerge and found the following	ency cart on the Rehab	Unit						
	a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016.								
	b. Nine 10 ml 0.9% So syringes with an expir	odium Chloride pre-fille ation date of 5/2016.	d			,			
	2:25 PM Surveyor #1 staff (Staff Member # the interview Surveyor	ween the hours of 1:00 interviewed central su 18). During the course or #1 asked how often t carts are checked. The	pply of he						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		Ι' '	LE CONSTRUCTION	(X3) DATE SUR COMPLETE			
•	50401			B. WING	A. A	12/21	/2016		
	OWDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N	ADDRESS, CITY, STATE, ZIP CODE 44 MILITARY ROAD SOUTH (WILA, WA 98168					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	B EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
A 724	central supply person part of his/her respondents monthly. He/sh checked the crash called the called the crash called the cra	n was unaware that it was ibilities to check the destated that he/she has arts 4 months previous is on, document review and failed to follow action for preventive ation and routine clean indicacturer's instruction ince, routine cleaning as the growth of ich places patients head series/W, MCD400AW, AW, D400AW Ice Manual Service Manual Service Manual Service Manual Service installation arect installation as followater can collect that restricts ice flow at results in wet ice and problems	crash ad ly. Indicate the ser. Intraction of and and and and and and and and and and	A 724	#2 Ice Machines The Plant Operations Direct certified contractor to performanufacturer recommended cleaning for the Ice machin were serviced during the ward 1/20/17. This certified control Plant Operations Staff on patechniques. Person Responsible: Director of Plant Operation Monitoring: The Plant Operation Monitoring: The Plant Operations inspections of all Ice machicle cleanliness and operations will be promptly addressed environmental rounds. Resumention monthly Plant Committee and meetings.	orm the ed maintenance and es. All machines eek of 1/16/17 to ractor will also train roper cleaning es. Any deficiencies I during the lits of the be reported in the	2/10/17		

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SI COMPLE	
		504011 [,]		B. WING		12/	21/2016
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL		MLITARY RC LA, WA 9816			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE
A 724	following cleaning fre page 14 and 17: "the sanitizing ice machinibelow:" Semi-annually prever Drain Line - weekly Drain Pan/Drip Pan - Findings: 1. On 12/13/2016 bet and 1:45PM Surveyo from a Follett Ice Mac to the floor drain. The the patient kitchen ar preventive maintenar 9/2016 and the grate build-up. 2. On 12/14/2016 bet and 10:00 AM, Surve hospital plant manag Member #19 stated it maintenance was bet a company to get the how often they get prhe/she said, annually from the company, "Neveral machines recompanded in the prevention, Surveyor #1 generated from the ha "Follett" ice machines cheduled for preventions sheduled for preventions.	quency for both models frequency in cleaning a according to the scheen according to the scheen according to the scheen according to the scheen according to the scheen according to the weekly ween the hours of 1:00 and the was not slope to go ice machine was located and the Rehab unit. The sticker was past due on the drip pan had resulted the ween the hours of 8:30 and the drip pan had resulted the ween that the ice machined so they contracted the condition of the work order did not indicated the work order did not indicat	and odule OPM ine grade ed in The e sidue O AM Staff hine I with ked ers owed rough te cated	A 724	DEFICIEN	NUT)	
	scheduled for preven 2/11/2015, was cross			- Constitution of the Cons			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBER		ALIA [* '		2) MULTIPLE CONSTRUCTION BUILDING		/EY D	
		504011		B, WING		12/21	/2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSF	PITAL	12844 N	RESS, CITY, STA MILITARY RO _A, WA 9810	DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X6) COMPLETION DATE
A 724	work was done. 3. On 12/14/2016 be and 2:45 PM Survey	tween the hours of 1:00 or #1 observed soil buil drain line of the ice mad	ldup	A 724			
A 726	482.41(c)(4) VENTIL TEMPERATURE CO There must be proportemperature controls preparation, and oth This Standard is not Based on observation implement policies a with the Washington WAC 246-215 and FAdministration. Failure to follow the staff, and visitors at Findings: 1. On 12/12/2016 be PM, Surveyor #1 ob pasta greater than 2 refrigerator. For foc 2 inches, staff must and times to ensure cooling time-frame a State Retall Food C document cooling time-frame as	ATION, LIGHT, onTROLS er ventilation, light, and a in pharmaceutical, focer appropriate areas. met as evidenced by: on, the hospital staff fail and procedures consiste State Retail Food Codfederal Food and Drug food code places patie risk for foodborne illness at the served two containers of the code in the walk-in code with a depth greater document temperature foods cool within the reas specified by Washing ode. The hospital did names for the pasta. In the state Retail Food of the pasta. In the state Retail Food of the pasta.	ed to ent ent e, nts, as. 2:15 of cooling r than dates equired gton ot Code i01.14		A 0726 Corrective Actions The Dietary Manager purchased in thermometers and provided training the new thermometers. The Diet reeducated all dietary staff on the techniques and requirements of otemperatures and maintaining reffreezer temperatures. All require temperature requirements will be Person Responsible: Director of Dietary Monitoring: The Dietary Director/perform weekly inspections of all refrigerator, and freezer temperamonitor adherence to the WAC 24 and FDA3-501.14 codes. The Diet Director/designee will perform we observation monitors of staff peritemperature checks. Any deficie promptly addressed during the mof the both monitors will be reported the poth monitors will be reported the monitors.	ng on use of ary Manager proper btaining food rigerator and delogged daily. designee will food, tures logs to accept the early random forming encies will be onitor. Results are the din the	2/10/17
		etween 11:00 AM and 1 served dietary staff (Sta		-	,		

	OF DEFICIENCIES FOORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	LIA IR:	l' '	LE CONSTRUCTION	(X3) DATE SURV COMPLETER	
		504011	B. WING			12/21/	/2016
	OVIDER OR SUPPLIER		STREET ADDRE				
CASCADE	BEHAVIORAL HOSP	ITAL		LITARY RO A, WA 9810	OAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X6) COMPLETION DATE
A 726	Member #20) using a inaccurately when tal "Ruben Sandwich". I temperature indicator stem; the staff inserts sandwich thereby poreading. The type of staff was not designed meat patties, fish filled in addition, Surveyor thermometer's accurate thermometer with 2 control ice-bath registered at the temperature.	a food probe thermome king the temperature of the thermometer is located half way uped only the tip into the tentially giving an inact thermometer used by the to temp thin foods suts, and other thin food i	the curate he che sch as tems. In the dwich" grees		Amendment 2/1/2017: Daily a being conducted in the kitchen. Is under revision. Staff education process. The dietary manager were process are dietary manager were proposed for monitoring real-tire compliance related to food temperature throughout the department. The Control nurse will double check, weekly basis, to make sure staff complying with standards. The remarked throughout first go to the weekly Committee on Wednesday, Febr 2017. The target compliance is secore below 90% will require remarked analysis of possible system issued.	The policy n is in iil be me eratures Infection on a are esults of y PI uary 1, 90%. Any nediation or further	
A 749	WAC 246-215-04338 Reference: Washing WAC 246-215-04586 482.42(a)(1) INFECT The infection control develop a system for investigating, and co communicable disea personnel. This Standard is not ltem #1 Hand Hygier Based on observatio	ton State Retail Food C) TION CONTROL PROC officer or officers must identifying, reporting, ntrolling infections and ses of patients and met as evidenced by: ne	Code, BRAM	A 749	communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practitioner Control Practition Control Prac	importance nedication ided during vritten ontrol hand tration with sper unit. during the swill be	2/10/17
		e, staff failed to perform			reported during the monthly PI and MEC meetings.		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU		LIA		LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		504011		B, WING		12/21/	/2016
NAME OF PF	OVIDER OR SUPPLIER			ESS, CITY, STA			
CASCADE	BEHAVIORAL HOS	PITAL		IILITARY R .A, WA 981	OAD SOUTH 68		
(X4) ID PREFIX TAG	FACH DEFICIENCY MUS	BTATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE PRIATE	(X5) COMPLETION DATE
A 749	Failure to perform he staff at risk for infect Findings: 1. Facility policy titles #IC.HH.100, review. III. INDICATIONS FANTISEPSIS C. Dhaving direct or indice Decontaminate hampatient's intact skin. after contact with be mucous membranes. 2. On 12/13/2016 at observed a register administer oral medications, and with the patient's or administration, did in the patient's oral medications, and in the patient's oral medications, and in the patient's oral medications, did in the patient's skin. Item #2 Dietary Sar Based on observations with the compliance with	and hygiene puts patiention. and "Hand Hygiene", ed 10/2016 read in part: OR HANDWASHING Al Decontaminate hands be rect contact with patient ds after contact with a G. Decontaminate han ody fluids or excretions, s" 19:00 AM Surveyor #4 ed nurse (Staff Member dications to a patient. S/l ygiene (HH) before prep d though s/he came in o al secretions during not perform HH afterwar t 9:45 AM Surveyor #4 red nurse (Staff Member dications to a patient. S/l or to or following pite numerous contacts infation ion, the hospital failed to and procedures to ensu a Washington State Ret 15 WAC) and the Federa	" ND efore s F. nds #14) ne did earing contact d. #15) he did with		2) The Dietary Manager obtained in thermometers designed to measure temperatures properly. The Dietary educated the dietary staff on the properties of the food thermometers with an empacturate insertion. The education with during staff meetings with the use of written communications. Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a of 30 random audits per month x 3 ensure proper temperature monito deficiency will be promptly address of the audit will be reported in the land quarterly MEC meetings. 3) The Infection Control Practitioner educated the housekeeping staff following procedures for proper clepatient care areas: -Allowing for a 10-minute contact the using Virex 256 disinfectant solutionavoidance of cross-contamination cleaning brushes. -Proper dusting procedures to avoid exposure. -Maintaining possession of carts at Person Responsible: Plant Operations Director	food Manager oper use of chasis on as provided if verbal and minimum months to ring. Any ed. Results monthly Pi er on the aning of time when in, when using d patient	

	STATEMEN OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN C CORRECTION IDENTIFICATION NUMB			1.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	504011			B, WING		12/21	/2016	
		A STATE OF THE STA	OTREET ADOC	RESS, CITY, STA	TE ZID CODE			
	OVIDER OR SUPPLIER				•	-		
CASCADE	BEHAVIORAL HOSP	ITAL	-	4 MILITARY ROAD SOUTH WILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES I' BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	ON DBE PRIATE	(X5) COMPLETION DATE		
A 749	Continued From pag	e 50		A 749	Monitoring			
11110	Failure to follow best	food practices places sitors at risk for foodbo	rne		The Plant Operations Director will pomonthly environmental rounds of the care units to monitor contact times, of cleaning brushes and dusting, and	ne patient proper use		
	Findings: 1. On 12/12/2016 between 11:00 AM and 12:15				maintenance of cleaning carts. Any will be promptly addressed during the environmental round. Results of the	deficiencies he		
	PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer.				environmental rounds will be report monthly to EOC and PI committees a quarterly MEC meetings.	L		
		on State Retall Food C (2) (2009 FDA Food C						
	PM Surveyor #1 obse	tween 11:00 AM and 13 erved signs of algae gr panel of the ice machi itchen.	owth		-			
	Reference: Washingt WAC 246-215-04605	on State Retail Food 0 (5)(d)(ii)	ode,					
	Item #3 Housekeepir	ng Cleaning						
	Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms.		-					
	use and hospital poli	ufacturer's instructions ces and procedures infection/illness to patie						
	solution to hard, non-	56 Diversey: "Apply us porous environmental s must remain wet for 1						

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	OMDERISUPPERRICAIA II.		LE CONSTRUCTION	(X3) DATE SURVEY.	
		504011		B. WING	Market I and a second s	12/21/	2016
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL			OAD SOUTH 68		ME
(X4) ID PREFIX TAG	(FACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE DATE.	
A 749	Findings: 1. In review of hospit titled: "Daily Cleaning 8/2016) stated in part the room to clean. Cat all times." 2. On 12/13/2016 at observed a houseked during a daily clean eviron with the proceeding. The houseked contact time as requinstruction for use. 3. On 12/13/2016 at observed a houseked during a daily clean surveyor observed to clean a shower flet to clean a shower flet the same brush. 4. On 12/13/2016 at observed a houseked during a daily clean surveyor observed to clean a shower flet to clean a shower flet the same brush. 4. On 12/13/2016 at observed a houseked during a daily clean surveyor observed to light fixture over the was sleeping, potent dust particles. 5. On 12/13/2016 at observed housekee a patient room at the housekeeping of the particles.	cal's policy and proceducy of Patient Area" (Revit III, "Take cart with your art should be within eye as:30 AM Surveyor #1 eper (Staff Member #2 of a patient room, appliant solution" on a patient edded to wipe it off with per did not allow 10-mi ired per manufacturer's estaff Member #2 of a patient room. The he housekeeper use a por after cleaning a toil estaff Member #2 of a patient room. The he housekeeper dustin patient's head while a stially exposing the patient end of the hallway less art in the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the hallway unatter the patient of the patie	ised u into esight 1) ed obts a dry inute 3 2) brush et with 22) g a patient ent to) enter eaving ended.		Addendum 2/1/2017: Daily aubeing conducted in the kitchen. is under revision and will be presthe PI Committee for approval or 17, 2017. Staff education is in proper sanitation throughout the department. The COO/CNO will check staff's compliance related of chlorine solution, on a weekly make sure staff are complying w standards. The results of those go to the weekly PI Committee of Wednesday, February 8, 2017. compliance is 90%. Any score is will require remediation with the employee and/or further analysis possible system issues. Additionally, daily audits are being conducted throughout the hospit observing housekeepers in their routines. Staff education is in procedures when cleaning patient infection Control nurse will check, on a weekly basis, to ma staff are complying with standar results of those audits first go to PI Committee on Wednesday, F2017. The target compliance is score below 90% will require rewith the affected employee and/analysis of possible system issue.	The policy ented to a February rocess. Consible for related to double to the use basis, to ith audits first in The target below 90% affected s of al, daily rocess. The tolk ont rooms. It double to the weekly ebruary 1, 90%. Any mediation or further	
	0 0 10/45/2048 o	1.00 PM Surveyor #1					1

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SUR COMPLETI		
·	504011			B. WING 12/21/2016				
NAME OF PR	OVIDER ORSUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL.	12844 N	IILITARY RO	DAD SOUTH			
			TUKWIL	.A, WA 9816	88			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 749				A 749				
	reviewed a facility do Prevention" the docu indicators for 2016. C identified was Patien "Target" of success of	cument titled, "Infectior ment provides a line ils one of the Indicators t Room Cleaning with a of 95% or better. For the lanuary through Nover	t of					
				·				

PRINTED: 08/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		504011	B. WING				R 30/2017
	PROVIDER OR SUPPLIER E BEHAVIORAL HOS	PITAL		12	REET ADDRESS, CITY, STATE, ZIP CODE 844 MILITARY ROAD SOUTH JKWILA, WA 98168		777
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENT	rs	{A 00	00}	·		
	MEDICARE HOSP FOLLOW-UP VISIT	ITAL COMPLAINT SURVEY					
	(DOH) in accordance of Participation set	ate Department of Health ce with Medicare Conditions forth in 42 CFR 482, th and safety survey.					
	Onsite dates: 08/29	/17					
	This survey was co	nducted by:					
	Paul Kondrat, RN, I Joy Williams, RN, B		:				
•	hospital complaint s	iciencies found during the survey follow-up visit on I7 in which the facility was					
	42 CFR 482.12 Gov	verning Body					
	42 CFR 482,13 Pati	ient Rights					
	corrected all Condit	e facility has substantially ion-level deficiencies cited - 07/21/17 hospital complaint it.					
		n substantial compliance with ions of Participation set forth are Hospitals.					
		ED/SI IDDI IED DEDDESENTATIVES SIAN					

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Printed: 05/31/2017 FORM APPROVED OMB NO. 0938-0391

			T) FROMBENGOFFLIENCLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		RVEY	
504011				B. WING		R 05/05/2017		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	re, ZIP CODE			
CASCADE	BEHAVIORAL HOSP	ITAL		I MILITARY ROAD SOUTH VILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
{A 000}	INITIAL COMMENTS			{A 000}				
	MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT An on-site follow-up visit was conducted on May 1 - 5, 2017 by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Joyce Williams, RN,							
:	BSN, and Alex Giel, REHS, PHA. During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539. This visit was to verify correction of Condition-level deficiencies found during the							
		rvey revisit on March 7						
	42;CFR 482.12 Gove	rning Body					:	
	42 CFR 482.12 Patie	nt Rights						
	During the course of the follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the seriousness of the findings. This resulted in the declaration of IMMEDIATE JEOPARDY in the following area:						,	
	Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation.							
	was verified on 5/5/20	of IMMEDIATE JEOPA 017 at 2:15 PM by Eliza Joyce Williams, RN, B	beth					
		NOT IN COMPLIANCE						
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE	E'S SIGNATURE		TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE					
		504011 B. WING R 05/05/20				,	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	•	
CASCADI	E BEHAVIORAL HOSP	PITAL		ILITARY RO A, WA 981	DAD SOUTH 68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
{A 000}	Medicare Hospital Co 42 CFR 482.12 Gove Shell #27QV13	onditions for:		{A 000}	A 023 482.11 (c) Licensure of Pers Corrective Action: All personnel have been audited for licensure and other applicable stand	current ards that	All corrective actions will be completed by June 30, 2017
A 023	licensed or meet other are required by State This Standard is not. Based on interview, a policy and procedure,	sure that personnel are rapplicable standards or local laws. met as evidenced by: and review of hospital's the hospital failed to eursing (DON) was prop	that	A 023	are required by state and local laws. staff members will be validated for lic and certification prior to starting emp Cascade Behavioral Hospital. Monitoring Plan: The director of human resources will responsible for the auditing of all exisemployees for licensure and certifical monthly. All findings will be reported monthly to the CBH Performance Impulsion in the control of t	censure bloyment at be sting ation out provement	
	Failure to ensure that appropriately licensed places patients at risk unqualified staff. Findings: 1. In review of the hostitled, "License and C (Policy Number: HR - September 1, 2015) u "procedure", stated "t employment, candida that require a license original licensure to 2. On 5/4/2017 at 1:00 interviewed the human Member #6) in regard of new employees. De	the hospital's staff is a prior to employment, for care provided by spital's policy and proceeding proceeding proceeding proceeding proceeding proceed proceeding	ns heir Staff sess veyor		Committee, and quarterly to the MECGoverning Board. Persons Responsible: CEO Director Human Resources PI/Risk Manager	o anu	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	1
		504011		B, WING	WALKER STATEMENT AND THE STATE	R 05/05/2017	
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168				OAD SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	TION
	#7's nursing license asked to see the Sta human resource mar did not have a currer while the human resourcation. The human that the DON was a	dicated that Staff Memk had expired in 2015. When the file, the nager stated in part that at file because s/he was purce manager was on a resource manager indire-hire but was unable the file. Staff Member #6	s/he hired cated	A 023			
	legally responsible for If a hospital does not governing body, the process for the conduct of the functions specified in governing body This Condition is not Based on interviews hospital failed to meet CFR 482.12 Condition Governing Body. Failure to ensure state knowledge, skills and patient's emergency in providing emergent Findings: The Governing Body the functioning of the from harm as evident JEOPARDY conditions.	fective governing body to the conduct of the hose have an organized persons legally response hospital must carry out this part that pertain to the met as evidenced by: and document reviews, at the requirements at 4 and of Participation for	spital. ible t the the the the cheir ays nent. nage ents for	(A 043)	Immediately following the exit summ CEO, Governing Board Members, CRisk Manager, Director of Clinical Stand Directors of nursing reviewed thand began formulation of a plan of completion corrective action action to the CEO/I who along with the Medical Director member of the Governing Board. The Designee is responsible for reporting results of corrective actions and use monitoring systems to the full Governing Board on the Performance Improvement Continuation in the Ceo/I with the Medical Director member of the Governing Board. The Designee is responsible for reporting results of corrective actions and use monitoring systems to the full Governing Event Increased monitoring for that do not meet the thresholds that established by the Committee. This monitoring will continue until complia obtained and sustained for two reporting periods.	NO, PI/ ervices, e findings orrection. of all Designee is a e CEO/ g the the of ning Board. mittee will any items have been increased ance is	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED	
		504011		B. WING		1	R 5/2017	
	OVIDER OR SUPPLIER BEHAVIORAL HOSP	PITAL	12844 N	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH NILA, WA 98168				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
{A 043}	resulting in delay of c resuscitation. Due to the scope and detailed under 42 CF	ardiopulmonary severity of deficiencies R 482.12 Condition of erning Body was NOT N		{A 043}	A 045 482.12 (a)(1) Medical Staff Corrective Action: The CBH Policy "Physician Assistar Privileges" (Policy No: MS.P.310)' w	vill be	All corrective actions will be completed by June 30, 2017	
A 045	[The governing body	must] determine, in e law, which categories ble candidates for edical staff,	s of	A 045	updated to reflect the scope of practice contained in the physician assistant agreement. Evaluations will be perfeated accordance with the OPPE/FPPE promote the contained plan: Monitoring Plan: Evaluation Results will be reported to the contained plan.	collateral ormed in olicy.		
	the hospital policy and failed to ensure the sufollowed the physician agreement in regards evaluations. The hospithat the physician ass	n assistants' delegation	tal re the		to the CBH performance improveme committee, and quarterly to the MEG governing board. Persons Responsible: Chief Medical Officer	ent		
	written in the physicia agreement and to pro consistent with physic places patients' safety	ian assistant practice,	as					
	titled, "Physician Assis MS.P.310; Last Revie 2: "physician assistar	spital's policy and procestant Privileges" (Policewed 1/2017) stated in the are not to write ordesponsibility for that patien	y No: part ers or					

	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLET	(X3) DATE SURVEY COMPLETED	
		504011					R 05/05/2017	
	ASCADE BEHAVIORAL HOSPITAL 1284			ESS, CITY, STA IILITARY RO .A, WA 9810	DAD SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
A 045	care. Part 3 stated, "a make an independent patient should be adn 2. On 5/4/2017 betwee and 10:30 AM Survey delegation agreement personnel file (Staff Melegation agreement Authority, the agreement non-certified physicial order, to administer a and Schedule II-V con addition to reviewing supervisory physician as follows: Weekly fair reviews twice a week evaluations. In review (Staff member #8) crewas unable to validate meetings had occurred conducted twice a weagreement. In addition (Staff Member #8) was required by the agree 3. On 5/4/2017 at 1:00 Patient #4's medical in Physician Assistant (Sthe patient to the hosprequired supervisory was not present in the	a physician assistant is to decision as to whether it decision as to whether it in a physician assistant fember #8). In review of the time a physician assistant fember #8). In review of the time a physician assistant fember #8 and to dispense legend introlled substances. In medical orders, the amust provide supervision assistant to prescribe and quarterly performating physician assistant fedentialing file, Surveyor that face to face weeled or that chart reviews seek as required by the in, the physician assistant is not evaluated quarter.	r the M Int's	A 045				
A 093	482.12(f)(2) EMERGE	ENCY SERVICES		A 093				
	hospital, the governing medical staff has written	s are not provided at the g body must assure tha en policies and proced gencies, initial treatmen	at the ures					

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING			(X3) DATE SURVEY COMPLETED			
		504011		B. WING 05/			R 5/ 2017
CASCADE BEHAVIORAL HOSPITAL 1284				RESS, CITY, STA MILITARY RO LA, WA 981	DAD SOUTH	., ,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 093	Based on interviews, review of hospital polithospital failed to ensurappropriate immediate emergency medical semergency medical semergency medical semergency medical semergency medical semergency medical semergency medical semergency rin activating the hosp system and initiating semergency medical	document review, and icy and procedures, the action to address an ituation. If had the required training to respond to medical needs risks de ital emergency responsurgent treatment. and procedure titled "Clical Emergency / Card M-024; Approved 8/201 policy of this facility to nonary resuscitation (C thing and/or pulse cear cardiopulmonary funct dical services arrive." The two code blue even the two code blue even requiring immediate occured during the mon pulse cardiopulmonary functions, Surveyors #2 and #3	a lays see Code lac 6) PR) se, lons onts cy ths of noted	A 093	A 093 482.12 (f)(2) Emergency Serice Corrective Action: All clinical staff will be trained to the sof healthcare provider AHA BLS prior assuming their role on shift. A checkly provided to all CNA staff and nursing regarding the emergency notification Monitoring Plan: Education results will be reported out the CBH performance improvement and quarterly to the MEC, and governous Responsible: CEO Director of Nursing PI/Risk Manager	standards r to list is g stations procedure. t monthly to committee,	All corrective actions will be completed by June 30, 2017

	OF DEFICIENCIES F CORRECTION	1		1 '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504011			B. WING		R 05/05/2017	
	CASCADE BEHAVIORAL HOSPITAL 1284				TE, ZIP CODE DAD SOUTH 68		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 093	bathroom door. b. On 5/2/2017 at 10: interviewed a register Member #3) about the #1's death by hanging hospital on 4/20/2017 s/he was the only RN and was preparing the records for the next of she/he heard the CNA a loud noise and was just hanged themselv immediately went to the room and saw the particular bathroom door. Staff s/he was unsure that the patient down so set the nurse's station and supervisor for help. In s/he called a code blue Once the nursing sup Member #4), they rembathroom door and become to 2-North. Staff interviewed the nursing Member #4) about the #1's death by hanging that exactly at 5:00 All adjustments and received the nursing on the staff of the more than the staff of the more than the staff of the more than the sistence from the sis	55 PM, Surveyors #2 a red nurse (RN) (Staff e events surrounding Pg which occurred in the Y. Staff Member #3 state on the unit with 15 pate e medication administrates. The RN indicated the (Staff Member #2) may yelling that a patient haves. Staff Member #3 he entrance of Patient stent hanging from the Member #3 indicated the she and the CNA could have a called the nursing Next, the RN indicated the followed by calling 9 hervisor arrived (Staff noved the patient from egan CPR. 5 AM, Surveyors #2 and house supervisor (See events surrounding Pg. Staff Member #4 indicated it indicated a call on the radio of the followed supervisor (See events surrounding Pg. Staff Member #4 stated it indicated to get to the nurs the unit, Staff Member manging on the edge of the follower supervisor surrounding house supervisor the unit, Staff Member manging on the edge of the follower supervisor surrounding house surrounding house surrounding house surrounding house surrounding house surrounding house surrounding house surrounding house surrounding house surroundin	ted ients ation hat aking ad #1's hat d get k to that 11. the d #3 taff atient cated affing to took ing #4 the or bor, t	A 093			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		1, ,	E CONSTRUCTION	(X3) DATE SUI COMPLET	ED
	504011		B. WING		05/0	R 5/2017
NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL		12844 N	RESS, CITY, STAT MILITARY RO LA, WA 9816	AD SOUTH		
PRÉFIX (EACH DEFICIENCY I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	OTION SHOULD BE OTHE APPROPRIATE:	(X5) COMPLETION DATE
the code blue were the circumstances for assistance (code could have been then asked Staff March problems with any indicated that ther and connecting the self-inflating bag-Member #4 confineraceived no practice downward of the events about the events about the events about the events about the events about the code blue notice assist in the code surveyors asked if problems, Staff March staff members were assembling/operamember indicated on how to put the confirmed the facily practice drills invoresuscitation since there. e. Review of the Confirmed without Amburbag until the assembled. On the answer question #1	vent, Staff Member #4 ind it as well as it could have but acknowledged that it de blue) for the emergency started earlier. The survey Member #4 if there were a of the equipment. S/he is was some difficulty in lose mask to the "ambu bag' valve mask device). Staff med that night shift personce code blue training or distance (Staff Member #5 indicated s/he is relinical unit when s/he is fication and left her/his un blue response. When the ithere had been any equipment #5 indicated the 2-	given ne call by yors ny cating ' (a nnel rills. and #3 er #5) leath n was heard ait to pment North staff hem y ent n in e first ere ne t which	A 093			

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : COMPL						
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					TE, ZIP CODE DAD SOUTH 68		
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A 093	whether the CPR [cal was uninterrupted an f. Review of the disch 4/28/2017 in Patient an entry by a physicia revealed that in his/hirelated to resuscitation of documentation to uninterrupted and of g. On 5/2/2017 at 12: interviewed the hospi Member #1) about cotraining. S/he indicate procedures and revied during hospital orient this training was by let training or practice coorientation process. hospital had not condat any time during he indicated that mock coscheduled to begin in REVIEW OF CODE #2. Surveyor #2 review that occurred on 3/15 year-old admitted for withdrawal syndrome summary in Patient #2 had a history of sewithdrawal and was proceed to the process of the poor apparently don his/her back, the phis/her airway. A patient #4 patient way. A patient was patient way. A patient was patient way.	rdiopulmonary resuscited high quality. Parge summary dictated (#1's medical record shown (\$1's medical record shown (\$1's medical record shown (\$1's medical record shown efforts by staff there support that CPR was high standards. 35 PM, Surveyor #3 tal clinical educator (\$1's to blue education and led that code blue wo fithe crash cart is to be action. She acknowled that code blue wo fithe crash cart is to be action. She acknowled that code blue wo fithe crash cart is to be action. She acknowled that code blue wo fithe code blue of the code drills for the facility two weeks. #2 Ved another code blue of the code drills for the facility two weeks.	d on owed that that that the the that the the that the that the the that the the that the the that the the the the the the the the the th	A 093			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		1	LE CONSTRUCTION	(X3) DATE SUF	
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NAME OF PE	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
CASCADE BEHAVIORAL HOSPITAL 1284				MILITARY RO			:
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A 093	. •			A 093			
	breathing again. The assisting him/her to k side then the RN left paramedics. Once the (licensed practical nunursing assistants) are to manage the patient to the unit with the patient to documentation, a cPM. Upon arrival on tover resuscitation efforms. No Code Blue Forms response to the patient located in the patient.	e RN left the unit, an L rse) and 2 CNAs (certif nd physician were left a t situation. The RN returamedics and observed d on the patient. Accor- code blue was called at the unit, the paramedical orts. In documenting the staff nt's cardiac arrest could s medical record. In the Evaluation Form could	ent ner PN fied alone urned d that rding 5:10 s took f's				
A 396	AM revealed that the cardiac arrest was dis (Staff Member #11) sl unit with the patient a member to meet the p 482.23(b)(4) NURSIN The hospital must ens develops, and keeps for each patient. The part of an interdiscipli This Standard is not Based on record revision policy and procedure, staff assess patients for	ter #12) on 5/4/2017 at response to the patient sorganized and that the mould have remained on the sent another staff paramedics. IG CARE PLAN sure that the nursing structurent, a nursing care nursing care plan may nary care plan met as evidenced by: The wand review of hospit the hospital failed to e	t's RN n the aff plan be tai nsure	A 396			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIVAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVIVAN OF CORRECTION (X3) DATE SURVIVAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) DATE SURVIVAN OF CORRECTION (X6) DATE SU		ED Ì				
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	· · · · · · · · · · · · · · · · · · ·
CASCADE	E BEHAVIORAL HOSP	PITAL		ILITARY RO .A, WA 981	DAD SOUTH 68		
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A 396	admission puts patier Findings: 1. The hospital policy "Suicide Risk Assessi Reviewed 1/2017) rea or Intake Personnel w suicide risk assessme possible but no later t admission If any s renders information th immediately affect pa a score of High or Se be contacted immedia 2. Surveyor #2 review three patients recently and noted the followin a. Patient #3 was adm PM with a chief comp being transferred from A review of the "Intak Hand-Off" form was of notification with the b with Plan". The initial was completed on 5/1 after admission. Patie	ents for suicide upon hts at risk for self-harm. and procedure titled ment" (Policy # PC.SP. ad in part; "The admittivill complete the initial ent (SRA form) as soorthan 2 hours after uicide risk assessment hat has potential to tient safety and/or resuvere, the psychiatrist sately." I wed the medical recorder admitted on 4/30/2017 at alocal acute care hose to Nursing Communitiocumented as a high rox marked "Suicidal Ide suicide risk assessment 1/2017 at 9:20 AM, 13	ang RN as alts in hall s of tal after spital. cation risk eation nt hours	A 396	A 396 482.23 (b)(4) Nursing Care P Corrective Action: All clinical staff we trained to the standards of the Suicide Assessment, and that the Suicide Rise Assessment be completed at a minim hours from admission. If any suicide assessment renders information that potential to immediately affect patien and/or results in a score of High or Spsychiatrist shall be contacted immediately affect patien. The Directors of Nursing will perform chart audits for timeliness of suicide assessments and the completion of the Nursing Communication Hand Off. The Director of Intake/Chief Nursing (CNO) will be informed regarding of suicide risk assessment renders informated in the completion of the safety. Monitoring Plan: Education results will be reported out the CBH performance improvement and quarterly to the MEC, and govern Audit results will be reported out mor CBH performance improvement com quarterly to the MEC, and governing intake director will inform leadership failure in hand-off communication reginitial suicide risk assessment that reinformation for a potential to immediate patient safety. Persons Responsible: CEO CNO Director of Nursing PI/RM Director	vill be le Risk sk num of 2 risk has the it safety severe, the diately. 30 random risk the Intake to Office any initial rmation that atient t monthly to committee, ning board. nthly to the imittee, and board. The daily of any garding any enders	
					I WAN DIRECTOR	=	

Printed: 05/31/2017 FORM APPROVED OMB NO. 0938-0391

			PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE		
CASCADE	BEHAVIORAL HOSP	ITAL		LITARY RC 4, WA 9816	OAD SOUTH 68		
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(A 000)	INITIAL COMMENTS			{A 000}			
	MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT An on-site follow-up visit was conducted on May 1 - 5, 2017 by Paul Kondrat, RN, MN, MHA; Flizabeth Gordon, RN, MN; Joyce Williams, RN						
	Elizabeth Gordon, RN, MN; Joyce Williams, RN, BSN, and Alex Giel, REHS, PHA.						
	During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539.						
	This visit was to verify correction of Condition-level deficiencies found during the hospital complaint survey revisit on March 7 -10, 2017 in which the facility was found not in compliance with:						
	42:CFR 482.12 Gove	erning Body					
	42 CFR 482.12 Patie	nt Rights					
	During the course of the follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the seriousness of the findings. This resulted in the declaration of IMMEDIATE JEOPARDY in the following area:		risk the				
		when an emergency me and requiring immediate ardiopulmonary			·		
	Removal of the state of IMMEDIATE JEOPARDY was verified on 5/5/2017 at 2:15 PM by Elizabeth Gordon, RN, MN and Joyce Williams, RN, BSN.		abeth				
		NOT IN COMPLIANCE					
LABORATOR'	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (A 000) Continued From page 1 Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13 A 024 A 025 A 025 A 025 A 026 A 027 A 027 A 028 A 029		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(XO) DATE SOLVE	
CASCADE BEHAVIORAL HOSPITAL 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (A 000) Continued From page 1 Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13 A 023 482.11(c) LICENSURE OF PERSONNEL The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This Standard is not met as evidenced by: 10 PROVIDER'S PLAN OF CORRECTION (CACH CORRECTION HOULD BE (PREFIX TAG) PREFIX (FACH CORRECTIVE ACTION SHOULD BE (PREFIX TAG) PROPRIED ACTION SHOULD SHOULD SHOULD SHO		504011 B. WING 05/0						
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Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13 482.11(c) LICENSURE OF PERSONNEL A 023 A 023 A 023 482.11 (c) Licensure of Personnel Corrective Action: All corrective actions be completed by state and other applicable standards that are required by state and local laws. All new staff members will be validated for licensure and certification prior to starting employment at licensed or meet other applicable standards that are required by State or local laws. This Standard is not met as evidenced by: The director of human resources will be responsible for the auditing of all existing.	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(X5) COMPLETION DATE
Based on interview, and review of hospital's policy and procedure, the hospital failed to ensure that the Director of Nursing (DON) was properly vetted prior to employment. Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff. Findings: 1. In review of the hospital's policy and procedure titled, "License and Certification Verification" (Policy Number: HR - 130; Effective Date: September 1, 2015) under the heading titled "procedure", stated "that prior to offer of employment, candidates applying for positions that require a license must present proof of their original licensure to human resources." 2. On 5/4/2017 at 1:00 PM Surveyor #1 interviewed the human resource manager (Staff Member #6) in regards to the screening process of new employees. During the interview Surveyor #1 asked to see the Director of Nursing (DON) (Staff Member #7) licensure. The human	, ,	Medicare Hospital Co. 42 CFR 482.12 Gove Shell #27QV13 482.11(c) LICENSUR The hospital must assicensed or meet other are required by State This Standard is not Based on interview, a policy and procedure, that the Director of Novetted prior to employ Failure to ensure that appropriately licensed places patients at risk unqualified staff. Findings: 1. In review of the hostitled, "License and Co. (Policy Number: HR - September 1, 2015) to "procedure", stated "Gemployment, candidathat require a license original licensure to 2. On 5/4/2017 at 1:0 interviewed the human Member #6) in regard of new employees. D #1 asked to see the Desire the state of the see the Desire the See the Desire the see the Desire the See the Desire the See the Desire the see the Desire the See the De	enditions for: Inning Body E OF PERSONNEL Sure that personnel are applicable standards or local laws. Index evidenced by: Index ev	ensure enty edure I ens their		Corrective Action: All personnel have been audited for licensure and other applicable stand are required by state and local laws. staff members will be validated for licensure and certification prior to starting employees Behavioral Hospital. Monitoring Plan: The director of human resources will responsible for the auditing of all exicently. All findings will be reported monthly. All findings will be reported monthly to the CBH Performance Imcommittee, and quarterly to the MEGOVERNING Board. Persons Responsible: CEO Director Human Resources	current ards that All new censure cloyment at libe sting ation out	corrective actions will be completed

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURV COMPLETE	D
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CASCADE	E BEHAVIORAL HOSF	PITAL		MILITARY RO LA, WA 981	DAD SOUTH 68		
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE	
A 023	Continued From pag	e 2		A 023			
	#7's nursing license hasked to see the Stafhuman resource mandid not have a curren while the human resourcation. The human that the DON was a resource of the second secon	dicated that Staff Membrad expired in 2015. While Member #7's file, the ager stated in part that the because s/he was curce manager was on resource manager inde-hire but was unable to file. Staff Member #67.	hen s/he hired icated o				
{A 043}	482.12 GOVERNING	BODY		{A 043}	A043 482.12 Governing Board		
	legally responsible fo If a hospital does not governing body, the properties of the conduct of the functions specified in governing body This Condition is not a based on interviews a hospital failed to mee CFR 482.12 Condition Governing Body. Failure to ensure staff knowledge, skills and	persons legally respons hospital must carry ou this part that pertain to met as evidenced by: and document reviews, t the requirements at 4 n of Participation for	spital. sible t the the the		Immediately following the exit summ CEO, Governing Board Members, C Risk Manager, Director of Clinical Stand Directors of nursing reviewed the and began formulation of a plan of a The Governing Board delegated the responsibility of ensuring completion corrective action action to the CEO/I who along with the Medical Director member of the Governing Board. The Designee is responsible for reporting results of corrective actions and use monitoring systems to the full Govern The Performance Improvement Con implement increased monitoring for that do not meet the thresholds that established by the Committee. This	ervices, and findings correction. In of all Designee is a and the of ching Board. In office will any items have been	
	in providing emergent Findings: The Governing Body the functioning of the from harm as evidence JEOPARDY condition failure to intervene wh	failed to effectively man hospital to protect pations and by the IMMEDIATE dentified on 5/3/2017 hen an emergency mediate	nage ents for dical		monitoring will continue until complia obtained and sustained for two repo periods.	ance is	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A, BUILDING		(X3) DATE SURVEY COMPLETED		
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	E BEHAVIORAL HOSP	PITAL			OAD SOUTH			
			TUKWIL	.A, WA 9810	68			
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{A 043}	Continued From page	e 3		{A 043}				
	resulting in delay of c resuscitation.	ardiopulmonary						
	Due to the scope and severity of deficiencies detailed under 42 CFR 482.12 Condition of Participation for Governing Body was NOT MET. Cross- Reference: Tags A093 482.12(a)(1) MEDICAL STAFF [The governing body must] determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.				A 045 482.12 (a)(1) Medical Staff Corrective Action: The CBH Policy "Physician Assistar	1		
					Privileges" (Policy No: MS.P.310)' w	/ill be	All	
A 045				A 045	agreement. Evaluations will be performed in accordance with the OPPE/FPPE policy.		corrective actions will	
			s of				be completed by 08-01-2017	
		met as evidenced by:	,		Monitoring Plan:		:	
	the hospital policy and failed to ensure the si followed the physician	n assistants' delegation	tal		Evaluation Results will be reported to the CBH performance improvement committee, and quarterly to the MEC governing board.	ent		
	agreement in regards evaluations. The hosp	то репогталсе pital also failed to ensu	re		Persons Responsible:			
		sistants were following procedures in regards			Chief Medical Officer			
	written in the physicial agreement and to pro	cian assistant practice,	as					
	Findings							
	titled, "Physician Assi MS.P.310; Last Revie 2: "physician assistal	spital's policy and procestant Privileges" (Policewed 1/2017) stated in the are not to write ordeponsibility for that patie	y No: part ers or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
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A 045	Continued From page 4			A 045			
	care. Part 3 stated, "a physician assistant is not to make an independent decision as to whether the patient should be admitted to the hospital." 2. On 5/4/2017 between the hours of 8:30 AM						
	and 10:30 AM Surveyor #1 reviewed the delegation agreement in a physician assistant's personnel file (Staff Member #8). In review of the delegation agreement, under Prescriptive Authority, the agreement allows a certified or non-certified physician assistant to prescribe, to order, to administer and to dispense legend drugs and Schedule II-V controlled substances. In addition to reviewing medical orders, the supervisory physician must provide supervision as follows: Weekly face to face meetings; chart reviews twice a week and quarterly performance evaluations. In reviewing physician assistant's (Staff member #8) credentialing file, Surveyor #1 was unable to validate that face to face weekly meetings had occurred or that chart reviews were conducted twice a week as required by the agreement. In addition, the physician assistant (Staff Member #8) was not evaluated quarterly as required by the agreement.						
			kly were ant				
	3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a Physician Assistant (Staff Member #9) admitted the patient to the hospital on 3/21/2017. The required supervisory physician counter signature was not present in the record. This finding was confirmed by Human Resource Manager (Staff Member #6).						
A 093	482.12(f)(2) EMERGE	ENCY SERVICES		A 093			
	hospital, the governin medical staff has writt	s are not provided at the g body must assure the en policies and proced gencies, initial treatmen	at the lures				

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLETE			
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	OVIDER OR SUPPLIER E BEHAVIORAL HOSP	PITAL	12844 N	RESS, CITY, STAT MILITARY RO LA, WA 9816	AD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 093	Based on interviews, review of hospital polithospital failed to ensurappropriate immediate emergency medical s Failure to ensure staff knowledge, skills, and patient's emergency rin activating the hosp system and initiating significant for the second of	met as evidenced by: document review, and icy and procedures, the are that staff took e action to address an ituation. If had the required d training to respond to medical needs risks de ital emergency respons urgent treatment. and procedure titled "C fical Emergency / Card M-024; Approved 8/201 policy of this facility to nonary resuscitation (C othing and/or pulse cear cardiopulmonary funct dical services arrive."	a lays se Code lac 6) PR) se, lons nts cy	Corrective All clinical shealthcare perferency their role on Mock Code, for all clinical orientation. A checklist regarding the Monitoring Education in performance MEC, and go All code blumonthly Perplan develoand governi	Action: taff will be trained to the standards of provider AHA BLS, emergency notific code response procedures prior to as a shift. //Hands On training will be conducted all employees, and during new employers are emergency notification procedure. Plan: esults will be reported out monthly to be improvement committee, and quarterly overning board. e documentation will be reviewed at a formance Improvement (PI) meeting pment, and reported out quarterly to any board.	cation, and ssuming annually yee ang stations the CBH erly to the the CBH for action	All corrective actions will be completed by 08-01-2017
		6 year-old admitted on					
	On 4/20/2017, a code	on with suicidal ideation blue was initiated in le patient hanging on h					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE \$ COMPLI	ETED
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NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE		
CASCADE BEHAVIORAL HOSP	ITAL		MILITARY ROA LA, WA 98168	D SOUTH		
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A 093 Continued From page bathroom door. b. On 5/2/2017 at 10:5 interviewed a registers Member #3) about the #1's death by hanging hospital on 4/20/2017. s/he was the only RN and was preparing the records for the next dashe/he heard the CNA a loud noise and was just hanged themselve immediately went to the room and saw the patition bathroom door. Staff N s/he was unsure that set the patient down so s/the nurse's station and supervisor for help. N s/he called a code blue Once the nursing super Member #4), they rem bathroom door and be c. On 5/4/2017 at 7:35 interviewed the nursing Member #4) about the #1's death by hanging that exactly at 5:00 AN adjustments and receivements and receivements and receivements and receivements and receivements and receivements. Upon arrival on the observed Patient #1 he bathroom door. The nursing with assistance from the immediately removed in placed them on the gracompressions. When a	so PM, Surveyors #2 and nurse (RN) (Staff events surrounding P which occurred in the Staff Member #3 state on the unit with 15 pate and the unit with 15 pate and the RN indicated the (Staff Member #2) may elling that a patient has. Staff Member #3 he entrance of Patient hanging from the Member #3 indicated the followed by calling 9 ext, the RN indicated the followed by calling 9 ervisor arrived (Staff oved the patient from gan CPR. If AM, Surveyors #2 and ghouse supervisor (Seevents surrounding P. Staff Member #4 indiff, s/he was making staved a call on the radio of Member #4 stated it nute to get to the nurshe unit, Staff Member anging on the edge of ursing house supervisone 2-North staff the patient from the document, and began ches	ted iients ation hat aking ad #1's hat d get k to that i'11. the d #3 taff atient ccated affing to took ing #4 the or oor, t	A 093			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	504011			B. WING	·	05/0	R 5/2017	
CASCADE BEHAVIORAL HOSPITAL 1284				ESS, CITY, STA IILITARY RC .A, WA 9810	DAD SOUTH	·		
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A 093	the resuscitation wenthe code blue went as the circumstances but for assistance (code it could have been start then asked Staff Memproblems with any of indicated that there wand connecting the maself-inflating bag-valv Member #4 confirmed received no practice of d. On 5/2/2017 at 11: interviewed a register about the events sumby hanging which occ 4/20/2017. Staff Memworking on another of the code blue notifica assist in the code blue surveyors asked if the problems, Staff Memworking/operating member indicated that on how to put the masconfirmed the facility practice drills involving resuscitation since shall the code blue surveyors asked if the problems, Staff Memworking on another confirmed the facility practice drills involving member indicated that on how to put the masconfirmed the facility practice drills involving resuscitation since shall the masconfirmed without the Ambu bag until the massembled. On the sanswer question #4 under the code patient #1's medical of two cycles of bag valver performed without the Ambu bag until the massembled. On the sanswer question #4 under the code patient #1 assembled. On the sanswer question #4 under the code blue surveyors asked if the problems, Staff Membuster in the code blue surveyors asked if the problems, Staff Membuster in the code blue surveyors asked if the problems, Staff Membuster in the code blue surveyors asked if the problems, Staff Membuster in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if the problems in the code blue surveyors asked if th	t, Staff Member #4 indicts well as it could have got acknowledged that the blue) for the emergency ted earlier. The survey other #4 if there were are the equipment. S/he hask to the "ambu bag" e mask device). Staff of that night shift person code blue training or dread and the founding Patient #1's decurred in the hospital or other #5 indicated s/he within and left her/his unite response. When the ere had been any equipment #5 indicated the 2-heaving difficulty the "ambu bag". The set s/he had to instruct the sk on the device. S/he had not conducted any got cardiopulmonary the began her employment en Blue Evaluation Form the ere mask ventilation were mask connected to the emask connected to the entation and the the emask connected to the emask connected to the emask connected to the emask connected to the entation were emask connected to the entation were emask connected to the entation were emask connected to the entation were emask connected to the entation were emask connected to the entation were emask connected to the entation were entation.	given e call / ors ny cating (a nel ills. nd #3 eath was eath to ment North staff eem	A 093				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLET	TED
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	COVIDER OR SUPPLIER E BEHAVIORAL HOSE	PITAL			DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 093	whether the CPR [cal was uninterrupted and f. Review of the disch 4/28/2017 in Patient is an entry by a physicial revealed that in his/herelated to resuscitation to documentation to uninterrupted and of log. On 5/2/2017 at 12: interviewed the hospin Member #1) about contraining. S/he indicate procedures and revied during hospital orientation process. hospital had not conduct any time during herindicated that mock concentation process. hospital had not conduct any time during herindicated that mock coscheduled to begin in REVIEW OF CODE #2. Surveyor #2 review that occurred on 3/15. Year-old admitted for withdrawal syndrome, summary in Patient ##2 had a history of sewithdrawal and was prontrol seizures as a 3/15/2017 at 5:08 PM the floor apparently don his/her back, the phis/her airway. A pati	rdiopulmonary resuscited high quality. arge summary dictated the part of the facility and for the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart only with no hand of the crash cart is the cart of the crash cart is the cart only with no hand of the crash cart is the cart of the crash cart is the cart only with no hand of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the crash cart is the cart of the car	on owed that that that that that that the that the drills were drills were event a 58 and harge fient. On on lying ad the	A 093			

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED R	
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	OVIDER OR SUPPLIER			ESS, CITY, STA		<u> </u>		
CASCADI	E BEHAVIORAL HOSP	ITAL		ILITARY RO .A, WA 981	SAD SOUTH			
(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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY CONTROL OF THE PROVIDER OF THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
A 093	the patient to his/her is breathing again. The assisting him/her to ke side then the RN left is paramedics. Once the (licensed practical nunursing assistants) are to manage the patient to the unit with the patient of the documentation, a control of the commentation, a control of the patient of the unit with the unit with the patient of the unit with the uni	left side. The patient single RN instructed the patient on his/lithe unit to meet the left the unit, an Lingle RN left the unit, an Lingle RN left the unit, an Lingle RN reft and physician were left at situation. The RN reft ramedics and observed on the patient. Accorded blue was called at the unit, the paramedics	ent ner PN fied alone arned d that ding 5:10	A 093		.*		
	a. No Code Blue Form documenting the staff's response to the patient's cardiac arrest could be located in the patient's medical record. In addition, no Code Blue Evaluation Form could be located within the facility.							
	b. An interview with the Director of Clinical Services (Staff Member #12) on 5/4/2017 at 8:44 AM revealed that the response to the patient's cardiac arrest was disorganized and that the RN (Staff Member #11) should have remained on the unit with the patient and sent another staff member to meet the paramedics.							
A 396	482.23(b)(4) NURSIN	IG CARE PLAN		A 396		÷		
	develops, and keeps	sure that the nursing st current, a nursing care nursing care plan may nary care plan	plan					
	This Standard is not	met as evidenced by:						
	policy and procedure, staff assess patients t	ew and review of hospit the hospital failed to e for suicide risk upon atient records reviewed	nsure					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C	IVLIA .		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	504011			B. WING		i .	R 5/ 2017
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
CASCADE	E BEHAVIORAL HOSP	ITAL	12844 N	MILITARY RO	DAD SOUTH		
			TUKWIL	.A, WA 981	68		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE	
A 396	(Patient #3). Failure to assess patinal admission puts patient Findings: 1. The hospital policy "Suicide Risk Assessme Reviewed 1/2017) read or Intake Personnel was uicide risk assessme possible but no later that admission. If any surenders information that immediately affect path a score of High or Seebe contacted immediately and noted the following and noted the following transferred from A review of the "Intake Hand-Off" form was donotification with the bowith Plan". The initial was completed on 5/1 after admission. Patient	ents for suicide upon ats at risk for self-harm. and procedure titled ment" (Policy # PC.SP. ad in part: "The admittin rill complete the initial ent (SRA form) as soon han 2 hours after uicide risk assessment at has potential to tient safety and/or resuivere, the psychiatrist slately." red the medical records y admitted to the hospitag: nitted on 4/30/2017 at 8 laint of being "suicidal" a local acute care hose to Nursing Communic ocumented as a high ripx marked "Suicidal Ide suicide risk assessmen /2017 at 9:20 AM, 13 h	100; ng RN as as as as as as as as as as as as as	A 396	<u> </u>	vill be le Risk sk num of 2 risk has the it safety evere, the diately. 30 random risk the Intake to Office any initial rmation that atient t monthly to committee, ning board. nthly to the mittee, and board. The daily of any garding any enders	
					Persons Responsible: CEO CNO Director of Intake Director of Nursing PI/RM Director		

Kondrat, Paul M (DOH)

From:

Timothy Hall <Timothy.Hall@cascadebh.com>

Sent:

Tuesday, June 13, 2017 3:23 PM

To: Cc: CMS_RO10_CEB@cms.hhs.gov

Subject:

Michael Uradnik; Jennifer Hamilton; Pat Brewer; Kondrat, Paul M (DOH)
Attn: Karen Roe CMS POC Cascade Behavioral Health Hospital - Amendment

Attachments:

Cascade Behavioral Health CMS POC 06132017 Corrections,pdf

Importance:

High

Good afternoon -

This communication is in response to the deficiencies identified on the Plan of Correction Form CMS 2567.

Please see the attached plan of correction that was amended per our conversation this afternoon.

Timothy C. Hall Director of Quality and Risk Management Cascade Behavioral Health Hospital 12844 Military Rd S, Tukwila, WA 98168 (206) 248-4538

Priviledged and Confidential Quality Assurance Related Document Protected by RCW 70.41.200 & 70.41.230



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Printed: 05/31/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 · · · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		RVEY FED
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				⁄IILITARY ROA _A, WA 98168			
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(A 000)	INITIAL COMMENTS	3		{A 000}			
	MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT						
	An on-site follow-up visit was conducted on May 1 - 5, 2017 by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Joyce Williams, RN, BSN, and Alex Giel, REHS, PHA.						
	During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539.						
	This visit was to verify correction of Condition-level deficiencies found during the hospital complaint survey revisit on March 7 -10, 2017 in which the facility was found not in compliance with:						
	42:CFR 482.12 Gove	erning Body					
·	42 CFR 482.12 Patie	ent Rights					
	During the course of the follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the seriousness of the findings. This resulted in the declaration of IMMEDIATE JEOPARDY in the following area:			·			
	Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation.						
	Removal of the state of IMMEDIATE JEOPARDY was verified on 5/5/2017 at 2:15 PM by Elizabeth Gordon, RN, MN and Joyce Williams, RN, BSN.						
		NOT IN COMPLIANCE					
LABORATOR	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIV	E'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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(A 000)	Medicare Hospital Co 42 CFR 482.12 Gove Shell #27QV13 482.11(c) LICENSUR The hospital must ass licensed or meet othe are required by State This Standard is not . Based on interview, a policy and procedure, that the Director of Nu vetted prior to employ Failure to ensure that appropriately licensed places patients at risk unqualified staff. Findings: 1. In review of the hos titled, "License and Co (Policy Number: HR - September 1, 2015) u "procedure", stated "ti employment, candidat that require a license original licensure to 2. On 5/4/2017 at 1:00 interviewed the huma	rning Body E OF PERSONNEL sure that personnel are rapplicable standards or local laws. met as evidenced by: nd review of hospital's the hospital failed to eursing (DON) was propment. the hospital's staff is prior to employment, for care provided by spital's policy and proceentification Verification	that Insure erly edure heir	{A 000}	A 023 482.11 (c) Licensure of Pers Corrective Action: All personnel have been audited for licensure and other applicable standare required by state and local laws. staff members will be validated for licend certification prior to starting employees dependent of the suditing of all existences and certification prior to starting employees for licensure and certification prior to starting employees for licensure and certification prior to starting employees for licensure and certification prior to starting employees for licensure and certification prior to starting employees for licensure and certification prior to starting employees for licensure and certification prior to the development of the suditing of all existences prior to the MECO development of the suditing of all existences prior to the MECO development of the suditing of all existences prior to the MECO development of the suditing of all existences prior to the MECO development of the suditing of all existences prior to the MECO development of the suditing of all existences prior to the suditing of all exist	current ards that All new censure cloyment at be sting ation out provement	All corrective actions will be completed by 06-30-2017
	of new employees. Du	s to the screening produring the interview Survirector of Nursing (DOI ensure. The human	/eyor				

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CASCADE BEHAVIORAL HOSPITAL 128			12844 N	DDRESS, CITY, STATE, ZIP CODE 4 MILITARY ROAD SOUTH VILA, WA 98168				
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A 023	resource manager inc #7's nursing license hasked to see the Staf human resource man did not have a curren while the human reso vacation. The human that the DON was a re-	dicated that Staff Membrad expired in 2015. Wiff Member #7's file, the ager stated in part that the tile because s/he was urce manager was on resource manager indie-hire but was unable to shile. Staff Member #6	s/he hired cated	A 023				
(A 043)	There must be an effel legally responsible for legally responsible for legally responsible for legally responsible for legally responsible for the conduct of the functions specified in governing body This Condition is not Based on interviews a hospital failed to mee CFR 482.12 Condition Governing Body. Failure to ensure staff knowledge, skills and patient's emergency r in providing emergency r in providing emergency r in providing of the from harm as evidency JEOPARDY condition failure to intervene where the control of the standard patient's emergency r in providing the functioning of the from harm as evidency JEOPARDY condition failure to intervene where the control of the standard patient's emergency r in providing the functioning of the from harm as evidency JEOPARDY condition failure to intervene where the control of the standard patient is the control of the standard patient in the control of the standard patient is the control of the standard patient in the control of the standard patient in the control of the standard patient is the control of the standard patient in the control of the standard patient is the control of the standard patient in the control of the standard patient is the control of the standard patient in the control of the standard patient is the control of the standard patient in the control of the c	ective governing body to the conduct of the hose have an organized persons legally responsions hospital must carry out this part that pertain to met as evidenced by: and document reviews, to the requirements at 4 hospital modern and corrections of the participation for	spital. ible t the the the the the for	{A 043}	Immediately following the exit summ CEO, Governing Board Members, C Risk Manager, Director of Clinical Se and Directors of nursing reviewed the and began formulation of a plan of c The Governing Board delegated the responsibility of ensuring completion corrective action action to the CEO/I who along with the Medical Director member of the Governing Board. The Designee is responsible for reporting results of corrective actions and use monitoring systems to the full Governing Board. The Performance Improvement Committeement increased monitoring for that do not meet the thresholds that established by the Committee. This monitoring will continue until complications and sustained for two reporting and sustained for two reporting and sustained for two reporting and sustained for two reporting and sustained for two reporting and sustained for two reporting suits and sustained for sustai	NO, PI/ ervices, e findings orrection. of all Designee is a e CEO/ g the the of ning Board. nmittee will any items have been increased ance is		

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{A 043}	Continued From page	e 3		{A 043}				
	resulting in delay of c resuscitation.	ardiopulmonary						
		severity of deficiencies R 482.12 Condition of	S		A 045 482.12 (a)(1) Medical Staff			
		erning Body was NOT N	ΛΕΤ.		Corrective Action: The CBH Policy "Physician Assistan			
	Cross- Reference: Ta	gs A093			Privileges" (Policy No: MS.P.310)' w			
A 045	482.12(a)(1) MEDICA	AL STAFF		A 045	updated to reflect the scope of pract contained in the physician assistant	collateral	All corrective actions will	
	[The governing body accordance with State practitioners are eligit appointment to the months of the	e law, which categories ble candidates for	of		agreement. Evaluations will be performed accordance with the OPPE/FPPE po		be completed by 06-30-2017	
		met as evidenced by:			Monitoring Plan:			
	the hospital policy and failed to ensure the su	eview of personnel files d procedure, the hospit upervising physician n assistants' delegation	al		Evaluation Results will be reported of to the CBH performance improvement committee, and quarterly to the MEO governing board.	ent		
		oital also failed to ensu			Persons Responsible:			
		sistants were following i procedures in regards		·	Chief Medical Officer			
	written in the physicia agreement and to pro	cian assistant practice,	as		·			
	Findings						,	
	titled, "Physician Assi: MS.P.310; Last Revie 2: "physician assistar	spital's policy and procestant Privileges" (Policeswed 1/2017) stated in ints are not to write ordeponsibility for that patie	y No: part ers or					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
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A 045	make an independent patient should be addressed to a decide the patient should be addressed to a decide the patient should be addressed to a decide the patient should be addressed to a decide the patient should be addressed to a decide the patient should be addressed to a decide the patient should be a decide the patient should be a decide the patient to the hos required supervisory was not present in the patient should be addressed to the patient to the hos required supervisory was not present in the patient and patient in the patient in t	a physician assistant is at decision as to whether mitted to the hospital." een the hours of 8:30 A yor #1 reviewed the at in a physician assistant Member #8). In review of the at in a physician assistant to prescribe and to dispense legend antrolled substances. In medical orders, the an must provide supervisione to face meetings; chand quarterly performating physician assistant edentialing file, Surveyor that face to face weeked or that chart reviews seek as required by the anot evaluated quarter to whether the physician assistant as not evaluated quarter	r the M nt's of the r e, to drugs ion eart ance e's or #1 kly were ant rly as ewed that a tted ature as	A 045				
A 093	482.12(f)(2) EMERG If emergency service hospital, the governir medical staff has write	ENCY SERVICES s are not provided at the ng body must assure the ten policies and proced gencies, initial treatmer	at the ures	A 093				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SUR COMPLETE	₽ D	
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CASCADE	BEHAVIORAL HOSP	PITAL			AD SOUTH			
			TUKWIL	A, WA 9816	i8			
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A 093	Continued From pag	e 5		A 093				
	and referral when app	o ro priate.					l i	
				A 093 482.	l2 (f)(2) Emergency Services		All	
	This Standard is not met as evidenced by:			Corrective	Action:		corrective actions will be	
	Based on interviews,	document review, and		*** II t			completed	
	review of hospital policy and procedures, the				le clinical staff will be trained to the s		by	
ļ	hospital failed to ensu				e provider AHA BLS, which includes I skill validation of CPR competency (06-30-2017	
i	appropriate immediat	e action to address an			All applicable clinical staff must com			
	emergency medical s	ituation.			aining provided in healthcare provide			
					assuming any direct patient care rol			
	Failure to ensure staf			-	_ ,			
		d training to respond to			s will be initiated at CBH starting 06-2			
		medical needs risks de			e until all applicable clinical staff have			
		ital emergency respons		participated in a mock code. (100 percent). All applicable clinical staff will receive mock code training annually				
	system and initiating	urgent treatment.			The educational content of the mock			
į	Findings:				Include the appropriate response to			
	i ilidiligo.	•			hanging scenario.	•		
	1. The hospital policy	and procedure titled "(Code					
		lical Émergency / Card	iac		was provided to all CNA staff and nu			
	Arrest" (Reference El	M-024; Approved 8/201	(6)	stations reg	arding the emergency notification pro	ocedure.		
		policy of this facility to		Monitoring	Plan]	
		nonary resuscitation (C	PK)	viiitoi iiig	· PARTI			
!		thing and/or pulse cea		Education r	esults will be reported out monthly to	the CBH		
	•	cardiopulmonary funct	ions	performanc	e improvement committee, and quart	erly to the		
	or the emergency me	dical services arrive."			overning board. These education res			
	2. During a review of	the two code blue eve	nto		ercentage of staff requiring AHA BLS	training		
}		f the two code blue eve als to activate emergen		as well as t	nose requiring mock code training.			
	response for patients	_	Cy					
		occured during the mon	ths of	All code blu	e documentation will be reviewed at	the CBH		
i		, Surveyors #2 and #3			rformance Improvement (PI) meeting			
	the following:				pment, and reported out quarterly to			
	REVIEW OF CODE #	‡ 1		9010111	a= 20. 20.			
	a Defiant #4 0	الحالاندالي مام ممري		Persons Re	esponsible:			
		6 year-old admitted on		CEO	-			
•	On 4/20/2017, a code	on with suicidal ideatio		Chief Nursi				
		e blue was initiated in ne patient hanging on h	is/her	PI/RM Direc	ctor			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504011		B. WING			R 5/2017
	ROVIDER OR SUPPLIER E BEHAVIORAL HOS F	PITAL	12844 M	ESS, CITY, STA ILLITARY RO .A, WA 9810	DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 093	bathroom door. b. On 5/2/2017 at 10: interviewed a register Member #3) about th #1's death by hanging hospital on 4/20/2017 s/he was the only RN and was preparing the records for the next of she/he heard the CN, a loud noise and was just hanged themselvimmediately went to the room and saw the part bathroom door. Staff s/he was unsure that the patient down so staff s/he was unsure that the patient	55 PM, Surveyors #2 ared nurse (RN) (Staff e events surrounding Pg which occurred in the Y. Staff Member #3 stated on the unit with 15 pate e medication administrated. The RN indicated to A (Staff Member #2) may yelling that a patient haves. Staff Member #3 the entrance of Patient stient hanging from the Member #3 indicated to she and the CNA could have a called the nursing Next, the RN indicated to the followed by calling 9 pervisor arrived (Staff noved the patient from egan CPR. 5 AM, Surveyors #2 and house supervisor (See events surrounding Pg. Staff Member #4 indicated it indicated a call on the radio off Member #4 stated it indicated to get to the nurs the unit, Staff Member manging on the edge of the surrounding house supervisor the surrounding on the edge of the surrounding on the edge of the surrounding house supervisor surrounding house supervisor the unit, Staff Member thanging on the edge of the surrounding house supervisor surrounding house surrounding house supervisor surrounding house supervisor surrounding house surrounding house surrounding house surrounding house surrounding house su	tatient ted ients ation hat aking ad #1's hat d get k to that 11. the d #3 taff atient cated affing to took ing #4 the or oor, t	A 093			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENT(FICATION NUMB)		1 .	LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		504011		B. WING			R 5/ 2017
	OVIDER OR SUPPLIER BEHAVIORAL HOSE	PITAL	12844 N	RESS, CITY, STA IILITARY RO .A, WA 9810	DAD SOUTH	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATO OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
A 093	the code blue went at the circumstances but for assistance (code could have been statthen asked Staff Men problems with any of indicated that there wand connecting the maself-inflating bag-valve Member #4 confirmed received no practice of d. On 5/2/2017 at 11: interviewed a register about the events surrolly hanging which occur 4/20/2017. Staff Men working on another code blue notificates assist in the code blue surveyors asked if the problems, Staff Memistaff members were hassembling/operating member indicated the on how to put the maconfirmed the facility practice drills involving the code brooking on the code blue assist in the code blue notificates assist in the code blue assist in the code blue notificates assist in the code blue notif	t, Staff Member #4 indis well as it could have on acknowledged that the blue) for the emergency red earlier. The survey other #4 if there were and the equipment. She was some difficulty in lower as some difficulty in lower as some difficulty in lower as some difficulty in lower as some difficulty in lower as some difficulty in lower as some difficulty in lower as a some difficulty or and the she was a some difficulty and left her/his unit are response. When the ere had been any equipment #5 indicated the 2-lower #5	given e call y rors ny cating (a anel ills. and #3 er #5) eath n was eard it to coment North staff nem	A 093			
	Patient #1's medical retwo cycles of bag value performed without the Ambu bag until the massembled. On the sanswer question #4 units with the massemble control of the sanswer question #4 units with the massemble control of the sanswer question #4 units with the control of the	e Blue Evaluation Form record revealed that the ve mask ventilation well e mask connected to the ask was found and lame form, staff did not lander Code Standards v 'Yes" or "No" regarding	e first re e which				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		504011		B, WING	·		R 5/ 2017
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE		
CASCADI	E BEHAVIORAL HOSF	PITAL		IILITARY RO .A, WA 9816			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 093	whether the CPR [cal was uninterrupted and f. Review of the disched 4/28/2017 in Patient; an entry by a physicial revealed that in his/hirelated to resuscitation of documentation to uninterrupted and of g. On 5/2/2017 at 12: interviewed the hospid Member #1) about contraining. S/he indicate procedures and revied during hospital orient this training was by letraining or practice concentation process, hospital had not concat any time during he indicated that mock of scheduled to begin in REVIEW OF CODE #2. Surveyor #2 review that occurred on 3/15 year-old admitted for withdrawal syndrome summary in Patient ##2 had a history of sewithdrawal and was proceed to the process of the poor apparently don his/her back, the phis/her airway. A patient ##2 had a rivay.	rdiopulmonary resuscitated high quality. marge summary dictated #1's medical record shown (Staff Member #10) are review of documentation efforts by staff there support that CPR was high standards. 35 PM, Surveyor #3 attal clinical educator (Staff Member #1 stated when the crash cart is to action. S/he acknowled be education and the staff Member #1 stated when the code blue remployment. S/he acknowled in the code drills for the facility at two weeks. #2 wed another code blue of #2017. Patient #2 was a alcohol dependence are According to the discard medical record, Patient #2 was alcohol dependence are According to the discard medical record, Patient #2 was a state when the staff member #1 was a alcohol dependence are According to the discard medical record, Patient #2 was a state when the staff member #2 was alcohol dependence are According to the discard medical record, Patient #2 was a state when the staff member #2 was a state when the staff member #2 was a state when the staff member #2 was a state when the staff member #4 was a staf	aff aught ged ds-on I the drills were event a 58 ad harge ient On lying ed the	A 093			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETI	ED
		504011		B. WING			R 5/2017
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CÓDE		
CASCADI	BEHAVIORAL HOSP	PITAL		ILITARY RO A, WA 9810	DAD SOUTH 68	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 093	the patient to his/her breathing again. The assisting him/her to k side then the RN left paramedics. Once the (licensed practical nunursing assistants) are to manage the patien to the unit with the patent to documentation, a company of the patient of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patent of the unit with the patient with the unit with the unit with the unit with the patient the unit with the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the patient the unit with the unit with the patient the unit with the unit with the patient the unit with the unit with the patient the unit with the unit with the patient the unit with the patient the unit with the unit with the unit with the patient the unit with th	left side. The patient si RN instructed the patie eep the patient on his/h the unit to meet the ee RN left the unit, an L rse) and 2 CNAs (certif nd physician were left a t situation. The RN retu- tramedics and observed d on the patient. Accor- code blue was called at the unit, the paramedics orts.	ent ner PN fied alone urned d that rding 5:10 s took	A 093			
A 396	b. An interview with the Services (Staff Member AM revealed that the cardiac arrest was dis	te Evaluation Form coulility. The Director of Clinical or #12) on 5/4/2017 at response to the patient sorganized and that the hould have remained ond sent another staff paramedics.	8:44 t's RN	A 396			
	The hospital must end develops, and keeps for each patient. The part of an interdiscipli. This Standard is not. Based on record revie policy and procedure, staff assess patients in the development of the policy and procedure.	sure that the nursing st current, a nursing care nursing care plan may nary care plan met as evidenced by: ew and review of hospit the hospital failed to e	plan be tal ensure				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
		504011		B. WING	·		R 5/2017
•	OVIDER OR SUPPLIER E BEHAVIORAL HOSP	PITAL			DAD SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
A 396	(Patient #3). Failure to assess pati admission puts patier Findings: 1. The hospital policy "Suicide Risk Assessi Reviewed 1/2017) rea or Intake Personnel was uicide risk assessme possible but no later that admission If any seronders information the immediately affect patients a score of High or Sebe contacted immediately affect patients recently and noted the following a. Patient #3 was admitted patients and noted the following transferred from A review of the "Intake Hand-Off" form was denotification with the bewith Plan". The initial was completed on 5/2 after admission. Patients.	and procedure titled ment" (Policy # PC.SP. ad in part: "The admittinvill complete the initial ent (SRA form) as soon than 2 hours after uicide risk assessment hat has potential to tient safety and/or resuvere, the psychiatrist slately." I wed the medical records y admitted to the hosping: In a local acute care hose to Nursing Communication of the process of the policidal of the medical records y admitted to the hosping: In a local acute care hose to Nursing Communication of the process of the process of the policidal of the	100; ng RN as as alts in nall s of tal 3:08 after spital. cation isk eation nt nours	A 396	Corrective Action: All clinical staff v trained to the standards of the Suicide Assessment, and that the Suicide Ris Assessment be completed at a minin hours from admission. If any suicide assessment renders information that potential to immediately affect patien and/or results in a score of High or S psychiatrist shall be contacted immediately affect patiens and the completion of the Nursing Communication Hand Off. The Director of Intake/Chief Nursing (CNO) will be informed regarding of suicide risk assessment renders info has potential to immediately affect pasafety. Monitoring Plan: Education results will be reported out the CBH performance improvement and quarterly to the MEC, and govern Audit results will be reported out mor CBH performance improvement compuraterly to the MEC, and governing intake director will inform leadership failure in hand-off communication reginital suicide risk assessment that reinformation for a potential to immediately affect of initial suicide risk assessment that reinformation for a potential to immediately patient safety. Persons Responsible: CEO CNO Director of Intake Director of Nursing PI/RM Director	vill be le Risk sk num of 2 risk has the t safety evere, the diately. 30 random risk he Intake to Office any initial rmation that atient t monthly to committee, ning board nthly to the mittee, and board. The daily of any garding any enders	

Cascade Behavioral Hospital Plan of Correction August 18, 2017

Tag Number A144	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of POC
Item One	All psychiatric admissions to Cascade Behavioral Hospital will have an initial assault/ violence assessment performed indicating the necessity for interventions be considered. All admissions will be audited for the presence of the assaultive/violence assessment. Data will be reported out weekly to governing board, monthly to Performance Improvement committee, and quarterly to Medical Executive Committee.	Chief Nursing Officer	08-28-2017	100%	90 % or below
Item Two	A policy will be created and implemented, "Assaultive Patient: Precaution and Treatment", outlining three intervention levels once a patient has been identified by the following criteria; A. Previous history of violence/assault B. Assessment results indicating a risk of violence/assault C. An allegation regarding the threat of violence/assault D. A verbal altercation/threat E. A physical confrontation of of violence/assault	Chief Nursing Officer	08-28-2017	Policy Approval	NA
Item Three	The procedure outlined in the policy, "Assaultive Patient: Precaution and Treatment", will outline the following three intervention levels (once a patient has been identified through assessment or action indicating assaultive/violent behavior). The interventions for each level are listed below: Level One: A patient that has had previous history of assault/violence and/or has an assessment result indicating a risk of violence/assault. Intervention: Patient is to be placed on assault precautions. Level Two: A patient has an allegation regarding the threat of violence/assault while staying at CBH. Intervention: Focused treatment team immediately following the threat of	Chief Nursing Officer	08-28-2017	100%	90 % or below

Tag Number A 045	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of
ltem One	CEO will communicate to governing board weekly the status of plan of correction beginning Thursday, August 17, 2017.	CEO	08-28-2017	100%	100%
Tag Number A 043	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of POC
	assessed. Patient's observation levels will be evaluated. Daily assaultive/violence assessment to be conducted. Level Three: A patient that has had a physical confrontation of of violence/assault while staying at CBH. Intervention: Focused treatment team meeting immediately following the act of assault or violence to address specific treatment plans. Medical interventions will be assessed. Patient's observation level will be evaluated. Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use. Patient will be considered for hospital transfer based on acuity. An assaultive/violence assessment will be conducted every shift. All physical confrontation incident reports will be audited for the appropriate process steps outlined in the policy. Data will be reported out weekly to governing board, monthly to Performance Improvement Committee, and quarterly to Medical Executive Committee.				

ltem	Physician Assistant supervision will be documented according to delegation agreement	СМО	08-28-2017	100%	100%
One	by supervising physician. Compliance will be monitored weekly and reported to governing board starting week of August 21, 2017				
Tag Number A 115	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of POC
Item One	Corrective Action: All clinical staff will be educated regarding the finding of "PRN orders for restraints and seclusion". All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. Cascade no longer uses PRN orders for restrictive interventions. Monitoring Plan: Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and weekly to the Governing Board.	CMO/CNO	08-28-2017	100%	90%
Tag Number A 169	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of POC
Item One	All clinical staff will be educated regarding the appropriate use of restraint and seclusion (i.e orders for restraint and seclusion are not prn, least restrictive means must be used for seclusion and restraint, etc.) All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. Monitoring Plan: Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and weekly to Governing Board.	CMO/CNO	08-28-2017	100%	90%

Cascade Behavioral Hospital Plan of Correction August 17, 2017

Tag Number A144	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Complian ce	Action Level Indicating Need for Change of POC
Item One	All psychiatric admissions to Cascade Behavioral Hospital will have an initial assault/violence assessment performed indicating the necessity for interventions be considered. All admissions will be audited for the presence of the assaultive/violence assessment. Data will be reported out weekly to governing board, monthly to Performance Improvement committee, and quarterly to Medical Executive Committee.	Chief Nursing Officer	09-11-2017	100%	90 % or below
Item Two	A policy will be created and implemented, "Assaultive Patient: Precaution and Treatment", outlining three intervention levels once a patient has been identified by the following criteria; A. Previous history of violence/assault B. Assessment results indicating a risk of violence/assault C. An allegation regarding the threat of violence/assault D. A verbal altercation/threat E. A physical confrontation of of violence/assault	Chief Nursing Officer	09-11-2017	Policy Approval	NA
Item Three	The procedure outlined in the policy, "Assaultive Patient: Precaution and Treatment", will outline the following three intervention levels (once a patient has been identified through assessment or action indicating assaultive/violent behavior). The interventions for each level are listed below: Level One: A patient that has had previous history of assault/violence and/or has an assessment result indicating a risk of violence/assault. Intervention: Patient is to be placed on assault precautions. Level Two: A patient has an allegation regarding the threat of violence/assault while staying at CBH.	Chief Nursing Officer	09-11-2017	100%	90 % or below
	Intervention: Focused treatment team immediately following the threat of violence or assault with specific treatment plans. Medical interventions will be				

assessed. Patient's observation levels will be evaluated. Daily assaultive/violence assessment to be conducted.

Level Three: A patient that has had a physical confrontation of of violence/assault while staying at CBH.

Intervention: Focused treatment team meeting immediately following the act of assault or violence to address specific treatment plans. Medical interventions will be assessed. Patient's observation level will be evaluated. Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use. Patient will be considered for hospital transfer based on acuity. An assaultive/violence assessment will be conducted every shift.

All physical confrontation incident reports will be audited for the appropriate process steps outlined in the policy. Data will be reported out weekly to governing board, monthly to Performance Improvement Committee, and quarterly to Medical Executive Committee.

Plan of Correction

Cascade Behavioral Hospital

Amended plan of correction date: 08-16-2017

A 043 Governing Body

CEO will communicate to governing board weekly the status of plan of correction beginning Thursday, August 17, 2017.

A 045 Medical Staff

Physician Assistant supervision will be documented according to delegation agreement by supervising physician. Compliance will be monitored weekly and reported to governing board starting week of August 21, 2017.

A 144 Patient Rights: Care in Safe Setting

Plan of correction includes a focus on different levels of intervention for improving patient safety.

Admission criteria policy update, including a 'high risk' addendum to further identify patients who may pose a safety threat.

Admission communication that patients have been informed of patient rights will be audited daily upon admission.

Development of an assessment for assault risk, similar to suicide risk assessment. It will be monitored through the current nursing admission audit.

Implement assault precautions and treatment policy that addresses assaultive risk and interventions. Initial intervention includes identifying individual patient drivers/triggers and incorporating them into individual treatment plans. The second level of intervention for patient safety includes identifying threatening behavior and implementing medical and physical interventions. The third level of intervention includes Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use and transferring of the patient to a different facility.

Nursing admission audit will be utilized to monitor the identification of patient drivers/triggers and their incorporation into treatment plans. Action plans will be developed based on focused review to implement patient safety improvements for medical and physical interventions. Incident Reports related to assaults will be reviewed to ensure that the appropriate levels of intervention were in place or considered. After every assault, an audit process will be initiated immediately. Based upon the results of that audit, a focused review will be conducted directed by CNO or PI/Risk Director to determine if interventions were appropriate or needed to be adjusted. Data regarding audits will be reviewed weekly by governing board, monthly by PI Committee and quarterly by governing board and MEC.

Safety Huddle improvement to specifically emphasize high-assault-risk patients, done each shift and reviewed and audited daily.

Additional de-escalation training focusing on multiple levels of intervention and assault precautions and treatment.

CNO or designee will attend all emergency response (e.g. Code Grey) and review interventions, and assess need for increased, improved treatment.

Develop an assaultive patient taskforce focused on implementing and improving interventions.

Audit results will be shared weekly with governing board and monthly with Performance Improvement Committee and quarterly with Medical Executive Committee.

All corrective actions will be completed by September 11, 2017