STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	504011		R 07/21/2017

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 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482, conducted this health and safety survey. Onsite dates: 07/19/17 to 07/21/17 The survey was conducted by: Paul Kondrat, RN, MN, MHA Elizabeth Gordon, RN, MN Kimberly Metz, RN, MSN DOH staff found the facility NOT IN COMPLIANCE with the following Conditions of Participation: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient's Rights	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 interviews and document reviews, the Governing Body failed to maintain effective systems that ensure that patients received care that met their needs in a safe environment.	A 043		

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 043	Continued From page 1 Failure to ensure patients are provided with care that meets their needs in a safe environment risks poor patient healthcare outcomes. Findings included: 1. The Governing Body failed to ensure physician oversight of mid-level providers practice as stated in the delegation agreement after previously having been cited. 2. The Governing Body failed to maintain a safe and secure environment that risked serious injury for patients and staff. Due to the severity of deficiencies cited under 42 CFR 482.12 and 42 CFR 482.13, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A045, A0144	A 043		
A 045	482.12(a)(1) MEDICAL STAFF [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, record review, and review of policy and procedure, the hospital failed to ensure the supervising physician for a mid-level provider followed the physician assistants' delegation agreement in regards to performance review and evaluation. Failure of the supervising physician to provide oversight of the physician assistant's practice as stated in the delegation agreement risks patients receiving inadequate or substandard care.	A 045		

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A 045	Continued From page 2 Findings included: 1. Record review of the document titled, "Physician Assistant Delegation Agreement and Standardized Procedures Reference & Guidelines," signed by the supervising physician (Staff A) and the Physician Assistant (Staff B) on 11/20/13, showed that the supervision plan included weekly face to face meetings, chart reviews twice a week and quarterly performance evaluations. The section of the agreement titled, "Alternate Supervising Physician Data," was blank. 2. Lack of supervision of the physician assistant was previously cited on 05/05/17. Record review of the hospital's plan of correction for the citation showed that evaluation results would be reported monthly to the performance improvement committee, and quarterly to the Medical Executive Committee, and governing body. Record review of meeting minutes for the performance improvement committee, Medical Executive Committee and Governing Body showed there was no documentation indicating that the evaluation results for the physician assistant by the supervising physician were discussed. 3. During an interview with Surveyor #1 on 07/19/17 at 2:58 PM, Staff C, the Manager of Risk and Quality stated that he was unable to find reports sent to the committees regarding physician assistant evaluations. Staff C suggested Surveyor #1 interview the Chief Medical Officer (Staff D) about the evaluations. 4. During an interview with Surveyor #1 on 07/19/17 at 3:10 PM, Staff D, the Chief Medical	A 045		

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A 045	Continued From page 3 Officer stated that he discussed the issue related to physician assistant oversight requirements with medical staff during the June 2017 medical executive committee meeting. He was unable to find the information in the meeting minutes. During the interview, the Chief Medical Officer presented an evaluation for Staff B to the surveyor. The evaluation was completed by the Chief Medical Officer on the day of the interview, 07/19/17, but had not yet been reviewed with the physician assistant. The Chief Medical Officer was not listed in the physician assistant's delegation agreement as an alternate supervising physician. 5. Record review of the physician assistants credentialing file by Surveyor #1 showed no evidence supporting the supervising physician was performing his oversight responsibilities as stated in the "Physician Assistant Delegation Agreement". THIS CITATION WAS PREVIOUSLY CITED ON 05/05/17	A 045		
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 interviews, document reviews, and review of policies and procedures, the hospital failed to protect and promote patient rights. Failure to protect and promote each patient's rights risk the patients' loss of personal freedom, dignity, psychological harm and physical harm. Findings included:	A 115		

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A 115	Continued From page 4 1. The hospital failed to ensure patients receive care in a safe setting which safeguards vulnerable individuals from harm from others. 2. The hospital failed to ensure restraint or seclusion orders were not written on an as needed basis (PRN). Due to the severity of deficiencies cited under 42 CFR 482.13, the Condition of Participation for Patient Rights was NOT MET. Cross-Reference: Tags A0144, A0169	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: . Based on interview, record review and review of policy and procedure, the hospital failed to provide a safe and secure environment for patients and/or staff in 1 of 5 patient records reviewed for patient to patient assault. Failure to maintain a safe and secure environment risked serious injury or death for patients and staff. Findings included: 1. Review of the hospital's policy and procedure titled "Patient Observations," revised 6/2017, showed that: a. Every 5-Minute Checks, a level of observation, was required when the patient could make an	A 144		

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A 144	Continued From page 5 attempt to harm themselves or others. b. 1:1 Observation Level was considered the highest level of observation and was reserved for patients who were so unpredictable that without a dedicated staff member there was a risk of a patient harming self or others ... Staff assigned as 1:1 monitors of patients were required to remain within arm's reach of the patient at all times. 2. Review of the medical record of Patient #1 showed the following: a. Patient #1 was admitted on 06/22/17 for treatment of psychosis and disorganized behavior related to his diagnosis of bipolar/schizoaffective disorder. Review of the document titled "Intake to Nursing Communication Hand-off," dated 06/22/17, showed that the patient was psychotic, confused, had the potential for aggression and had behavior problems. The document also showed that the patient had a previous history of property destruction at Cascade Behavioral Hospital. b. Review of the document titled "Nurse to Nurse," dated 06/22/2017, showed that the patient was in 2-point restraints when he arrived at the hospital. c. Review of the "Psychiatric Evaluation" completed by Staff F upon admission, dictated on 06/23/17, showed that Patient #1 had a history of multiple assaultive behaviors. d. Upon admission, Patient #1's observation level was "Every 15 minute checks" as were all patients admitted to the hospital unless the physician orders a higher level of observation.	A 144		

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A 144	Continued From page 6 e. Review of a nursing note dated 06/23/17 at 3:00 PM, showed that Patient #1 was responding to internal stimuli, had poor boundary control and was intrusive. The note also annotated that Patient #1 would get very close to staff, was observed going in and out of rooms, was very hard to redirect and needed close observation. The patient's observation status was unchanged and continued at "Every 15-minute checks." f. Review of a hospital document showed that on 06/23/17 at 3:45 PM, Patient #1 had a sexual encounter with another patient (Patient #2). At 4:00 PM the same day, a physician (Staff D) wrote an order to implement "Every 5-minute checks" and Sexually Acting Out Precautions (SAO). g. On 06/24/17 at 9:42 PM, Patient #1 was in a physical altercation with another patient (Patient #3). A nursing assistant observed the patient hit Patient #3 in the head twice. Patient #3 was not injured in the altercation. Staff placed Patient #1 in a physical hold and escorted him to a seclusion room. The on-call psychiatrist was notified and medications were ordered. The phone call to the patient's psychiatrist did not result in an order for an increase in the patient's observation level. h. On 06/25/17 (note not timed), a nursing note entered into Patient #1's medical record stated that the patient continued to have poor boundaries, required constant redirection due to verbal aggression and physical contact with peers. The patient's observation level remained at "Every 5-minute checks." i. On 06/27/17 at 8:30 AM, Patient #1's psychiatrist ordered "Every 5-minute checks" with a designated staff assigned to him.	A 144		

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A 144	Continued From page 7 j. On 06/27/17 at 11:30 AM, a nursing note entered into Patient #1's medical record stated that the patient started threatening to leave the hospital. Staff attempted to redirect the patient but the patient continued to escalate. Staff tried to administer medications but the patient refused. Patient #1 threatened to attack patients or staff if he was not released from the hospital. Staff called the patient's psychiatrist to request a medication order. While the staff were busy preparing medication for Patient #1, the patient attacked another patient (Patient #3) by hitting him in the face multiple times. The hospital transferred Patient #3 to a local hospital emergency department for care. Patient #3 suffered a facial abrasion, lip laceration, and a nasal bone fracture as a result of the assault according to discharge documentation from the emergency department. Staff escorted Patient #1 to a quiet room and administered medication as ordered by the patient's psychiatrist (Staff D). The phone call to the patient's physician did not result in an order for increased monitoring of Patient #1 despite the severity of the injury to Patient #3. k. Review of a physician's note dated 06/28/17 at 12:00 PM, showed that the patient was refusing medication but that staff had coaxed the patient into taking his medications. In the same note, the physician noted that staff were afraid of the patient. l. A nursing note dated 06/28/17 at 2:00 PM, showed that Patient #1 continued to threaten to attack patients. Staff administered multiple doses of medication to the patient due to his behavior. The nurse documented that the patient had the potential to act out again. Review of the nursing note showed that the patient was on 1:1	A 144		

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A 144	Continued From page 8 monitoring, however the physician's orders and monitoring documentation showed that the patient remained on every 5-minute checks. m. On 06/28/17 at 4:32 PM, a nursing note entered into Patient #1's medical record stated that the patient threatened to break things if not discharged. The patient threw a tray and spit on staff. A code gray (overhead page used to bring more staff to help with a combative patient) was called due to the patient's aggressive behavior toward staff. The provider was notified and emergency medications were administered. Again, notification of the patient's physician did not result in an order for an increase in the patient's observation level or any other intervention to protect the patients and staff. n. According to documentation, on 07/01/17 at 4:30 PM Patient #1 hit another patient in the face as the two were walking in the hallway. Patient #1 was given medication and placed in a quiet room. o. A nursing note dated 07/02/17 for the time period of 07:00 AM to 10:00 AM stated that Patient #1 was standing by the exit door but was redirectable. The patient refused to participate in activities and stated he wanted to go back to jail. p. According to documentation dated 07/02/17 at 2:50 PM, Patient #1 hit another patient (Patient #4) multiple times. The note stated that Patient #4 lost consciousness for about 30-45 seconds, was confused for 2 minutes and a significant amount of blood was observed. The hospital transferred Patient #4 to a local hospital emergency department for evaluation and treatment. The police were notified and took custody of Patient #1.	A 144		

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A 144	Continued From page 9 3. During an interview with Surveyor #1 on 07/19/17 at 5:15 PM, the Director of Nursing Services (Staff E) and the Chief Medical Officer (Staff D) were asked about Patient #1 and his ordered observation status (Every 5-minute Checks). Both Staff E and D acknowledged that Patient #1 was dangerous. The Director of Nursing Services stated that in providing care for a patient like this they have to consider staff safety as well as patient safety. 4. An interview with the Chief Medical Officer (Staff D) and the Chief Nursing Officer (Staff E) on 07/21/17 at 1:30 PM showed that the Chief Medical Officer approved admission of Patient #1 to the hospital not understanding that the patient was on the hospital "do not admit" list. The patient was placed on the "do not admit list" because his violent behavior resulted in significant property damage during a prior admission. The Chief Medical Officer stated that in hindsight he should have increased the observation level for this patient from "Every 5-minute Checks" to "1:1 Observation" then to "2:1 Observation" or implemented other interventions in order to protect patients and staff.	A 144		
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This Standard is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure that hospital staff members wrote orders for restraints which were specific to the	A 169		

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A 169	Continued From page 10 type of restraint required and not on an "as needed" basis. Failure to have physician orders for restraints specific as to type places patients at risk for not having appropriate re-evaluations based on their changing conditions. Findings: 1. The hospital's policy and procedure, "Seclusion and Physical & Mechanical Restraint," Policy # PC.R.100, last reviewed on 01/17 showed that orders for restraints shall never be written as a standing order or on as needed basis (PRN). 2. On 07/21/17, Surveyor #3 reviewed the medical record of Patient #5 who was admitted on 06/27/17 for Acute Psychosis. On 07/11/17 at 11:30 AM, Patient #5 became verbally and physically aggressive and attempted to pour a cup of hot coffee on a peer. 3. The medical record review showed the following: -On 07/11/17 at 11:30 AM, documentation on the "Restraint/Seclusion Progress Note" shows the staff called a "Code Gray" (a standardized Hospital Emergency Code that alerts all staff to potentially or actively combative persons) and the patient was placed in a physical hold and Mechanical 4-point Restraints were applied. -On 07/11/17 at 11:30 AM, documentation on the "RN Assessment-Seclusion & Restraint Form" reflects the patient was placed in Physical Restraint, Mechanical Restraint and "transferred to a seclusion room".	A 169		

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A 169	Continued From page 11 -On 7/11/17 at 11:30 AM, a telephone order for Physical Hold, Seclusion and Mechanical 4-point Restraints was written. A physician assistant co-signed the order on 07/11/17 at 11:30 AM. -On 7/11/17 at 12:05 PM, the original order was amended and the seclusion order check box was circled and "omit PJB 7/11@ 1205" was written on the physician order form. -On 07/11/17 at 12:40 PM, documentation states, "Continue with seclusion with L (left) arm/hand and R (right) leg restraint in place." - On 07/11/17 at 1:40 PM, documentation states, "Patient lying supine with L (left) arm and R (right) leg restraint in place. Discussed criteria for L (left) arm and R (right) leg restraint and seclusion release." -On 07/11/17 at 2:45 PM, documentation on the "RN Assessment-Seclusion & Restraint Form" under the section titled "Release from Restraint/Seclusion," shows the patient was released from restraint/seclusion at that time. 4. On 07/21/17 at 1:36 PM, Surveyor #3 interviewed the Charge Nurse (Staff G) related to the physician order that reflected simultaneous orders for Physical Hold, and Seclusion, and 4-point Restraints. Staff G told the surveyor when the staff call the doctor they get what they need-in case including physical, mechanical, seclusion or chemical restraint.	A 169		