State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	C 06/02/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINTINVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. Investigation dates: 05/13/20 -06/02/20 Intake number: #100399 Examination number: 2020-6632 The investigation was conducted by: Investigator #42599 There were violations found pertinent to this complaint.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: * The regulation number and/or the tag number; * HOW the deficiency will be corrected; * WHO is responsible for making the correction; * WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and * WHEN the correction will be completed. 3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. PLAN OF CORRECTION DUE: June 26, 2020. 4. The Administrator or Representative's signature is required on the first page of the original. 5. Return the original report with the required signatures.	
L 670	322-050.12G RECORDS-PERFORM EVALS WAC 246-322-050 Staff. The licensee shall: (12) Maintain a record on the	L 670		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J Vuke | TITLE: CEO | (X6) DATE: JUNE 26, 2020

Plan of correction Received 06/26/20 Plan of correction Approved 06/30/20 CB 7/01/20

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L 670	Continued From page 1 hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to: (g) Annual performance evaluations. This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to develop an effective process to ensure annual performance evaluations were conducted and records retained for 4 of 6 staff members reviewed (Staff #1, #3, # 7, and #8.) Failure to conduct annual performance evaluations limits the hospital's ability to ensure that staff members are satisfactorily performing required job duties. Findings included: 1. Record review of the hospital policy titled, "Performance Evaluation Process," policynumber HR.PE.140, revised 01/20, showed that hospital employees receive performance evaluations following 90 days of initial employment and then annually, either on the anniversary date or a facility wide review date established by management. 2. On 06/01/20 at 1:00 PM, the investigator conducted a video interview with the Human Resources Director (Staff #6), the Chief Nursing Officer (Staff #9), and the Director of Risk and Quality (Staff #5). Record review of the personnel files showed that: a. Aregistered nurse (Staff #1) received his most recent performance evaluation on 01/31/19.	L 670	TAG L670 322-050, 12G RECORDS-PERFROMANCE EVALS How: The Hospital's Human Resource Director will change the HR policy to reflect: 1) the facility will utilize a static (fixed) date, annual job performance evaluation date for all employees. We will move away from a rolling calendar performance assessment due date on the employee's hire date. This will allow for easier auditing and establish a common completion date amongst all managers. Who: All Clinical Managers will implement this static (fixed) date performance evaluation process. This will ensure that the performance evaluations are completed annually on a reoccurring, non-changing annual date. When: -Prior to 08/01/2020, the HR policy will be changed to reflect a static (fixed) date annual performance evaluation date for all employees, moving away from the performance evaluation due date based on the employee's hire date. -Prior to 08/01/2020, all annual performance evaluations will be obtained, reviewed with the employee, signed, and placed within the employees' human resources file. What: -Clinical managers will ensure: 1) that their employees performance evaluations are completed,	

			reviewed with the employee, signed by the employee, and a copy placed within the employee's human resources file every year by the due date. **Evaluation Method:** -The Human Resource Director will monitor for compliance, beginning with data collection in August 2020. -On a monthly basis, the Human Resource Director will report compliance through the Quality Council Scorecard. GOAL= 95%	

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L 670	Continued From page 2 b. A mental health technician (Staff #3) received her most recent performance evaluation on 11/19/18. c. A mental health technician (Staff #7) received her most recent performance evaluation on 03/29/17. d. A social worker (Staff #8) received his most recent performance evaluation on 3/29/19. 3. On 06/01/20 at 4:06 PM Staff #5 confirmed via email that the identified staff members did not have annual performance evaluations conducted in the past 12 months.	L 670		
L1290	322-200.3K RECORDS-NURSE SERVICES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (k) Nursing services; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to include nursing documentation of nursing assessments and progress notes in the medical record for 2 of 2 patient records reviewed (Patients #1 and #2.) Failure to have complete medical records that contain all patient information risks unsafe care due to lack of complete, accurate, and timely information.	L1290	TAG L1290 322-200.3K RECORDS-NURSING SERVICES How: Nursing services personnel (RNs) will be reeducated regarding the policy related to the completion of nursing assessments, incident reporting, assessment of risk pertaining to sexual violence, and daily nursing progress notes. Relevant critical clinical information will be communicated during mid-shift safety huddles, and documented within the huddle book communication. Who: The Chief Nursing Officer with the assistance of the Nurse Managers, will ensure that all nursing services personnel (RNs) will receive this education/retraining. Nurse managers in conjunction with the charge nurses will ensure that the critical clinical information is communicated during the mid-	

			shift safety huddles and documented within the huddle book communication. **When:** -Prior to 08/01/2020, the Chief Nursing Officer will ensure that all education/retraining has occurred-with documented evidence in the personnel files. -Prior to 08/01/2020, emphasized education regarding completion of nursing assessments, incident reports, assessments of risk pertaining to sexual violence towards others, and daily progress notes will be stressed in new employee orientation, added to the orientation checklist, and completed in the annual nursing skills fair. -Prior to 08/01/2020, nurse managers and nursing supervisors will observe the mid-shift safety huddles and huddle book communications daily. **What:** -Chief Nursing Officer in conjunction with the Nurse Managers will ensure: 1) That education regarding completion of nursing assessments, incident reports, assessments of risk pertaining to sexual violence towards others, and daily progress notes will be stressed in new employee orientation, added to the orientation checklist, and completed in the annual nursing skills fair. **Evaluation Method:** -The charge nurse during the treatment team meeting will review the charts daily, to ensure the documentation is present. If it is not, they will notify nursing administration immediately. -On a monthly basis, nursing administration will audit 30 charts and report those findings through the Quality Council Scorecard. **GOAL**= 90%	

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L1290	Continued From page 3 Findings included: 1. Document review of the hospital policy titled, "Incident Reporting," Policy #RM.200, revised 01/20, showed that when incidents involving patients occur at the hospital, staff must document relevant information including precisely what happened, in the patient's medical record. Document review of hospital policy titled, "Sexual Safety Precautions," Policy #CS.SSP.101, approved 09/25/19, showed that on admission and throughout hospitalization, all patients will be assessed for risk of sexual violence toward others using the "Sexual Acting Out Risk Assessment" form. Document review of the hospital policy titled, "Assessment/Re-Assessment," Policy #PC.A.700, reviewed 02/20, showed that a registered nurse (RN) will perform a comprehensive nursing assessment on all patients within 8 hours of admission to the hospital. 2. Review of facility incidents showed that on 04/10/20 at 12:15 PM, Patient #2 was observed entering the room of Patient #1. The report showed that the staff member immediately called for help and rushed into Patient #1's room. Patient #2 was instructed to leave the room, but he initially refused to leave. He was escorted back to his own room by two staff members. Patient #1 was observed looking fearful as she stood in front of Patient #2. Patient #1 told staff that Patient #2 touched her on the breast and on her private area. 3. Document review of patient medical records	L1290		

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L1290	Continued From page 4 showed that: a. Patient #1 was admitted to the facility for opioid addiction treatment on 02/26/20. While hospitalized, Patient #1 became delusional and psychotic, and on 03/20/20, a court order for involuntary detainment was received, and she was transferred to the acute inpatient psychiatric unit on 3W. A social work progress note dated 04/10/20 at 3:30PM, showed that on 04/10/20, Patient #1 was transferred to 2N following an "incident on 3W," and the patient reported feeling "okay" and "lucky it didn't go further." Medical record review showed no evidence of documentation that Patient #1 was the victim of an alleged sexual assault on 04/10/20. Review of Patient #1's medical record showed that all ofthe nursing reassessment and progress note documents for 04/10/20 were missing. b. Record review showed that Patient #2 arrived to the facility on 04/03/20 at 09:15 AM, and at 3:00 PM, nursing staff documented that since his arrival that day, Patient #2 had stripped naked multiple times, repeatedly made sexually inappropriate comments to staff, attempted to touch female staff members in a sexual manner, and on one occasion disrobed and grabbed onto a female staff member until other staff members physically intervened. Review of the medical record showed that staff failed to perform a Sexual Acting Out (SAO) Risk Assessment within 8 hours of admission according to hospital policy. 4. On 05/28/20 at 10:30 AM Staff #1, a registered nurse, was interviewed. Staff #1 stated that when incidents involving patients and staff occur in the hospital, staff complete an incident report, write a progress note in the patient's chart, and discuss the incident with the supervisor. Staff #1 stated	L1290		

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L1290	Continued From page 5 that when a patient is admitted to the facility, the admit nurse completes the admission paperwork including the Sexual Acting Out (SAO) Risk Assessment, and they notify the provider if the patient requires orders for special precautions. 5. On 05/28/20 at 12:27 PM Staff #2, a registered nurse, was interviewed. Staff #2 stated that when incidents involving patients occur in the hospital, staff complete an incident report and write a progress note in the patient's chart. Staff #2 stated that on 04/10/20, she completed a nursing reassessment and progress note for Patients #1 and #2, but hospital staff were unable to locate the nursing reassessments and progress notes dated 04/10/20 in Patient #1's medical chart. 6. On 05/27/20 at 4:40 PM, the 3W Nurse Manager, Staff #4, confirmed via email that the hospital was unable to locate the 4/10/20 nursing reassessments and progress notes for Patient #1. Staff #4 also stated that Patient #2 was placed on SAO precautions, but Staff #4 was unable to locate a SAO Risk Assessment form in Patient #2's medical record. 7. During a video conference interview on 06/01/20 at 1:00 PM, Staff #5, the Director of Risk and Quality, confirmed the investigator's findings that the hospital was unable to locate the 4/10/20 nursing reassessments and progress notes for Patient #1, hospital staff failed to document the incident of alleged sexual assault in Patient #1's medical record according to hospital policy, and hospital staff did not complete a SAO Risk Assessment for Patient #2.	L1290		
L1305	322-200.4A RECORDS-DATE	L1305		

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L1305	Continued From page 6 WAC 246-322-200 Clinical Records. (4) The licensee shall ensure each entry includes: (a) Date;: (b) Time of day; (c) Authentication by the individual making the entry; This Washington Administrative Code is not met as evidenced by: Based on interview, review of patient records and review of hospital policies and procedures, the hospital failed to ensure that all medical records contained accurate date entries for 2 of 2 medical records reviewed (Patients #1 and #2). Failure to develop and maintain accurately dated medical record entries risks misinterpretation of information. Findings included: 1. Document review of the hospital policy titled, "Documentation Protocols," Policy #PC.L.300, reviewed 02/20, showed that all medical records are to be accurate, truthful, and complete. Policy review showed that all medical record entries are to be confirmed by written signature, dates, times, and credentials. 2. Record review showed that: a. Four patient observation records contained no date (Patient #1). b. Three patient observation records contained no date (Patient #2). c. Patient #1 had two different patient observation records for day shift and two different observation records for night shift dated 03/28/20.	L1305	TAG L1305 322-200, 4A RECORDS-DATE How: Nursing services personnel will be reeducated regarding the accurate dating of elements within the medical record, to include the observation records. Elements within the patient's clinical record will be reviewed daily for accuracy. Who: The Chief Nursing Officer with the assistance of the Nurse Managers, will ensure that all nursing services personnel (RNs) will receive this education/retraining. The charge nurse will be responsible for reviewing each chart daily. When: -Prior to 08/01/2020, the Chief Nursing Officer will ensure that all education/retraining has occurred-with documented evidence in the personnel files. -Prior to 08/01/2020, accurate dating of nursing elements, including the observation records, will be checked daily by the charge nurse and treatment team. Accurate dating of elements within the patient's clinical record will be stressed in new employee orientation, added to the orientation checklist, and completed in the annual nursing skills fair. What:	

			-Clinical managers will ensure: 1) that the charge nurse is ensuring the correct date is reflected on the elements within the patient record. Any discrepancies will be rectified if possible or reported to the nurse manager and Chief Nursing Officer. **Evaluation Method:** -The charge nurse during the treatment team meeting will review the charts daily, to ensure the documentation is present. If it is not, they will notify nursing administration immediately if it is absent. -On a monthly basis, nursing administration will audit 30 charts and report those findings through the Quality Council Scorecard. **GOAL**= 90%	

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L1305	Continued From page 7 Patient #1 did not have any observation records dated 03/29/20. d. The patient observation records dated 03/08/20 should have been dated 04/08/20 (Patients #1 and #2). 3. During a video conference interview on 06/01/20 at 1:00 PM, Staff #5, the Director of Risk and Quality, confirmed the investigator's findings that hospital staff failed to ensure that the patient observation flowsheets contained accurate dates.	L1305		

Cascade Behavioral Hospital
Progress Report for
State Licensing Complaint Investigation
100399/2020-6632, Off-site Investigation Dates: 05/13-06/02/20

PR. Received 9/08/20 CB.
PR approved 9/14/20
CBarnum RN.

Tag Number	How Corrected	Date Completed	Results of Monitoring
L670	Human resources policy EHB.P.200 was revised to reflect 1) the facility will utilize a static (fixed) date, annual job performance evaluation date for all employees. This policy was approved by the Monthly Quality Council and is being submitted to the Quarterly Governing Body for approval.	08/26/2020	The Human Resources Director is sending weekly updates via email on any outstanding performance evaluations to all leaders that have direct reports. The CEO educated all Leaders on completion on of performance evaluation during monthly leadership meeting on August 7th, 2020 and September 8th, 2020. Human Resource Director is monitoring compliance rates for performance evaluations on monthly basis and is reporting data to Quality Council. The current compliance rate for both the 90 day reviews and annual reviews is: June = 62.9% compliance July = 61.3% compliance August = 76.1% compliance Human Resource Director will continue to send weekly email to all leaders that have direct reports until hospital reaches 95% compliance. Hospital will reach 95% compliance before 10/30/2020.
L1290	Chief Nursing Officer with the assistance of Nurse Managers provided training to all nursing staff (RNs) regarding completion of nursing assessments, incident reports, and assessments of risk pertaining to sexual violence towards others. Training of documentation related to nursing assessments, incident reports, assessments of risk pertaining to sexual violence towards others, and daily progress notes was added to the new employee orientation. Training of documentation related to nursing assessments, incident reports, assessments of risk pertaining to sexual violence towards others, and daily progress notes is added to the annual skills fair.	08/26/2020 07/30/2020 10/30/2020	Training for all RNs was completed during the monthly nursing meeting and also, on each unit during shift report. Content included completion of nursing assessments, incident reports, and assessments of risk pertaining to sexual violence towards others. Evidence of training is documented via sign-in-sheet. 100% of full time RNs have been educated. Training has been added to the new RN orientation and to the annual skills fair. The Chief nursing officer with the assistance of Nurse Managers is completing audit of 30 charts and reporting findings through the quality council. Hospital will reach 90% compliance by 10/30/2020. The current compliance rate for nursing assessments, and assessments of risk pertaining to sexual violence towards others is: June = 75% compliance July = 76% compliance August = 85% compliance Audit of incident reports started on September 1st, 2020. Audit results for incidents reports for September, 2020 is as follows:

	Interim Director of Risk educated all RNs on completing incident report and calling the Interim Director of Risk on all incidents as soon as the incident occurs on 08/15/2020. Interim Director of Risk educated all Nurse Mangers and Charge nurses on completing the appropriate documentation related to the incident before the end of the shift on 08/15/2020. Nurse Mangers with the assistance of Charge Nurses are auditing shift incidents to ensure all necessary documentation is in the medical record. The Interim Director of Risk educated Chief nursing officer and nurse manager on competing the monthly audit of 30 charts during plan of correction monthly quality meeting.	08/30/2020 08/26/2020	September = 100% The Chief Nursing Officer with the assistance of Nurse Mangers will complete audit of 30 charts and continue education of all RNs until hospital reaches compliance rate of 90%. RNs not in compliance will receive reeducation or corrective action.
L1305	The Chief Nursing Officer with the assistance of nursing managers provided training to all nurses' services RNs and MHTs on accurate dating of nursing elements, including the observation records. Accurate dating of elements within the patient's clinical record is added to new employee training and orientation. Accurate dating of elements within the patient's orientation is added to annual nursing skill fair. The charge nurse during the treatment team meeting is reviewing the charts daily to ensure the documentation is present. The Interim Director of Risk educated Chief nursing officer and nurse manager on competing the monthly audit of 30 charts during plan of correction monthly quality meeting.	07/30/2020 07/30/2020 10/30/2020 07/30/2020 08/26/2020	Training for all RNs and MHTs was completed during the monthly nursing meeting and also, on each unit during shift report. Content included accurate dating of nursing elements, including the observation records. Evidence of training is documented via sign-in-sheet. 100% of full time RNs and MHTs have been educated. Training on accurate dating of nursing elements including the observation records has been added to the new RN/MHT orientation and to the annual skills fair. 80% of all Part time RNs and MHTs have received education. Shift Supervisor will complete education to all Part Time RNs and MHTs before the part time RN or MHT is scheduled to work on the unit. Current compliance rate for dating of nursing elements including observation records is: June = 100% July = 95% August = 97% The charge nurse during the treatment team meeting will continue to review the charts daily to ensure the documentation is present and notify the nursing administration if the documentation is not present immediately. Any deficiencies will be corrected immediately. Staff not in compliance will receive reeducation or corrective action. The Chief Nursing officer with the assistance of Nurse Managers will continue to audit of 30 charts and report findings though the quality council. Hospital will continue to maintain 90% compliance by 10/30/2020

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

09/14/20

Soni Helmicki, Interim Director of Risk and Quality
Cascade Behavioral Hospital
12844 Military Rd. S.
Tukwila, WA 98168

Re: Complaint #100399/2020-6632

Dear Ms. Helmicki,

I conducted a state hospital licensing complaint investigation at Cascade Behavioral Hospital on 05/13/20 to 06/02/20. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 06/30/20.

Hospital staff members sent a Progress Report dated 09/14/20 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Hospital's attestation that it will correct all deficiencies cited at Chapter 246-322 WAC.

We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Coleen Barron RN

Coleen Barron, MBA, BSN, RN
Nurse Investigator