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 06/22/2021

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 COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety investigation. On site dates: 06/22/2021 Case numbers: 2020-3363 Intake numbers: 98351 The investigation was conducted by: Investigator #15 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 PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by July 30, 2021. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 320	322-035.1D POLICIES-PATIENT RIGHTS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 320		

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L 320	Continued From page 1 consistent with this chapter and services provided: (d) Assuring patient rights according to chapters 71.05 and 71.34 RCW, including posting those rights in a prominent place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Based on interview and record review, the hospital failed to develop and implement policies and procedures to provide patients and their families access to reasonable and clearly defined visiting hours. Failure to provide patients and their families clear and reasonable opportunities to visit during the patient's admission puts the patient at risk for the loss of healthy interactions and benefits of healing and recovery that visits with families and friends provide. Findings included: 1. Document review of the hospital's policy and procedure titled, "Visitation Policy," Policy #PC.V.100, reviewed 01/18, showed that visiting hours are as follows: Geropsychiatric Unit (4West): Daily from 5:30 pm to 7:00 pm and at other times as needed by the family. Detox Unit: No visitors will be permitted. Adult Acute Psychiatric Unit (2North, 2West, 3West): Daily from 6:00 pm to 7:00 pm. Inpatient Addiction Recovery Rehab/Stabilization	L 320		

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L 320	Continued From page 2 Unit: Thursday 7:00 pm to 8:00 pm and Saturday and Sunday 2:00 pm to 4:00 pm. Document review of the hospital's brochure titled, "Visitor Information," no date, provided to families at the patient's admission, showed that visiting hours are as follows: Senior Unit: Daily from 6:00 pm to 7:00 pm. (4West) Adult Psychiatry Unit: Daily from 6:00 pm to 7:00 pm. (2North, 2West, 3West) Co-Occurring Unit: Daily from 6:00 pm to 7:00 pm. (Detox) Addiction Recovery Rehabilitation Unit: Thursday 6:00 pm to 7:30 pm and Saturday and Sunday from 1:00 pm to 2:30 pm. 2. On 06/22/21 at 1:15 pm, Investigator #15 and an Administrator (Staff #1501), reviewed the medical record for Patient #1503. The record review showed the following: a. The patient was a 77-year-old male admitted voluntarily on 01/10/19, with a diagnosis of Dementia from Parkinson's and Alzheimer's with behavioral dyscontrol. b. On 01/11/21, the admitting provider documented that Patient #1503's initial treatment plan was to review and possibly modify his medications. The provider stated that the use of Selective serotonin reuptake inhibitors (SSRI's) and antipsychotics may be exacerbating the patient's behavioral symptoms. c. Nursing progress notes showed the following:	L 320		

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L 320	Continued From page 3 i. On 01/10/19, the patient's wife was present when the patient was admitted at 7:50 pm to the Gero-Psychiatric Unit (4West). ii. On 01/11/19, the patient was visiting with family in the sunroom at 11:30 am. iii. On 01/12/19, Investigator #15 found no evidence documenting a visit with family. iv. On 01/13/19, the family came for a visit at 11:15 am and found that the patient had significant change in condition. The patient was transported to a medical hospital for evaluation and treatment at approximately 2:30 pm. 3. On 06/21/21, during an interview with Investigator #15, the Patient's wife stated that information provided during Patient #1503's admission to the Gero-psychiatry Unit (4West) noted that visiting hours were restricted to 10:00 am to 12:00 pm and 2:00 pm to 4:00 pm. When the Patient was transported to the medical hospital on 01/13/2019, Patient #1503's wife was told by nursing staff that there are "no designated visiting hours and that she could have visited at any time." 4. On 06/22/21, at 1:00 pm, during an interview with Investigator #15, Staff #1501 stated that the hospital's policy for visitation had not changed since 2019 when Patient #1503 was admitted to the facility. Staff #1501 provided Investigator #15 with the hospital's Visitation Policy, last reviewed on 01/18 and last revised on 01/15. Staff #1501 also provided a brochure titled, "Visitor Information," no date, which she reported was given to all patient's families upon admission to the hospital. Staff #1501 verified that the	L 320		

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L 320	Continued From page 4 information between the two documents was contradicting. 5. On 06/22/21, at 2:55 pm, during an interview with Investigator #15, Registered Nurse (Staff #1505), stated that she has worked on the Gero-Psychiatry Unit (4West) since 2017. She reported that the visiting hours are determined by each unit and communicated to the hospital's main desk and the patient's families upon admission. Staff #1505 stated that the visiting hours for 4West have been the same since 2017. Visitors are permitted from 10:00 am to 12:00 pm and 4:00 pm to 6:00 pm. Any exceptions to these hours would be evaluated by staff on the unit. 6. Investigator #15 found that the hospital's policy titled, "Visitation Policy," Policy #PC.V.100, reviewed 01/18, the brochure provided to families upon admission titled, "Visitor Information," and current practices for designated visiting hours reported by staff and patient's families failed to provide a clear, reasonable, and consistent practice for visiting patient's admitted to the hospital.	L 320		
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying	L 355		

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L 355	Continued From page 5 family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: . Based on interview and record review, the hospital staff failed to respond to a serious change in the patient's condition or notify the family of the patient's change in status for 1 of 4 patient's reviewed (Patient #1503). Failure to respond to a serious change in a patient's condition or notify families of a serious change in a patient's medical condition puts the patients at risk for potential harm and/or adverse outcomes. Findings included: 1. Document review of the hospital's policy and procedure titled, "Change in Condition - Triage of Critically Ill Patient," Policy #PC.E.100, reviewed 02/2019, showed the following: a. Staff will assess for acute changes/declines in patient condition, including changes in level of consciousness and failure to respond to treatments. b. Notify the attending physician and nurse manager. c. Transfer patient to Emergency Department, as ordered by physician.	L 355		

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L 355	Continued From page 6 d. Notify family of patient's change in condition and transfer/pending transfer to hospital. Document that family was notified. 2. On 06/22/21 at 1:15 pm, Investigator #15 and an Administrator (Staff #1501), reviewed the medical record for Patient #1503. The record review showed the following: a. The patient was a 77-year-old male admitted voluntarily on 01/10/19, with a diagnosis of Dementia from Parkinson's and Alzheimer's with behavioral dyscontrol and an initial treatment plan to review and possibly modify medications. The provider stated that the use of Selective serotonin reuptake inhibitors (SSRI's) and antipsychotics may be exacerbating the patient's behavioral symptoms. b. On 01/10/19, the Initial Nursing Assessment document showed that the patient was alert, oriented, and oriented to self. Patient #1503 was able to verbalize his needs. When admitted, the patient used a walker for ambulation. c. On 01/11/19, staff documented on the Nursing Reassessment that the patient was alert and responsive. Staff reported that the patient slept through breakfast, and then later visited with family at 11:00 am, and ate dinner in the dining room. d. On 01/12/19, nursing staff documented on the Nursing Reassessment at 2:00 pm, that the patient was observed pacing up and down the hallway. Previous nursing documentation reported that the patient was using a wheelchair to ambulate and was considered a 2-person assist (requiring a minimum of two staff members to transfer the patient from wheelchair to bed or	L 355		

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L 355	Continued From page 7 toilet). e. On 01/12/19, nursing staff documented on the Nursing Reassessment at 10:30 pm, that the patient was in a wheelchair, refused dinner, took one "bite of his 5:00 pm medications," and refused his 6:00 pm medications. f. On 01/13/19, nursing staff documented on the Nursing Reassessment at 1:00 pm, that the patient "slept in" and did not eat breakfast. The patient's morning medication was held due to sleepiness. Nursing staff documented that the family arrived at approximately 11:00 am and were concerned about the patient's change in condition/mentation. The Registered Nurse (RN) notified the provider and House Supervisor to request an order to transfer the patient to the hospital for medical evaluation. g. Investigator #15's review of the Patient Observations records for 01/12/19 and 01/13/19 showed that staff documented the patient as in his room, lying down or appeared to be asleep, from 7:30 pm on 01/12/19 until 10:30 am on 01/13/19 (15 hours). At approximately 10:30 am on 01/13/19, staff woke the patient and assisted him in preparing for the family visit at 11:00 am. 3. On 06/22/21 at 1:30 pm, during an interview with Investigator #15, Registered Nurse (Staff #1503) and Staff #1501, Staff #1503 verified that there was no evidence in nursing documentation for the patient's change in condition prior to the nursing note on 01/13/19 at 1:30 pm. Staff #1501 stated that there might be missing documentation in the medical record due to the patient's transfer to the medical hospital for evaluation and treatment.	L 355		

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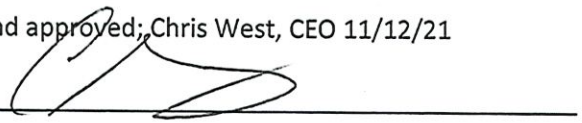
L 355	Continued From page 8 4. On 06/21/21, during an interview with Investigator #15, the Patient's wife stated that when the family visited the patient on 01/13/19, there was a significant change in the patient's condition from the visit on 01/12/19. The patient appeared to be in a comatose state, sitting in a reclining wheelchair, and unable to move his arms, hands, feet, or open his eyes. 5. Investigator #15 failed to find evidence of documentation that staff assessed and responded to the patient's change in condition prior to the family voicing concerns during their visit on 01/13/19 at 11:15 am.	L 355		

Plan of Correction
Recieved 11.12.21
Approved 01.18.22
Mary Drew DOH

Cascade Behavioral Hospital
Plan of Correction for
State Investigation
(Case #2020-3363)

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 320 322-035. 1D POLICIES-PATIENT RIGHTS	What: Visitation hours will be consistent in policy and patient handouts. How: The Director of Business Development has reviewed the Hospital Visitation Policy #PC.V.100 and the brochure titled "Visitor Information" and Patient Handbook and updated the hours to match. Cascade is currently allowing for no visitation as per CDC COVID-19 guidelines. When visitation is reinstated the revised hours will be communicated with an "all staff" email prior to the reinstatement and via bulletin boards on all floors and elevators as well as various other locations in the facility. An "all staff" meeting will occur prior to the reinstatement of visitation hours to communicate when visitation will resume and expectations of visitors, staff and patients. A copy of the brochure and patient handbook is included with every new patient admission packet with the hours of visitation permitted at Cascade, when visitation resumes.	Director of Business Development	7/28/21	The updated policy and handouts are attached with this POC.
L 355 322-035. 1K POLICIES-STAFF ACTIONS	What: Written policies and procedures for (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death. How: Policy for Elopement were revised on 9/2021 and included the procedure on what steps to take in the event of an elopement from a patients designated unit or the facility. This Policy is up for approval by Governing board on 11/15/21, Med exec 11/11/21 and Quality Council on 11/19/21. Once approved, education regarding the changes in these policies will be provided to staff via individual department meetings, "all staff" emails and "all staff" meetings.	Director of RM and Chief Nursing Officer	9/30/21 8/5/21	Sign in sheets and attendance records from all meetings/trainings are compared to a list of current staff to ensure all staff received the required education/information. The Director of Risk Management reviews all patient charts monthly where the patient was sent to another facility due to a change in their medical condition. Any deficiencies discovered in the medical record, including documentation and response to the change of condition by nursing, medical

	Policy POC.EM.101 Emergency, Medical last revised 4/2021 will also be shared with all medical and nursing staff at the next scheduled "all staff" meeting and separate departmental meetings to ensure all staff are clear of the requirements to notify family of a change in a patient's medical condition			and psychiatric providers, EMS response time, code blue documentation (if applicable), previous records (if available), admitting presentation, medical and nursing documentation prior to the event will be shared with the corresponding department leader to address with their staff. Department leaders whose staff did not meet the documentation requirements will have individual counseling with their staff to address any deficiencies and re-educate them on requirements and expectations. All medical records of those sent out of Cascade for additional medical care will be reviewed. Compliance goal is that 90% of the charts reviewed have complete, accurate and timely documentation surrounding the event that lead to transfer out of Cascade. The auditing of these medical records will continue until the goal of 90% is sustained for 3 consecutive months. The Facility established a Medical Consult Log book in October where staff notify the Medical Providers of patients needing a medical assessment. The Director of Quality will review this log book monthly and audit 5 charts per month for timeliness of consult completion (provider sees patient in less than 24 hours from documented request) and appropriate nursing and Provider documentation surrounding the need for and results from the medical consultation. Goal is 90% compliance for required elements in the charts reviewed. Department leaders whose staff did not meet the

	Reviewed and approved; Chris West, CEO 11/12/21 Signature: 			documentation requirements will have individual counseling with their staff to address any deficiencies and re-educate them on requirements and expectations. Monitoring will continue until compliance is 90% or greater for 3 consecutive months. The Director of Risk Management also reviews all events surrounding any reported elopement or attempted elopements to determine if re-education is needed in any department or any issues pertaining to hospital security measures need to be addressed. Director of Risk Management will advise appropriate department leaders if staff re-education is needed or if the facility itself has a security deficiency (i.e. broken door latch, missing hospital badge, etc.). Goal is to have a rate lower than the Acadia expectation of 1.6 per 1000 patient days. Rate is calculated monthly at the corporate level, reported monthly to the facility and data shared with Quality Council and Governing Board.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874
OR Mailing address of investigator

February 17, 2022

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

Re: Complaint #98351/Case #2020-3363

Dear Mr. Fenton,

I conducted a state hospital complaint investigation at Cascade Behavioral Hospital on June 22, 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on January 18, 2022.

Hospital staff members sent a Progress Report dated February 1, 2022 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Hospital's attestation that it had corrected all deficiencies cited at Chapter 246-322 WAC.

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

Sincerely,

Mary New

Mary New, MSN, RN
Nurse Consultant