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FORM APPROVED

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 11/23/2021

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

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L 000	INITIAL COMMENTS	L 000		

STATE COMPLAINT INVESTIGATION

Onsite dates: 10/18/21-10/19/21, 11/03/21-11/04/21, 11/09/21-11/10/21, 11/15/21-11/20/21
Offsite dates: 10/20/21-10/22, 11/02, 11/05, 11/08, 11/12, 11/22

Case number: 2021-11820
Intake number: 116355

The investigation was conducted by:

Investigator #12
Investigator #15
Investigator #16

During the investigation, the DOH investigators determined that there was a high risk of serious harm, injury, or death due to the hospital's failure to ensure that there were effective processes in place to ensure that only patients meeting the hospital's admission criteria were admitted to the hospital.

The state of IMMEDIATE RISK TO PATIENT SAFETY was declared on 11/17/21 at 5:57 PM. Hospital staff created a plan to remove the immediate risk to patients that was approved on 11/19/21 at 9:53 AM. Investigators verified removal of the Immediate Risk to Patient Safety on 11/19/21 at 3:02 PM.

Cross reference: WAC 246-322-170 Patient Care Services

The CEO, Governing Board members, Medical Director, Chief Nursing Officer, and PI/Risk Management Director reviewed the findings and began formulation of a plan of correction during the survey and immediately following the exit summation. 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.
All corrective actions will be completed no later than 2.1.2022.

The CEO and leadership team conduct daily Leadership rounds and meetings in order to promptly assess and address any issues related to patient care and to ensure the implementation of corrective actions. Any safety or quality issue identified will be addressed immediately through training, education or disciplinary action as needed. The CEO/Designee is responsible for reporting the results of the corrective actions and use of monitoring systems to the Governing Board.

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

12/22/21

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L 000	Continued From page 1 During the investigation, the DOH Investigators determined that there was a high risk of serious harm, injury, or death due to the hospital's failure to ensure that there were effective processes in place to ensure that nursing services personnel demonstrated knowledge of and followed hospital policies and procedures for reporting and monitoring abnormal vital signs, conducting patient observations, and completing the documentation of admission assessments, nursing reassessments, and restraint and seclusion packets. The state of IMMEDIATE RISK TO PATIENT SAFETY was declared on 11/19/21 at 3:39 PM. Hospital staff created a plan to remove the immediate risk to patients that was approved at 11/20/21 at 11:00 AM. Investigators verified removal of the Immediate Risk to Patient Safety on 11/20/21 at 6:25 PM. Cross reference: WAC 246-322-035 Policies and Procedures Significant deficiencies remained uncorrected at the time of the investigation exit. Cascade Behavioral Hospital remains NOT IN COMPLIANCE with the Washington Administrative Code.	L 000		
L 305	322-035.1A POLICIES-ADMIT CRITERIA WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 305		

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L 305	Continued From page 2 consistent with this chapter and services provided: (a) Criteria for admitting and retaining patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that there was an effective process in place to ensure that only patient's meeting the hospital's admission criteria were admitted to the facility. Failure to ensure that all patient's meet admission criteria risks the inability to provide appropriate, quality healthcare that meets patient's needs in a safe environment, risks deterioration of the patient's condition, and risks poor healthcare outcomes. Findings included: 1. Document review of the hospital's policy titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," effective 06/07/21, showed the following: a. Each Admitting Physician must abide by the criteria for admitting patients to the Hospital and each program as approved by the Medical Staff and the Governing Board. b. Admitting Physicians are responsible for obtaining information prior to admission as may be necessary to establish that the patient meets all admission criteria and to promote the safety of the patient and that of other patients at the Hospital.	L 305	Corrective Action: The Chief Medical Officer reviewed the Immediate Risk to Patient Safety with the practitioners on 11/18/21. The Medical Executive Committee reviewed and revised PC.A.200 Admission Criteria and forwarded to the Acadia Chief Medical Officer and Governing Board for review and approval on 11/18/21. All medical practitioners were educated on the revisions to the Admission Criteria policy as well as the "Intake Guide for Admission Acceptance" document on 11/19/21 as evidenced by read receipts via email or signed attestations. A Guide was created to assist intake staff with the review of medical exclusionary criteria and admission criteria with the on call provider on 11/18/21 A process was created to demonstrate Intake staff reviewed pertinent medical exclusionary and admission criteria with the admitting provider on 11/18/21. The Director of Admissions educated all admissions staff on the requirement to follow the "Intake Guide for Admission Acceptance", created 11/18/21, as well as what pertinent information to discuss with the on-call provider. Education will be verified via read receipt or signed attestation. Intake staff will review pertinent medical information with the accepting practitioner as evidenced by initials of intake assessor directly on clinical packet next to each item discussed.	1.22.22

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L 305	Continued From page 3 c. The Hospital, through the Chief Medical Officer (CMO) or the Chief Executive Officer (CEO), reserves the right to refuse admission or to recommend to the Admitting Physician that a patient be referred to another facility because such patient's needs cannot be met and/or because treatment cannot be adequately provided by the Hospital. Document review of the hospital's policy titled, "Admission Criteria," policy number PC.A.200, reviewed 03/21, showed the following: Addiction Recovery Services criteria for admission to the Detox unit included the need for medical care and intensive nursing care for one or more of the following: IV fluid and/or medication administration; frequent monitoring for unstable vital signs; serious head trauma or loss of consciousness with persistent mental status or neurological changes; requiring close observation; drug overdose or intoxication compromising the patient's mental status, cardiac function or vital signs; presence of medical conditions that require inpatient treatment (liver failure, pancreatitis, acute gastrointestinal bleeding, cardiovascular disorders requiring monitoring); recurrent or multiple seizures. 2. On 11/15/21 at 4:30 PM Investigator #12 and Investigator #15 observed a Code Blue response on the 2 North Detox/Rehab Unit. Investigators observed Patient #1208 lying on his left side on the bathroom floor, surrounded by three staff. The patient admitted to smoking fentanyl prior to admission, earlier that day, but denied use of any other drugs or alcohol. 3. On 11/15/21 at 4:40 PM, Investigator #12 and Investigator #15 interviewed the Attending Provider (Staff #1224) following Patient #1208's	L 305	Cont from pg 3 Additionally, a notation of the physician contacted with date, time and signature of the admissions assessor will be on the last page of the clinical information provided by the referring hospital. Completed clinical packet will be scanned into internal Admissions Patient folder on the S-Drive. Monitoring Plan: The Director of Admissions will review 30 completed clinical packets monthly to assess compliance with the requirement to follow the Admission Criteria policy and the Intake Guide for Admissions. Any identified deficiencies will be reviewed with the admissions staff member. Identified deficiencies will be trended and reported to Quality Council monthly along with plans for improvement and to Medical Executive Committee and Governing Board quarterly until 90% compliance has been reached for three consecutive months. Responsible Persons: Admissions Director	

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L 305	Continued From page 4 Code Blue. Staff #1224 stated that Patient #1208 had a negative urine tox screen but attributed the patient's seizures to alcohol withdrawal. Staff #1224 stated that he was not aware that Patient #1224 had a prior history of seizures, that the patient attributed the seizures to fentanyl withdrawal, or that the patient was supposed to have a work-up for a seizure disorder. Staff #1224 stated that he did not know if the Internal Medicine Lead was aware of the patient's past medical history, but that "it would have been beneficial to know." Staff #1224 confirmed that the hospital did not have a way to communicate if a patient that did not meet admission criteria was reviewed and deemed safe for admission. 4. On 11/16/21 at 10:45 AM, Investigator #12 and Investigator #15 interviewed the Internal Medicine Lead Physician (Staff #1212). The interview showed that Staff #1212 is called for all patient admissions to the Detox Unit and when there is a medical concern regarding a psychiatry patient. Staff #1212 stated that if a patient requires IV fluids, they would need to be sent out to an acute care hospital. The hospital will admit patients with a history of seizures as long as they are controlled, the patient was on medications and had appropriate records and tests. Investigators reviewed the Admission Criteria policy with Staff #1212 to clarify the hospital's admission criteria to the Detox Unit. The interview showed that the hospital did not admit patients requiring IV fluids and/or medications, frequent behavior monitoring due to agitation and/or confusion, unstable vital signs, patients experiencing seizures, patients experiencing severe head trauma, or loss of consciousness with persistent mental status or neurological changes requiring close observation, drug	L 305		

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L 305	Continued From page 5 overdose or intoxication that has compromised the patient's mental status, cardiac function or vital signs, biomedical conditions requiring inpatient treatment, acute gastrointestinal bleeding, cardiovascular conditions that require monitoring, recurrent multiple seizures and severe altered mental status. 5. On 11/17/21 at 9:00 AM, Investigators #12, #15, and #16 interviewed the hospital's Governing Board. The interview showed that the Governing Board reviews new hospital policies and those policies that require revision. Investigators reviewed the hospital's Admission Criteria policy with the Governing Board. The Governing Board stated that the admission criteria was incorrect and that the hospital did not admit patients requiring IV fluids and/or medications, frequent behavior monitoring due to agitation and/or confusion, unstable vital signs, patients experiencing seizures, patients experiencing severe head trauma, or loss of consciousness with persistent mental status or neurological changes requiring close observation, drug overdose or intoxication that has compromised the patient's mental status, cardiac function or vital signs, biomedical conditions requiring inpatient treatment, acute gastrointestinal bleeding, cardiovascular conditions that require monitoring, recurrent multiple seizures and severe altered mental status. During the interview, the governing board members stated that the policy needed reviewing and revising.	L 305		
L 310	322-035.1B ASSESSMENT POLICY	L 310		

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L 310	Continued From page 6 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: (b) Methods for assessing each patient's physical and mental health prior to admission; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review the hospital failed to ensure that all nursing personnel followed policies and procedures for documenting each patient's physical and mental health status prior to admission for 2 of 2 patient records reviewed Patients #1503, #1505). Failure to ensure that all nursing personnel follow hospital policies and procedures while performing and documenting patient assessments places patients at risk for serious injury, serious harm and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Nursing Standards forPatient Care," policy number PC.N.200, last revised 12/13, showed the following: a. Each patient has an initial assessment that includes consideration of physical, perceived pain, psychological, social status, nutritional, functional/age related and educational needs upon arrival to the nursing unit. b. All patients will have an initial nursing assessment within 8 hours of admission/transfer	L 310	Corrective action #1 All open records of patients admitted in the previous 7 days were reviewed to ensure Nursing Assessments were completed without blanks on 11/20/21. The Chief Nursing Officer/Designee reeducated the RNs on the requirement to complete Nursing Assessments accurately and fully with no blanks unless a note is completed documenting the patient's refusal or inability to respond. Staff should use the signature blocks to note each unsuccessful attempt to complete the Nursing	1.22.22

Cont from pg 7.

Assessment.

Monitoring Plan:
Evidence of reeducation will be maintained in HR employee files.

The Chief Nursing Officer/Designee will audit 30 records monthly, using the 2567 Audit Tool, to assess compliance with the requirement of nursing staff to complete Nursing Assessments, completely and accurately with no blanks.

Identified deficiencies will be trended and staff reeducated as needed up to and including progressive disciplinary action.

Identified deficiencies will be aggregated and trended and reported to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until a 90% compliance rate has been achieved for three consecutive months.

Responsible Persons:
Chief Nursing Officer

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L 310	Continued From page 7 to a nursing unit. c. A Registered Nurse (RN) assesses the patient's needs or validates an assessment of patient needs at the time of admission or within 8 hours of admission. d. Assessment data are consistent with the therapies of other disciplines. e. Assessment data are available to all personnel involved in the patient care. f. Assessment serves as the foundation for the development of the nursing diagnosis and the implementation of the nursing care plan. g. Each patient's care is based on identified nursing diagnosis and/or patient care needs and patient care standards. h. Whenever possible, goals are mutually set with the patient and/or family and are based on the nursing assessment. i. Care decisions are based on patient needs identified through evaluation of the assessment data. 2. Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number PC.T.200, last revised 02/21, showed the following: a. The purpose of treatment planning is to provide a complete, individualized plan of care based on an integrated assessment of the patient's specific needs and problems and prioritization of those needs/problems.	L 310		

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L 310	Continued From page 8 b. Within 8 hours of admission, the Registered Nurse (RN) will initiate the Initial Treatment Plan. This initial plan shall include behavioral and medical problems and appropriate interventions as determined by the initial nursing assessment. 3. Document review of the hospital's policy and procedure titled, "Documentation Protocols," policy number PC.L.300, last revised 09/21, showed that all medical records are to be accurate, truthful, and complete. Patient #1505 4. On 11/09/21 at 3:45 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1505, a 49-year-old male, admitted involuntarily on 07/01/21, with a psychiatric diagnosis of Schizoaffective Disorder. Review of the Patient's medical record showed the following: a. On the Initial Nursing Assessment, dated 07/01/21, nursing staff documented the date and time of the Patient's arrival to the unit, the Patient's legal status, and admission vital signs. Staff documented the Patient's chief complaint as "unable to assess." The body/safety search was performed by two staff; however, the time of the search was not documented. b. Nursing staff failed to complete the Initial Nursing Assessment for Patient #1505. The following data was not documented (left blank) during the Initial Nursing Assessment performed on 07/01/21: i. Educational Data and Learning Barriers and Preferences - Left blank.	L 310		

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L 310	Continued From page 9 ii. Hygiene and Sleep Patterns - Left Blank. iii. Pain Assessment - Left Blank. iv. Functional Screening - Left Blank. v. Nutritional Screening - Left Blank. vi. Falls History - Left Blank vii. Elopement Risk Assessment - Left Blank. viii. Alcohol/Drug History and Withdrawal Symptoms - Left Blank. ix. Tobacco Use Screening - Left Blank. x. Review of Systems - Left Blank. xi. Psychiatric Assessment - Left Blank. xii. Seclusion and Restraint Screening - Left Blank. xiii. Abnormal Involuntary Movement Scale (AIMS) Screening - Left Blank. xiv. Discharge Planning - Left Blank. xv. Suicide Risk Assessment Screening - Left Blank. Nursing staff documented that they were "unable to assess." c. The admitting RN documented in the Summary of the Initial Nursing Assessment that Patient #1505 was "disoriented and disorganized, unable to assess upon admission." d. Page 9 of the Initial Nursing Assessment provided a space to document additional attempts	L 310		

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L 310	Continued From page 10	L 310		

to complete the assessment. "If unable to complete the assessment because the patient is unable or unwilling, document daily attempts. Add additional lines as needed." The document did not contain evidence of additional nursing staff 's attempts to complete the Patient's Initial Nursing Assessment.

5. Staff #1501 verified that the InitialNursing Assessment for Patient #1505 was not completed.

Patient #1503

6. On 11/09/21 at 4:30 PM, Investigator #15 reviewed the medical record for Patient #1503, a 68-year-old female, admitted involuntarily on 09/30/21 at 12:40 AM, with a psychiatric diagnosis of Depression and Anxiety and a medical history of Hypertension, Chronic Heart Failure, Chronic Atrial Fibrillation, Cardiomyopathy, Mitral Regurgitation, Peripheral Vascular Disease, Chronic Alcoholism, Kidney Disease - Stage III, Aortic Valve Stenosis, Severe Protein Calorie Malnutrition. Review of the Patient's medical record showed the following:

a. On the Initial Nursing Assessment, dated 09/30/21, nursing staff documented the date and time of the Patient's arrival to the unit, the Patient's legal status, and admission vital signs. Staff documented the Patient's chief complaintas "patient refused to talk." The body/safety search was performed by two staff at 12:50 AM.

b. Nursing staff failed to complete the Initial Nursing Assessment for Patient #1503. The following data was incomplete or not documented (left blank) during the Initial Nursing Assessment performed on 09/30/21:

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L 310	Continued From page 11 i. Educational Data and Learning Barriers and Preferences - Left blank. ii. Hygiene and Sleep Patterns - Nursing staff documented "patient refused to talk." iii. Pain Assessment - Left Blank. iv. Functional Screening - Nursing staff documented the Patient was "independent" for eating and "needed supervision" for dressing, bathing, and toileting. v. Nutritional Screening - Nursing staff documented "patient refused to assess." vi. Falls History - Nursing staff documented "patient refused." vii. Elopement Risk Assessment - Nursing staff documented that the Patient was not an elopement risk. viii. Alcohol/Drug History and Withdrawal Symptoms - Nursing staff documented that the "patient refused to assess." ix. Tobacco Use Screening - Nursing staff documented that the "patient refused to assess." x. Review of Systems - Nursing staff documented that the patient "refused assessment." xi. Psychiatric Assessment - Left Blank. xii. Seclusion and Restraint Screening - Left Blank. xiii. Abnormal Involuntary Movement Scale	L 310		

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L 310	Continued From page 12	L 310		

(AIMS) Screening - Nursing staff partially completed the AIMS Screening.

xiv. Discharge Planning - Left Blank.

xv. Suicide Risk Assessment Screening - Left Blank.

c. The admitting RN documented in the Summary of the Initial Nursing Assessment that Patient #1503 "came from MultiCare Covington Hospital, refused to take medications in MultiCare. Vital signs are 98/58 blood pressure, 97.9 temperature, 61 pulse, 98% oxygen saturation. Patient was one-to-one observation in Hospital. Patient was on oxygen in Hospital. But Patient oxygen is 98% saturation on room air. Patient refused assessment. Continue to monitor the Patient Q5 (every 5 minutes)."

d. Page 9 of the Initial Nursing Assessment provided a space to document additional attempts to complete the assessment. "If unable to complete the assessment because the patient is unable or unwilling, document daily attempts. Add additional lines as needed." The document did not contain evidence of additional nursing staff 's attempts to complete the Patient's Initial Nursing Assessment.

e. On 09/30/21 at 7:45 AM, after shift change, nursing staff entered Patient #1503's room to check her blood sugar. Patient #1503 was unresponsive. A Code Blue (hospital emergency code - critical status of patient) was called and staff notified 911. Medics arrived at Cascade and transported Patient #1503 to the hospital. The receiving hospital called the Charge Nurse to report that the Patient had passed away at 10:13 AM.

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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 310	Continued From page 13 7. On 11/15/21 at 9:40 AM, during an interview with Investigator #12, #15 and #16, the Chief Nursing Officer (CNO) (Staff #1508) stated that she was not aware of Initial Nursing Assessments that were not being completed in a timely manner. Staff #1508 stated that the hospital is in the process of training and/or re-training nursing competencies to all nursing staff and explained that they have not trained the staff on nursing assessments. She reported that the new medical provider team has offered to train the nursing staff on assessment competencies. When asked about the process for completing the Initial Nursing Assessment when the patient refuses to participate, Staff #1508 stated that she would have to refer to hospital policy but noted, "you just have to re-engage." The CNO stated that "oversight is coming, next week on day shift the house supervisor will be auditing. In real time, we are just not there yet." .	L 310		
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document	L 315		

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L 315	Continued From page 14 review, the governing body failed to implement policies and procedures that ensure practitioners authenticate all verbal and/or telephone orders within 48-hours for 6 of 6 patient records reviewed (Patients #1201, #1202, #1206, #1207, #1209, #1210) (Item #1). The hospital failed to ensure that all nursing personnel implemented policies and procedures for documenting and reporting blood pressures outside of established parameters for 5 of 9 patient records reviewed (Patients #1201, #1202, #1207, #1210,#1212) (Item #2); followed the policies and procedures for patient rounding and documenting patient observations for 5 of 5 patient records reviewed (Patients #1201, #1203, #1204, #1205,#1604) (Item #3); and followed the policies and procedures ensuring complete and accurate documentation of Nursing Reassessments for 4 of 4 patient records reviewed (Patients #1202, #1206, 1207, 1210) (Item #4)and Nursing Assessments for 2 of 5 records reviewed (Patients #1503, #1505) (Item #5). Failure to ensure that providers authenticate verbal and telephone orders within 48 hours places patients at risk for serious injury, serious harm, or death. Item #1 Authenticating Orders Findings included: 1. Review of the hospital document titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," effective 06/07/21, showed the following: a. Each Admitting Physician must abide by the criteria for admitting patients to the Hospital and each program as approved by the Medical Staff	L 315	Corrective action Item #1 The Chief Medical Officer reeducated all practitioners on the requirement to authenticate telephone orders within 48 hours. Monitoring Plan: The Health Information Manager/Designee will audit 30 records monthly to assess compliance with the requirement to authenticate telephone	1.22.22

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L 315	Continued From page 15 and the Governing Board. b. All entries to the medical record must be legibly written, dated, timed, and authenticated. c. All telephone orders given to a licensed nurse, or in the case of the order for a medication, either to a licensed nurse or a licensed pharmacist, must be signed within forty-eight hours by the Attending Physician or by any medical MD/DO or Advanced Registered Nurse Practitioner Provider. d. Any order dictated over the phone shall be signed, dated, and timed by the person who took the order and shall include the name of the Practitioner giving the order. The Practitioner must acknowledge that the read-back is accurate. 2. Investigator #12 reviewed the medical records of six patients admitted to the facility between 09/04/21 and 11/03/21. The medical record review showed that: a. 5 of the 6 patient records reviewed (Patients #1201, #1206, #1207, #1209, #1210) contained telephone or verbal orders from providers that were missing provider signatures or that were signed by a practitioner greater than 48-hours from the time the order was given. b. 4 of the 6 patient records reviewed (Patients #1201, #1206, #1207, #1209) contained Psychiatric Admission Orders that were not signed by a practitioner. 3. On 11/10/21 at 5:00 PM, during an interview with Investigator #12, Staff #1201 verified that it is the expectation of the hospital that all telephone orders are authenticated by a medical provider	L 315	Continued from page 16 orders within 48 hours. The HIM Director will notify the Chief Medical Officer of patterns as they are identified. The Chief Medical Officer will reeducated individual practitioners as deficiencies are identified. The HIM Director will reported deficiencies/trends of deficiencies to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until 90% compliance has been achieved for three consecutive months. Responsible Persons: Chief Medical Officer HIM Director	

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L 315	Continued From page 16 within 48 hours. Item #2 Blood Pressures Findings Included: 1. Document review of the hospital policy titled, "Vital Signs & Parameters," policy number PC.VS.101, revised 09/21, showed that: a. All patients will have vital signs, including blood pressure, pulse, temperature, respirations and oxygen saturation, taken upon admission, daily, and more frequently if ordered by the provider or warranted by the patient's condition. Nursing staff assigned to the patient will take the blood pressure, document the findings in the patient's chart and report all changes/abnormal findings to the charge nurse and physician. b. Vital signs obtained by the Behavioral Health Associate (BHA) are reviewed by the nurse assigned to the patient. If a patient's systolic blood pressure is less than 90 mm/Hg or greater than 160 mm/Hg, or the diastolic blood pressure is less than 60 mm/Hg or greater than 105 mm/Hg, the nurse will assess the patient for symptoms. The nurse will treat the vital signs with any ordered PRN medications and recheck the vital signs in one hour. If no PRN meds are ordered, the nurse will contact the provider for orders. c. Communication with the provider regarding vital signs outside of the parameters should include: all vital signs, patient assessments or complaints, patient allergies, and current medications. Any communications should be documented in the progress notes along with the provider's response.	L 315	Corrective action Item #2 The vital sign policy was reviewed by the Chief Medical Officer and nursing leaders reviewed all open records to assess compliance with the requirement to notify the practitioner for any vital signs out of policy parameters. The vital sign parameters were laminated and affixed to all vital sign machines on 11/20/21. All nursing staff were reeducated on the vital sign policy parameters; the requirement of BHAs to notify the RN if a patient's vital signs are out of range; requirement of the RN to recheck vital signs that are out of policy parameters and to notify the practitioner if vital signs remain outside policy parameters. The Nurse will document on a progress note which Provider was notified with date/time of notification. On December 16, 2021, the Medical Executive Committee met and reviewed the Vital Sign policy and voted to change the diastolic blood pressure lower limit to less than 50 mm/hg. Laminated signs were made and affixed to all vital sign machines and affixed to the BHA's clipboards for easy reference. All nursing staff were reeducated on the change to the policy parameters. Monitoring Plan: Evidence of reeducation will be maintained in HR employee files.	1.22.22

The Chief Nursing Officer/Designee will audit 30 records monthly, using the 2567 Audit Tool, to assess compliance with the requirement to notify the practitioner of vital signs outside of policy parameters after recheck and the documentation of the notification on the nurses progress note. Identified deficiencies will be trended and staff reeducated as needed.

Identified deficiencies will be reported monthly to Quality Council and quarterly to Medical Executive Committee and Governing Board until 90% compliance has been achieved for three consecutive months.

Responsible Persons:
Chief Nursing Officer

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L 315	Continued From page 17	L 315		

2. Investigator #12 reviewed the medical records of five patients hospitalized between 09/04/21 and 11/20/21. The medical record review showed the following:

a. Patient #1201 transferred from an acute care hospital to the facility on 09/30/21 involuntarily for treatment of major depressive disorder with psychosis. Prior to the transfer, Patient #1201 was hospitalized since 09/13/21 for treatment of atrial fibrillation (an irregular heartbeat), high blood pressure, altered level of consciousness and suicide ideation.

Upon arrival to the 3 North unit on 09/30/21 at 12:40 AM, Patient 1201's blood pressure was 98/58. Prior to admission, the nurse to nurse report showed the patient's blood pressure was 119/72 on 09/29/21 at 9:00 PM, and the Intake Assessment form showed that at 4:30 PM, the patient's blood pressure was 114/72.

On 09/30/21 at 4:00 AM, a nurse signed a telephone order for admission orders from a provider listed as "Shelby," no last name, no credentials provided. There was no evidence of documentation showing that the nurse identified the patient's blood pressure was outside of parameters, reassessed the patient, repeated the blood pressure, or notified the provider of the patient's low systolic and diastolic blood pressure readings.

On 09/30/21 at 7:45 AM, nursing staff found Patient #1201 unresponsive, pulseless, and not breathing. Staff began cardiopulmonary resuscitation (CPR), called a Code Blue, and called 911. Paramedics transported the patient to a nearby acute care hospital at 8:25 AM, but the

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L 315	Continued From page 18	L 315		

patient did not survive.

b. Four of eight patient records reviewed (Patients #1202, #1207, #1210, and #1212) showed patients had blood pressure readings outside of the parameters identified in the hospital's "Vital Signs & Parameters Policy." The record review showed that:

i. Patient #1202's blood pressure was outside of parameters on: 09/06/21-109/55 (low diastolic); 09/08/21-190/81 (high systolic); 09/09/21-180/80 (high systolic); 09/10/21 208/85 (high systolic)

ii. Patient #1207's blood pressure was outside of parameters on: 10/24/21-100/46 (low diastolic); 10/30/21-114/56 (low diastolic); 10/31/21-116/58 (low diastolic); 11/01/21-116/58 (low diastolic); 11/02/21-97/59 (low systolic and low diastolic)

iii. Patient #1210's blood pressure was outside of parameters on: 09/06/21-177/83 (high systolic)

iv. Patient #1212's blood pressure was outside of parameters: 10/08/21-125/58 (low diastolic); 10/14/21-189/77 (high systolic)

c. There was no evidence to show that nursing staff assessed the patient, rechecked the blood pressure, or notified the provider of the patients' blood pressure results.

3. On 10/19/21 at 4:00 PM, Staff #1201 confirmed that it was the hospital's expectation for staff to assess the patient, notify the provider, and document their actions when a patient's blood pressure falls outside of the established parameters. Staff #1201 confirmed the investigators findings that Patient #1201's blood pressure was outside of the hospital's established

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L 315	Continued From page 19 parameters, and nursing staff should have notified the provider of the patient's blood pressure reading. Item #3 Patient Rounding and Observations Findings included: 1. Document review of the hospital's policy, "Suicide Risk Assessment," no policy number, dated 08/21, showed that staff use the Columbia Suicide Risk Assessment process to screen every patient upon admission to identify protective factors and to assess the patient for thoughts, plans and suicide intent. If a patient is found to be at moderate or high risk for suicide, practitioner's orders for admission will include suicide precautions and the appropriate level of monitoring of the patient on the unit and that during the Intake process, patients found to be at moderate or high suicide risk are continually monitored until the patient is admitted and moved to the unit. Document review of the hospital's policy titled, "Documentation Protocols," policy number PC.DP.300, revised 09/21, showed that all medical records are to be accurate, truthful, and complete. Document review of the hospital's policy titled, "Patient Levels and Safety Precautions," policy number PC.PLSP.100, reviewed 01/19, showed that patients are screened for safety precautions on admission. Patients who have unstable medical conditions that may require immediate intervention will be placed on Medical Alert precautions. Patients will have "MA" indicated on the round sheet.	L 315	Corrective action Item #3 All open records had been reviewed to ensure that practitioner orders for observations and precautions matched the Observation Sheets carried by the BHAs on 11/20/21 by 1100. The Chief Nursing Officer/Designee reeducated the nursing staff on the following: • the requirement of the RN to immediately notify the BHA holding the Patient Observation forms of any change in practitioner order for level of observation or precautions • the requirement of the BHA to complete patient observations per practitioner order • types of facility precautions; possible patient behaviors for each type of precaution and interventions to be used for the safety of the patient (BHAs were provided an education sheet to carry on their clipboards) • RNs were reeducated on the requirement to monitor the BHAs completing observation rounds to ensure observations are being completed per practitioner order and initial the rounding sheet once per shift to document their review and agreement that the precautions and observation levels are accurate. Monitoring Plan: Evidence of reeducation will be maintained in	1.22.22

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HR employee files.

Facility leaders will conduct Leadership Rounds daily and review Patient Observation forms to assess compliance with the requirement to

monitor patients per practitioner order.

Deficiencies identified will be reviewed in daily leadership meeting along with plans for improvement and recorded on the Flash Report.

The Chief Nursing Officer/Designee will audit 30 records monthly, using the 2567 Audit Tool, on the requirement of nursing staff to monitor patients according to practitioner order for observations and precautions. Identified deficiencies will be trended and staff reeducated as needed.

Identified deficiencies will be reported monthly to Quality Council and quarterly to Medical Executive Committee and Governing Board until 90% compliance has been achieved for three consecutive months.

Responsible Persons:
Chief Nursing Officer

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L 315	Continued From page 20 2. On 11/10/21 between 8:00 AM and 10:30 AM, Investigators #12, #15, and #16 observed patient-care activities on the 3 North inpatient unit. At the time of the observation, the unit had a census of 16 adult patients, and three patients requiring observation every 5 minutes. There were two Behavioral Health Associates (BHAs) (Staff #1225, Staff #1226) and one BHA orientee (Staff #1227) working in the unit. The investigators observed the staff performing the 5-minute observations. Investigator #12 observed staff members (staff #1225 and #1227) documenting the 5-minute observations as they occurred at 8:28 AM, 8:43 AM, and 8:50 AM. During the observation, Investigators #12 and #16 also noted that 5 pencils were on the table in the patient care area, and one pencil was on the bookshelf in the patient care area. No staff members were seen monitoring those areas. During the observation, Investigator #16 interviewed Staff #1225, Staff #1226, and Staff #1227 regarding special precautions including suicide precautions and sexual high risk. The interviews showed that no staff could identify which patients were currently on special precautions for suicide or describe what behaviors to watch for or actions that were needed when working with patients on special precautions for suicide. The interview also showed that Staff #1225, Staff #1226, and Staff #1227 were unaware that the observed pencils could potentially be used for self-harm or that the pencils were easily available to patients. 3. On 11/10/21 at 2:00 PM, observation by Investigator #16 showed the arrival and admission of Patient #1604, a 63-year-old female voluntarily admitted after an intentional overdose of prescription medications. The patient was	L 315		

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L 315	Continued From page 21 given hospital scrubs and directed by an intake specialist (Staff # 1604) to change into the scrubs in an unsupervised restroom down the hall. 4. On 11/10/21 at 2:05 PM an interview with Staff #1604 showed that Staff #1604 stated that he had not done the original intake for Patient #4 and was unaware of the reason for her admission (intentional overdose). When asked if it was safe to give items that could be used for ligature (hospital scrubs) to a patient at risk for suicide, and then send the patient unattended to the restroom, Staff #4 stated "No", but did not go to check on the patient. 5. Investigator #12 reviewed the medical record of Patient #1201, a 68-year-old involuntary patient admitted on 09/30/21 at 12:40 AM for the treatment of major depressive disorder with psychosis and anxiety. Pertinent medical history included recent hospitalization for atrial fibrillation (irregular heartbeat), high blood pressure, altered mental status, and suicide ideation. Document review showed the following: a. On 09/30/21 at 12:40 AM, staff attempted to complete the Admission SAFE-T Columbia Suicide Screen during the intake process, but staff checked the box indicating that the patient refused the assessment. At 1:15 AM staff scribbled over this selection and marked the box showing that the patient was at moderate risk for suicide. b. On 09/30/21 at 4:00 AM, a nurse entered telephone orders showing that Patient #1201 was placed on 5-minute observations. The nurse wrote "A-fib, COPD, HTN" (Atrial fibrillation, chronic obstructive pulmonary disease, hypertension) next to Medical Alert, but the nurse	L 315		

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L 315	Continued From page 22 entering the order failed to check the box for the Medical Alert to indicate that medical precautions were needed. The nurse also failed to check the box for Suicide Precautions. c. The Patient Observations Q5 (Five) Minute Observation Record for the 11:30 PM to 7:25 AM shift showed that Patient #1201 was on 5-minute observations and suicide precautions. Documentation showed that the patient remained calm, in her room, and appeared to be sleeping with chest rising/falling or sitting/lying from 12:55 AM until 7:25 AM. d. The Patient Observations Q5 (Five) Minute Observation Record for the 7:30 AM to 3:25 PM shift showed that Patient #1201 remained on 5-minute checks, but no precautions were checked. Documentation showed that at 7:40 AM, Patient #1204 was calm, in her room, receiving medication. At 7:45 AM, the patient was calm, in her room, sitting/lying in bed, and at 7:50 AM, the patient was in her room talking with staff. At 7:55 AM, staff began documenting "CPR" until 8:30 AM when the patient went to the hospital. e. Review of the admission orders and medication administration record showed that Patient #1201 had no active medication orders and no documentation of medications that were administered while hospitalized at the facility. f. On 11/04/21 between 9:40 AM and 11: 30 AM, Investigator #12 interviewed three staff nurses who worked with Patient #1201 prior to the Code Blue event (Staff #1210, Staff #1220, Staff #1221). Staff #1210, Staff #1220, and Staff #1220 stated that they did not give Patient #1201 any medications on 09/30/21. Staff #1220 and Staff #1221 stated that they did not see or speak to	L 315		

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L 315	Continued From page 23 Patient #1201 at any time before the Code Blue event. g. Review of the Emergency Medical Service (EMS) documents showed that hospital staff reported Patient #1201's "last known well time" was 7:20 AM. The patient was breathing and did not appear in distress. When staff returned to the room at approximately 7:50 AM, Patient #1201 was not breathing and without a pulse. 6. On 11/04/21 at 4:00 PM, Investigator #12 interviewed Staff #1201 about the staff documentation process and rounding. Staff #1201 confirmed the investigators findings that staff did not complete truthful and accurate documentation when they documented on 09/30/21 that Patient #1201 had received medications or was talking with staff. Item #4 Reassessments Findings included: 1. Document review of the hospital's policy titled, "Documentation Protocols," Policy #PC.DP.300, revised 09/21, showed that all medical records are to be accurate, truthful, and complete. Entries must be confirmed by written signature, date, time and credentials. Staff signatures must be legible, use first and last name and credentials. 2. Investigator #12 reviewed four patient records. The document review showed the following: a. Nursing signatures were missing from 3 of 4 patient records reviewed (Patients #1202, #1207, and #1210). b. Nursing staff failed to document the last bowel	L 315	Corrective action item #4 The Chief Nursing Officer/Designee reeducated the RNs on the requirement to complete patient reassessments including bowel movement, skin assessments, education provided, progress toward all treatment goals, in a manner congruent to other documentation, and to sign, date and time the reassessments. The Chief Nursing Officer and the Chief Clinical Officer or Designees will audit 30 patient records monthly using Nursing Audit Tools, to ensure compliance with the requirement to complete nursing reassessments including bowel movement, skin assessments, education provided, progress toward all treatment goals, in a manner congruent to other documentation, and to sign, date and time the reassessment. Identified deficiencies will be remediated with staff as appropriate. Repeated	1.22.22

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violations of the hospitals education and policy on this measure by any staff member will have 1:1 coaching with the Chief Nursing Officer and may face progressive disciplinary action.

Identified deficiencies will be trended and reported to Quality Council monthly until a 90% compliance has been achieved for three consecutive months.

Responsible Persons:
Chief Nursing Officer

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 315	Continued From page 24 movements for 3 of 4 patient records reviewed (Patients #1202, #1206, and #1207). c. Nursing staff failed to perform daily skin assessments for 2 of 4 patient records reviewed (Patients #1202 and #1207). d. Nursing staff failed to document daily education provided for 4 of 4 patient records reviewed (Patients #1202, #1206, #1207, and #1210). e. Nursing staff failed to document daily progress toward treatment goals, whether patients participated in groups, if patients were progressing toward medical treatment goals and document how patients were meeting/not meeting their treatment goals in the daily progress notes for 4 of 4 records reviewed (Patients #1202, #1206, #1207, and #1210). 3. On 11/18/21, Investigator #15 reviewed the medical record for Patient #1510. Document review showed the following: a. On the Daily Nursing Reassessments, dated from 10/08/21 to 10/21/21, nursing staff documented that Patient #1510 had a "good appetite." b. On the Vitals Graphic (Form NURS-0011), dated from 10/08/21 to 10/21/21 staff documented that Patient #1510 refused 30 of 40 meals and ate 25% or less for 5 of 40 meals. c. The information contained on the Daily Nursing Reassessments was incongruent with the data reported on the Vitals Graphics. d. Nursing staff failed to document the Patient's	L 315		

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L 315	Continued From page 25 oral intake and nutrition status accurately, based on the Vital Graphics data. 4. On 11/15/21 between 9:30 AM and 12:00 PM, Investigators #12, #15, and #16 interviewed the Chief Nursing Officer (Staff #1203) about the staff competency process. Staff #1203 stated that the hospital is retraining nursing staff on how to complete all nursing forms, and the goal for completion date is 12/07/21 Item #5 Patient Assessments Findings included: Based on interview, policy review, and record review, the hospital failed to ensure that nursing staff members followed the policies and procedures for performing an initial nursing assessment upon each patient's admission, as demonstrated by 2 of 5 records reviewed (Patients #1503, #1505). Failure to ensure that nursing staff members followed the hospital's policies and procedures by performing an initial nursing assessment places the patient's at risk for inappropriate, inconsistent and delayed care, creating the potential for negative patient outcomes, harm, or death. 1. Document review of the hospital's policy and procedure titled, "Nursing Standards for Patient Care," policy number PC.N.200, last revised 12/13, showed the following: a. Each patient has an initial assessment that includes consideration of physical, perceived pain, psychological, social status, nutritional, functional/age related and educational needs upon arrival to the nursing unit.	L 315	Corrective action item #5 All open records of patients admitted in the previous 7 days were reviewed to ensure Nursing Assessments were completed without blanks on 11/20/21. The Chief Nursing Officer/Designee reeducated the RNs on the requirement to complete Nursing Assessments accurately and fully with no blanks unless a note is completed documenting the patient's refusal or inability to respond. Staff should use the signature blocks to note each unsuccessful attempt to complete the Nursing Assessment. Monitoring Plan: Evidence of reeducation will be maintained in HR employee files. The Chief Nursing Officer/Designee will audit30 records monthly, using the 2567 Audit Tool, to assess compliance with the requirement of nursing staff to complete Nursing Assessments, completely and accurately with no blanks. Identified deficiencies will be trended and staff reeducated as needed up to and including	1.22.22

Cont from pg 30

progressive disciplinary action.

Identified deficiencies will be aggregated and trended and reported to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until a 90% compliance rate has been achieved for three consecutive months.

Responsible Persons:
Chief Nursing Officer

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L 315	Continued From page 26 b. All patients will have an initial nursing assessment within 8 hours of admission/transfer to a nursing unit. c. A Registered Nurse (RN) assesses the patient's needs or validates an assessment of patient needs at the time of admission or within 8 hours of admission. d. Assessment data are consistent with the therapies of other disciplines. e. Assessment data are available to all personnel involved in the patient care. f. Assessment serves as the foundation for the development of the nursing diagnosis and the implementation of the nursing care plan. g. Each patient's care is based on identified nursing diagnosis and/or patient care needs and patient care standards. h. Whenever possible, goals are mutually set with the patient and/or family and are based on the nursing assessment. i. Care decisions are based on patient needs identified through evaluation of the assessment data. 2. Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number PC.T.200, last revised 02/21 showed the following: a. The purpose of treatment planning is to provide a complete, individualized plan of care based on an integrated assessment of the patient's specific	L 315		

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L 315	Continued From page 27	L 315		

needs and problems and prioritization of those needs/problems.

b. Within 8 hours of admission, the Registered Nurse (RN) will initiate the Initial Treatment Plan. This initial plan shall include behavioral and medical problems and appropriate interventions as determined by the initial nursing assessment.

3. Document review of the hospital's policy and procedure titled, "Documentation Protocols," policy number PC.L.300, last revised 09/21 showed that all medical records are to be accurate, truthful, and complete.

Patient #1505

4. On 11/09/21 at 3:45 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1505, a 49-year-old male, admitted involuntarily on 07/01/21, with a psychiatric diagnosis of Schizoaffective Disorder. Review of the Patient's medical record showed the following:

a. On the Initial Nursing Assessment, dated 07/01/21, nursing staff documented the date and time of the Patient's arrival to the unit, the Patient's legal status, and admission vital signs. Staff documented the Patient's chief complaint as "unable to assess." The body/safety search was performed by two staff; however, the time of the search was not documented.

b. Nursing staff failed to complete the Initial Nursing Assessment for Patient #1505. The following data was not documented (left blank) during the Initial Nursing Assessment performed on 07/01/21:

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L 315	Continued From page 28 i. Educational Data and Learning Barriers and Preferences - Left blank. ii. Hygiene and Sleep Patterns - Left Blank. iii. Pain Assessment - Left Blank. iv. Functional Screening - Left Blank. v. Nutritional Screening - Left Blank. vi. Falls History - Left Blank vii. Elopement Risk Assessment - Left Blank. viii. Alcohol/Drug History and Withdrawal Symptoms - Left Blank. ix. Tobacco Use Screening - Left Blank. x. Review of Systems - Left Blank. xi. Psychiatric Assessment - Left Blank. xii. Seclusion and Restraint Screening -Left Blank. xiii. Abnormal Involuntary Movement Scale (AIMS) Screening - Left Blank. xiv. Discharge Planning - Left Blank. xv. Suicide Risk Assessment Screening - Left Blank. Nursing staff documented that they were "unable to assess." c. The admitting RN documented in the Summary of the Initial Nursing Assessment that Patient #1505 was "disoriented and disorganized, unable to assess upon admission."	L 315		

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L 315	Continued From page 29 d. Page 9 of the Initial Nursing Assessment provided a space to document additional attempts to complete the assessment. "If unable to complete the assessment because the patient is unable or unwilling, document daily attempts. Add additional lines as needed." The document did not contain evidence of additional nursing staff 's attempts to complete the Patient's Initial Nursing Assessment. 5. Staff #1501 verified that the Initial Nursing Assessment for Patient #1505 was not completed. Patient #1503 6. On 11/09/21 at 4:30 PM, Investigator #15 reviewed the medical record for Patient #1503, a 68-year-old female, admitted involuntarily on 09/30/21 at 12:40 AM, with a psychiatric diagnosis of Depression and Anxiety and a medical history of Hypertension, Chronic Heart Failure, Chronic Atrial Fibrillation, Cardiomyopathy, Mitral Regurgitation, Peripheral Vascular Disease, Chronic Alcoholism, Kidney Disease - Stage III, Aortic Valve Stenosis, Severe Protein Calorie Malnutrition. Review of the Patient's medical record showed the following: a. On the Initial Nursing Assessment, dated 09/30/21, nursing staff documented the date and time of the Patient's arrival to the unit, the Patient's legal status, and admission vital signs. Staff documented the Patient's chief complaint as "patient refused to talk." The body/safety search was performed by two staff at 12:50 AM. b. Nursing staff failed to complete the Initial Nursing Assessment for Patient #1503. The	L 315		

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L 315	Continued From page 30 following data was incomplete or not documented (left blank) during the Initial Nursing Assessment performed on 09/30/21: i. Educational Data and Learning Barriers and Preferences - Left blank. ii. Hygiene and Sleep Patterns - Nursing staff documented "patient refused to talk." iii. Pain Assessment - Left Blank. iv. Functional Screening - Nursing staff documented the Patient was "independent" for eating and "needed supervision" for dressing, bathing, and toileting. v. Nutritional Screening - Nursing staff documented "patient refused to assess." vi. Falls History - Nursing staff documented "patient refused." vii. Elopement Risk Assessment - Nursing staff documented that the Patient was not an elopement risk. viii. Alcohol/Drug History and Withdrawal Symptoms - Nursing staff documented that the "patient refused to assess." ix. Tobacco Use Screening - Nursing staff documented that the "patient refused to assess." x. Review of Systems - Nursing staff documented that the "refused assessment." xi. Psychiatric Assessment - Left Blank. xii. Seclusion and Restraint Screening - Left	L 315		

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L 315	Continued From page 31 Blank. xiii. Abnormal Involuntary Movement Scale (AIMS) Screening - Nursing staff partially completed the AIMS Screening. xiv. Discharge Planning - Left Blank. xv. Suicide Risk Assessment Screening - Left Blank. c. The admitting RN documented in the Summary of the Initial Nursing Assessment that Patient #1503 "came from Multicare Covington Hospital, refused to take medications in Multicare. Vital signs are 98/58 blood pressure, 97.9 temperature, 61 pulse, 98% oxygen saturation. Patient was one-to-one observation in Hospital. Patient was on oxygen in Hospital. But Patient oxygen is 98% saturation on room air. Patient refused assessment. Continue to monitor the Patient Q5 (every 5 minutes)." d. Page 9 of the Initial Nursing Assessment provided a space to document additional attempts to complete the assessment. "If unable to complete the assessment because the patient is unable or unwilling, document daily attempts. Add additional lines as needed." The document did not contain evidence of additional nursing staff 's attempts to complete the Patient's Initial Nursing Assessment. e. On 09/30/21 at 7:45 AM, after shift change, nursing staff entered Patient #1503's room to check her blood sugar. Patient #1503 was unresponsive. A Code Blue (hospital emergency code - critical status of patient) was called and staff notified 911. Medics arrived at Cascade and transported Patient #1503 to the hospital. The	L 315		

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L 315	Continued From page 32 receiving hospital called the Charge Nurse to report that the Patient had passed away at 10:13 AM. 7. On 11/15/21 at 9:40 AM, during an interview with Investigator #12, #15 and #16, the Chief Nursing Officer (CNO) (Staff #1508) stated that she was not aware of Initial Nursing Assessments that were not being completed in a timely manner. Staff #1508 stated that the hospital is in the process of training and/or re-training nursing competencies to all nursing staff and explained that they have not trained the staff on nursing assessments. She reported that the new medical provider team has offered to train the nursing staff on assessment competencies. When asked about the process for completing the Initial Nursing Assessment when the patient refuses to participate, Staff #1508 stated that she would have to refer to hospital policy but noted "you just have to re-engage." The CNO stated that "oversight is coming, next week on day shift the house supervisor will be auditing." "In real time, we are just not there yet."	L 315		
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 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	L 320	Corrective Action: The Chief Medical Officer reeducated practitioners on the requirement to obtain informed consent for all newly prescribed psychotropic medications, including prn medications, from the patient or legal representative prior to first dose administration after providing the patient with purpose for the treatment, common side effects including contraindications with other medications, details of the risks, benefits and alternatives.	1.22.22

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L 320	Continued From page 33 place for the patients to read; This Washington Administrative Code is not met as evidenced by: . Based on interview, policy review, and record review, the hospital failed to ensure that the patient's rights were protected by providing informed consent (detailing the risks, benefits, and alternatives) for all prescribed psychotropic medications, as demonstrated by 7 of 9 records reviewed (Patient #1502, #1504, #1505, #1506, #1507, #1508, and #1509). Failure to ensure that patients receive informed consent for all prescribed psychotropic medications, including scheduled and PRN (as needed) medications violates the patient's rights to receive details of the risks, benefits and alternatives for all psychotropic medications prior to administration. Reference: RCW 71.05.215 Right to refuse antipsychotic medicine - Rules: A person found to be gravely disabled or found to present a likelihood of serious harm as a result of a behavioral health disorder has a right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm. The hospital shall attempt to obtain the informed consent of the person prior to the administration of antipsychotic medications. The practitioner or nurse shall document the attempt to obtain informed consent and the reasons for the medication administration over the person's lack of consent. Findings included:	L 320	Cont from pg 38 The Chief Nursing Officer reeducated the licensed nursing staff on the requirement to note the MAR when consent has been obtained from the patient or legal representative for a newly prescribed psychotropic medication and to ensure consent has been obtained prior to administering the first dose of a psychotropic medication to a patient. The Chief Nursing Officer/Designee will audit 30 patient records monthly using the Nursing Audit tool to assess compliance with the requirement of a completed informed consent for newly prescribed psychotropic medications. Identified deficiencies related to psychotropic medication consent will be immediately addressed as appropriate. Identified deficiencies, along with plans for correction will be reported to Quality Council monthly and Medical Executive Committee and Governing Board monthly until 90% compliance has been achieved for three consecutive months. Responsible Persons: Chief Medical Officer Chief Nursing Officer	

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L 320	Continued From page 34 1. Document review of the hospital's policy and procedure titled, "Informed Consent, Psychotropic Medications," policy number MM.01.110, last revised 08/21, showed the following: a. All patients (and legal representatives of patients) who have psychotropic medication ordered will be informed of the benefits and risks involved in taking the prescribed medication. b. The ordering practitioner will discuss the prescribed medications with the patient and/or legal representative at the time the new psychotropic medication is ordered. c. Information sheets are available to provide to the patient. Patient #1502 2. On 11/09/21 at 1:30 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1502, a 94-year-old female voluntary patient, admitted on 09/04/21, with a psychiatric diagnosis of Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), and Suicidal Ideation (SI). Review of the Patient's medical record showed the following: a. On the Informed Consent for Psychotropic Medications, dated 09/05/21, signed by both the provider and Patient #1502, staff documented that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of the proposed medications, including contraindications and clinically significant interactions with other	L 320		

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L 320	Continued From page 35 medications." The provider documented that the Patient had been given information regarding the following psychotropic medications: Lexapro (Depression), Restoril (Insomnia), and Klonopin (Anxiety). b. Patient #1502 had been prescribed the following additional psychotropic medications during their admission: Ativan (Anxiety), Vistaril (Agitation), and Gabapentin (Anxiety). c. The Informed Consent for Psychotropic Medication was not updated to include the additional psychotropic medications: Ativan, Vistaril, and Gabapentin. Investigator #15 failedto find evidence that the hospital informed Patient #1502 of the benefits and risks involved in taking the prescribed psychotropic medications. Patient #1504 3. On 11/09/21 at 3:00 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1504, a 52-year-old male, admitted involuntarily on 10/26/21, with a psychiatric diagnosis of Delusional Disorder and Auditory Hallucinations. Review of the Patient's medical record showed the following: a. The Informed Consent for Psychotropic Medications, dated on 10/27/21 was signed by the provider. Staff documented that the Patient "refused to sign." Two psychotropic medications were marked: Thorazine (Antipsychotic) and Depakote (Mood Stabilizer). Investigator #15's review of the Informed Consent found no evidence to document that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of	L 320		

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L 320	Continued From page 36 the proposed medications, including contraindications and clinically significant interactions with other medications." b. Patient #1502 had been prescribed the following additional psychotropicmedications: Ativan (Agitation), Olanzapine (Extreme Agitation), Haldol (Psychosis), and Cogentin (Extrapyramidal Side Effects). c. The Informed Consent for Psychotropic Medication was not updated to include the additional psychotropic medications: Ativan, Olanzapine, Haldol, and Cogentin. Investigator #15 failed to find evidence that the hospital informed Patient #1504 of the benefits and risks involved in taking the prescribed psychotropic medications. Patient #1505 4. On 11/09/21 at 3:45 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1505, a 49-year-old male, admitted involuntarily on 07/01/21, with a psychiatric diagnosis of Schizoaffective Disorder. Review of the Patient's medical record showed the following: a. The Informed Consent for Psychotropic Medications, dated on 07/01/21 was signed by the provider. Staff documented that "Patient refused to consent to take medication." One psychotropic medication was marked: Zyprexa (Antipsychotic). Investigator #15's review of the Informed Consent found no evidence to document that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of	L 320		

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L 320	Continued From page 37	L 320		

the proposed medications, including contraindications and clinically significant interactions with other medications."

b. Patient #1505 had been prescribed the following additional psychotropic medications: Ativan (Agitation), Haldol (Extreme Agitation), Ambien (Insomnia), and Abilify (Psychosis).

c. The Informed Consent for Psychotropic Medication was not updated to include the additional psychotropic medications: Ativan, Haldol, Ambien, and Abilify. Investigator #15 failed to find evidence that the hospital informed Patient #1505 of the benefits and risks involved in taking the prescribed psychotropic medications.

5. On 11/09/21 at 4:00 PM, during an interview with Investigator #15, Staff #1501 stated that each psychotropic medication prescribed for patients should be documented on the Informed Consent for Psychotropic Medications, including medications ordered on the patient's admission order, and any subsequent order after that. Staff #1501 verified that the Informed Consent's for Patient #1502, #1503, and #1505 were incomplete, and failed to include all the psychotropic medications prescribed, as outlined in the hospital's policy.

Patient #1507

6. On 11/10/21 at 10:00 AM, Investigator #15 and Registered Nurse (RN) (Staff #1505) reviewed the medical record for Patient #1507, a 64-year-old male, admitted voluntarily on 10/23/21, with a psychiatric diagnosis of Major Depressive Disorder (MDD) and Suicidal Ideation (SI). Review of the Patient's medical record showed the following:

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a. The Informed Consent for Psychotropic Medications was completely blank and not filled out by staff.

b. Investigator #15's review of the medical record found that Patient #1507 had been prescribed the following psychotropic medications: Lexapro (Depression), Abilify (Psychosis), Zyprexa (Psychosis), Depakote (Mood), Buspar (Anxiety), and Ativan (Anxiety).

c. Investigator #15 found no evidence that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of the proposed psychotropic medications, including contraindications and clinically significant interactions with other medications."

7. On 11/10/21 at 10:15 AM, during an interview with Investigator #15, Staff #1505 stated that they were unfamiliar with the document titled "Informed Consent for Psychotropic Medications." Staff #1505 stated that he was "not sure who fills that out, I don't remember seeing it before."

Patient #1508

8. On 11/10/21 at 11:15 AM, Investigator #15 and Staff #1501 reviewed the medical record for Patient #1508, a 76-year-old female, admitted voluntarily on 09/15/21, with a psychiatric diagnosis of Major Depressive Disorder (MDD) and Alcohol Dependence. Review of the Patient's medical record showed the following:

a. Investigator #15 failed to find evidence of an Informed Consent for Psychotropic Medications in

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L 320	Continued From page 39 Patient #1508's medical record. b. Patient #1508 had been prescribed the following psychotropic medications: Wellbutrin (Depression), Naltrexone (Alcohol Cravings), Paxil (Depression), Trazadone (Insomnia), and Vistaril (Agitation). c. Investigator #15 found no evidence that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of the proposed psychotropic medications, including contraindications and clinically significant interactions with other medications." Patient #1509 9. On 11/10/21 at 11:30 AM, Investigator #15 and Staff #1501 reviewed the medical record for Patient #1509, a 70-year-old male, admitted voluntarily on 09/14/21, with a psychiatric diagnosis of Major Depressive Disorder (MDD) and Alcohol Dependence. Review of the Patient's medical record showed the following: a. Investigator #15 failed to find evidence of an Informed Consent for Psychotropic Medications in Patient #1509's medical record. b. Patient #1509 had been prescribed the following psychotropic medications: Vistaril (Agitation, Trazadone (Insomnia), Fluoxetine (Depression), Bupropion (Bipolar Disorder/Mood), Naltrexone (Alcohol Cravings), and Vivitrol (Alcohol Cravings). c. Investigator #15 found no evidence that the Patient had been given "detailed information	L 320		

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about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of the proposed psychotropic medications, including contraindications and clinically significant interactions with other medications.

Patient #1506

10. On 11/10/21 at 11:45 AM, Investigator #15 and Staff #1501 reviewed the medical record for Patient #1506, a 65-year-old female, admitted involuntarily on 09/07/21, with a psychiatric diagnosis of Schizoaffective Disorder. Review of the Patient's medical record showed the following:

a. Investigator #15 failed to find evidence of an Informed Consent for Psychotropic Medications in Patient #1506's medical record.

b. Patient #1506 had been prescribed the following psychotropic medications: Ativan (Agitation), Seroquel (Extreme Agitation), Risperidone (Schizophrenia), Zyprexa/Zydis (Psychosis), Depakote (Mood), and Clonazepam (Anxiety).

c. Investigator #15 found no evidence that the Patient had been given "detailed information about the proposed medications, the purpose for the treatment, and common short-term and long-term side effects of the proposed psychotropic medications, including contraindications and clinically significant interactions with other medications.

11. On 11/10/21 at 12:30 PM, during an interview with Investigator #15, Staff #1501 verified that the Informed Consent's for Patient #1506, #1508,

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L 320	Continued From page 41 and #1509 were missing from the patient's medical records and that staff failed to document that the patient's had been provided informed consent for the prescribed psychotropic medications. .	L 320		
L 335	322-035.1G POLICIES-EMERGENCY CARE 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: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview and document review the hospital failed to adopt and implement policies and procedures for accessing emergency medical supplies and equipment as evidenced by 3 of 4 patient-care staff interviewed were unable to locate the closest automated external defibrillator (AED) (Staff #1215, Staff #1216, and Staff #1217). Failure to ensure that staff can quickly locate emergency supplies and equipment places patients at risk for serious injury, serious harm, and death. Findings Included:	L 335	Corrective Action: All nursing staff were re-educated to the location of the AEDs and the requirement to check them nightly to ensure they are in good working order. Monitoring Plan: Facility leaders completing daily Leadership rounds will ask unit staff to show them the location of the nearest AED. Leaders will continue to query staff and record deficiencies on the Leadership Round form. Identified deficiencies, along with plans for correct will be reported to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until 90% compliance has been achieved for three consecutive months. Responsible Persons: Chief Nursing Officer	1.22.22

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L 335	Continued From page 42 1. Document review of the hospital's policy titled, "Emergency, Medical," policy number POC.EM.101, last reviewed 04/21, showed that upon arriving at the scene of a medical emergency, the registered nurse (RN) will assess the patient an determine the immediate interventions needed, and additional staff will assist with the Code Blue response, including retrieving the emergency medical cart and automated external defibrillator (AED). 2. Review of hospital documents showed that the hospital failed to provide documentation of unit orientation, including the location of emergency medical equipment, to 8 of 9 patient-care staff (Staff #1209, #1210, #1211, #1220, #1226, #1228, #1229, #1230). 3. On 10/18/21 between 12:30 and 1:00 PM, Investigator #12 toured the 3 North and 2 North patient-care units and interviewed patient-care staff. Three of four staff interviewed (Staff #1215, Staff #1216, and Staff #1217) stated they had received orientation to the department upon hire, but they were unable to locate the closest AED. 4. On 10/18/21 at 3:15 PM, Investigator #12 interviewed the Director of Risk (Staff #1201) who confirmed it was the expectation of the hospital that staff know where to locate the emergency medical equipment, including the AED, and this training occurs during the orientation and training process of all new employees.	L 335		
L 340	322-035.1H PROCEDURES-BEHAVIOR	L 340		

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L 340	Continued From page 43 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: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed implement policies and procedures to ensure that a specially trained registered nurse (RN) completed and documented evidence of a 1-Hour Face-to-Face Assessment within one hour of restraint initiation and the RN consulted the attending or on-call practitioner as soon as possible after completing the 1-Hour Face-to-Face Assessment for 3 of 3 patient records reviewed (Patients #1211, #1210, #1209). Failure to ensure that a specially trained RN performs a 1-hour face-to-face evaluation within 1 hour of the initiation of a restraint or notifies the attending or on-call practitioner as soon as possible after the completion of the evaluation risks serious physical harm, psychological harm and violation of patient rights. Findings included: 1. Review of the hospital policy, "Restraint,"	L 340	Corrective Action: The Chief Nursing Officer/Designee reeducated all RNs on the requirement to complete all elements of the Seclusion Restraint Packet including One Hour Face to Face Assessment and consultation with the practitioner as soon as possible after an incident of physical, mechanical or chemical restraint or seclusion. The RNs were also educated on the requirement to sign, date and time all pages of the forms with a signature block. Monitoring Plan: The Director of Risk Management will audit 100% of all seclusion restraint packets to assess compliance with the requirement to complete the One Hour Face to Face Assessment and the consultation of the practitioner as soon as possible after completion of the evaluation. The Director of Risk Management will review identified deficiencies with the Chief Nursing Officer and report trends along with plans for correction to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until 90% compliance has been achieved for three consecutive months. Responsible Persons: Chief Nursing Officer Director of Risk Management	1.22.22

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L 340	Continued From page 44 Policy #POC.01.90, last reviewed 08/21, showed the following: a. A physical restraint includes manual measures to limit or restrict body movement. Holding a patient who is not cooperative with receiving a medication injection is considered a physical hold. b. Mechanical restraint includes the restriction or limitation of body movements by use of bed restraints (up to 4 points) in a Seclusion room with a restraint bed. c. A chemical restraint is defined as a drug or medication used to manage a patient's behavior or restrict the patient's freedom of movement. Chemical restraints are medications used in addition to or in replacement of a patient's regular drug regimen to control extreme behavior in an emergency. d. A practitioner or specially trained registered nurse shall conduct a face-to-face evaluation of the patient within one hour of initiation of restraint to assess physical and psychological status. The evaluation must be completed, even if the restraint has been discontinued prior to one hour. Review of the hospital policy, "Seclusion," Policy #POC.01.91, last reviewed 08/21, showed the following: a. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. b. A practitioner or specially trained registered nurse shall conduct a face-to-face evaluation of the patient within one hour of initiation of	L 340		

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seclusion to assess physical and psychological status.

2. Investigator #12 reviewed the medical records of three patients who were physically restrained by staff while a nurse administered an injection . The document review showed that:

a. On 11/06/21 at 9:30 PM staff obtained a telephone order to physically restrain Patient #1211. Staff performed a physical hold between 9:33 PM and 9:35 PM to administer medication. Documentation on the 1-Hour Face-to-Face Assessment document showed the letters "N/A" written on the form. There was no date or staff signature. There was no evidence that a nurse conducted a face-to-face assessment within 1 hour of initiation of restraint to assess the patient's physical and psychological status, even if the restraint was discontinued, according to hospital policy.

b. Staff obtained telephone orders for restraint and/or seclusion for Patient #1210 5 times between 09/30/21 and 10/17/21. Review of the 1-Hour Face-to-Face Assessment documents showed that:

i. Nursing staff failed to accurately document or complete the 1- Hour Face-to-Face Assessments for 5 of 5 records reviewed.

ii. Nursing staff failed to document evidence that a provider consult occurred as soon as possible following the 1-Hour Face-to-Face Assessment for five of five records reviewed.

c. Staff obtained telephone orders for restraint and/or seclusion for Patient #1209 5 times between 09/08/21 and 09/27/21. Review of the

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L 340	Continued From page 46 One Hour Face-to-Face Assessment documentation showed that: i. Nursing staff failed to accurately document or complete the 1-Hour Face-to-Face Assessments for 5 of 5 records reviewed. ii. Nursing staff failed to document evidence that a provider consult occurred as soon as possible following 1-hour of restraint initiation and/or 1-Hour Face-to-Face Assessment for five of five records reviewed. 3. On 11/15/21 from 9:30 to 11:45AM, Investigators #12, #14, and #15 interviewed the Chief Nursing Officer (Staff #1203). The interview showed that all registered nurses were trained to do the 1-Hour Face-to-Face Assessment as part of the hospital's forms class and restraint and seclusion training. Nurses receive training that "the clock starts the minute we lay hands on the patient," and the 1-Hour Face-to-Face Assessment is expected to occur "within 59 minutes of this time." Staff #1203 verified that the 1-Hour Face-to-Face Assessment occurs with all patients in restraints and/or seclusion. 4. On 11/15/21 at 5:15 PM, the Director of Risk Management (Staff #1201) confirmed the investigator's findings of the missing documentation of the 1-hour face-to-face assessments and evidence that the nurse consulted the attending or covering provider as soon as possible following the 1-Hour Face-to-Face Assessment. .	L 340		
L 345	322-035.1i POLICIES-PHARMACY	L 345		

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L 345	Continued From page 47 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: (i) Pharmacy and medication services consistent with WAC 246-322-210; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, policy review, and record review, the hospital failed to ensure that staff members followed the policies and procedures for safe medication practices by ensuring the reconciliation and proper storage of medications, including controlled substances, brought in by patients. Failure to ensure that staff members followed safe medication practices for the reconciliation/inventory and storage of patient own medications, including controlled substances, puts the hospital at risk for potential medication diversion and the inability to comply with State and Federal laws, Joint Commission Standards, and professional best practices. Reference: WAC 246-322-210 (3)(g) Pharmacy and medication services - The hospital shall develop policies and procedures for the storage and control of medications and drugs owned by the patient but not dispensed by the pharmacy including, storing Scheduled II drugs in a separate locked drawer, compartment, cabinet, or safe.	L 345	Corrective action: All nursing staff were re-educated using the Medication Administration Competency and exam which include a section on reconciling Patient Own medications. New Log binders were placed in every medication room which also includes a copy of the proper storage and logging of Patient Own Medications. Monitoring plan: The Director of Risk Management will perform monthly inspections of the hospitals medication rooms to ensure Patients medications are properly stored, logged and cabinets are locked. Deficiencies will be addressed with staff immediately and reported to the Chief Nursing Officer for follow up. Results of the monthly inspections will be reported to Quality Council monthly, Medical Executive Committee and Governing Board quarterly. Reporting will continue until there are 3 consecutive months without discrepancies Responsible Parties: Chief Nursing Officer Director of Risk Management	1.22.22

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L 345	Continued From page 48 Findings included: 1. Document review of the hospital's policy and procedure titled, "Medications Brought in With Patients," policy number PHR.118 and MM.03.01.03/MM.05.01.13, last reviewed 09/21, showed the following: a. The purpose of the policy is to ensure that medications brought in with the patient during their stay are disposed of properly or stored properly in a manner consistent with State and Federal law, Joint Commission Standards, and professional practice. b. When a patient brings in medications from home, it will be documented upon admission to the facility. Once the patient has been taken to the unit where they will be staying, the medications brought in by the patient will be inventoried by the staff nurse at that unit . The inventory sheet will be signed by the patient and the nurse conducting the inventory and will be faxed to the pharmacy and kept in the patient's chart. The same sheet and procedure will be used upon discharge. c. If the medications brought in by the patient will not be administered during the patient's stay, all medications will be given back to the patient's family to be taken home if possible. d. If the patient's family cannot be notified, then all medications are placed in a tamperresistant sealed bag. e. Controlled substances that cannot be returned to the family, must be counted with the quantity noted on the inventory sheet. The patient and the staff member receiving the medications will sign	L 345		

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the form.

f. The entire bag with the inventory form will be secured under lock in the medication room onthe unit where the patient is located of other designated area.

g. Copies of the inventory form are kept with the bag of medications and in the patient's record.

h. When a patient has controlled substances being returned at discharge, the quantity being returned to the patient will be noted by the nurse (and witness if available) in the patient's medical record. The patient or care giver will also verify that the count is correct.

i. Documentation regarding disposition of medications will be maintained for a period oftwo years.

2. On 11/10/21 from 8:15 AM to 9:00 AM, Investigator #15 inspected the medication room on 3 North. The observation showed the following:

a. The sign on the upper cabinet doorwhich contained the medications brought in by the patients, noted that the "cabinet doors must remain locked at all times."

b. All cabinet doors in the medication roomwere unlocked.

c. Inside the unlocked cabinet, Investigator #15 found a sealed bag containing medication brought in by Patient #1511. Inside of the sealed bag, there was an undated copy of the Patient's Belongings Inventory Sheet. Staff documented that the medication/s were "placed in bag and

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L 345	Continued From page 50 given to unit nurse." Staff failed to document the name of the medication/s or the quantity of the medication upon the Patient's admission, as directed by hospital policy. d. The sealed bag contained the medication Alprazolam/Xanax, which is a controlled substance. Investigator #15 found that staff failed to ensure that staff inventoried and secured the medication in a locked cabinet, as directed by hospital policy. e. In a binder titled "E Kit (Emergency Kit) and Temperature Binder," Investigator #15 found a page titled "controlled drug" log for Patient #1511, dated 11/03/21, that listed the medication Alprazolam, with a quantity of 57.5 pills. Staff documented that the inventory count had been verified by two nurses twice on 11/03/21 at 2:05 AM and 7:15 AM, and then again on 11/06/21 at 11:00 PM. No other staff documented verifying the medication count for the controlled substance. 4. Review of Patient #1511's medical records failed to find evidence that staff documented and inventoried the medications, including the controlled substance, that the patient brought in during admission. 5. On 11/10/21 at 8:30 AM, during an interview with Investigator #15, Registered Nurse (RN) (Staff #1505) stated that they were unsure of what to do if a patient brings in a controlled medication. Staff #1505 was unfamiliar with the "controlled drug" log for Patient #1511. 6. On 11/10/21 at 8:35 AM, during an interview with Investigator #15, RN (Staff #1507) stated that controlled medications brought in by patients	L 345		

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L 345	Continued From page 51	L 345		

should be in a locked cabinet. Staff #1507 stated that usually the staff will place the patient's "controlled drug" log on the bulletin board to help staff remember to count the medication during shift change.

7. On 11/10/21 at 8:40 AM, during an interview with Investigator #15, RN (Staff #1506) stated that controlled medications brought in by patients should be counted each shift and stored up inthe cabinet. When asked about the unlocked cabinet, Staff #1506 stated that is how we have always done it.

8. On 11/10/21 at 8:45 AM, during an interview with Investigator #15, the Director of Risk (Staff #1501) verified that the cabinet containing the controlled substances brought in by the patient was unlocked. Staff #1501 stated that nursing staff was not following the hospital's policy for safe medication inventory and storage.

9. On 11/15/21 from 5:00 PM to 5:15 PM, Investigator #12 and Investigator #15 inspected the medication room on 2 North. The observation showed the following:

a. The sign on the upper cabinet doorwhich contained the medications brought in by the patients, noted that the "cabinet doors must remain locked at all times."

b. All cabinet doors in the medication room were unlocked. Inside the unlocked cabinet containing the medication brought in by patients, the Investigators found the following:

i. An unsealed bag containing medication brought in by Patient #1514. The unsealed bag contained the following controlled substances: Lorazepam

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(Ativan) and Trazadone HCL 50 mg. The bag failed to contain a copy of the Patient's Belongings Inventory Sheet. The Investigators counted a quantity of 6 - 1 mg Lorazepam and 20 - 50 mg Trazadone.

ii. An unsealed bag containing medication brought in by Patient #1515. The unsealed bag contained the following controlled substance: Buprenorphine/Naloxone. The bag failed to contain a copy of the Patient's Belongings Inventory Sheet. The Investigators counted a quantity of 26 Buprenorphine/Naloxone.

iii. An unsealed bag containing medication brought in by Patient #1516. The unsealed bag contained the following controlled substance: Naltrexone. The bag failed to contain a copy of the Patient's Belongings Inventory Sheet. The Investigators counted a quantity of 4.5 Naltrexone.

iv. A sealed bag containing medication brought in by Patient #1517. The sealed bag contained the following controlled substance: Dextroamphetamine. The bag failed to contain a copy of the Patient's Belongings InventorySheet. Keeping the sealed bag intact, the Investigators noted a bottle of the medication that was recently filled which appeared to contain 30 tablets and a partially filled prescription bottle containing approximately 10 tablets.

10. On 11/15/21 at 5:15 PM, during an interview with Investigator #12 and Investigator #15, Staff #1501 verified that the cabinet containing the controlled substances brought in by the patient was unlocked. Staff #1501 verified that the unlocked cabinet contained 4 patient's medication bags with unsecured controlled substances. Staff

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L 345	Continued From page 53 #1501 stated that this was another example of nursing staff was not following the hospital's policy for safe medication inventory and storage. .	L 345		
L 565	322-050.6E ORIENTATION-DUTIES WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (e) Specific duties and responsibilities; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview and document review, the hospital failed to ensure that all staff received appropriate orientation and training to specific duties and responsibilities as evidenced by the staff member's failure to secure the doors of a locked unit upon entering or exiting the patient-care area. Failure to restrict patient access to unauthorized areas places patients at risk for serious injury, serious harm, and death. Findings included: 1. On 11/09/21 at 12:00 PM, Investigator #12 and Investigator #16 toured the 3 North inpatient unit, a 21-bed locked, patient-care unit. The observation showed a patient census of 17, with six patients requiring staff observation every 5-minutes. At 12:04 PM investigators observed a nutrition services staff member enter the locked unit with a tray of food. Investigators observed that the door did not close completely behind the	L 565	Corrective Action: The Director of Facilities had the Davis Doors Company come out to assess and repair the door on 3 North to ensure it properly latches with each staff entry or exit. Monitoring plan: The Director of Facilities will monitor any work orders put in by staff pertaining to any door not functioning properly and ensure they are addressed immediately. The Director of Facilities will report any work order generated pertaining to doors not latching properly to Quality Council monthly and the Environment of Care meeting monthly. Monitoring and reporting on this measure will continue until there are no reports of doors malfunctioning for three consecutive months. Responsible parties: Director of Facilities	1.22.22

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L 565	Continued From page 54 staff member, creating a potential elopement risk for patients. At 12:09 PM, the nutrition services staff exited the unit through the same door, and again failed to ensure that the door closed securely upon exit. The investigators observed a red sign posted on the door reminding staff to "make sure door closes behind you." 2. Review of hospital documents showed that the hospital had seven instances of patients in unauthorized areas during the past two months, including two that involved the door on 3 North not latching properly. 3. On 11/15/21 at 1:30 PM, interview and document review with Staff #1201 showed thata workorder was entered on 11/13/21. Staff #1201 stated that the a hospital maintenance department hospital employee had evaluated the door and that the employee stated that "there was nothing wrong with the door" and that "staff just needed to make sure they pulled the door closed." .	L 565		
L1035	322-170.1B ADMIT REQUIREMENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (b) Admit only those patients for whom the hospital is qualified by staff, services and equipment to give adequate care; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the governing body failed to implement	L1035	Corrective action item: The Medical Executive Committee reviewed and revised PC.A.200 Admission Criteria and forwarded to the Acadia Chief Medical Officer and Governing Board for review and approval on 11/18/21. All medical practitioners were educated on the revisions to the Admission Criteria policy as well as the "Intake Guide for Admission Acceptance" document on 11/19/21 as evidenced by read receipts via email or signed attestations.	1.22.22

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L1035	Continued From page 55 policies and procedures that ensure only patients meeting the hospital's admission criteria were admitted to the facility for 2 of 6 patient records reviewed (Patients #1201, #1208). Failure to implement policies and procedures and ensure the hospital uses an effective admission process to verify that all patients meet established admission criteria creates the likelihood that practitioners will admit patients with acute medical conditions. Item #1 Effective Processes forEstablished Admission Criteria Findings included: 1. Document review of the hospital's policy titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," effective 06/07/21, showed the following: a. Each Admitting Physician must abide by the criteria for admitting patients to the Hospital and each program as approved by the Medical Staff and the Governing Board. b. Admitting Physicians are responsible for obtaining information prior to admission as may be necessary to establish that the patient meets all admission criteria and to promote the safety of the patient and that of other patients at the Hospital. c. The Hospital, through the Chief MedicalOfficer (CMO) or the Chief Executive Officer (CEO), reserves the right to refuse admission or to recommend to the Admitting Physician that a patient be referred to another facility because such patient's needs cannot be met and/or	L1035	Cont from pg 60 A Guide was created to assist intake staff with the review of medical exclusionary criteria and admission criteria with the on call provider on 11/18/21 A process was created to demonstrate Intake staff reviewed pertinent medical exclusionary and admission criteria with the admitting provider on 11/18/21. The Director of Admissions educated all admissions staff on the requirement to follow the "Intake Guide for Admission Acceptance", created 11/18/21, as well as what pertinent information to discuss with the on-call provider. Education will be verified via read receipt or signed attestation. Intake staff will review pertinent medical information with the accepting practitioner as evidenced by initials of intake assessor directly on clinical packet next to each item discussed. Additionally, a notation of the physician contacted with date, time and signature of the admissions assessor will be on the last page of the clinical information provided by the referring hospital. Completed clinical packet will be scanned into internal Admissions Patient folder on the S-Drive. Monitoring Plan: The Director of Admissions will review 30 completed clinical packets monthly to assess compliance with the requirement to follow the Admission Criteria policy and the Intake Guide for Admissions. Any identified deficiencies will be reviewed with the admissions staff member.	

Cont from pg 61

Identified deficiencies will be trended and reported to Quality Council monthly along with plans for improvement and to Medical Executive Committee and Governing Board quarterly until 90% compliance has been reached for three consecutive months.

Responsible Persons:
Admissions Director

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because treatment cannot be adequately provided by the Hospital.

Document review of the hospital's policy titled, "Admission Criteria," policy number PC.A.200, reviewed 03/21, showed the following:

a. Addiction Recovery Services criteria for admission to the Detox unit included the need for medical care and intensive nursing care for one or more of the following: IV fluid and/or medication administration; frequent monitoring for unstable vital signs; serious head trauma or loss of consciousness with persistent mental status or neurological changes; requiring close observation; drug overdose or intoxication compromising the patient's mental status, cardiac function or vital signs; presence of medical conditions that require inpatient treatment (liver failure, pancreatitis, acute gastrointestinal bleeding, cardiovascular disorders requiring monitoring); recurrent or multiple seizures.

b. Inpatient Geriatric Psychiatric Patient admission exclusion criteria included: medical care needs beyond the resources of the unit; the presence of a medical condition that requires intensive management and is beyond the hospital's capacity to treat, including patients who refuse treatment and medications; exceptions may be made on a case by case basis by the Medical Director with agreement by the Chief Executive Officer or designee; additional Medical Screening may occur when other acute medical conditions are present including: Congestive Heart Failure (CHF); Blood Pressure - systolic , < 100 or > 170 and/or diastolic >100; Arrythmia (an irregular heart beat); Dysphagia; Modified Diet to include mechanical soft, mechanical chopped, pureed, ground; Liquids-thin honey, nectar,

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L1035	Continued From page 57 pudding; medically complex patients will be considered on an individual basis depending on available staffing and/or current milieu. Patient #1201 2. On 10/18/21 at 1:30 PM, Investigator #12 interviewed an Intake Clinician (Staff #1207) about the intake process. Staff #1207 stated that certain medical conditions that cause patients to be excluded from admission include severe mental retardation, dementia, indwelling urinary catheters, insulin pumps, wound vacs, bariatric patients requiring specialized equipment, patients requiring physical therapy (PT) or occupational therapy (OT), patients requiring CPAP who donot have their own equipment at the time of admission, pregnancy after the first trimester, some Level II and all Level III sex offenders. Staff #1207 stated that patients requiring wheelchairs for mobility must be able to toilet themselves, and if they require assistance with transfers to and from the wheelchair, the provider must approve the admission, depending on the acuity of the unit. If the patient meets mental health criteria for admission, but has a complicated medical history, Staff #1207 stated that intake staff will text the information to the Admitting Provider on call. Staff #1207 stated that the Admitting Practitioners "rarely" spoke with providers at other hospitals when accepting patients transferred from outside facilities. Staff #1207 confirmed that the hospital does not admit patients who require medications administered intravenously (IV). On 10/22/21 at 10:30 AM, investigator #12 interviewed an Intake Clinician (Staff #1208) working on 09/29/21 when an acute care hospital requested to transfer Patient #1201 to the facility. The interview showed that:	L1035		

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L1035	Continued From page 58 a. The hospital does not admit patients if they require IV medication administration. Staff#1208 did not recall seeing that Patient #1201 was on any IV blood pressure medications. b. Patients must be taking their medications reliably. If they are not, the intake clinicians will run it by the provider and let them decide whether or not to admit the patient. c. When providing admission request information to the physician, Staff #1208 stated that she enters the most recent vital signs provided by the facility. Additional information is provided on a case by case basis or if requested by the provider. Staff #1208 stated that she did look at the patient's vital sign information, but she did not discuss it with the admitting provider. d. The former Internal Medicine Lead Physician (Staff #1223) preferred to communicate by text message. The request to admit Patient #1201 was sent to Staff #1223 by text message. The provider received a picture of the intake form sent via text message. Staff #1208 did not recall Staff #1223 asking any additional questions about Patient #1201 before accepting the patient for admission. 3. Investigator #12 reviewed the medical record for Patient #1201 who was admitted on 09/30/21 for the involuntary treatment of Depression and Anxiety. The medical record showed that: a. Patient #1201 had a history of atrial fibrillation, high blood pressure, chronic obstructive pulmonary disease (COPD), stage III kidney disease, an abnormal head CT (computerized tomography), and an abnormal lung CT. Patient	L1035		

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#1201 was hospitalized at an acute care hospital between 09/13/21 to 09/29/21, she was being treated for atrial fibrillation, high blood pressure, electrolyte imbalance, kidney failure, and severe protein calorie malnutrition. The acute care hospital requested to transfer Patient #1201 and faxed clinical documents to Cascade Behavioral Hospital on 09/29/21.

b. Before accepting the patient for admission, Cascade Behavioral Hospital received clinical documents with the following information for review:

i. Patient #1201's blood pressure and/or heart rate taken 09/29/21:

" 4:00 AM 167/111 and 147 beats per minute
" 4:29 AM 155/120 and 153 beats per minute
" 7:15 AM heart rate 118 beats per minute
" 7:32 AM 136/91
" 12:26 PM 143/117 and 145 beats per minute
" 3:11 PM 114/70 and 88 beats per minute

ii. Medications given to Patient #1201 on 09/29/21:

" 2:34 AM Lopressor 10 mg IV
" 4:06 AM Hydralazine 10 mg IV
" 6:37 AM Lopressor 10 mg IV
" 9:30 AM Hydralazine 50 mg tablet by mouth; multivitamin tablet by mouth; verapamil tablet SR 240 mg tablet by mouth; (refused Toprol XL 50 mg tablet by mouth)
" 11:05 AM Timoptic eye drops
" 11:48 AM Pred Forte eye drops
" 3:56 PM Hydralazine 50 mg tablet by mouth; Lopressor 10mg IV; saline flush IV

iii. Progress note dated 09/26/21 at 11:43 AM

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L1035	Continued From page 60 stating prior to discharge to inpatient psych facility, "Afib with RVR will need to be better controlled (patient will need to be good enough to take her medications)." c. Review of the Intake Assessment form, showed that: i. Patient #1201's current medications included "IV Lipressor" (Lopressor) ii. The patient was not compliant with taking medications, refused scheduled and PRN meds sometimes, but "not for the past two shifts" d. The provider accepted the patient for admission on 09/29/21 at 4:30 PM e. On 09/30/21 at 7:45 AM, Patient #1201 was not breathing and did not have a pulse. Staff started cardiopulmonary resuscitation (CPR) and called 911. Paramedics transported Patient #1201 to a nearby hospital, but the patient did not survive and was pronounced dead at 10:13AM. 4. On 11/04/21 at 11:30 AM, Investigator #12 interviewed the Internal Medicine Lead Physician (Staff #1212), who stated that patients requiring IV medication to maintain a normal blood pressure due to high blood pressure and heart rate due to atrial fibrillation (an irregular heart rhythm) did not meet criteria for admission. Staff #1212 also stated that the practitioner would require a more in depth review of the medical record to consider admitting a patient weighing 85 pounds with severe protein calorie malnutrition, a weight loss of five pounds in two weeks, and a body mass index of less than 17. Staff #1212 stated that Patient #1201 did not appear to meet the hospital's admission criteria.	L1035		

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L1035	Continued From page 61 Patient #1208 5. On 11/15/21 at 4:30 PM Investigator #12 and Investigator #15 observed a Code Blueresponse on the 2 North Detox/Rehab Unit. Investigators observed Patient #1208 lying on his left side on the bathroom floor, surrounded by three staff. The patient admitted to smoking fentanyl prior to admission, earlier that day, but denied use of any other drugs or alcohol. 6. On 11/15/21 at 4:40 PM, Investigator #12 and Investigator #15 interviewed the Attending Provider (Staff #1224) following Patient #1208's Code Blue. Staff #1224 stated that Patient#1208 had a negative urine tox screen but attributed the patient's seizures to alcohol withdrawal. Staff #1224 stated that he was not aware that Patient #1224 had a prior history of seizures, that the patient attributed the seizures to fentanyl withdrawal, or that the patient was supposed to have a work-up for a seizure disorder. Staff #1224 stated that he did not know if the Internal Medicine Lead was aware of the patient's past medical history, but that "it would have been beneficial to know." Staff #1224 confirmed that the hospital did not have a way to communicate if a patient that did not meet admission criteria was reviewed and deemed safe for admission. 7. On 11/16/21 at 10:45 AM, Investigator #12 and Investigator #15 interviewed the InternalMedicine Lead Physician (Staff #1212). The interview showed that Staff #1212 is called for all patient admissions to the Detox Unit and when there is a medical concern regarding a psychiatry patient. Staff #1212 stated that if a patient requires IV fluids, they would need to be sent out to an acute care hospital. The hospital will admit patients with a history of seizures as long as they are	L1035		

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L1035	Continued From page 62 controlled, the patient was on medications and had appropriate records and tests. Investigators reviewed the Admission Criteria policy with Staff #1212 to clarify the hospital's admission criteria to the Detox Unit. The interview showed that the hospital did not admit patients requiring IV fluids and/or medications, frequent behavior monitoring due to agitation and/or confusion, unstable vital signs, patients experiencing seizures, patients experiencing severe head trauma, or loss of consciousness with persistent mental status or neurological changes requiring close observation, drug overdose or intoxication that has compromised the patient's mental status, cardiac function or vital signs, biomedical conditions requiring inpatient treatment, acute gastrointestinal bleeding, cardiovascular conditions that require monitoring, recurrent multiple seizures and severe altered mental status. 8. On 11/17/21 at 9:00 AM, Investigators #12, #15, and #16 interviewed the hospital's Governing Board. The interview showed that the Governing Board reviews new hospital policies and those policies that require revision. Investigators reviewed the hospital's Admission Criteria policy with the Governing Board. The Governing Board stated that the admission criteria was incorrect and that the hospital did not admit patients requiring IV fluids and/or medications, frequent behavior monitoring due to agitation and/or confusion, unstable vital signs, patients experiencing seizures, patients experiencing severe head trauma, or loss of consciousness with persistent mental status or neurological changes requiring close observation, drug overdose or intoxication that has compromised the patient's mental status, cardiac	L1035		

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L1035	Continued From page 63 function or vital signs, biomedical conditions requiring inpatient treatment, acute gastrointestinal bleeding, cardiovascular conditions that require monitoring, recurrent multiple seizures and severe altered mental status. During the interview, the governing board members stated that the policy needed reviewing and revising. .	L1035		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based on interview, policy review, and record review, the hospital failed to ensure that staff developed, implemented, reviewed, and revised,	L1065	Corrective Actions: The Director of Quality and Compliance for Acadia Healthcare educated Cascade's Chief Medical Officer on the provider requirements in regarding treatment planning. The Chief Medical Officer then trained the practitioners on the requirements. The Director of Clinical Services and Chief Nursing Officer or Designees have reeducated all RNs and Social Services staff using the Treatment Planning Wizard on the requirements of treatment planning including completion of the Initial Nursing Treatment Plan within 8 hours of admission; completion of the Master Treatment Plan within 3 days of admission including the following: admission and anticipated discharge dates; all substantiated psychiatric and medical diagnoses; list of patient assets and liabilities; patient treatment preferences; initial discharge criteria including ability to meet ADLs; initial discharge plan; individually numbered problem list for both psychiatric and medical problems for all active problems; list of deferred problems for inactive medical or psychiatric problems and reason for deferral; evidence of patient or legal representative involvement	1.22.22

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L1065	Continued From page 64 when appropriate, an interdisciplinary treatment plan for all patients that included behavioral and medical problems, with individualized patient-specific interventions, as demonstrated by 4 of 4 records reviewed (Patient #1502, #1504, #1506, and #1510). Failure to ensure the development, implementation, review, and revision, when appropriate, of an interdisciplinary treatment plan for behavioral and medical problems places the patient's at risk for inappropriate, inconsistent and delayed care, creating the potential for negative patient outcomes, harm, or death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Treatment Planning," policy number PC.T.200, last revised 02/21, showed the following: a. Each patient admitted to the hospital shall have a written, individualized treatment plan that is responsive and timely to the treatment needs of the patient, based on information provided by the patient, patient's family, and assessment by the clinical treatment team. b. The treatment plan serves as an organized tool, whereby the care rendered each patient is designed, implemented, assessed, and updated in an orderly and clinically sound manner. c. Within 8 hours of admission, the Registered Nurse (RN) will initiate the Initial Nursing Treatment Plan that includes behavioral and medical problems with appropriate physician and nursing interventions as determined by the initial assessment and physicians' orders.	L1065	Continued from page 70 in treatment planning or reasons for the non-participation; evidence of multiple attempts to involve the patient in treatment planning until the day of discharge; evidence of staff involvement in treatment planning by way of RN, Social Services, and MD on the Master Treatment Plan. Completion of problem sheets for all active psychiatric and medical problems to include the following: evidence/symptoms of the problem; long term goal; patient goal in their own words; individualized short term goals; target dates; and services and interventions to be provided for all disciplines including the MD and RN. Requirement to update treatment plans, including target dates at least weekly; for each newly diagnosed/identified psychiatric or medical problem; when there is a change in patient condition, such as sexual acting out; and when there is a change in the course of treatment. Requirement to include the following in the Treatment Plan Update: current progress and plan for each active goal for each identified psychiatric or medical problem; synopsis of psychiatric and medical problems by each discipline; change in diagnoses; discharge plan and status of /updates to discharge; estimated length of	

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L1065	Continued From page 65 d. Within 72 hours of admission, the treatment team shall develop the interdisciplinary treatment plan that is based on a comprehensive assessment of the patient's presenting problems, physical health, emotional and behavioral status. e. Identified medical problems that are stable, but the patient is receiving medication/treatment for the problem and need to be continually assessed for exacerbation, may be combined under the problem title "Medical Problems." f. Goals and interventions will be addressed for each identified medical problem. g. The initial treatment plan shall be reviewed, updated and/or revised within 7 days of a patient's admission. All subsequent updates to the plan shall occur at least every 7 days of hospitalization and as appropriate to patient needs. h. Treatment plan reviews and updates shall include the following: i. Review of progress towards goals and effectiveness of interventions for each problem on the Problem List. ii. Modification or additions made to the goals and interventions, as appropriate. Patient #1502 2. On 11/09/21 at 1:30 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1502, a 94-year-old female voluntary patient, admitted on 09/04/21, after being found at her independent living facility	L1065	Continued from page 71 stay; anticipated discharge date; justification for continued stay; evidence of involvement of patient or representative in treatment planning update; reasons for patient or representative nonparticipation; evidence of multiple attempts to involve the patient or representative if not able initially; and signatures of each treatment team member; requirement of clinicians and practitioners to document progress toward treatment goals via progress notes and group notes. Evidence of reeducation will be documented via skills checklists, meeting sign in sheets or attestation and kept in the HR departments staff training folders. Monitoring Plan: The Director of Human Resources will audit all new RN or Social Services staff HR files to ensure HR files contain evidence of training at the time of hire. No new hire or existing employee will be allowed to complete the skills independently until competence has been assessed and established via completion and passing of the competency exam and skill assessment. The CNO/designee will review the updated Staff Competency spreadsheet daily to ensure staff working on the units have completed/passed their treatment plan competency. Any staff who have not yet completed/passed the treatment plan competency shall not work on a patients treatment plan until the competency has been established. The CNO/designee will ensure that there are staff available each shift who have passed the competency for treatment plan completion until all staff have completed the competency.	

Cont from pg 72

The Chief Compliance Officer and Chief Nursing Officer or Designees review a total of 30 Treatment Plans and Treatment Plan Updates monthly to ensure compliance with all elements of the Treatment Planning and Treatment Plan Update process. Deficiencies are identified in real time and addressed with staff members for correction. Identified trends will trigger reeducation for patient care area that may be affected.

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L1065	Continued From page 66 cutting her left wrist. The Patient was taken to the hospital and had a blood pressure of 257/77 on 09/03/21, prior to her admission to Cascade on 09/04/21. The Patient's admitted with a psychiatric diagnosis of Generalized Anxiety Disorder (GAD), Major Depressive Disorder (MDD), and Suicidal Ideation (SI) and a medical diagnosis of Hypertension (High Blood Pressure), Insomnia, Generalized Muscle Weakness (Required assistive devices to ambulate), Acute Urinary Tract Infection (UTI), and Sinus Arrhythmia. Review of the Patient's medical record showed the following: a. On 09/05/21, the Interdisciplinary Master Treatment Plan (MTP) was initiated and one problem was identified: Psychiatric Problem #1 - Depression. Review of the MTP found no evidence that staff documented any additional psychiatric problems other than Problem #1 - Depression or added any medical problems to the MTP Problem List. b. Staff initiated the following Individual Treatment Plans: i. Psychiatric Problem #1 - Depressed Mood without Psychosis, dated 09/04/21. ii. Medical Problem #1 - Potential Injury related to Fall - Impaired Gait - Ambulatory Aid or Wheelchair, dated 09/04/21. iii. Medical Problem #2 - Hypertension (HTN), dated 09/04/21. iv. Medical Problem #3 - Altered Elimination related to Urinary Tract Infection (UTI), dated 09/04/21.	L1065	Continued from page 72 The Director of Clinical Services met with clinical services staff to review completed Treatment Plans and Treatment Plan Updates to provide feedback on of the quality of the documentation. Written coaching forms are completed for repeated deficiencies. The Chief Clinical Officer, Director of Clinical Services and Chief Nursing Officer/Designees are auditing 30 medical records monthly using the Clinical Services and Nursing Audit Tools. Identified deficiencies are tracked and trended and reported along with plans for improvement to Quality Council monthly and Medical Executive Committee and Governing Board quarterly until 90% compliance has been achieved three consecutive months. Responsible Persons: Chief Clinical Officer Chief Nursing Officer Director of Clinical Services Director of Performance Improvement Human Resources Director	

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L1065	Continued From page 67 v. Medical Problem unnumbered - Ineffective airway management - Upper Respiratory Infection (URI), dated 09/07/21. c. Investigator #15 found no evidence that staff added any of the medical problems identified by the initiation of Individual Treatment Plans to the MTP Problem list. d. On the Admission Order, dated 09/04/21, the provider ordered "wound protocol" to treat the Patient's laceration on their left wrist, which resulted from their suicide attempt on 09/03/21. Staff failed to include wound care on the MTP Medical Problem List or initiate an individual treatment plan to address the provider ordered "wound protocol." e. On the History and Physical Assessment, dated 09/04/21, the provider documented the Plan of Care for Patient #1502 to include treatment/interventions for the following medical problems: HTN, Generalized Muscle Weakness, UTI, and Insomnia. Staff failed to include Insomnia on the MTP Medical Problem List or initiate an individual treatment plan to address the provider's plan of care. f. Review of Patient #1502's medical recordfound that the Patient had been transported to the hospital on two different occasions for medical treatment. On 09/05/21, Patient #1502 experienced a hypotensive (low blood pressure) syncopal (fainting) episode, reported a heart rate of 30 beats per minute (bpm), and a loss of consciousness for 1 minute. On 09/10/21, the Patient experienced a second episode of loss of consciousness (for 2 minutes), reported as a hypertensive (high blood pressure) episode.	L1065		

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L1065	Continued From page 68 g. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to address the two medical incidents requiring outside medical interventions. 3. On 11/09/21 at 1:45 PM, during an Interview with Investigator #15, Staff #1501 verified that Patient #1502's MTP was not updated to reflect the identified medical problems. Patient #1504 4. On 11/09/21 at 3:00 PM, Investigator #15 and the Director of Risk (Staff #1501) reviewed the medical record for Patient #1504, a 52-year-old male, admitted involuntarily on 10/26/21, with a psychiatric diagnosis of Delusional Disorder and Auditory Hallucinations and Bilateral Fluid-Filled Blister on Left Heel. Review of the Patient's medical record showed the following: a. On 10/29/21, the Interdisciplinary Master Treatment Plan (MTP) was initiated and one problem was identified: Psychiatric Problem #1 - Disturbed Thought. Review of the MTP found no evidence that staff documented any additional psychiatric problems other than Problem #1 - Depression or added any medical problems to the MTP Problem List. b. Staff initiated the following Individual Treatment Plans: i. Psychiatric Problem #1 - Disturbed Thought with Paranoia, Delusions, and Auditory and Visual Hallucinations, dated 10/26/21. ii. Medical Problem #1 - Health Maintenance-Smoking Cessation, dated 10/26/21.	L1065		

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L1065	Continued From page 69 c. Investigator #15 found no evidence that staff added the identified medical problem (Smoking Cessation) to the MTP Problem list. d. On the History and Physical Assessment, dated 10/26/21, the provider documented the Plan of Care for Patient #1504 to include treatment/interventions for the following medical problems: Fluid-Filled Blister to Left Heel. Staff failed to include this medical problem on the MTP Problem List or initiate an individual treatment plan to address the provider's plan of care. e. On 10/28/21, the provider wrote an order for Bactrim (an antibiotic) to treat the Patient's newly diagnosed Cellulitis, related to the Left Heel Blister. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to guide the interventions/treatment. f. On 11/04/21, the provider wrote an order for Diclofenac (a topical gel to reduce inflammation) to treat the Patient's newly diagnosed Chronic Neck Pain, related to a cycling accident several years ago. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to guide the interventions/treatment. g. On 11/04/21, the provider wrote an order to perform a fecal occult blood test (to rule out a gastrointestinal bleed). The Patient's MTP was not updated or revised to include the newly identified medical problem/symptom or to initiate a plan of care to guide the interventions/treatment. 5. On 11/09/21 at 3:10 PM, during an Interview	L1065		

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L1065	Continued From page 70	L1065		

with Investigator #15, Staff #1501 verified that Patient #1504's MTP was not updated to reflect the identified medical problems.

Patient #1506

6. On 11/10/21 at 11:45 AM, Investigator #15 and Staff #1501 reviewed the medical record for Patient #1506, a 65-year-old female, admitted involuntarily on 09/07/21, with a psychiatric diagnosis of Schizoaffective Disorder and a medical diagnosis of Hypertension (HTN), Hypothyroidism, and Avascular Necrosis of Right Hip. Patient #1506 was found in front of an apartment complex, sitting in her wheelchair for five days, refusing food and drink. Review of the Patient's medical record showed the following:

a. On 09/07/21, the Interdisciplinary Master Treatment Plan (MTP) was initiated and one psychiatric problem was identified: Psychiatric Problem #1 - Disturbed Thought; and two medical problems were identified: Hypothyroidism and Fall Risk. Review of the MTP found no evidence that staff documented any additional psychiatric problems or added any medical problems to the MTP Problem List.

b. Staff initiated the following Individual Treatment Plans:

i. Psychiatric Problem #1 - Disturbed Thought with Paranoia and Delusions, dated 09/07/21.

ii. Medical Problem unnumbered - Hypothyroidism, dated 09/07/21.

iii. Medical Problem unnumbered - Potential for Injury related to Fall, dated 09/07/21.

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L1065	Continued From page 71 c. On the History and Physical Assessment, dated 09/07/21, the provider documented the Plan of Care for Patient #1506 to include treatment/interventions for the following medical problems: Hypomagnesemia, Nicotine Abuse, Bilateral Lower Leg Edema, Insomnia, Urinary Incontinence, Osteoarthritis with Hip Pain. Staff failed to include these medical problems on the MTP Problem List or initiate an individual treatment plan to address the provider's plan of care. d. On 09/25/21, the provider wrote an order for Triple Antibiotic Ointment and daily foot soaks to treat the Patient's newly diagnosed Ingrown Toenail. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to guide the interventions/treatment. e. On 10/03/21, the provider wrote an order for Clonidine (antihypertensive medication to treat high blood pressure). The Patient's MTP was not updated or revised to include the newly diagnosed medical problem or to initiate a plan of care to guide the interventions/treatment. 7. On 11/10/21 at 12:10 PM, during an Interview with Investigator #15, Staff #1501 verified that Patient #1506's MTP was not updated to reflect the identified medical problems. Patient #1510 8. On 11/18/21 at 11:30 AM, Investigator #15 reviewed the medical record for Patient #1510, a 68-year-old female, admitted involuntarily on 10/05/21, with a psychiatric diagnosis of Brief Psychotic Disorder, Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD)	L1065		

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L1065	Continued From page 72	L1065		

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and a medical diagnosis of Hypertension (HTN), Dehydration, Hyponatremia (Low sodium level in the blood), Anorexia, Hypokalemia (Low potassium), Hypomagnesemia (Low magnesium), Urinary Tract Infection (UTI), Insomnia, and Edentulism (Complete loss of teeth). Patient #1506 was found on the floor of her home in acute psychosis. Patient #1510 reported that she had all of her teeth pulled in June of 2021 and had dentures at home but did not bring them with her. Review of the Patient's medical record showed the following:

a. On 10/05/21, the Interdisciplinary Master Treatment Plan (MTP) was initiated and one psychiatric problem was identified: Psychiatric Problem #1 - Disturbed Thought - Confusion; and three medical problems were identified: Hypertension, Hypokalemia and Urinary Tract Infection. Review of the MTP found no evidence that staff documented any additional psychiatric problems or added any medical problems to the MTP Problem List.

b. Staff initiated the following Individual Treatment Plans:

i. Psychiatric Problem #1 - Disturbed Thought with Confusion, dated 10/05/21.

ii. Medical Problem #2 - Hypokalemia, dated 10/05/21.

iii. Medical Problem #3 - Altered Elimination related to UTI, dated 10/05/21.

iv. Medical Problem #4 - Hypertension, dated 10/05/21.

v. Medical Problem unnumbered - Health

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L1065	Continued From page 73 Maintenance - Smoking Cessation, dated 10/05/21. vi. Medical Problem unnumbered - Insomnia, dated 10/05/21. c. Investigator #15 found no evidence that staff added the following identified medical problems to the MTP Problem list: Smoking Cessation and Insomnia. d. On the History and Physical Assessment, dated 10/05/21, the provider documented the Plan of Care for Patient #1510 to include treatment/interventions for the following medical problems: Dehydration, Hyponatremia, Anorexia, Hypomagnesemia, Insomnia, and Edentulism (with no dentures on site). Staff failed to include these medical problems on the MTP Problem List or initiate an individual treatment plan to address the provider's plan of care. e. On 10/06/21, the provider wrote an order to restrict the Patient's Fluid Intake (Free Water Restriction) to 1.5 Liters per day related to the Patient's Hyponatremia. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to guide the interventions/treatment. f. On 10/07/21, the provider wrote an order for the staff to document the Patient's intake and output (I & O) related to the Patient's refusal to eat or drink. The Patient's MTP was not updated or revised to include the newly identified medical problem or to initiate a plan of care to guide the interventions/treatment. g. Review of Patient #1510's medical record found that the Patient had been transported to the	L1065		

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L1065	Continued From page 74 hospital for medical intervention on 10/13/21 related to: Failure to Thrive (FTT), Hyponatremia, Hypokalemia, Low GFR (Glomerular Filtration Rate-Kidney Failure), Very Poor Oral Intake, and requesting the administration of Intravenous (IV) fluids. h. The Patient's MTP was not updated or revised to include the newly identified medical problems or to initiate a plan of care to address the medical incident requiring outside medical interventions. 9. On 11/15/21 at 12:00 PM, during an interview with Investigator #15, the Chief Nursing Officer (Staff #1508), stated that she was unable to speak to the treatment plans for Patient #1502, #1504, #1506, and #1501, however she was doing an in-depth training on treatment plans for the nurses currently. Staff #1508 reported that night shift staff is doing an audit for "checks and balances" to make sure that the treatment planning documentation is complete. Staff #1508 stated that the audits should have identified any missing treatment documentation. .	L1065		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff.	L1165	Corrective Action: The Chief Nursing Officer/Designee reviewed the list of supplies to be kept on the emergency carts including IV fluids and start kits. Leadership ensured all emergency carts were stocked with these items as well as updating our list of required items to include IV fluids, IV tubing and IV start kits. All emergency carts were inspected to determine what supplies were missing and those items replaced.	1.22.22

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 11/23/2021

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

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L1165	Continued From page 75 This Washington Administrative Code is not met as evidenced by: . Based on observation, review of policies and procedures, and interview, the hospital failed to ensure adequate emergency supplies were accessible to patient care staff for 3 of 3 patient-care units reviewed. Failure to provide clean emergency supplies readily available for patient use places patients at risk for delayed care, serious harm, and death. Reference: WAC 246-322-180(2) Patient safety and seclusion care: The hospital shall provide adequate emergency supplies including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. Findings included: 1. Document review of the hospital's policy titled, "Emergency Cart," policy number PC.C.110, last reviewed 09/19, showed that all emergency carts will be stocked with according to WAC 246-322-180 standards. Emergency carts will be secured, and easily accessible to patient-care staff on all units, at all times. At the end of a code, any used items will immediately be restocked by floor staff, and the cart will be re-locked. Document review of the hospital's daily log for emergency cart inventory checks for the 2 North, 3 North and 3 West units showed a list of the cart's contents by drawer. The inventory list did not include items to start intravenous (IV) therapy	L1165	Cont from pg 81 All nursing staff were reeducated to the list of items that are kept in the emergency carts and the requirement to check the cart daily to ensure no supplies are expiring or missing. Staff were reeducated to the requirement to recheck the card after every code to ensure the cart is restocked with the required supplies and re-locked. Monitoring Plan: Nursing Supervisors will check the emergency carts daily to ensure they are locked and all items listed on the Required Items list are present. If the lock has been breached the nursing supervisor will inventory the cart and replace any missing items. Monthly monitoring logs will be given to the Chief Nursing Officer and evaluated for discrepancies. Any discrepancies will be immediately addressed by the Chief Nursing Officer. The Chief Nursing Officer will report data on Emergency Cart compliance monthly to Quality Council and quarterly to the Medical Executive Committee. Monitoring will continue until 90% compliance with crash cart logs being completed correctly and issues are addressed in a timely fashion for 3 consecutive months. Responsible Persons: Chief Nursing Office	

State of Washington

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L1165	Continued From page 76 as part of its contents. 2. On 10/18/21 at 12:30 PM, Investigator #12 toured the 3 North and 2 North patient-care units and inspected the emergency crash carts. The investigator found that each crash cart had a 1-liter bag of 0.9% normal saline IV solution, but there were no supplies necessary to start IV therapy in either crash cart. The investigator found that the 3 North crash cart had a used bag-valve mask and AMBU bag, and without these items readily available on the cart, it was not ready for emergency use. 3. On 10/18/21 at 1:00 PM, Investigator #12 interviewed the Director of Quality and Performance Improvement (Staff #1202). Staff #1202 stated that hospital staff did not perform IV therapy on patients, and the hospital did not carry any supplies to administer IV fluids. Staff #1202 stated that none of the emergency carts contained IV supplies as part of their inventory stock. When the investigator showed Staff #1202 the dirty bag-valve mask and ambu bag, staff #1202 stated that she agreed the items appeared dirty, and she immediately called to have the supplies replaced.	L1165		

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

April 20, 2023

Shaun Fenton, CEO
Cascade Behavioral Health
12844 Military Rd S
Tukwila, WA 98168

Re: Complaint #116355/2021-11820

Dear Mr. Fenton,

Investigators from the Washington State Department of Health conducted a state hospital licensing and Medicare hospital complaint investigation at Cascade Behavioral Health on 10/17/22 to 10/27/22. Hospital staff members developed a plan of correction to fix deficiencies cited during this investigation. This plan of correction was approved on 12/24/22.

Hospital staff members sent a Progress Report dated 04/14/23 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Health's attestation that it will correct all deficiencies cited at Chapter 246-320 WAC and Medicare regulations.

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

Sincerely,

Coleen Barron, MBA, BSN, RN
Nurse Consultant Investigator