

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/28/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>504011</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/05/2017</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CASCADE BEHAVIORAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>12844 MILITARY ROAD SOUTH</b> <b>TUKWILA, WA 98168</b>
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{A 000}	<p>INITIAL COMMENTS</p> <p>MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT</p> <p>An on-site follow-up visit was conducted on May 1 - 5, 2017 by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Joyce Williams, RN, BSN, and Alex Giel, REHS, PHA.</p> <p>During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539.</p> <p>This visit was to verify correction of Condition-level deficiencies found during the hospital complaint survey revisit on March 7 -10, 2017 in which the facility was found not in compliance with:</p> <p>42:CFR 482.12 Governing Body</p> <p>42 CFR 482.12 Patient Rights</p> <p>During the course of the follow-up visit, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the seriousness of the findings. This resulted in the declaration of IMMEDIATE JEOPARDY in the following area:</p> <p>Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation.</p> <p>Removal of the state of IMMEDIATE JEOPARDY was verified on 5/5/2017 at 2:15 PM by Elizabeth Gordon, RN, MN and Joyce Williams, RN, BSN.</p>	{A 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE <b>01/20/2017</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 000}	Continued From page 1	{A 000}			
A 023	<p>The hospital remains <b>NOT IN COMPLIANCE</b> with Medicare Hospital Conditions for:</p> <p>42 CFR 482.12 Governing Body</p> <p>Shell #27QV13 <b>LICENSURE OF PERSONNEL</b> CFR(s): 482.11(c)</p> <p>The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on interview, and review of hospital's policy and procedure, the hospital failed to ensure that the Director of Nursing (DON) was properly vetted prior to employment.</p> <p>Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff.</p> <p>Findings:</p> <p>1. In review of the hospital's policy and procedure titled, "License and Certification Verification" (Policy Number: HR -130; Effective Date: September 1, 2015) under the heading titled "procedure", stated "that prior to offer of employment, candidates applying for positions that require a license must present proof of their original licensure ... to human resources."</p> <p>2. On 5/4/2017 at 1:00 PM Surveyor #1</p>	A 023		2/10/17	

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A 023	Continued From page 2 interviewed the human resource manager (Staff Member #6) in regards to the screening process of new employees. During the interview Surveyor #1 asked to see the Director of Nursing (DON) (Staff Member #7) licensure. The human resource manager indicated that Staff Member #7's nursing license had expired in 2015. When asked to see the Staff Member #7's file, the human resource manager stated in part that s/he did not have a current file because s/he was hired while the human resource manager was on vacation. The human resource manager indicated that the DON was a re-hire but was unable to locate his/her previous file. Staff Member #6 was hired on April 17, 2017.	A 023			
{A 043}	GOVERNING BODY CFR(s): 482.12  There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...  This CONDITION is not met as evidenced by: . Based on interviews and document reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body.  Failure to ensure staff had the required knowledge, skills and training to respond to their patient's emergency medical needs risks delays in providing emergency response and treatment.	{A 043}			

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{A 043}	Continued From page 3 Findings:  The Governing Body failed to effectively manage the functioning of the hospital to protect patients from harm as evidenced by the IMMEDIATE JEOPARDY condition identified on 5/3/2017 for failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation.  Due to the scope and severity of deficiencies detailed under 42 CFR 482.12 Condition of Participation for Governing Body was NOT MET.	{A 043}			
A 045	Cross- Reference: Tags A093 MEDICAL STAFF CFR(s): 482.12(a)(1)  [The governing body must] determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff.  This STANDARD is not met as evidenced by: . Based on interview, review of personnel files and the hospital policy and procedure, the hospital failed to ensure the supervising physician followed the physician assistants' delegation agreement in regards to performance evaluations. The hospital also failed to ensure that the physician assistants were following the hospital's polices and procedures in regards to writing orders.  Failure to provide performance evaluations as written in the physician assistant delegation	A 045		2/10/17	

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A 045	<p>Continued From page 4</p> <p>agreement and to provide polices that are consistent with physician assistant practice, places patients' safety and health at risk.</p> <p>Findings</p> <p>1. In review of the hospital's policy and procedure titled, "Physician Assistant Privileges" (Policy No: MS.P.310; Last Reviewed 1/2017) stated in part 2: "physician assistants are not to write orders or otherwise accept responsibility for that patient's care. Part 3 stated, "a physician assistant is not to make an independent decision as to whether the patient should be admitted to the hospital."</p> <p>2. On 5/4/2017 between the hours of 8:30 AM and 10:30 AM Surveyor #1 reviewed the delegation agreement in a physician assistant's personnel file (Staff Member #8). In review of the delegation agreement, under Prescriptive Authority, the agreement allows a certified or non-certified physician assistant to prescribe, to order, to administer and to dispense legend drugs and Schedule II-V controlled substances. In addition to reviewing medical orders, the supervisory physician must provide supervision as follows: Weekly face to face meetings; chart reviews twice a week and quarterly performance evaluations. In reviewing physician assistant's (Staff member #8) credentialing file, Surveyor #1 was unable to validate that face to face weekly meetings had occurred or that chart reviews were conducted twice a week as required by the agreement. In addition, the physician assistant (Staff Member #8) was not evaluated quarterly as required by the agreement.</p> <p>3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a</p>	A 045			

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A 045	Continued From page 5 Physician Assistant (Staff Member #9) admitted the patient to the hospital on 3/21/2017. The required supervisory physician counter signature was not present in the record. This finding was confirmed by Human Resource Manager (Staff Member #6).	A 045			
A 093	<b>EMERGENCY SERVICES</b> CFR(s): 482.12(f)(2)  If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.  This STANDARD is not met as evidenced by: . Based on interviews, document review, and review of hospital policy and procedures, the hospital failed to ensure that staff took appropriate immediate action to address an emergency medical situation.  Failure to ensure staff had the required knowledge, skills, and training to respond to a patient's emergency medical needs risks delays in activating the hospital emergency response system and initiating urgent treatment.  Findings:  1. The hospital policy and procedure titled "Code Blue Response - Medical Emergency / Cardiac Arrest" (Reference EM-024; Approved 8/2016) read in part, "It is the policy of this facility to administer cardiopulmonary resuscitation (CPR) when a person's breathing and/or pulse cease, until person resumes cardiopulmonary functions	A 093		2/10/17	

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A 093	Continued From page 6 or the emergency medical services arrive."  2. During a review of the two code blue events (term used by hospitals to activate emergency response for patients requiring immediate resuscitation) which occurred during the months of March and April 2017, Surveyors #2 and #3 noted the following:  REVIEW OF CODE #1  a. Patient #1 was a 66 year-old admitted on 4/5/2017 for depression with suicidal ideation. On 4/20/2017, a code blue was initiated in response to finding the patient hanging on his/her bathroom door.  b. On 5/2/2017 at 10:55 PM, Surveyors #2 and #3 interviewed a registered nurse (RN) (Staff Member #3) about the events surrounding Patient #1's death by hanging which occurred in the hospital on 4/20/2017. Staff Member #3 stated s/he was the only RN on the unit with 15 patients and was preparing the medication administration records for the next day. The RN indicated that she/he heard the CNA (Staff Member #2) making a loud noise and was yelling that a patient had just hanged themselves. Staff Member #3 immediately went to the entrance of Patient #1's room and saw the patient hanging from the bathroom door. Staff Member #3 indicated that s/he was unsure that s/he and the CNA could get the patient down so s/he decided to run back to the nurse's station and called the nursing supervisor for help. Next, the RN indicated that s/he called a code blue followed by calling 911. Once the nursing supervisor arrived (Staff Member #4), they removed the patient from the bathroom door and began CPR.	A 093			

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A 093	Continued From page 7  c. On 5/4/2017 at 7:35 AM, Surveyors #2 and #3 interviewed the nursing house supervisor (Staff Member #4) about the events surrounding Patient #1's death by hanging. Staff Member #4 indicated that exactly at 5:00 AM, s/he was making staffing adjustments and received a call on the radio to come to 2-North. Staff Member #4 stated it took him/her less than a minute to get to the nursing unit. Upon arrival on the unit, Staff Member #4 observed Patient #1 hanging on the edge of the bathroom door. The nursing house supervisor with assistance from the 2-North staff immediately removed the patient from the door, placed them on the ground, and began chest compressions. When asked by the surveyors how the resuscitation went, Staff Member #4 indicated the code blue went as well as it could have given the circumstances but acknowledged that the call for assistance (code blue) for the emergency could have been started earlier. The surveyors then asked Staff Member #4 if there were any problems with any of the equipment. S/he indicated that there was some difficulty in locating and connecting the mask to the "ambu bag" (a self-inflating bag-valve mask device). Staff Member #4 confirmed that night shift personnel received no practice code blue training or drills.  d. On 5/2/2017 at 11:20 PM, Surveyors #2 and #3 interviewed a registered nurse (Staff Member #5) about the events surrounding Patient #1's death by hanging which occurred in the hospital on 4/20/2017. Staff Member #5 indicated s/he was working on another clinical unit when s/he heard the code blue notification and left her/his unit to assist in the code blue response. When the surveyors asked if there had been any equipment problems, Staff Member #5 indicated the 2-North	A 093			



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A 093	<p>Continued From page 8</p> <p>staff members were having difficulty assembling/operating the "ambu bag". The staff member indicated that s/he had to instruct them on how to put the mask on the device. S/he confirmed the facility had not conducted any practice drills involving cardiopulmonary resuscitation since she began her employment there.</p> <p>e. Review of the Code Blue Evaluation Form in Patient #1's medical record revealed that the first two cycles of bag valve mask ventilation were performed without the mask connected to the Ambu bag until the mask was found and assembled. On the same form, staff did not answer question #4 under Code Standards which asked staff to check "Yes" or "No" regarding whether the CPR [cardiopulmonary resuscitation] was uninterrupted and high quality.</p> <p>f. Review of the discharge summary dictated on 4/28/2017 in Patient #1's medical record showed an entry by a physician (Staff Member #10) that revealed that in his/her review of documentation related to resuscitation efforts by staff there was no documentation to support that CPR was uninterrupted and of high standards.</p> <p>g. On 5/2/2017 at 12:35 PM, Surveyor #3 interviewed the hospital clinical educator (Staff Member #1) about code blue education and training. S/he indicated that code blue procedures and review of the crash cart is taught during hospital orientation. S/he acknowledged this training was by lecture only with no hands-on training or practice component as part of the orientation process. Staff Member #1 stated the hospital had not conducted mock code blue drills at any time during her employment. S/he</p>	A 093			

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A 093	<p>Continued From page 9 indicated that mock code drills for the facility were scheduled to begin in two weeks.</p> <p>REVIEW OF CODE #2</p> <p>2. Surveyor #2 reviewed another code blue event that occurred on 3/15/2017. Patient #2 was a 58 year-old admitted for alcohol dependence and withdrawal syndrome. According to the discharge summary in Patient #2's medical record, Patient #2 had a history of seizures from alcohol withdrawal and was placed on medication to control seizures as a preventative measure. On 3/15/2017 at 5:08 PM, the patient was found on the floor apparently due to a seizure. While lying on his/her back, the patient's tongue occluded his/her airway. A patient who was assisting the registered nurse (RN)(Staff Member #11) moved the patient to his/her left side. The patient started breathing again. The RN instructed the patient assisting him/her to keep the patient on his/her side then the RN left the unit to meet the paramedics. Once the RN left the unit, an LPN (licensed practical nurse) and 2 CNAs (certified nursing assistants) and physician were left alone to manage the patient situation. The RN returned to the unit with the paramedics and observed that CPR had been started on the patient. According to documentation, a code blue was called at 5:10 PM. Upon arrival on the unit, the paramedics took over resuscitation efforts.</p> <p>a. No Code Blue Form documenting the staff's response to the patient's cardiac arrest could be located in the patient's medical record. In addition, no Code Blue Evaluation Form could be located within the facility.</p> <p>b. An interview with the Director of Clinical</p>	A 093			

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A 093	Continued From page 10 Services (Staff Member #12) on 5/4/2017 at 8:44 AM revealed that the response to the patient's cardiac arrest was disorganized and that the RN (Staff Member #11) should have remained on the unit with the patient and sent another staff member to meet the paramedics.	A 093			
A 396	<b>NURSING CARE PLAN</b> CFR(s): 482.23(b)(4)  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan  This STANDARD is not met as evidenced by: . Based on record review and review of hospital policy and procedure, the hospital failed to ensure staff assess patients for suicide risk upon admission for 1 of 3 patient records reviewed (Patient #3).  Failure to assess patients for suicide upon admission puts patients at risk for self-harm.  Findings:  1. The hospital policy and procedure titled "Suicide Risk Assessment" (Policy # PC.SP.100; Reviewed 1/2017) read in part: "The admitting RN or Intake Personnel will complete the initial suicide risk assessment (SRA form) as soon as possible but no later than 2 hours after admission. . . If any suicide risk assessment renders information that has potential to immediately affect patient safety and/or results in a score of High or Severe, the psychiatrist shall be contacted immediately."	A 396		2/10/17	

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A 396	Continued From page 11  2. Surveyor #2 reviewed the medical records of three patients recently admitted to the hospital and noted the following:  a. Patient #3 was admitted on 4/30/2017 at 8:08 PM with a chief complaint of being "suicidal" after being transferred from a local acute care hospital. A review of the "Intake to Nursing Communication Hand-Off" form was documented as a high risk notification with the box marked "Suicidal Ideation with Plan". The initial suicide risk assessment was completed on 5/1/2017 at 9:20 AM, 13 hours after admission. Patient #3's suicide risk assessment was determined to be at the high risk level.	A 396			