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{A 000}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT An on-site follow-up visit was conducted on March 7 - 10, 2017 by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Joy Williams, RN, BSN, and Alex Giel, REHS, PHA. The Fire Life Safety (F/LS) follow-up visit was conducted on March 7, 2017 by Washington State Patrol Deputy Fire Marshal Don West. During the survey, surveyors also assessed issues related to the following Medicare complaints: #71391; #71515; and #71516. This visit was to verify correction of Condition-level deficiencies found during the hospital complaint survey on 12/12-16/2016 and 12/19-21/2016 in which the facility was found not in compliance with: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights 42 CFR 482.21 Quality Assessment and Performance Improvement 42 CFR 482.25 Pharmaceutical Services 42 CFR 482.41 Physical Environmental 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 serious of the findings. This resulted in the	{A 000}		

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

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 declaration of IMMEDIATE JEOPARDY in the following area: Failure to conduct effective security procedures when wanding newly admitted patients for identification of hazards associated with danger to self and others (3/9/2017 at 2:45 PM). Removal of the state of IMMEDIATE JEOPARDY was verified on 3/10/2017 at 2:10 PM by Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN, Alex Giel, REHS, PHA, and Joy Williams, RN, BSN. The hospital remains NOT IN COMPLIANCE with Medicare Hospital Conditions for Participation for: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights Shell #27QV12 .	{A 000}		
{A 043}	482.12 GOVERNING BODY 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 observation, interviews, and document reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of Participation for Governing Body.	{A 043}	**A043 482.12 - Governing Body** Immediately following the March 10, 2017 exit summation, the CEO, Governing Board Member, Chief Nursing Officer/Chief Operating Officer, PI/Risk Manager, Director of Clinical services and Directors of Nursing reviewed the findings and began formulation of a plan of correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO currently conducts a daily Leadership Meeting which includes reporting of levels of observation, unusual occurrences, results of unit rounds and any required	

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{A 043}	Continued From page 2 Failure to meet patient rights risks an unsafe healthcare environment for patients, visitors, and staff. Findings: 1. 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 3/9/2017 for failure to ensure patients receive care in an environment in which the safety and well-being of patients are assured. 2. Failure to conduct effective safety and security procedures for identification of hazards associated with danger to self and others. Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A0115	{A 043}	corrective actions. The CEO/Designee is responsible for reporting the results of corrective actions and use of monitoring systems to the full Governing Board. The Performance Improvement Committee will implement increased monitoring for any items that do not meet the thresholds that have been established by the Committee. The increased monitoring will continue until compliance is obtained and sustained for two reporting periods. See A115, A144, A164 and A286	
{A 115}	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of hospital policies and procedures, the hospital failed to protect and promote patient rights. Failure to protect and promote each patient's rights risk the patient's loss of personal freedom,	{A 115}	**A115 482.13 - Patient Rights** See A144 and A164	

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{A 115}	Continued From page 3 privacy, dignity, and psychological harm. Findings: 1. Failure to ensure patients receive care in a safe setting which safeguards vulnerable individuals from self-harm and harm from others. 2. Failure to utilize the least restrictive alternative when using seclusion and restraints. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for patient safety and protect patient rights. Due to the scope and severity of deficiencies under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross Reference: Tags A0144, A0164 .	{A 115}		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This Standard is not met as evidenced by: . ITEM #1 SECURITY PROCEDURES AND IDENTIFICATION OF HAZARDS Based on observations, review of manufacturer's instructions for use, and review of hospital policy and procedures, hospital staff members failed to follow manufacturer's instructions when using the hand held metal detector. Failure to ensure that staff are trained and skill competency verified to operate the hand-held	A 144	**A144 482.13(c)(2) - Patient Rights: Care in a Safe Setting** *Security Procedures and Identification of Hazards* **Corrective Action:** All staff responsible for wanding patients have been retrained on (1)the requirement to wand all individuals admitted to the hospital, (2)the requirement to wand based on manufacturer recommendations and "Wanding - Use of Hand-Held Metal Detector Wand" and (3)requirement to document completion of wanding on Nursing Communication Hand-Off form. Only staff members that have validated competency have been allowed to perform wanding procedures as of March 9, 2017.	All corrective actions will be completed by April 28, 2017

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A 144	Continued From page 4 metal detector correctly puts patients, staff, and visitors at risk for contraband and other dangerous hazards entering the facility posing a serious threat which may result in injury or death. Reference: Garrett Metal Detector Super Scanner User Manual. Findings: 1. The hospital's policy and procedure titled "Wanding - Use of Hand-Held Metal Detector Wand" (Reviewed/2017) stated in part, "All patients will be wanded prior to or immediately upon arriving on an inpatient unit". The section titled "Procedure" read in part: "Staff should not allow the scanee to influence them as to what is actually causing an alarm. For instance, if the detector denotes the presence of a suspicious item under a shirt sleeve, do not fail to completely investigate the source of the alarm even though the scannee assures you that [it] is just his/her watch." Page 4 of the hospital policy illustrates the proper technique and procedure to use when operating the wand; wanding from the front to the back and ending with the underfoot of the individual. The user manual for the Garrett Metal Detector Super Scanner under the section titled "Components/Function" (pp 5-6) read in part: "Interface Elimination Button- The detector is factory set for maximum sensitivity to detect the smallest of items. The high level of sensitivity may produce alarms when approaching a floor containing rebar. Press and hold this button to decrease sensitivity to a level that does not respond to the rebar. Release button and detector returns to normal sensitivity."	A 144	Continued from page 4 <u>Monitoring Plan:</u> The Directors of Nursing and Director of Intake or Designee will be responsible for random weekly audits of staff performing wanding. Any deficiencies in the wanding procedure will be identified and staff members retrained on the spot. The Directors of Nursing will perform 30 random chart audits of the Nursing Communication Hand-Off form. Any adverse findings will be reported in the Leadership meeting daily and to Governing Board weekly unit 100% compliance has been attained for one month. Upon attainment of 100% compliance, monitoring will be reported monthly to the PI Committee and quarterly to the Medical Executive Committee and Governing Board. <u>Persons Responsible:</u> CEO Directors of Nursing Director of Intake PI/Risk Manager	

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A 144	Continued From page 5 2. On 3/7/2017 between 8:00 PM and 8:28 PM, Surveyor #1 requested a certified nurse's aide (CNA) (Staff Member #2) to demonstrate the use of the hand-held metal detector. During the observation, the CNA turned the metal detector on and the metal detector appeared to be malfunctioning with the surveyor noting that all LED lights were flashing on and off. Staff Member #2 pushed a button on the side of the metal detector and the flashing LED lights shut off except for a single green light. The CNA then proceeded to scan the surveyor while continuously holding (depressing) the side button. Staff Member #2 acknowledged in a follow-up interview with Surveyor #1 that he/she was unaware of the side button's function or purpose. 3. On 3/8/2017 at 9:00 AM, Surveyor #1 interviewed the Director of Intake Personnel (Staff Member #4) about the use of hand-held metal detectors and training of personnel. S/he confirmed the metal detector used on 3/7/2017 by Staff Member #2 had malfunctioned and the battery had been replaced. The hospital did not have a system in place to check the battery status of the hospital's eight metal detectors. 4. On 3/10/2017 between 11:00 AM and 11:45 AM, Surveyor #1 observed an Intake Personnel staff member (Staff Member #3) demonstrate the use of the hand-held metal detector wand. During the observation, Staff Member #3 pushed the side button (interference elimination button) and proceeded to wand the front of the patient. The metal detector beeped and a red light flashed when the wand was located near the patient's feet. Staff Member #3 asked the patient (Patient #5) if they had anything in his/her socks. Patient #5 stated "no". Staff Member #3 continued the	A 144		

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A 144	Continued From page 6 wanding procedure to include both sides of the patient (left and right). Staff Member #3 did not wand the backside (posterior aspect) of the patient as required by hospital policy. The staff member failed to wand the underside of the patient's feet or investigate further the source of the beeping as required by hospital policy. 5. On 3/10/2017 at 2:30 PM, Surveyor #1 reviewed eight medical records and the "Intake to Nursing Communication Hand-Off" forms and noted the following: a. Four of eight records reviewed were not marked "Yes" or "No" to document and confirm the patient had been wanded. b. One of eight records reviewed was marked "No" reflecting that the patient had not been wanded. c. Three of the eight records reviewed were marked "Yes" indicating the patient had been wanded on admission. Upon further review, the surveyor found: 1. Patient #3 had a metal "X-Acto: blade" found after the patient had done harm to self by cutting themselves. The record indicated the patient acknowledged hiding the metal blade in his/her sock. 2. Patient #6 had a cellular phone found during the skin/clothing check by the nursing staff upon arrival on the unit. 3. Patient #7 had a cellular phone discovered on the day of discharge after a five day hospital stay.	A 144		

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A 144	Continued From page 7 ITEM #2 LINE OF SIGHT MONITORING Based on record review and review of hospital policy and procedures, the hospital failed to ensure that patients on "Line of Sight" (LOS) observation were kept safe from self-harm or injury from other patients. Failure to protect patients from self-harm and harm by other patients may lead to serious injury or death. Findings: 1. The hospital's policy and procedure titled, "Patient Observation"(Policy # PC.P.300; Reviewed 1/2017) stated in part, ". . .III. Levels of Observation. . . B. Line of Sight. The patient will be kept within eyesight and accessible at all times, day and night. Tools or instruments that could be used to harm themselves or others should be removed. This level of observation is required when the patient could, at any time, make an attempt to harm themselves or others. Positive engagement with the patient is an essential aspect of this level of observation." The hospital policy and procedure titled, "Patient Rights and Responsibilities" (Policy # ADM.P.300; Reviewed 1/2017) stated in part: ". . . Procedure . . . B. The list of patient rights shall include but are not limited to the following: . . . 5. The right to receive care in a safe setting." 2. Patient #3 was an 18 year-old admitted on 2/24/2017 for treatment of depression with suicidal ideation. The patient received a score of 40 on the Suicide Assessment scale which was completed on admission. A review of the overall risk level scoring tool indicated that medium risk	A 144	*Line of Sight Monitoring* **Corrective Action:** Policy PC.P.300was reviewed and revised to (1)clarify that LOS monitoring be assigned to a specific staff member, (2)clarify that the patient must be visible to the assigned staff member at all times, (3)the staff member must take action to prevent potential for patient to harm self or others, and (4)staff must document efforts to prevent harm in the patient record. Reeducation was initiated for all staff responsible for monitoring observation levels of patients' regarding the changes to the policy. RNs were reeducated on their ability to increase a patient's level of observation without a physician order and all staff performing observations were reeducation on the risk factors for each level of precaution. Monitoring Plan: The Directors of Nursing/Designee will conduct rounds each shift on each unit to ensure monitoring is performed as ordered. Failure to perform monitoring as expected will be immediately addressed. Results of observations will be reported daily in the Leadership meeting and weekly to the Governing Board until monitoring is maintained at 100% for one month. Upon attainment of 100% compliance, results will be reported monthly to the PI Committee and quarterly to Medical Executive Committee and Governing Board. Persons Responsible: CEO Directors of Nursing PI/Risk Manager	

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A 144	Continued From page 8 is classified as a score between 25 and 41. Other than the routine every 15 minute checks that are completed for all patients on the unit, no special observation status was assigned until after the physician had examined the patient on the following day (2/25/2017) after which the patient was placed on line of sight (LOS). 3. On 2/27/2017 at 10:00 PM, a Registered Nurse (RN) (Staff Member #7) entered a note into the patient's medical record stating that the RN had examined the patient and found multiple cuts on her/his left wrist and arm. The RN notified the patient's physician. A telephone order documented by the RN on 2/27/2017 at 9:30 PM stated that the patient was on LOS observation status and that the patient was responsible for remaining in LOS of assigned staff. The patient's physician had ordered LOS observation status earlier in the day at 2:25 PM as well. The RN phone call to the physician about her/his concerns related to the patient's self-harm did not result in an order for increased monitoring of the patient. 4. Review of a physician (Staff Member #9) note dated 3/2/2017 at 1:00 PM showed the physician assessed the patient to have an increased suicide risk. The physician ordered increased staff monitoring of the patient. The physician's order dated 3/2/2017 at 10:45 AM stated "LOS Q [every] 5-minute checks for 24 hours." 5. According to documentation, on 3/2/2017 around 10:00 PM, a licensed nurse (Staff Member #8) found that Patient #3 was bleeding in the area of her/his left hand/wrist area. The patient was noted to be sitting on the floor with a blanket covering her/his arm. Initially, Patient #3 stated she/he cut themselves using a pencil.	A 144		

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A 144	Continued From page 9 After further questioning, it was discovered that the patient had used a metal blade [X-Acto blade]. The patient reported that she/he kept the blade hidden in her/his sock. 6. Review of documentation dated 3/2/2017 at 11:00 PM, following the blade cutting incident, revealed that staff felt the patient should have been in 1:1 observation status because while the patient was in LOS of staff and on every 5 minute checks the incident still occurred. 7. An interview with a RN (Staff Member #7) on 3/8/2017 at 3:20 PM with Surveyor #2 showed that she/he felt that Patient #3 should have been on 1:1 observation status as the patient had a history of grabbing pencils and using them to harm herself/himself even though she/he was on LOS observation status. Staff Member #7 also reported that Patient #3 harmed themself with a metal blade while on LOS observation status with every 5 minute checks. 8. An interview with the Director of the Adult Psychiatric Unit (Staff Member #10) on 3/9/2017 at 10:40 AM confirmed the incident related to Patient #3. Staff Member #10 revealed that she/he was unsure how Patient #3 came to be in possession of such a dangerous object. Staff Member #10 stated that Patient #3 told staff that she/he brought the blade from home. 9. On 3/09/2017 at 10:00 AM, Surveyor #4 reviewed the inpatient record of Patient #4. S/he was admitted on 2/13/2017 due to concerns that the patient might harm themselves. Patient #4 was initially placed on 1:1 observation from 2/13/2017 to 2/18/2017, and then was placed on LOS observation for safety. The patient remained on LOS observation until 3/8/2017. An	A 144		

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A 144	Continued From page 10 entry in the medical record by a registered nurse (Staff Member #5) dated 3/7/2017 at 5:37 PM documented "Pt. A&O (alert and oriented) x3. Mood is anxious and restless. Pacing about unit. Approached nurse with blood streaming down R (right) forearm from self-inflicted injury." The self-harm injury sustained by Patient #4 occurred while the patient was ordered for LOS. No other documentation in the medical record was found to indicate the hospital staff attempted to stop the patient from harming themselves prior to the patient presenting themselves to the nursing staff. 10. On 3/9/2017 at 9:15 AM, Surveyor #3 reviewed the medical records of three patients who were involved in a total of eight patient on patient assault incidents of which five occurred while on LOS monitoring. The surveyor noted the following: a. On 2/25/2017 at 6:15 AM, Patient #8 while on LOS monitoring was noted in the record to be "exiting seeking, frequently trying to open doors . . .Pt [patient] is observed wandering into peers bedroom & taking their belongs. Staff stated that pt. was observed punching a much larger peer who assaulted him back. Staff was able to break up the argument & redirect pt's to different locations." b. On 2/11/2017 at 9:45 PM, Patient #2 while on LOS monitoring was noted in the record as "Patient threw a punch and knocked . . . patient to the ground . . .Police officers arrived in unit [to] investigate the case. . .Patient medicated PRN [as needed] meds. Remain in room for a while until the second patient transferred for safety". 11. On 3/7/2017 at 9:15 AM, Surveyor #3 interviewed a registered nurse (Staff Member #6)	A 144		

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A 144	Continued From page 11 about the different levels of observation and the difference between them. The nurse indicated that LOS is similar to the 15 minute checks with the entire staff and no one person responsible for the monitoring. Staff Member #6 acknowledged that only when a patient is ordered for 1:1 monitoring is a specific individual assigned to monitor the patient. 12. An interview with the Director of Quality and Risk (Staff Member #11) with Surveyor #2 revealed that the facility was not collecting data on the use and effectiveness of levels of observation (i.e. LOS, 1:1) of patients. He/she also stated that there were no current improvement projects concerning LOS and 1:1 patient monitoring.	A 144		
{A 164}	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This Standard is not met as evidenced by: Based on record review and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying simultaneously both restraints and seclusion for 3 of 6 patients reviewed. (Patients #1, #2, #3). Failure to utilize or consider less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity.	{A 164}	**A164 482.13(e)(2) – Patient Rights: Restraint or Seclusion** *Utilize least restrictive alternative when using restraint or seclusion* **Corrective Action:** Policy PC.R.100 "Seclusion and Physical & Mechanical Restraint" was reviewed on March 10, 2017 and providers and staff were reeducated regarding the requirement to utilize and document the utilization of the least restrictive alternative when using restraints or seclusion.	All corrective actions will be completed no later than April 28, 2017

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	504011		R 03/10/2017

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

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{A 164}	Continued From page 12 Findings: 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Reviewed 1/2017; Policy # PC.R.100) under the section "Policy" read in part: "Seclusion and restraints may only be used 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 . . . " The section titled "Patient Rights" read in part: "Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient or others from harm. The type of technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm." 2. On 3/8/2017 at 9:15 AM, Surveyors #3 and #4 reviewed the records of five patients who were placed in either seclusion or restraints during their hospital stay and noted the following: a. Patient #1 was placed in 4-point restraints and seclusion simultaneously by hospital staff on 2/9/2017 at 7:45 PM. Subsequently, Patient #1 was released from restraints at 9:15 PM and from seclusion at 10:45 PM. No documentation indicating that a less restrictive alternative had been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found. b. Patient #2 was placed in 4-point restraints and seclusion simultaneously by hospital staff on	{A 164}	**Monitoring Plan:** The Directors of Nursing/Designee will perform audits on each incident of restraint or seclusion. Failure to adhere to PC.R.100 will be immediately addressed with staff involved in the incident. Results of the audits will be reported daily in Leadership meeting, and weekly to the Governing Board until monitoring is maintained at 100% for one month. Upon attainment of 100% monitoring, results of audits will continue to be reported in Leadership but will be reported monthly to the PI Committee and quarterly to Medical Executive Committee and Governing Board. **Persons Responsible:** CEO Directors of Nursing Director of Intake PI/Risk Manager	

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{A 164}	Continued From page 13 2/25/2017 at 6:00 PM. Subsequently, Patient #2 was released from restraints at 9:00 PM and from seclusion at 9:45 PM. No documentation indicating that a less restrictive alternative had been considered or attempted first prior to the simultaneous application of both physical restraints and seclusion could be found. 3. During the survey, Surveyor #2 toured the Adult Psychiatric Unit 2 West and reviewed the medical record of Patient #3. The surveyor noted the patient was ordered for both seclusion and 4-point restraints simultaneously on 3/2/2017, 3/3/2017, and 3/6/2017 respectively. No documentation could be located in the medical record to indicate a less restrictive technique (either seclusion or restraint used alone) was attempted prior to the simultaneous application of both physical restraints and seclusion.	{A 164}		
{A 286}	482.21(a), (c)(2), (e)(3) PATIENT SAFETY (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and	{A 286}	**A286 482.21(a), (c)(2), E3 – Patient Safety** *Program Scope, Activities and Executive Responsibilities* **Corrective Action:** PI/RM was reeducated on the facility Performance Plan on March 29, 2017 which includes the objectives to: (1)achieve an effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes (2)providing an effective, planned, systematic mechanism to design, measure, assess and improve the performance of the facility (3)to facilitate a proactive approach toward continuous quality improvement and evaluate actions taken to assure that desired results are achieved and sustained (4)to promote communication and reporting of performance improvement activities by and between departments, administration, medical staff, Governing Board and others as deemed necessary.	All corrective actions will be completed no later than April 28, 2017

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{A 286}	Continued From page 14 responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This Standard is not met as evidenced by: Based on interview, record review and review of policy and procedure, the hospital failed to track and document the staff response to a patient's cardiac arrest event as required by hospital policy and procedure. Failure to document a patient's cardiac arrest event decreases the quality of the information the hospital can provide for ongoing treatment of the patient and leaves the hospital unable to evaluate the effectiveness of emergency response for quality improvement purposes. Findings: 1. The hospital's policy and procedure titled "Code Blue" (Policy #PC.C.100; Reviewed 1/2017) stated that a patient cardiac arrest should be documented on the Code Blue Record and placed in the patient's medical record. 2. Patient #9 was a 49 year-old admitted on 12/19/2016 for treatment of alcohol use disorder. Patient #9 required treatment for alcohol withdrawal and was admitted to the detoxification unit. On 12/21/2016 at 12:54 PM the patient was found unresponsive and cyanotic (bluish discoloration of the skin). At the same time, Staff called a Code Blue (a code used in hospitals for	{A 286}	**Monitoring Plan:** Unusual occurrences will be reported daily in Leadership, weekly to Governing Board and investigated by the PI/RM. Incidents will be tracked, trended and reported by PI/RM along with plans for improvement monthly to PI Committee and quarterly to Medical Executive Committee and Governing Board. **Persons Responsible:** CEO PI/Risk Manager	

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{A 286}	Continued From page 15 medical emergencies) and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 1:10 PM and continued administering CPR until the patient was pronounced dead at 1:40 PM. Review of Patient #9's medical record revealed that there was no detailed record (Code blue Record) of the staff response to the patient's cardiac arrest. 3. An interview with the Chief Operating Officer (Staff Member #12) on 3/8/2017 at 10:10 AM confirmed these findings.	{A 286}	**A286 482.21(a), (c)(2), E3 – Patient Safety** *Code Blue* **Corrective Action:** PC.C.100 "Code Blue" was reviewed and all nursing staff retrained regarding documentation requirements and forms to be utilized. Going forward the hospital will conduct annual mock Code Blue drills. **Monitoring Plan:** All Code Blue incidents will be reviewed by PI/RM and a staff debrief conducted post incident to ensure documentation requirements have been met. Adverse findings will be reported in Leadership daily and results of investigations, action plans and chart audits will be reported monthly to PI Committee and quarterly to Medical Executive Committee and Governing Board. **Persons Responsible:** CEO PI/Risk Manager	All corrective actions will be completed no later than April 28, 2017