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 _____ | 04/19/2023 |

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

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| L 000 | INITIAL COMMENTS<br><br>STATE LICENSING SURVEY<br><br>The Washington state department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital Licensing Regulations, conducted this health and safety survey.<br><br>Onsite dates: 04/17/23 - 04/19/23<br><br>Examination number: 2023-243<br><br>The survey was conducted by:<br><br>Surveyor #6<br>Surveyor #7<br>Surveyor #8<br>Surveyor #9<br>Surveyor #10<br><br>The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell SKEX12.<br><br>During the course of the survey, surveyors investigated issues related to State Complaints #2021-14024 and 2023-2681. | L 000 | 1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.<br><br>2. EACH plan of correction statement must include the following:<br><br>The regulation number and/or the tag number;<br><br>HOW the deficiency will be corrected;<br><br>WHO is responsible for making the correction;<br><br>WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and<br><br>WHEN the correction will be completed.<br><br>3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on 05/11/23.<br><br>4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter. | |
| L 315 | 322-035.1C POLICIES-TREATMENT<br><br>WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures | L 315 | | |

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| L 315 | 322-035.1C POLICIES-TREATMENT<br><br>WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures | L 315 | | |

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| L 315 | Continued From page 1<br>consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Item #1 Rounding<br><br>Based on interview, medical record review, and review of the hospital's policy and procedure, the hospital failed to ensure staff followed the policy on close observation and documentation for 11 of 13 Observation Records reviewed (Patient's #701, #702, #703, #704, #705, #706, #707, #708, #714, #715 and #716).<br><br>Failure to ensure staff accurately document the time of observation rounding and to document Physician ordered precautions can lead to patient elopement or serious risk to patient safety.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled, "Patient Observations," policy #PC.OBS.101, last approved 12/13 showed "q" (every) 5-minute checks: This level of observation is required when the patient could, at any time, make an attempt to harm themselves or others.<br><br>Document review of the hospital's document titled; "Behavioral Health-Patient Observation Sheet," number, no date, showed the following are to be documented:<br><br>a. Time.<br><br>b. Location. | L 315 | | |

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| L 315 | Continued From page 2<br>c. Behavior.<br><br>d. Observer.<br><br>2. On 04/17/23 at 12:00 PM, Surveyor #7, the Cheif Nursing Officer (Staff #703), and a Satfety Technician (Staff #705), reviewed the rounding document titled "Intake-Patient Observation Record" for Patient #715. Document review showed every 5 minute observation rounding from 11:35 AM - 12:00 PM. Staff #705 states she had not rounded on the patient and the observation rounding had been documented by Staff #704.<br><br>3. On 04/17/23 at 12:05 PM, Surveyor #7 interviewed an Intake Specialist (Staff #704), who verified she had been with Surveyor #7 at the time of the documentation and had not actually seen the patient she had rounded on, but had known the patient was "sleeping in the room with the door closed". Staff #704 further stated she should not have charted observation rounding without actually seeing the patient.<br><br>4. On 04/17/23 at 3:09 PM, Surveyor #7 and an Intake Specialist (Staff #706) reviewed the observation rounding sheet for Patient #716. The review showed the document had been filled out every 5-minutes until 3:40 PM. Staff #706 verified she had filled out the document and stated, "Sometimes I get messed up with military time."<br><br>5. On 04/18/23 from 4:35 PM- 5:01 PM, Surveyor #7 reviewed the observation rounding sheets of 7 patients on q-5 minute observation for 04/17/23. The review showed the following:<br><br>Patient #701 | L 315 | | |

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| L 315 | Continued From page 3<br>4:01 AM rounding, next rounding at 4:10 AM, 9 minutes later.<br><br>5:58 AM rounding, next rounding at 6:06 AM, 8 minutes later.<br><br>7:33 AM rounding, next rounding at 7:41 AM, 8 minutes later.<br><br>8:02 AM rounding, next rounding at 8:16 AM, 14 minutes later.<br><br>9:48 AM rounding, next rounding at 9:55 AM, 7 minutes later.<br><br>11:19 AM rounding, next rounding at 11:28 AM, 9 minutes later.<br><br>6:18 PM rounding, next rounding at 6:25 PM, 7 minutes later.<br><br>7:28 PM rounding, next rounding at 7:34 PM, 6 minutes later.<br><br>7:43 PM rounding, next rounding at 7:49 PM, 6 minutes later.<br><br>Patient #702<br><br>2:21 AM rounding, next rounding 2:28 AM, 7 minutes later.<br><br>4:00 AM rounding, next rounding 4:10 AM, 10 minutes later.<br><br>3:43 PM rounding, next rounding 3:49 PM, 6 minutes later.<br><br>Patient #703 | L 315 | | |

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| L 315 | Continued From page 4<br><br>7:33 AM rounding, next rounding 7:41 AM, 8 minutes later.<br><br>8:56 AM, rounding, next rounding 9:03 AM, 6 minutes later.<br><br>9:19 PM rounding, next rounding 9:26 PM, 7 minutes later.<br><br>10:06 PM rounding, next rounding 10:13 PM, 7 minutes later.<br><br>6. Patients #704, #705, #706, #707 and #708 all had similar documentation of late 1-5 minute checks..<br><br>7. At the time of the review, a Nurse Manager (Staff #702) verified the late/missing observation times.<br><br>8. On 04/19/23 at 11:08 AM, Surveyor #7 reviewed the medical record for Patient #714 who was admitted for psychosis on 01/13/23 and discharged on 02/03/23. Surveyor #7 was not able to locate any observation documentation. Staff #702 verified there was no observation rounding documentation in the medical record.<br><br>Item #2 Rounding location.<br><br>Based on interview, medical record review, and review of the hospital's policy and procedure, the hospital failed to ensure staff followed their policy on close observation and documentation for 10 of 14 observation Records reviewed (Patients #701, #708 #709, #710, #711, #712, #713, #714, #901 and #903).<br><br>Failure to correctly document the patients' location can lead to patient elopement or serious | L 315 | | |

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| L 315 | Continued From page 5<br>risk to patient safety.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled, "Patient Observations," policy #PC.OBS.101, last approved 12/13 showed all patients will be on a minimum of 15-minute observations, the levels of observation are every 15-minute, every 5-minute checks, and 1:1 observation.<br><br>Document review of the hospital's document titled; "Behavioral Health - Patient Observation Sheet," no #, no date, showed the following are to be documented:<br><br>a. Time.<br><br>b. Location.<br><br>c. Behavior.<br><br>d. Observer.<br><br>Location Legend shows:<br><br>a. H= Hallway.<br><br>b. PR= Patient Room.<br><br>c. C= Cafeteria.<br><br>Behavior Legend shows:<br><br>a. C= Calm.<br><br>b. TWP= Talking With Peers.<br><br>c. AG= Agitated or Attending Group. | L 315 | | |

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| L 315 | Continued From page 6<br>d. T/H= Toileting/Hygiene.<br><br>e. S= Sitting.<br><br>f. W/P= Walking/Pacing.<br><br>g. AS= Appears Sleeping.<br><br>h. A= Anxious.<br><br>i. TOP = Talking on Phone.<br><br>j. LA =Leisure Activity.<br><br>Document review of the Daily Schedule per unit, showed the following:<br><br>a. Unit 4 West is scheduled for breakfast in the cafeteria at 7:00 AM, lunch in the cafeteria at 11:00 AM, and dinner in the cafeteria at 5:00 PM, Monday through Sunday.<br><br>b. Unit 3 West is scheduled for breakfast in the cafeteria at 7:30 AM, lunch in the cafeteria at 11:30 AM, and dinner in the cafeteria at 5:30 PM, Monday through Sunday.<br><br>c. Unit 2 North is scheduled for breakfast in the cafeteria at 8:00 AM, lunch in the cafeteria at 12:00 PM, and dinner in the cafeteria at 6:00 PM, Monday through Sunday.<br><br>d. Unit 2 West is scheduled for breakfast in the cafeteria at 8:30 AM, lunch in the cafeteria at 12:30 PM, and dinner in the cafeteria at 6:30 PM, Monday through Sunday.<br><br>2. On 04/18/23 from 4:35 PM - 5:01 PM, Surveyor #7 reviewed observation rounding sheets of patients on q-5-minute observation for 04/17/23. | L 315 | | |

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| L 315 | Continued From page 7<br>The review of the 04/17/23 observation sheets showed the following:<br><br>Patient #701 Unit 3West on q5-minute rounding on 04/17/23.<br><br>Time: 10:27 AM - 12:25 PM, Location: Cafeteria, Behavior: documented as eating to sleeping.<br><br>Time: 2:48 PM - 3:36 PM, Location: Cafeteria, Behavior: documented as eating and anxious.<br><br>Time: 5:07 PM - 5:45 PM, Location: Cafeteria, Behavior: eating and anxious.<br><br>Time: 9:03 PM, Location Cafeteria, Behavior: watching TV.<br><br>Patient #709 Unit 2 North, q5-minute rounding on 04/17/23.<br><br>Time: 10:00 AM - 3:21 PM, Location: Cafeteria, Behavior: TV, TWP, LA, W/P, E C, and AG.<br><br>Time: 5:12 PM - 6:02 PM, Location: Cafeteria, Behavior: TV, E, TWP.<br><br>Patient #710, Unit 2 West, q5-minute rounding on 04/17/23.<br><br>Time: 12:03 AM - 2:03 AM, Location: Cafeteria, Behavior: AS, W/P, S.<br><br>Time: 3:57 AM - 4:18 AM, Location: Cafeteria, Behavior: AS.<br><br>Time: 5:41 AM - 5:46 AM, Location: Cafeteria, Behavior: TWP.<br><br>Time: 9:52 AM, Location: Cafeteria, Behavior: | L 315 | | |

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| L 315 | Continued From page 8<br>TOP.<br><br>Time: 9:56 AM, Location: Cafeteria, Behavior: TWP.<br><br>Time: 12:42 AM - 12:49 AM, Location: Cafeteria, Behavior: E.<br><br>Time: 3:26 AM - 3:32 AM, Location: Cafeteria, Behavior: A.<br><br>Time: 4:12 PM - 4:18 PM, Location: Cafeteria, Behavior: E.<br><br>Time: 4:31 PM - 4:51 PM, Location: Cafeteria, Behavior: TV, TWP.<br><br>Time: 5:00 PM - 5:04 PM, Location: Cafeteria, Behavior: TV.<br><br>Time: 5:55 PM - 6:19 PM, Location: Cafeteria, Behavior: C, E.<br><br>Time: 8:21 PM - 10:54 PM, Location: Cafeteria, Behavior: E, S, AS.<br><br>Time: 11:01 PM - 11:59 PM, Location: Cafeteria, Behavior: C, S, AS.<br><br>Patient #711 Unit 3 West, q5-minute rounding on 04/17/23.<br><br>Time: 2:32 PM - 4:59 PM, Location: Cafeteria, Behavior: LA, AG, A, TV.<br><br>Time: 5:09 PM - 5:27 PM, Location: Cafeteria, Behavior, C, E.<br><br>3. Patients' #708, #710, #712, #713 and #714 all had similar incorrect lacation documentation. | L 315 | | |

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| L 315 | Continued From page 9<br><br>4. At the time of the review, a Nurse Manager (Staff #702) verified the times the patients were documented in the cafeteria and verified the scheduled mealtimes.<br><br>5. On 04/19/23 between 8:00 AM and 10:00 AM, Surveyor #9 reviewed rounding logs which showed the following:<br><br>a. On 03/20/23, Patient #903 was an in-patient on the 2 North unit. Documentation in the rounding log showed that Patient #903 was in the cafeteria between 8:01 AM and 8:22 AM, 9:40 AM and 10:15 AM, 11:10 AM and 11:55 AM, 12:05 PM and 12:28 PM, 12:35 PM, and 2:17 PM, 3:07 PM and 3:50 PM, 4:09 PM and 4:33 PM, 4:43 PM and 5:13 PM, 5:34 PM and 6:44 PM, 6:57 PM and 7:46 PM, 7:54 PM and 8:02 PM, 8:18 PM and 8:39 PM, 9:29 PM and 9:37 PM, and 9:44 PM and 10:04 PM (a total of 14 times).<br><br>b. Document review of the Daily Schedule for the 2 North unit showed that mealtimes in the cafeteria are from 8:00 AM to 8:30 AM, 12:00 PM to 12:30 PM, and 6:00 PM to 6:30 PM.<br><br>c. On 01/15/23, Patient #901 was an in-patient on the 2 West unit. Documentation in the rounding log showed that Patient #903 was in the cafeteria between 10:49 AM and 3:55 PM (a period of approximately 5 hours), 4:20 PM and 4:22 PM, 4:32 PM and 4:40 PM, 4:47 PM and 4:56 PM, 5:06 PM, 7:12 PM, and 10:23 and 10:32 PM (a total of 7 times).<br><br>d. Document review of the Daily Schedule for the 2 West unit showed that mealtimes in the cafeteria are from 8:30 AM to 9:00 AM, 12:30 PM to 1:00 PM, and 6:30 PM to 7:00 PM. | L 315 | | |

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| L 315 | Continued From page 10<br><br>6. On 04/19/23 at 10:10 AM, Assistant Director of Nursing (Staff #901) verified the documentation of location on the rounding logs and stated that patients only go to the cafeteria at mealtimes so there may have been a mistake in location documentation.<br><br>Item #3 Provider order for rounding<br><br>Based on interview and document review, the hospital failed to provide care in a safe setting by implementing policies and procedures that guide staff to effectively conduct patient observation for 1 of 2 medical records reviewed (Patient #904).<br><br>Failure to ensure that hospital staff follow policies and procedures to protect patients can lead to unsafe patient care through non-compliance with physician orders or with prescribed protocols regarding levels of observation and precautions.<br><br>Findings included:<br><br>1. Document review of the hospital's policy and procedure titled, "Patient Observations," policy number PC.OBS.101, last revised 02/23, showed the following:<br><br>a. An RN may increase the level of observation if a patient's condition changes.<br><br>b. An RN may not decrease the level of observation without a written order by the practitioner.<br><br>2. On 04/17/23 between 3:00 PM and 4:15 PM, Surveyor #9 and Assistant Director of Nursing (Staff #901) reviewed the rounding log of Patient #904 who was admitted on 04/16/23 for | L 315 | | |

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| 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 |
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| L 315 | Continued From page 11<br>substance use disorder. On 04/16/23 at 1:40 PM, the provider wrote an order for every 5 minute observation due to high risk for suicide. Surveyor #9 observed that on 04/16/23 from 1:22 PM until 10:55 PM (a period of approximately 9.5 hours), the rounding was documented every 15 minutes.<br><br>3. At the time of the review, Staff #901 verified that the rounding documentation was not at the time interval ordered. | L 315 | | |
| L 335 | 322-035.1G POLICIES-EMERGENCY CARE<br><br>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;<br>This Washington Administrative Code is not met as evidenced by:<br><br>Based on document review, observation, and interview, the hospital failed to ensure that staff followed procedure for storing and accessing emergency supplies on 2 of 2 units inspected (Units 2 West and 2 North) by recording inaccurate dates and allowing expired supplies to be available for use.<br><br>Failure to monitor for and remove expired emergency supplies can cause patient harm if supplies are missing or deteriorated. | L 335 | | |

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| L 335 | Continued From page 12<br><br>Findings included:<br><br>1. Document review of the hospital policy titled, "Emergency Cart", policy PC.C.110, revised 09/15, showed that a daily inventory check is done by the night unit charge nurse and documented on a log. The log is kept on the cart and includes columns for date, defibrillator test, defib pads/battery expiration date, lock serial number, and signature.<br><br>2. On 04/17/23 at approximately 12:15 PM, Surveyor #10 and the Clinical Services Director (Staff #1001) inspected the emergency cart on 2 West. The difib pads, located in the zippered automatic external defibrillator case on top of the cart, showed a manufacturer's expiration date of 01/11/25. The daily check logs showed the following documentation for defib pads expiration dates:<br><br>a. For 01/01/23 - 01/17/23: expiration dates read 01/13/23.<br><br>b. For 01/17/23: expiration date entry (01/13/23) was crossed out and an additional date of 01/24 was entered.<br><br>c. For 01/18/23 - 01/30/23: expiration dates read 01/2024.<br><br>d. For 01/31/23: expiration date read 01/11/25.<br><br>e. For 02/01/23 - 04/17/23: expiration dates read 01/24.<br><br>3. At the time of the inspection, Staff #1001 and a Registered Nurse (Staff #1007) verified that the expired defibrillator pads were available for use | L 335 | | |

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| L 335 | Continued From page 13<br>on patients from 1/14/23 to 1/17/23, and that an inaccurate expiration date for the pads was documented from 02/01/23 through 4/17/23 (a period of 75 days). Staff #1007 commented that it appeared that the staff doing the checks was copying a previous entry and not directly visualizing the expiration date printed on the defib pads.<br><br>4. On 4/17/23 at 2:45 PM, Surveyor #10 and Staff #1001 inspected the emergency cart on 2 North. The difib pads, located in the zippered automatic external defibrillator case on top of the cart, showed a manufacturer's expiration date of 01/11/25. The daily check logs showed the following documentation for defib pads expiration dates:<br><br>a. For 01/01/23 - 01/30/23: expiration dates read 01/13/23.<br><br>b. For 01/31/23: expiration date read 11/1/25.<br><br>c. For 02/01/23 - 02/09/23: expiration dates read 01/11/25.<br><br>d. For 02/10/23 - 02/14/23: expiration dates read "pads expired, battery - 01/11/25".<br><br>e. For 02/15/23 - 02/22/23: expiration dates read 01/11/25.<br><br>f. For 02/23/23 - 02/26/23: expiration dates read "pads expired, battery - 01/11/25".<br><br>g. For 02/27/23 - 02/28/23: expiration dates read 01/11/25.<br><br>h. For 03/01/23 - 04/16/23: expiration dates read "11-25". | L 335 | | |

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| L 335 | Continued From page 14<br><br>5. At the time of the inspection, Staff #1001 verified the findings that expired defibrillator pads had been available for patient use from 01/14/23 to 01/31/23, and that inaccurate expiration dates had been documented on the logs.<br>. | L 335 | | |
| L 415 | 322-035.2 P&P-ANNUAL REVIEW<br><br>WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed.<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on record review, the hospital failed to ensure that required policies and procedures were reviewed and updated annually as required.<br><br>Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled "Policies and Procedures," policy #ADM.P.500, last approved 12/13, revised 03/14 showed Risk management is responsible to ensure that Policies and procedures are reviewed annually.<br><br>2. Record review of the following policies showed that the facility did not review them on an annual basis as required, including but not limited to: | L 415 | | |

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| L 415 | Continued From page 15<br><br>a. Policies and Procedures: Original date of issue 12/13, last revised 03/14, last approved 12/13, last reviewed 05/19.<br><br>b. Definition of a Health Record: Original date of issue 12/13, last revised 01/18, no approval date or review date.<br><br>c. Telehealth: Original date of issue, last revised 12/22, no approval date or review date.<br><br>d. Documentation protocols: Original date of issue 12/13, last revised 03/14, last approved 12/13. No review dates.<br><br>e. Patient Observation: Original date of issue 12/14, last revised 02/23, last approved 12/13. No review dates.<br><br>f. Emergency cart: Original date of issue 02/13, last revised 09/21, last approved 02/14. No review dates.<br><br>g. Medical Staff Availability: Original date of issue 12/18, last revised 12/17, last approved12/18, last reviewed 05/20.<br><br>h. Involuntary Treatment Referral: Original date of issue 12/13, last revised 02/17, last approved 12/13, last reviewed 01/17.<br><br>i. Advanced Pharmaceutical Consultants Mediation Management: Original date of issue 02/14, last revised 11/15, no approval date, last review 09/21.<br><br>j. Patient Labor Work Exploitation: Original date of issue 12/13, last revised 12/17, last approved 12/13, last reviewed 05/21. | L 415 | | |

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| L 415 | Continued From page 16<br>k. Daily cleaning of Patient Areas: Original date of issue 12/13, last revised 08/16, last approved 12/13, last reviewed 04/21.<br><br>l. Biomedical Equipment inspection, Testing, Maintenance: Original date of issue 08/16, last revised 10/21, last approved 08/16. No review date.<br><br>m. Terminal Cleaning of Patient Rooms: Original date of issue 12/13, last approved12/13, last reviewed 04/21. No revisions.<br><br>n. Discharge Planning: Original date of issue 12/13, last approved, 12/13, last reviewed 02/21. No revisions.<br><br>o. Patient Rights: Original date of issue 12/13, last approved 12/13. No revisions or review dates.<br><br>p. Abuse or Neglect of Patients: Original date of issue 12/13, last revised 12/15, last approved 12/13, last reviewed 04/21.<br><br>q. Medication Orders: Original date of issue 12/13, last approved12/13, last reviewed 05/21.<br><br>r. Assaultive Patient Precautions and Treatment: Original date of issue 08/17, last revised 08/22, last approved 08/17. No review dates.<br><br>s. Plan for Provision of Patient Care: Original date of issue 05/18, last revised 10/21. No approval date, and no reviewed date.<br><br>t. Restraint: Original date of issue 04/20, last revised 02/23. No approval date; and no reviewed dates. | L 415 | | |

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| L 415 | Continued From page 17<br>u. Infection Control Plan: Original date of issue 01/21, last revised 01/22. No approval or review dates.<br><br>v. Smoking Regulations: Original date of issue 08/16, last reviewed 01/18.<br><br>w. Criminal Background and OIG Checks: Original date of issue 12/13, last revised 07/19, last approved 10/15, last reviewed 01/18.<br><br>x. Visitation Policy: Original date of issue 12/13, last revised 07/21, last approved 12/13, last reviewed 01/18.<br><br>y. Patient belongings and Valuables: Original date of issue 04/16, last revised 06/20, last approved 04/16. No reviewed dates.<br><br>3. On 04/19/23 at 2:40 PM, Surveyor #7 interviewed the CEO (Staff #701) who stated that they know the policies are outdated and are working on updates.<br>. | L 415 | | |
| L 420 | 322-040.1 ADMIN-ADOPT POLICIES<br><br>WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on interview, document review, and review of hospital policy, the hospital failed to ensure | L 420 | | |

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| L 420 | Continued From page 18<br>policies were approved by the Governing Body prior to being implemented.<br><br>Failure to adopt the implemented written policies concerning the purpose, operation, and maintenance of the hospital, the safe care, and the treatment of patients in the hospital, prevents staff from carrying out the intended functions of the organization and risks unsafe, inconsistent patient care.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled "Policies and Procedures," policy #ADM.P.500, last approved 12/13, revised 03/14, showed the "New policy approval process is located in Appendix B. Surveyor #7 did not receive Appendix B.<br><br>2. Record review of the following policies showed no approval by the Governing Body after a revision, prior to implementation, including but not limited to:<br><br>a. Policies and Procedures: Original date of issue 12/13, last revised 03/14, last approved 12/13, last reviewed 05/19.<br><br>b. Definition of a Health Record: Original date of issue 12/13, last revised 01/18, no approval date.<br><br>c. Telehealth: Original date of issue, last revised 12/22, no approval date.<br><br>d. Patient Observation: Original date of issue 12/14, last revised 02/23, last approved 12/13<br><br>e. Emergency cart: Original date of issue 02/13, last revised 09/21, last approved 02/14. | L 420 | | |

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| L 420 | Continued From page 19<br><br>f. Elopement: Original date of issue 08/13, last revised 09/21, last approved 08/13.<br><br>g. Medication Administration Documentation: Original date of issue 12/13, last revised 02/23, last approved 12/13.<br><br>h. Medication Order: Original date of issue 12/13, last revised 02/23, last approved 12/13.<br><br>i. Patient Transfer to Another Facility: Original date of issue 08/13, last revised 02/23, last approved 08/13.<br><br>j. Suicide Risk Assessment: Original date of issue 05/18, last revised 02/23, no approval date.<br><br>k. Inter Unit Transfer: Original date of issue 08/13, last revised 09/21, last approved 08/13.<br><br>3. On 04/19/23 at 2:40 PM, Surveyor #7 interviewed the CEO (Staff #701) who verified the policies were outdated and stated that they were in the process of updating them. Staff #701 advised a large batch of policies had been approved by the Governing Body recently. Surveyor #7 requested any documentation showing that the Governing Body had approved the aforementioned policies. The hospital did not provide the requested documentation. | L 420 | | |
| L 715 | 322-100.1E INFECT CONTROL-PROVISIONS<br><br>WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which | L 715 | | |

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| L 715 | Continued From page 20<br>includes at a minimum: (f) Provisions for: (i) Providing consultation regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on observation and interview, the hospital failed to have an effective quality control process to ensure that patient care supplies available for use did not exceed their manufacturer's expiration date.<br><br>Failure to ensure patient care supplies do not exceed the manufacturers expiration date places patients at risk for inadequate medical treatment and exposure to infectious organisms.<br><br>Findings included:<br><br>1. On 04/17/23 between 11:00 AM and 12:00 PM, Surveyor #9 and the Assistant Director of Nursing (Staff #901) inspected the 3 West unit. The inspection showed the following: | L 715 | | |

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| L 715 | Continued From page 21<br>a. One bottle of Level 1 glucometer control solution with a manufacturer's expiration date of 02/23.<br><br>b. One bottle of Level 3 glucometer control solution with a manufacturer's expiration date of 02/23.<br><br>c. One COVID test kit with a manufacturer's expiration date of 09/21.<br><br>d. Seven tongue depressors with a manufacturer's expiration date of 03/23.<br><br>e. Four purple top vacutainer tubes with a manufacturer's expiration date of 12/22.<br><br>f. One green top vacutainer tube with a manufacturer's expiration date of 01/23.<br><br>2. At the time of the observation, Staff #901 verified the expiration and removed the expired supplies from patient use.<br><br>3. On 04/17/23 between 2:30 PM and 3:30 PM, Surveyor #9 and a Registered Nurse (Staff #902) inspected the 4 West unit. The inspection showed the following:<br><br>a. One 21-gauge blood collection set with a manufacturer's expiration date of 12/22.<br><br>b. One 23-gauge blood collection set with a manufacturer's expiration date of 02/23.<br><br>c. Two tubes of Polident denture adhesive with a manufacturer's expiration date of 04/22.<br><br>4. At the time of the observations, Staff #902 verified the expiration and removed the expired | L 715 | | |

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| L 715 | Continued From page 22<br>supplies from patient use.<br><br>5. On 04/19/23 at 1:00PM, Surveyor #9 interviewed the Director of Risk Management (Staff #903) regarding a policy for expired supplies. Staff #903 presented a a document of House Supervisor tasks that are completed each shift that include checking for outdated supplies. Staff #903 stated there was not a policy that addresses the monitoring of patient supplies for expired items. | L 715 | | |
| L 780 | 322-120.1 SAFE ENVIRONMENT<br><br>WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors;<br>This Washington Administrative Code is not met as evidenced by:<br><br>Based on observation and interview, the hospital failed to provide a clean and sanitary environment for patients.<br><br>Failure to maintain a clean and sanitary physical environment puts patients at risk of increased exposure to harmful contaminants.<br><br>Findings included:<br><br>1. On 04/17/23 between 12:10 PM and 1:00 PM, Surveyor #6 toured the 2-North Unit with the Human Resources Director (Staff #604). The observation showed the following:<br><br>a. Consult Room #2N43A had two fist-sized holes in the wall; the room was in disarray with papers | L 780 | | |

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| L 780 | Continued From page 23<br>and drink cups on the table; an accumulation of dust & debris on the floor<br><br>b. Exam Room #2N36A held Patient Care Equipment that did not appear ready for use: a vital signs monitor and stand, and an ECG (Electrocardiogram) machine and cart each had an accumulation of dust & debris; the exam table had significant ink markings on the vinyl surface<br><br>c. 2-North Seclusion Room: the patient bed had a small tear in the mattress cover (uncleanable surface); dried debris on the bed deck under the mattress; and accumulated debris on the floor<br><br>2. At the time of the observations, the surveyor interviewed two Registered Nurses (RN) (Staff #605 and Staff #606). Staff #605 and Staff #606 each confirmed the observations. Staff #605 stated that a work-order for the holes in the wall of Room #2N43A would be placed immediately. Staff #606 stated that she did not know about the housekeeping schedule for the 2-North Seclusion Room but thought the room was cleaned after each patient use. | L 780 | | |
| L1040 | 322-170.1C TRANSFER PATIENTS<br><br>WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval by the receiving facility prior to transfer; and (iii) Immediately | L1040 | | |

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| CASCADE BEHAVIORAL HOSPITAL | 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 |

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| L1040 | Continued From page 24<br>notifying the patient's family.<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on document review and interview, the hospital failed to ensure staff completed documentation for transfer according to hospital policy in 3 of 3 medical records reviewed (Patient #1001, #1002, and #1003).<br><br>Failure to complete transfer documentation impairs care continuity and places patients at risk for suboptimal care and poor outcomes.<br><br>Findings included:<br><br>1. Document review of hospital policy titled, "Patient Transfer to Another Facility," policy number PC.TAF.101, revised 2/23, showed:<br><br>a. The procedure for a patient with or without an emergency medical condition includes:<br><br>i. The physician or qualified medical personnel (QMP), who may be a registered nurse, should directly communicate with the receiving facility.<br><br>ii. The QMP is responsible to facilitate transfer and secure acceptance by a receiving facility.<br><br>iii. The risks and benefits of the transfer should be explained to the patient/family and documented on the Transfer Consent/Refusal Form.<br><br>iv. Consent to transfer should be obtained and documented.<br><br>v. A Memorandum of Transfer should be completed, including the certification statement | L1040 | | |

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| L1040 | Continued From page 25<br>that the benefits of transfer outweigh the risks, and should be signed by (i) the physician /designee and (ii) an administrative representative of the facility. If the certification is provided by a QMP because of physician unavailability at the time of transfer, the physician is required to sign the certification on the Memorandum of Transfer as soon as possible.<br><br>2. On 04/18/23 between 2:00 PM and 4:30 PM, Surveyor #10 reviewed medical records of 3 patients who had been transferred to an acute care facility after admission. The review showed:<br><br>a. Patient #1001 was admitted on 02/28/23 at 11:05 PM and transferred by ambulance on 03/02/23 at 11:06 PM. The Transfer Summary document showed that the following areas were blank or incomplete:<br><br>i. Provider section: medical risks; receiving facility and individual.<br><br>ii. Nursing section: time of vital signs.<br><br>iii. Signatures: no patient or legal representative signature, date, time; no provider signature.<br><br>b. Patient #1002 was admitted on 03/20/23 at 10:38 AM and transferred by ambulance on 03/21/23 at 11:00 PM. The Transfer Summary document showed that the following areas were blank or incomplete:<br><br>i. Provider section: risks and benefit for transfer; receiving facility and individual.<br><br>ii. Nursing section: time of vital signs.<br><br>iii. Patient section: patient consent to "medically | L1040 | | |

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| L1040 | Continued From page 26<br>indicated" or "patient request" transfer.<br><br>iv. Signatures: no patient or legal representative signature, date, time; no provider name/signature, date, time.<br><br>c. Patient #1004 was admitted on 03/09/23 at 7:15 PM and transferred by ambulance on 03/10/23 at 8:12 PM. The Transfer Summary document showed that the following areas were blank or incomplete:<br><br>i. Provider section: medical risks; receiving facility and individual.<br><br>ii. Nursing section: time of vital signs.<br><br>iii. Signatures: no patient or legal representative signature, date, time; no provider name/signature, date, time.<br><br>3. At the time of the review, the Director of Risk Management (Staff #1004) reviewed the Transfer Summary documents and verified that the documentation was incomplete for Patients #1001, #1002, and #1004.<br><br>4. On 04/19/23 at 8:30 AM, Surveyor #10 interviewed the Chief Nursing Officer (Staff #1006) about the Transfer Summary form. Staff #1006 confirmed that the Transfer Summary served as the Memorandum of Transfer document.<br>. | L1040 | | |
| L1065 | 322-170.2E TREATMENT PLAN-COMPREHENS<br><br>WAC 246-322-170 Patient Care Services. (2) The licensee shall | L1065 | | |

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| L1065 | Continued From page 27<br>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:<br>.<br>Based on interview and document review, the hospital failed to document physician involvement in the updated individualized treatment plan for 3 of 3 Telehealth patients reviewed (Patients #903, #904, and #905).<br><br>Failure to ensure physician participation in their treatment care planning can result in inappropriate, inconsistent, or delayed treatment of patients' needs and may lead to patient harm and lack of appropriate treatment for a behavioral or medical condition.<br><br>Findings included:<br><br>1. Document review of the hospital's policy and procedure titled, "Telehealth," policy number PC.TH.100, last revised 12/22, showed that after the review of the treatment plan update, | L1065 | | |

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| L1065 | Continued From page 28<br>document the physician's input related to any change in diagnosis, estimate date of discharge and the reason for continued hospitalization. Document the physician's approval directly on the signature section as illustrated below with two witness signatures. The illustration shows the verbiage reviewed/approved telephonically by Dr. XXX on date and time followed by signature of registered nurse and second witness.<br><br>2. On 04/17/23 between 3:00 PM and 4:15 PM, Surveyor #9 and Assistant Director of Nursing (Staff #901) reviewed the charts of 2 patients. The review showed the following:<br><br>a. Patient #903 was admitted on 03/11/23 for substance use disorder and was currently a Telehealth patient. Surveyor #9 observed that on 04/03/23 and 04/10/23 the updated interdisciplinary treatment plan appeared to have the signature of an RN and a therapist and no documentation of physician involvement in the physician signature block.<br><br>b. Patient #904 was admitted on 04/16/23 for substance use disorder and was currently a Telehealth patient. Surveyor #9 observed that on 04/17/23 the interdisciplinary treatment plan appeared to have the signature of an RN and a therapist and no documentation of physician involvement in the physician signature block.<br><br>3. At the time of the review, Staff #901 verified that the signatures were an RN and therapist and not a physician.<br><br>4. On 04/18/23 at 10:35 AM, Surveyor #9 interviewed the Program Manager Addiction Service (Staff #905) regarding the process of signing in the physician signature block on the | L1065 | | |

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| L1065 | Continued From page 29<br><br>interdisciplinary treatment plan. Staff #905 stated that the physician visits the patient via Telehealth. When the visit is complete, the team, including the physician, meet to discuss the treatment plan. The Telehealth nurse and Staff #905 then sign in the physician signature block. Staff #905 was not aware of the Telehealth policy above and stated they would begin to document the physician approval of the plan immediately.<br><br>5. On 04/18/22 at 10:35 AM, Surveyor #9 reviewed the medical record of Patient #905 who was admitted on 03/20/23 and was currently a Telehealth patient. Surveyor #9 observed that on 04/03/23, 04/10/23, and 04/17/23 the updated interdisciplinary treatment plan appeared to have the signature of an RN and a therapist and no documentation of physician involvement in the physician signature block.<br><br>6. At the time of the review, Staff #905 verified that the signature in the physician signature block was theirs and a registered nurse.<br>. | L1065 | | |
| L1145 | 322-180.1C RESTRAINT OBSERVATIONS<br><br>WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervening as necessary, and recording observations and interventions in the clinical | L1145 | | |

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| L1145 | Continued From page 30<br>record;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's seclusion policy and procedure for 1 of 1 patients observed in the intake area of the hospital (Patient #715).<br><br>Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled, "Seclusion Policy," Policy # PC.SP.101, last revision 08/21, no approval date, showed the following:<br><br>a. DEFINITION: Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.<br><br>b. Seclusion may only be ordered by a psychiatrist, physician assistant practicing under the supervision of a psychiatrist, or a psychiatric advanced registered nurse practitioner and only for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others after less restrictive interventions are ineffective or ruled-out.<br><br>c. Seclusion is never used as a means of coercion, discipline, convenience, or staff | L1145 | | |

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| L1145 | Continued From page 31<br>retaliation.<br><br>d. The registered nurse will document behaviors which led to the need for the use of seclusion.<br><br>e. The patient shall be monitored and reassessed through continuous in-person observation.<br><br>f. Monitoring of the physical and psychological well-being of the patient who is secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of seclusion<br><br>2. On 04/17/23 from 11:25 AM to 12:19 PM, Surveyor #7, the Director of Nursing (Staff #703), and an Intake Specialist (Staff #704), toured the Intake lobby and the locked intake screening rooms. The tour showed the following:<br><br>a. At 11:25 AM, Surveyor #7 and Staff #703 noted the self-locking door of room #1N18A was closed, the lights were off, and no staff was present in the locked intake hallway or the Safety Technician room.<br><br>b. At 12:00 PM, Surveyor #7 and Staff #703 returned to the intake hallway and noted the door to room #1N18A was open and a Safety Technician (Staff #705), was sitting outside in the hallway with a clipboard.<br><br>c. Patient #715 was resting on a couch in room #1N18A.<br><br>3. Surveyor #7 verified with Staff #703 that Patient #715 was unable to leave the room and | L1145 | | |

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| L1145 | Continued From page 32<br>was in a locked area with no staff for at least 30 minutes.<br><br>4. On 04/17/23 at 12:00 PM, Surveyor #7 interviewed Staff #704 who verified Patient #715 had been alone in a locked room from 11:35 AM to 12:00 AM, and did not have an order for seclusion.<br><br>5. Surveyor #7 and Staff #703 reviewed the medical record for Patient #715, no order for seclusion was found. | L1145 | | |
| L1260 | 322-200.3E RECORDS-SIGNED ORDERS<br><br>WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (e) Authenticated orders for: (i) Drugs or other therapies; (ii) Therapeutic diets; and (iii) Care and treatment, including standing medical orders used in the care and treatment of the patient, except standing medical emergency orders;<br>This Washington Administrative Code is not met as evidenced by:<br><br>Based on document review and interview, the hospital failed to ensure that medical staff promptly authenticated verbal orders for drugs and other therapies in 5 records reviewed (Patients #901, #902, #1001, #1002, and #1003).<br><br>Failure to authenticate orders promptly risks | L1260 | | |

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| L1260 | Continued From page 33<br>patient harm from improper care and medical error.<br><br>Findings included:<br><br>1. Document review of the hospital's policy titled, "Medication Orders", policy number PC.M.100, revised 2/23, showed that verbal and telephone orders are to be countersigned by the prescriber within 72 hours.<br><br>2. Document review of the hospital document titled, "Rules and regulations of the Medical Staff of Cascade Behavioral Health", approved by the Governing Board 4/22, showed:<br><br>a. Appendix 7.8: Authentication of orders are to be completed no later than 48 hours after order given.<br><br>3. On 04/19/22 at 10:20 AM, Surveyor #9 and Assistant Director of Nursing (Staff #901) reviewed the medical charts of 2 discharged patients. The review showed the following:<br><br>a. On 01/20/23 at 12:50 PM, a Registered Nurse documented a verbal/telephone order on Patient #901 to discontinue every 5 minute observation and start every 15 minute observation. The order was authenticated by a provider on 03/01/23 at 11:00 AM (a period of approximately 38 days). On 01/23/23 at 10:05 AM, a Registered Nurse documented a verbal/telephone order on Patient #901 for Haldol (an antipsychotic medication) 5 milligrams intramuscularly now, Ativan (an antianxiety medication) 2 milligrams intramuscularly now, and Benadryl (a sedating medication) 50 milligrams intramuscularly now. The order was authenticated by a provider on 03/01/23 at 11:00 AM (a period of approximately | L1260 | | |

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| L1260 | Continued From page 34<br>38 days).<br><br>b. On 03/30/23 at 8:55 PM, a Registered Nurse documented a verbal/telephone order on Patient #902 for Zyprexa (an antipsychotic medication) 20 milligrams intramuscularly times 1 dose. The order was authenticated by a provider on 04/03/23 at 11:00 PM (a period of approximately 107 hours). On 03/30/23 at 9:15 PM, a Registered Nurse documented a verbal/telephone order clarification Patient #902 for Zyprexa 10 milligrams intramuscularly times 1 dose. The order was authenticated by a provider on 04/03/23 at 11:00 PM (a period of approximately 107 hours).<br><br>4. At the time of the review, Assistant Director of Nursing (Staff #901) verified the times of the orders and the provider authentication.<br><br>5. On 04/19/23 at 11:30 AM, Surveyor #10 and Assistant Director of Nursing (Staff #1002) reviewed the medical records of 3 discharged patients. The review showed the following:<br><br>a. On 03/02/23 at 5:55 PM, a Registered Nurse (RN) documented a telephone order/verbal order (T.O./V.O.) on Patient #1001 for every 5 minutes checks. The order was authenticated by a provider on 04/16/23 at 10:25 AM (a period of 45 days). On 03/02/23 at 7:00 PM, an RN documented a T.O./V.O. on Patient #1001 to discontinue 5 minute checks and begin 1:1 observations. The order was authenticated by a provider on 04/16/23 at 10:25 AM (a period of 45 days). On 03/02/23 at 10:48 PM, an RN documented a T.O./V.O. on Patient #1001 to send the patient to the emergency department. The order was authenticated by a provider on 04/16/23 at 10:25 AM (a period of 45 days). | L1260 | | |

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| L1260 | Continued From page 35<br><br>b. On 3/21/23 at 10:46 AM, an RN documented a T.O./V.O for Patient #1002 for two medications. The order was not authenticated at the time of the medical record review (a period of 29 days).<br><br>c. On 02/03/23 at 7:50 PM, an RN documented a T.O./V.O. for Patient #1003 for a medication. The order was authenticated by a provider on 02/20/23 at 10:08 AM (a period of 17 days). On 02/20/23 at 9:00 PM, an RN documented a T.O./V.O. for a medication and for a lab draw. The order was authenticated by a provider on 03/08/23 at 2:00 PM (a period of 16 days).<br><br>6. At the time of the medical record review, Staff #1002 verified that the orders had not been authenticated within the hospital policy timeframe.<br>. | L1260 | | |
| L1275 | 322-200.3H DATA BASE-PATIENT INFO<br><br>WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (h) Data bases containing patient information;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on document review and interview, the hospital failed to ensure prompt entry and filing of database records containing patient information into the clinical record in 3 of 15 patient records reviewed (Patient #901, #1001, and #1005).<br><br>Failure to include database records impairs the | L1275 | | |

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| | 60429197 | A. BUILDING: _____ B. WING _____ | 04/19/2023 |

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| CASCADE BEHAVIORAL HOSPITAL | 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168 |

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| L1275 | Continued From page 36<br>integrity of the clinical record, risking diagnosis and treatment errors in care continuity.<br><br>Findings included:<br><br>1. On 04/19/23 at 9:30 AM, Surveyor #9 reviewed the medical record of Patient #901 who was admitted on 11/26/22 and discharged on 01/25/23. Surveyor #9 observed that there were handwritten rounding logs in the medical record from 11/26/22 to 12/5/23, and no evidence of rounding logs from 12/15/23 to discharge.<br><br>2. On 04/19/23 at 10:00 AM, Surveyor #9 interviewed the House Supervisor (Staff #904) regarding the rounding logs. Staff #904 stated that this was around the time that the new rounding process of electronic rounding began and that they would look for the records. Staff #904 was able to present the rounding sheets that were not initially part of the medical record.<br><br>3. On 04/19/23 at 10:15 AM, Surveyor #10, Surveyor #7, and the Director of Risk Management (Staff #1004) went to the Medical Records department. Surveyor #10 interviewed the Medical Records Clerk (Staff #1005) about the process for maintaining the record of patient rounding observations in medical records after discharge. Staff #1005 stated that when medical record staff retrieved patient charts from the patient care unit at discharge, staff printed the "rounding logs" from the ObserveSmart system (the electronic documentation tool used in monitoring patient activity and behavior) to file into the permanent medical record.<br><br>4. On 04/19/23 at 11:30 AM, Surveyor #10 and the Assistant Director of Nursing (Staff #1002) reviewed the medical record of Patient #1001, | L1275 | | |

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| L1275 | Continued From page 37<br>who had been discharged on 03/10/23. Surveyor #10 found no evidence of the printed rounding observation sheets from ObserveSmart.<br><br>5. At the time of the review, Staff #1002 confirmed that no rounding observations sheets were in the medical record.<br><br>6. On 04/19/23 at 3:00 PM, Surveyor #10 and the House Supervisor (Staff #1003) reviewed the medical record of Patient #1005, who had been discharged on 03/14/23. Surveyor #10 found no evidence of the printed rounding observation sheets from ObserveSmart.<br><br>7. At the time of the review, Staff #1003 confirmed that no rounding observations sheets were in the medical record.<br>. | L1275 | | |
| L1295 | 322-200.3L RECORDS-PROGRESS NOTES<br><br>WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (I) Progress notes recorded by the professional staff responsible for the care of the patient or others significantly involved in active treatment modalities;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on document review and interview, the hospital failed to ensure that staff documented progress notes in the medical record for 1 of 4 | L1295 | | |

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| L1295 | Continued From page 38<br>patients reviewed (Patient #903).<br><br>Failure to document progress notes in the medical record risks patient harm from unrecognized or unmet care needs and inconsistent and unsafe care due to lack of a complete medical record.<br><br>Findings included:<br><br>1. Document review of the hospital's policy and procedure titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," dated 04/22 showed the following:<br><br>a. The attending physician or designee will see each patient at least 6-7 days per week.<br><br>b. Rehabilitation patients will be seen at least weekly.<br><br>c. Pertinent progress notes related to diagnosis and to treatment plan shall be recorded on the date of each visit.<br><br>2. On 04/17/23 between 3:40 PM and 4:30 PM, Surveyor #9 and the Assistant Director of Nursing Staff #901) reviewed the medical record of Patient #903 who was admitted to inpatient status on 03/11/23. Patient #903 was transferred to rehabilitation status on 03/21/23. Surveyor #9 found no evidence of any progress notes in the medical record except one dated 03/30/23.<br><br>3. At the time of the review, Staff #901 verified that there were no other progress notes and stated that they would try to locate them. None were provided by the end of the survey. | L1295 | | |

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| L1300 | Continued From page 39 | L1300 | | |
| L1300 | 322-200.3M RECORDS-DISCHARGE SERVICES<br><br>WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (m) A discharge plan and discharge summary.<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on interview and document review, the hospital failed to ensure prompt entry and filing of discharge summaries into the clinical record for 3 patients (Patients #901, #1004, and #1005).<br><br>Failure to create and file discharge summaries promptly puts patients at risk of harm from improper care and medical error, particularly for subsequent visits or hospitalizations.<br><br>Findings included:<br><br>1. Document review of the hospital document titled, "Rules and Regulations of the Medical Staff of Cascade Behavioral Health," approved by the Governing Board 4/22, showed:<br><br>a. Appendix 8.1: All discharge summaries and other medical record documentation shall be completed within 30 days following the patient's discharge.<br><br>2. On 04/18/23 at 2:00 PM, Surveyor #10 reviewed the medical record of Patient #1004, who was admitted on 03/09/23 and discharged on 03/10/23 at 8:12 PM to an emergency | L1300 | | |

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| L1300 | Continued From page 40<br>department. The discharge summary was dictated and signed on 04/13/23 (a period of 34 days).<br><br>3. On 4/18/23 at 4:45 PM, the Director of Risk Management (Staff #1004) verified that the discharge summary was not completed within 30 days of the patient's discharge.<br><br>4. On 04/19/23 between 10:00 AM and 10:30 AM, Surveyor #9 reviewed the medical record of Patient #901 who was admitted to the hospital on 11/26/22. The patient was discharged to transfer to another facility on 01/25/23. The discharge summary was electronically signed by a physician assistant on 03/04/23 and a physician on 03/04/23 (a period of 37 days from discharge).<br><br>5. At the time of the review, Assistant Director of Nursing (Staff #901) verified the admission and discharge dates and stated that the discharge summary should be completed within 30 days.<br><br>6. On 04/19/23 at 3:00 PM, Surveyor #10 reviewed the medical record of Patient #1005, who was admitted on 03/05/23 and discharged on 03/14/23 at 2:50 PM. Surveyor #10 found no discharge summary in the medical record at the time of the review (a period of 36 days).<br><br>7. At the time of the review, the House Supervisor (Staff #1003) confirmed that no discharge summary was in the medical record, exceeding the timeframe of 30 days. | L1300 | | |
| L1485 | 322-230.1 FOOD SERVICE REGS<br><br>WAC 246-322-230 Food and Dietary | L1485 | | |

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| L1485 | Continued From page 41<br>Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on observation and interview, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC).<br><br>Failure to follow food safety standards places patients at risk from food borne illness.<br><br>Findings included:<br><br>1. On 04/17/23 at 11:15 AM, Surveyor #6 toured the Food Service Department with the Food Services Director (Staff #601). The observation showed that the paper towel dispenser at the handwashing sink in the dining room did not provide paper towels. No other hand drying device was available.<br><br>2. At the time of the observation, Staff #601 confirmed that the paper towel dispenser was not operating and stated that she would request new batteries immediately.<br><br>Reference: Washington State Retail Food Code: WAC 246-215-06310 (FDA Food Code 6-301.12)<br><br>1. Document review of the Hoshizaki America, Inc. Cubelet Icemaker/Dispenser Models DCM-300BAH(-OS) Instruction Manual, revised 02/13/15, showed that drain lines must have a ¼" fall per foot (2 cm per 1 m) on horizontal runs to get a good flow.<br><br>2. On 04/17/23 at 11:15 AM, Surveyor #6 toured | L1485 | | |

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| L1485 | Continued From page 42<br><br>the Food Service Department with the Food Services Director (Staff #601). The observation showed that the drain line from the Hoshizaki America ice/water dispenser in the dining room was not sloped to drain. The drain hose was connected to copper drainpipe from the dispenser, sloped down to the floor of the cabinet below and continued horizontally to a floor sink several feet away. The drain hose showed black slime inside the hose continuing from the copper pipe connection to the floor sink.<br><br>3. On 04/19/23 at 9:00 AM, Surveyor #6 interviewed the Director of Facilities (Staff #603) about backflow prevention and the drainage of ice/water dispensers throughout the facility. Staff #603 stated that each of the ice/water dispensers have air gaps as backflow prevention and received scheduled preventive maintenance, including sanitization, according to the manufacturer's recommendations. He stated that he was not aware that the drainage was a problem.<br><br>Reference: Washington State Retail Food Code: WAC 246-215-04264 (FDA Food Code 4-204.120) | L1485 | | |
| L1505 | 322-230.2D FOOD SERVICE-SNACKS AVAILABLE<br><br>WAC 246-322-230 Food and Dietary Services. The licensee shall: (2) Designate an individual responsible for managing and supervising dietary/food services twenty-four hours per day, including: (d) Making nourishing snacks available as needed | L1505 | | |

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| L1505 | Continued From page 43<br>for patients, and posted as part of the menu;<br>This Washington Administrative Code is not met as evidenced by:<br>.<br>Based on document review, observation and interview, the hospital failed to post menus that included nourishing snacks.<br><br>Failure to provide patient menus that contain all food choices, including snacks, puts patients at risk of harm from inadequate nutrition.<br><br>Findings included:<br><br>1. Document review of 4 weekly patient food service menus, 04/16/23 - 04/22/23, 04/26/23 - 04/29/23, 04/30/23 - 05/06/23, and 05/07/23 - 05/13/23 showed 3 meal service menus (breakfast, lunch, dinner) for each day of the week. There was no mention of snacks on any of the weekly menus.<br><br>2. On 04/17/23 at 11:15 AM, Surveyor #6 toured the Food Service Department with the Food Services Director (Staff #601). The observation showed that the menus posted for the patients did not include nutritious snacks.<br><br>3. On 04/19/23 at 10:50 AM, Surveyor #6 interviewed the Registered Dietitian (Staff #602) about food service to the patients. Staff #602 stated that nutritious snacks are available to patients at any time upon request and that snacks are scheduled 3-times daily: 10:00 AM, 2:00 PM, and during the evening after dinner service. Staff #602 confirmed that the posted menu did not include snacks and stated that it would be corrected immediately.<br>. | L1505 | | |

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Plan of Correction received 11 May 23 under review

CEO 5/11/2023

Robin Munroe Team Lead

Cascade Behavioral Hospital
Plan of Correction for
2023-243 State Licensing Hospital Survey
04/17/23 – 04/19/23

| Tag Number | How the Deficiency Will Be Corrected | Responsible Individual(s) | Estimated Date of Correction | Target for Compliance & Monitoring procedure |
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| **L 315**<br>**322-035.1C**<br>**POLICIES-TREATMENT**<br>*WAC 246-322-035 Policies and Procedures* | **Observation**<br>**Item #1 Rounding**<br><br>The ObservSmart tools implemented on 12/3/2022: Patient observation sheet were replaced with digital tracing in the ObservSmart tool.<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, **"Patient Observations," policy #PC.OBS.101, last approved 2/2023** to reflect the procedures with the current ObserveSmart system. We will update this policy by 6/19/2023.<br><br>The Directors of Nursing, Quality, and Risk determined that all nursing staff members and house supervisors required further education and training on the observation policies and procedures with a focus on: | CNO/Risk/Quality | 6/19/2023 | Monitoring Process:<br><br>The CNO or leadership designee will audit 5 patient charts per day to assure compliance and completion of the observation rounding is completed.<br><br>The target goal for each indicator being audited as described above is 90% compliance including the documentation of observation rounding and active treatment efforts and interventions as well as progress made toward the treatment plan for all active problems. Monitoring for compliance will continue until 90% compliance is reached for 3 months or 90 consecutive days. |

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| | • The completion of rounding observations by the BHS and RNs<br>• That rounding and observation is done for each patient as necessary based on the patient's plan for care or change in their condition, including change in the patient's level of pain, fall risk, suicide risk, etc.<br><br>Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees utilizing this system. | - | | |
| **L 315 322-035.1C POLICIES-TREATMENT** | **Item #2 Rounding location**<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), | CNO/Risk/Quality | 6/19/2023 | Monitoring Process |

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| *WAC 246-322-035 Policies and Procedures* | Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, **"Patient Observations," policy #PC.OBS.101, last approved 2/2023 .** We will update this policy by 6/19/2023, to reflect the following necessary documentation:<br><br>Following are to be documented:<br>a. Time.<br>b. Location.<br>c. Behavior.<br>d. Observer.<br><br>The Directors of Nursing, Quality, and Risk determined that all nursing staff members and house supervisors required further education and training on the observation policies and procedures with a focus on:<br><br>• The completion of reporting rounding location of observation services by all nursing staff<br><br>Staff will complete retraining on this revised policy on or before 6/19/2023. Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation | | | The CNO or leadership designee will audit 5 patient charts per dayto assure compliance and completion of the observation rounding location reporting is completed<br><br>The target goal for each indicator being audited as described above is 90% compliance including the documentation of observation rounding location and active treatment efforts and interventions as well as progress made toward the treatment plan for all active problems.<br><br>Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council |

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| | form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees utilizing this system. | | | |
| **L 315**<br>**322-035.1C**<br>**POLICIES-TREATMENT**<br>*WAC 246-322-035 Policies and Procedures* | **Item #3 Provider order for rounding**<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, **"Patient Observations," policy #PC.OBS.101, last approved 2/2023.** We will update this policy by 6/19/2023.<br><br>The Directors of Nursing, Quality, and Risk determined that all nursing staff members and house supervisors required further education and training on the observation policies and procedures with an emphasis on the understanding and comprehension of the ability to change observation levels specifically that:<br><br>ObserveSmart observation times match orders for appropriate observation levels as ordered by providers. | CNO/Risk/Quality | 6/19/2023 | Monitoring Process<br><br>The CNO or leadership designee will audit 5 patient charts per day to assure compliance and completion of the Provider's order for observation rounding services is completed<br><br>Provider's order for observation rounding services will include an action plan utilizing the Plan, Do, Check, Act (PDCA) process in which monthly evaluation and planning will be conducted based on findings in the Quality Council and reported quarterly to Medical Executive Committee and Governing Board.<br><br>The target goal for each indicator being audited as described above is 90% compliance including the documentation of observation rounding and active treatment efforts and interventions as well as progress made toward the treatment plan for all active problems.<br><br>Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council. |

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| | Staff will complete retraining on this revised policy on or before 6/19/2023. Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees utilizing this system. | | | |
| L 335<br>**322-035.1G POLICIES-EMERGENCY CARE**<br>*WAC 246-322-035 Policies and Procedures* | **Crash Cart**<br><br>The Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, **"Emergency Cart", policy PC.C.110,** revised 09/15 and found no revisions necessary<br><br>The Directors of Nursing, Quality, and Risk determined that all nursing staff members and house supervisors required further education and training on checking and documentation of supply expiration dates. | House supervisors/ CNO/Risk/Quality | 6/19/2023 | Monitoring Process:<br>The CNO or leadership designee will audit 10 supervisor rounding sheets and logs per week to assure compliance and completion of accurate documented visual observation of inventory.<br><br>The audits will focus on:<br>Supplies, expiration dates, storing and accessing emergency supplies and equipment, are in alignment and meet the Washington administrative code.<br><br>The target goal for each indicator being audited as described above is 90% compliance including the documentation of observation rounding and active treatment efforts and |

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| | Staff to be re-trained on daily inventory checks to be done by the night unit charge nurse and staff and documented on a log.<br><br>Staff will complete retraining on this policy on or before 6/19/2023. Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this. | | | interventions as well as progress made toward the treatment plan for all active problems.<br><br>Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council. |
| L 415<br>**322-035.2 P&P-ANNUAL REVIEW**<br>*WAC 246-322-035 Policies and Procedures* | **Policy and procedures**<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's process "Policy Review, Revision Process" and found no revisions necessary.<br><br>All leadership was educated on the policy for annual review and revision of policies. | Director of Risk, Director of Quality | 6/19/2023 | Monitoring Process:<br>Risk Management will survey existing policies monthly to determine which policies need timely review. These policies will be reviewed by the Directors affected by the policies and solicit any needed changes. The changed policies and those reviewed and approved will be submitted to the Quality Council, Medical Executive Committee for final approval.<br><br>Compliance will be measured by maintaining a list of the policies approved monthly. |

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| | Annual review of policies have been changed to December of each year | | | |
| L 420<br>**322-040.1 ADMIN-ADOPT POLICIES**<br>WAC 246-322-040 Governing Body and Administration. | Governing Body policies<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's process "Policy Review, Revision Process" and found no revisions necessary.<br><br>All leadership was educated on the policy for annual review and revision of policies.<br><br>Annual review of policies have been changed to December of each year | CNO/Clinical /Risk/Quality/ Educator | 6/19/2023 | Risk Management will survey existing policies monthly to determine which policies need timely review. These policies will be reviewed by the Directors affected by the policies and solicit any needed changes. The changed policies and those reviewed and approved will be submitted to the Quality Council, Medical Executive Committee for final approval after which the Director of Risk management will catalog the policies and notify applicable staff.<br><br>Compliance will be measured by maintain documentation of the notification given to staff after Governing Board approval. |
| L 715<br>**322-100.1E INFECT CONTROL-PROVISIONS**<br>WAC 246-322-100 Infection Control | **Infection control**<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, **"Infection Control Plan " IC.01.02.01;IC,01.05.01 approved 1/2022** and determined no revisions were necessary regarding reporting requirements. | Director of Intake/HRD/CNO | 6/19/2023 | The CNO or leadership designee will audit 10 supervisor rounding sheets and logs per week to assure compliance and completion of accurate documented visual observation of inventory.<br><br>The audits will focus on:<br>Supplies, expiration dates, storing and accessing emergency supplies and equipment, are in alignment and meet the Washington administrative code.<br><br>The target goal for each indicator being audited as described above is 90% compliance including the documentation of observation rounding and active treatment efforts and |

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| | The Directors of Nursing, Quality, and Risk determined that all nursing staff members and house supervisors required further education and training on checking and documentation of supply expiration dates.<br><br>Staff to be re-trained on daily inventory checks to be done by the night unit charge nurse and staff and documented on a log. House supervisor check list for monitoring weekly for compliance.<br><br>Staff will complete retraining on this policy on or before 6/19/2023. Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure m to follow. At the conclusion of the training, | | | interventions as well as progress made toward the treatment plan for all active problems.<br>Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council. |
| L 780<br>**322-120.1 SAFE ENVIRONMENT**<br>***WAC 246-322-120 Physical Environment.*** | **Environment**<br><br>The Directors of Nursing, Quality, and Risk reviewed the policies **"General Cleaning Guide" Policy ES G 100** Rev. 4/21 and **"Daily Cleaning of Patient Area" Policy ES D 200** Rev. 4/21 and found no revisions necessary. | Director of Facilities | 6/19/2023 | Monitoring will be conducted by a weekly audit of the cleaning checklist for completeness and accuracy. In addition, daily Leadership rounds will focus on the sanitary physical environment.<br><br>Monitoring for compliance will continue on an ongoing basis until 90% compliance is reached for three months or 90 consecutive days. |

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| | The Directors of Nursing, Quality, and Risk determined that additional training would be needed by Environmental Services staff on the policies above<br><br>Staff will complete retraining on this policy on or before 6/19/2023. Training will be conducted in groups by the Director of Facilities or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>A daily checklist will be implemented for staff to use to validate their work<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this | | | |
| L1040<br>**322-170.1C TRANSFER PATIENTS** | **Transfer**<br><br>The Directors of Nursing, Quality, and Risk reviewed the policy, "Patient Transfer to Another Facility", | Director of Intake/HRD/CNO | 6/19/2023 | **Monitoring Process**<br>The CNO or designee will audit 100 % of any emergency transfers from intake for compliance with completion of applicable forms |

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| *WAC 246-322-170 Patient Care Services* | PC.RAF.101 rev.2/23 and found no revisions necessary.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this.<br><br>The Directors of Nursing, Quality, and Risk determined that additional training would be needed by all RN staff. Training will focus on compliance with completion of applicable forms:<br>• Request/consent for transfer,<br>• Physician certificate for transfer,<br>• Memorandum of transfer.<br><br>Staff will complete retraining on this policy on or before 6/19/2023. Training will be conducted in groups by the Director of Facilities or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a | | | The CNO will report each weekday the results of the audit to the daily leadership flash report.<br><br>The CNO will monitor any emergency transfers daily for 90 days or until 90% compliance is met for 90 continuous days.<br><br>The CNO will aggregate all monthly data and report results to the Director of Quality each month.<br><br>**Target for Compliance**<br>The Quality Council will evaluate compliance with the collection, audit, and analysis of these new PI indicators. Any finding less than 90% will result in a PDCA completion by the CNO. |

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| | part of new employee orientation for new employees assigned to this | | | |
| L1065<br>**322-170.2E TREATMENT PLAN-COMPREHENS**<br><br>*WAC 246-322-170 Patient Care Services.* | **Plan**<br><br>Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the "Telehealth Policy" PC.TH.100 and determined that the policies and the forms meet regulatory requirements.<br><br>The Directors of Nursing, Quality, and Risk determined that telehealth nursing staff required further education and training on the completion and of signatures for providers of telehealth<br><br>The target goal for re-education and training of telehealth nursing staff on the expectations of documentation compliance is 100%.<br><br>Training will be conducted in person by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented. | CNO | 6/19/2023 | **Monitoring Process**<br><br>The CNO or leadership designee will audit 5 patient charts per week to assure compliance and completion of telehealth procedures and signatures<br><br>**Target for Compliance**<br><br>The target goal for education and training of nursing staff and providers of the new expectations of documentation compliance is all active working staff. Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time will revert to the indicators and plan annually approved in the quality council. |

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| | Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this | | | |
| L1145<br>**322-180.1C RESTRAINT OBSERVATIONS**<br>*WAC 246-322-180 Patient Safety and Seclusion Care* | **Restraint**<br><br>The Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policies titled, "Restraint Policy" PC.PR.101 rev. 2/23 and "Seclusion Policy" PC.SP.101 found no revisions necessary.<br><br>The Directors of Nursing, Quality, and Risk determined that all intake staff members required further education and training on the completion and of individualized treatment plans<br><br>Training specific to RN Intake will focus on normal utilization of rounding staff services in the intake area to assure patients are attended to. In addition, staff will be trained on acquiring physician orders for any seclusion or restraint and the completion of the necessary documentation associated with it.<br><br>Daily leadership rounding Director of Intake have been revised to include observation of assessment rooms and intake for monitoring of rounds. | Director of Intake | 6/19/2023 | Monitoring Process:<br><br>Leadership rounds will be available and reported daily in Flash. Results will be reported to QC.<br><br>Target for Compliance:<br><br>The target goal is 90% compliance achieved and maintained for three months or 90 consecutive days. |

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| L1260<br>**322-200.3E RECORDS-SIGNED ORDERS**<br>*WAC 246-322-200 Clinical Records* | **Orders**<br><br>The Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policies titled, "Medication Orders" policy PC.M.100 rev. 2/23 and found that no revision is necessary<br><br>Training will be conducted in groups by the CMO and medical staff during training meetings. Medical staff will be re-educated on the rules and regulations, as well as order authentications and observation standards.<br><br>Staff will complete retraining on this policy on or before 6/19/2023. Training will be conducted in groups by the CNO or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this. | CMO | 6/19/2023 | Monitoring Process:<br>The CMO or designee will audit five charts per week to ensure that the verbal orders are authenticated<br><br>Target for Compliance:<br><br>The target goal is 90% compliance achieved and maintained for three months or 90 consecutive days. |

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| L1275<br>**322-200.3H DATA BASE-PATIENT INFO**<br>*WAC 246-322-200 Clinical Records* | **Data**<br><br>The Directors of HIM, Quality and Risk determined that all HIM members and house supervisors required further education and training on the filing of observation rounding documentation<br><br>Training will be conducted in groups by the HIM Director or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of new employee orientation for new employees assigned to this | HIM Director | 6/19/2023 | Monitoring Process<br>The HIM or leadership designee will audit 5 patient discharge records per week to assure compliance and completion of the data elements.<br><br>Review will consider if observation rounding documentation is present in the medical record<br><br>The target goal for each indicator being audited as described above is 100% compliance including the documentation of data and active treatment efforts and interventions as well as progress made toward the treatment plan for all active problems. Monitoring for compliance will continue until 90% compliance is reached for 3 months at which time auditing will revert to the indicators and plan annually approved in the quality council. |
| L1295<br>**322-200.3L RECORDS-PROGRESS NOTES**<br>*WAC 246-322-200 Clinical Records* | **Records**<br>Records<br><br>The Chief Medical Officer (CMO) HIM Director, reviewed the hospital's policy on "Rules and regulations of the medical staff of Cascade Behavioral Health" and determined | Director of Intake/HRD/CNO | On going | Monitoring Process<br>The Director of HIM or leadership designee will audit 5 patient charts per week to assure compliance and completion of the elements of the each progress note is documented.<br><br>Target for Compliance<br><br>Monitoring for compliance will continue until 90% compliance is reached for 3 months. |

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| | rules met the regulatory requirements.<br><br>The CMO, HIM Director determined that all medical staff members required further re - education and training in the bylaws and rules around placement of provider's daily documentation. Staff will be given training on the applicable policies and procedures by the Director of HIM | | | |
| L1300<br>322-200.3M<br>RECORDS-DISCHARGE SERVICES<br>*WAC 246-322-200 Clinical Records* | **Discharge**<br><br>The HIM Director and CMO determined that all medical staff members further re - education and training on the rules and regulations around the filing of discharge summaries into the medical record.<br><br>HIM Director will provide education on the filing of discharge summaries. | CNO | 6/19/2023 | Monitoring Process<br>The HIM Director or leadership designee will audit 5 patient charts per week to assure compliance and completion of Discharge Care Plans and Discharge Summaries.<br><br>Target for Compliance<br>The CNO and HIM Director reports all results from chart audits monthly, along with a plan of correction for any documentation audit indicators. |
| L1485<br>322-230.1<br>FOOD SERVICE REGS<br>*WAC 246-322-230 Food and Dietary* | **Food Services**<br><br>The Chief Medical Officer (CMO), Director of Clinical Services (DCS), Director of Quality, Director of Risk Management and Chief Nursing Officer (CNO) reviewed the hospital's policy titled, "Infection Control Plan " IC.01.02.01;IC,01.05.01. last | Director of Nutritional Services | 6/19/2023 | Monitoring Process:<br><br>Dietary Director or designee will inspect kitchen, cafeteria and any area where food may be present once per week to assure compliance of proper food handling techniques as well as the status of all hand hygiene stations. Results will be reported to the executive team. |

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| | approved 1/2022 and determined no revisions were necessary regarding reporting requirements.<br><br>Nutritional Services staff will be retrained on proper food handling techniques, hand hygiene, and preventing food borne illness. EVC will be re-educated on performing regular battery checks on hand drying equipment.<br><br>Training will be conducted in groups by the Dietary Director or delegate and will be presented in verbal and written formats. Staff will be educated on the applicable policy and procedure to follow. At the conclusion of the training, comprehension will be tested by verbal assessment. Each employee will sign an attestation form acknowledging of attendance and accountability for the material presented.<br><br>Employees will have this revision in their annual training. This will be a part of New employee orientation for new employees utilizing this system.<br><br>All plumbing and ice machines will be repaired so all tubing and drains will meet manufacturer guidelines by 6/19/2023 | | | Target for Compliance<br><br>The target goal for each indicator being audited as described above is 100% compliance. Monitoring for compliance will continue until 90% compliance is reached for 3 months or 90 consecutive days.<br><br>Individual instances of non-compliance were remedied on the day of the survey. |

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| L1505<br>322-230.2D<br>FOOD SERVICE-SNACKS AVAILABLE<br>*WAC 246-322-230 Food and Dietary Services* | **Snacks**<br><br>Director of Nutrition Services contacted the menu vendor to update the menu to include snacks.<br><br>Nutrition Director signed acknowledgment attestation of incorporating snack updates to the menus and distributions of these new menus throughout the units was achieved.<br><br>Training will consist of a refresher on the requirements for menu. | Director of Nutritional Services | 6/19/2023 | **Monitoring process:**<br>The Dietary Director or designee designee will audit menus each month to assure compliance and completion of the snacks in monthly menu is completed<br><br>Facility is in the process of updating and educating staff on updated menus during our Annual and or monthly and or in-service training sessions. |