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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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A 000	INITIAL COMMENTS	A 000		

MEDICARE HOSPITAL COMPLAINT SURVEY

This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN.

The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report).

Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136.

During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area:

Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served.

The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/20/2017

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A 000	Continued From page 1 Removal of the state of IMMEDIATE JEOPARDY was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment	A 000		
A 043	Shell # 27QV11 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 observation, interviews, and document reviews, the hospital failed to meet the requirements at 42 CFR 482.12 Condition of	A 043		2/10/17

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A 043	Continued From page 2 Participation for Governing Body. . Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. . 3. Failure to protect and promote each patient ' s rights. . 4. Failure to maintain the condition of the physical plant and the overall hospital environment of care. . Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. .	A 043		

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A 043	Continued From page 3 Cross-Reference: Tags A0115, A0263, A0490, A0700 .	A 043		
A 084	CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed	A 084		2/10/17

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A 084	Continued From page 4 -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: . Based on observation, interview, document 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, privacy, dignity, and psychological harm. . Findings: . 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. . 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. . 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. . 4. Failure to investigate patient complaints prior to closure of the complaint. . The cumulative effect of these systemic problems	A 115		10/22/17

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A 115	Continued From page 5 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 A0123, A0129, A0164, A0174 .	A 115		
A 123	PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION CFR(s): 482.13(a)(2)(iii) At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). . Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. . Findings: .	A 123		2/10/17

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A 123	Continued From page 6 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." . 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with the patient who filed the grievance. . 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. . 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation. .	A 123		
A 129	PATIENT RIGHTS: EXERCISE OF RIGHTS CFR(s): 482.13(b) Patient Rights: Exercise of Rights This STANDARD is not met as evidenced by: .	A 129		2/10/17

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A 129	Continued From page 7	A 129		

Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights.

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Failure to allow patients the right to refuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect.

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Findings:

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1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital and to assure that these rights are known by hospital staff, physicians and other health care providers."

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"B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect."

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2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively

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A 129	Continued From page 8 discharged from the hospital." . 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and coughing is no longer part of the process. . 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. . 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy	A 129		

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A 129	Continued From page 9 about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff. . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required. .	A 129		
A 164	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(2) 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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to	A 164		2/10/17

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A 164	Continued From page 10 using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 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 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. . 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines	A 164		

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A 164	Continued From page 11 how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. . 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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. .	A 164		
A 174	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). . Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom.	A 174		2/10/17

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A 174	Continued From page 12 . Findings: . 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." . 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. . 3. On 12/13/2016 at 11:30 AM in the adult psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and	A 174		

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A 174	Continued From page 13	A 174		

verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support."

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4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following:

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a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods:

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--From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes.

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--From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours.

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--From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours.

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--From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.

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b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early.

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5. The director of adult psychiatric services (Staff

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A 174	Continued From page 14 Member #6) confirmed the findings at the time of review. .	A 174		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: . Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans.	A 263		2/10/17

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A 263	Continued From page 15 Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected. The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and	A 263		

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A 263	Continued From page 16 Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	DATA COLLECTION & ANALYSIS CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3) (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and .... (3) The frequency and detail of data collection must be specified by the hospital's governing body. This STANDARD is not met as evidenced by: . Based on interview and review of the hospital's	A 273		2/10/17

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quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016.

Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement.

Findings:

1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis.

2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following:

a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this

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information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed.

b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review.

c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint and seclusion.

d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls, medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly

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to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data.

e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.

f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.

Cross-reference: Tag A-0084

g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting

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A 273	Continued From page 20 this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (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 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: .	A 286		2/10/17

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A 286	Continued From page 21 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286		

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a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement.

b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement.

c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement.

d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement.

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ITEM #2 - Reportable Adverse Events

Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events.

Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment.

Reference: WAC 246-302-010 Definitions
"Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events

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A 286	Continued From page 23 updated and adopted by the National Quality Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology	A 286		

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A 286	Continued From page 24 and Incident Recap Analysis." The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. . ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm.	A 286		

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A 286	Continued From page 25 Findings: 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done. .	A 286		
A 309	QAPI EXECUTIVE RESPONSIBILITIES CFR(s): 482.21(e)(1), (e)(2), (e)(5) The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the	A 309		2/10/17

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A 309	Continued From page 26 reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This STANDARD is not met as evidenced by: . Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and	A 309		

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non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.

The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws."

The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis.

2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff. The

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A 309	Continued From page 28 Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286 .	A 309		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: . Based on record review, interview, and review of policy and procedure, the hospital failed to ensure	A 405		2/10/17

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that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7).

Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm.

Findings:

1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score.

2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following:

a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms.

Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the

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A 405	Continued From page 30 patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff Member #4 did not know why nursing staff administered the higher doses. .	A 405		
A 490	PHARMACEUTICAL SERVICES CFR(s): 482.25 The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings:	A 490		2/10/17

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A 490	Continued From page 31 . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verified by a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units, and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	PHARMACY ADMINISTRATION CFR(s): 482.25(a) The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This STANDARD is not met as evidenced by: . Based on observation, interview, and review of	A 491		2/10/17

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policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications.

Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors.

Findings:

1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows:

"...for those medications that will be used by the patient during their admission at the facility, the medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..."

"The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form."

2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following:

a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date

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(12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification.

b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.

c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications

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A 491	Continued From page 34 but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	PHARMACY PERSONNEL CFR(s): 482.25(a)(2) The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services. This STANDARD is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened	A 493		2/10/17

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A 493	Continued From page 35 (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.58 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly average of 685 items. . 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. .	A 493		

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A 493	Continued From page 36 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. . 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units. .	A 493		
A 500	DELIVERY OF DRUGS CFR(s): 482.25(b) In order to provide patient safety, drugs and biologicals must be controlled and distributed in	A 500		2/10/17

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A 500	Continued From page 37 accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: . Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. . Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. . Findings: . 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of	A 500		

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key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year.

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3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override.

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4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines.

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A 500	Continued From page 39 He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. . 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation. .	A 500		
A 700	PHYSICAL ENVIRONMENT CFR(s): 482.41 The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: . Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a	A 700		2/10/17

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A 700	Continued From page 40 manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726 .	A 700		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care.	A 701		2/10/17

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Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors.

Findings:

1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns.

2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk

3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West.

4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was

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actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident.

5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded.

6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room.

7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard.

8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit.

9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.

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A 701	Continued From page 43	A 701		
A 710	LIFE SAFETY FROM FIRE CFR(s): 482.41(b)(1)(2)(3) (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the waiver does not adversely affect the health and safety of the patients.	A 710		2/10/17

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A 710	Continued From page 44 (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This STANDARD is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710		
A 724	FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE CFR(s): 482.41(c)(2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724		2/10/17

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A 724	Continued From page 45 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tipped applicators with an expiration date of 2/2016. d. One box of sterile cotton-tipped applicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of 10/2016. f. One 14 french Foley urethral catheter with an expiration date of 7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016.	A 724		

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A 724	Continued From page 46	A 724		

3. On 12/13/2016 at 1:35 PM Surveyor #4 inspected the gero-psychiatric unit (4 West) emergency cart and found the following:

a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016.

b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016.

c. Five Tegaderrm intravenous site dressings with expiration dates of 11/2015 and 4/2016.

4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016.

a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit.

5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following:

a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016.

b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016.

6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of

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A 724	Continued From page 47 the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope."	A 724		

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A 724	Continued From page 48 Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated	A 724		

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A 724	Continued From page 49 a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	VENTILATION, LIGHT, TEMPERATURE CONTROLS CFR(s): 482.41(c)(4) There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This STANDARD is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not	A 726		2/10/17

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A 726	Continued From page 50 document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580 .	A 726		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and	A 749		2/10/17

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A 749	Continued From page 51 personnel. This STANDARD is not met as evidenced by: . Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following	A 749		

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A 749	Continued From page 52	A 749		

administration, despite numerous contacts with the patient's skin.

Item #2 Dietary Sanitation

Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.

Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness.

Findings:

1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer.

Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14)

2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen.

Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii)

Item #3 Housekeeping Cleaning

Based on observation, review of hospital's policy

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A 749	Continued From page 53	A 749		

and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms.

Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors.

Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10 minutes. Wipe surfaces and let air dry."

Findings:

1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times."

2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use.

3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush.

4. On 12/13/2016 at 9:45 AM Surveyor #1

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A 749	Continued From page 54 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

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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	{A 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/20/2017

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{A 000}	Continued From page 1 of serious harm, injury, and death due to the serious of the findings. This resulted in the 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}	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:	{A 043}		

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{A 043}	Continued From page 2 . 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. 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}		
A 144	. PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by:	A 144		2/10/17

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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 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.

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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."

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

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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 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:

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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.

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.

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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 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

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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. 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.

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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 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

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A 144	Continued From page 10 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) 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}	PATIENT RIGHTS: RESTRAINT OR	{A 164}		

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{A 164}	Continued From page 11 SECLUSION CFR(s): 482.13(e)(2) 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. 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	{A 164}		

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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 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

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{A 164}	Continued From page 13 (either seclusion or restraint used alone) was attempted prior to the simultaneous application of both physical restraints and seclusion.	{A 164}		
{A 286}	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (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 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	{A 286}		

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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 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

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{A 286}	Continued From page 15 confirmed these findings.	{A 286}		

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{A 000}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT 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. During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539. 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: 42:CFR 482.12 Governing Body 42 CFR 482.12 Patient Rights 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: Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation. 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.	{A 000}		

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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 The hospital remains NOT IN COMPLIANCE with Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13	{A 000}		
A 023	LICENSURE OF PERSONNEL CFR(s): 482.11(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This STANDARD is not met as evidenced by: . 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. Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff. Findings: 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." 2. On 5/4/2017 at 1:00 PM Surveyor #1	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	Continued From page 4	A 045		

agreement and to provide polices that are consistent with physician assistant practice, places patients' safety and health at risk.

Findings

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."

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.

3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a

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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	EMERGENCY SERVICES 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	A 093		

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 occured 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.

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A 093	Continued From page 7	A 093		

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

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A 093	Continued From page 8	A 093		

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.

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.

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.

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

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A 093	Continued From page 9	A 093		

indicated that mock code drills for the facility were scheduled to begin in two weeks.

REVIEW OF CODE #2

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.

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.

b. An interview with the Director of Clinical

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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	NURSING CARE PLAN 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		

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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	POC RECEIVED 8/10/2017 POC EVALUATED 8/11/2017	
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		

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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	**A043 CFR 482.12 and 482.13** Immediately following the exit summation the CEO, Governing Board Members, CNO, 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 the responsibility of ensuring completion of all corrective action action to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO/ Designee is responsible for reporting the results of corrective actions and use the 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. This increased monitoring will continue until compliance is obtained and sustained for two reporting periods.	**All corrective actions will be completed by 09-11-2017**
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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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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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	**A 045 482.12 (a)(1) Medical Staff** **Corrective Action:** All physician assistant privileges will be updated to reflect the appropriate requirements for supervision and chart review. **Monitoring Plan:** Evaluation Results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. **Persons Responsible:** Chief Medical Officer	**All corrective actions will be completed by 09-11-2017**

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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	**A 115 482.13 Patient Rights** **Corrective Action:** All clinical staff will be educated regarding the finding of "PRN orders for restraints and seclusion". All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. Cascade no longer uses PRN orders for restrictive interventions. **Monitoring Plan:** Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and Governing Board. **Persons Responsible:** Chief Medical Officer, Chief Nursing Officer, and PI/RM Director	**All corrective actions will be completed by 09-11-2017**

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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 144	**A 144 482.13(c)(2) Patient Rights: Care in Safe Setting** **Corrective Action:** **1.** A multi-disciplinary admissions task force was created on 08-02-2017 to review all admission criteria for CBH. Part of the focus of this task force will be to further refine exclusionary criteria in the CBH policy ""Admission Criteria", and create, a "High Risk" addendum for further help identifying patients that may pose a threat to patient safety. **2.** Training will be developed and implemented regarding appropriate de-escalation processes and the appropriate interventions utilized at CBH. **3.** Safety Huddles (*i.e. brief meeting with key team leaders on each unit at the beginning of each shift and documented)* will be audited to review the appropriate capture of high risk patients and reviewed at leadership meetings daily. **4.** The use of the 1:1 intervention will be compared organizationally, and presented at PI Committee. **5.** The CNO or designee will attend all emergency responses (i.e. Code Gray) and review interventions, during and after the event. **Monitoring Plan:** Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and Governing Board. **Persons Responsible:** Chief Medical Officer, Chief Nursing Officer, and PI/RM Director	**All corrective actions will be completed by 09-11-2017**
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			

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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	**A 169 482.13(e)(6) Patient Rights: Restraint or Seclusion** **Corrective Action:** All clinical staff will be educated regarding the appropriate use of restraint and seclusion (i.e.. orders for restraint and seclusion are not prn, least restrictive means must be used for seclusion and restraint, etc.) All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. **Monitoring Plan:** Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and Governing Board. **Persons Responsible:** Chief Medical Officer, Chief Nursing Officer, and PI/RM Director	**All corrective actions will be completed by 09-11-2017**

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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

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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 Monitoring Plan: 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. Persons Responsible: 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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{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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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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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

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A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) Inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

Michael J Madia, CEO 2/18/17

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 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment Shell # 27QV11	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. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring Systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. 3. Failure to protect and promote each patient ' s rights. 4. Failure to maintain the condition of thephysical plant and the overall hospital environment of care. Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A0115, A0263, A0490, A0700	A 043	Amendment 2/1/2017: The CEO will issue weekly reports to the Governing Board related to the hospital's ongoing efforts toward compliance for all citations. Conference calls will be held as needed for dialogue. The target compliance is 90% for all standards cited. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: Based on observation, interview, document 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, privacy, dignity, and psychological harm. Findings: 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. 4. Failure to investigate patient complaints prior to closure of the complaint. 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 A0123, A0129, A0164, A0174	A 115	**See A 0123, A 0129, A 0164, A 0174**	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. Findings: 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Amendment 2/1/2017: The hospital's grievance policy, log for grievances, and letters that are to be mailed to patients have all been revised and will be presented at the weekly PI Committee on Thursday, February 9, 2017 for approval. From there, they will go the Medical Executive Committee on February 9, 2017 and Governing Board at its next meeting thereafter. Weekly data toward compliance in the new processes is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present an analysis of the grievance log and grievance responses to the monthly PI and quarterly MEC (next meeting is Feb 9, 2017) and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation.	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. Failure to allow patients the right to refuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. Findings: 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129	Amendment 2/1/2017: The hospital's skin check/contraband policy has been revised to remove the administrative discharge for patients who refuse the skin check process. Staff education has been conducted related to this change. Daily audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 129	Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.	A 129		

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A 164	Continued From page 9	A 164	**A 0164 Corrective Actions**	
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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 or seclusion used must be the least restrictive	A 164	The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." . 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. . 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. . 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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. .	A 164	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. Findings: 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.	A 174	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	**See A0273, A0286, A0309, A0490, A0700**	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service andoperations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and.... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint and seclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273	Amendment 2/1/2017: The 2016 data for grievances, anticoagulants, restraints & seclusions, elopements, medication consultations, Pharmacy & Therapeutics indicators, and contracted services have been abstracted and analyzed and will go the PI Committee on or before Thursday, February 9, 2017 and then to the Medical Executive Committee on Thursday, February 9, 2017 and Governing Board thereafter. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273	A 286 Corrective Actions	
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 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:	A 286	1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286	Amendment 2/1/2017: Going forward, the PI Committee will receive action plans for each Root Cause Analysis conducted along with a time frame for the completion of those action items. The PI Committee will add those items to minutes and receive follow-up at each of its meetings until all items are resolved. Action items will typically be resolved within 90 days, some sooner, depending on the urgency associated with that action item. The target compliance is 90% of all items completed with 90 days. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues	

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals abillty to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405	Amendment 2/1/2017: CIWA protocols are currently being audited daily by the Nursing Director of CD Services. Analysis of the audits will go to the PI Committee at each weekly PI Committee starting Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Once several weeks of compliance is achieved, monitoring will become monthly with the same targets.	

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses.	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. Findings: 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. 2. Patient home medications not being verified by a pharmacist prior to being administered. 3. Medication errors resulting from medication overrides of the automatic dispensing machines. 4. Expansion of hospital services, clinical units,	A 490	**See Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500 .	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: . Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought in with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initialing of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings. Amendment 2/1/2017: The pharmacy director is auditing 100% of home medications and will first report his findings to the weekly PI Committee on Wednesday, February 1, 2017, to the Medical Executive Committee on February 9, 2017 and to the Governing Board thereafter. Audits will continue until several weeks of compliance at or greater than 90% has been achieved and sustained. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.68 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a period of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493	Addendum 2/1/2017: Pharmacy has increased its hours of coverage in the evening hours. Overrides are being tracked daily and analyzed for time of day, type of drug, and reason for the override. The PI Director and Pharmacy Director will formally present their findings at the weekly PI Committee meeting beginning Wednesday, February 1, 2017. Pharmacy hours will continue to be adjusted as necessary to minimize the use of the override process. The facility will continue to evaluate hours needed by the pharmacy through recommendations by the contracted provider, number of over-rides due to lack of pharmacist to conduct the first dose review, and medication errors related to overrides.	

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units.	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. Findings: 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169I) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	**A 0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes. **A500 Amendment 2/18/2017** Cascade Behavioral Health was cited for pharmaceutical services not meeting the needs of its patients. The cumulative effect of these systemic problems/findings results in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. Immediate response included increased pharmacy hours by two (2) additional evening hours, seven (7) days per week. That staffing enhancement resulted in overrides being reduced to approximately 10 per day. Since then, the medical staff considered a night locker concept with a smaller inventory of medications but ultimately decided not to endorse this idea. Collectively, these systemic issues require additional time to implement process change, arrange additional pharmacy coverage, establish 24/7 coverage solution to review all orders, and eliminate nursing access and overrides.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation.	A 500	**Proposed Interim Plan** Temporary night and weekend pharmacists to provide additional coverage will be in place by February 24, 2017. They will physically be present in the pharmacy to review and enter all new orders during their shift, just as the day-shift pharmacists currently do. The nurses' ability to override medications will be disabled permanently. All medication orders will be verified by a pharmacist prior to administration. **Responsible Person** Pharmacy Director (Pharmacist in Charge) **Proposed Long Term Plan** On or about April 1, 2017, the facility will transition pharmacist coverage to 24/7 through a combination of pharmacist on site and remote order entry. The Pharmacy Director, CEO and COO are evaluating options to obtain the necessary resources to establish this service within this expedited timeframe.	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700		

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: . Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701	Amendment 2/1/2017: The pipes were occluded by temporary obstructions and have been assessed by an independent, professional plumber. The pipes have no on-going needs except routine cleaning and maintenance. To improve cleaning and maintenance, the hospital purchased distinct brushes to scour the drain pipes to remove hair and other debris. This cleaning will occur monthly and as needed and has been added to facility and housekeeping rounds. The hospital has switched to psych-safe paper towels that dissolve when wet to address drain clogging issues. **A701 Amendment 2/18/2017** We propose to cool, circulate, and dehumidify our outpatient/PHP rooms with two portable air conditioners designed for that purpose, one in each room where patient care is delivered. The rooms measure: 1) 19 feet by 19 feet (361 square feet) 2) 17 feet by 29 feet (493 square feet) Before the summer heat arrives, we will install two Honeywell model MM14CCS, or similar, units which are designed to cool 500 square feet. These quiet units provide 14,000 BTU cooling. They can be used to cool or use the fan and dehumidify the air. The units' venting kits would be installed for the air conditioner to operate properly.	

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.	A 701	Between now and the installation of these units, ventilation of these patient care rooms will be accomplished by the fan-forced heaters currently in use and oscillating fans. No policy is needed for staff to turn on the air conditioning. This will be based on a consensus of the group of patients and staff at the time as it relates to comfort.	
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports.	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tippedapplicators with an expiration date of 2/2016. d. One box of sterile cotton-tippedapplicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of10/2016. f. One 14 french Foley urethral catheter with an expiration date of7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724	Amendment 2/1/2017: Daily audits are being conducted on each of the units. Unit champions are responsible for checking the ice machine logs to make sure the cleanings are happening at least weekly. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90% per unit. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 724	Continued From page 44 inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderrm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Operations Director/designee will perform monthly inspections of all ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

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A 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for thepasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	Amendment 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to food temperatures throughout the department. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. **A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

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A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749	Addendum 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision and will be presented to the PI Committee for approval on February 17, 2017. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to proper sanitation throughout the department. The COO/CNO will double check staff's compliance related to the use of chlorine solution, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 8, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Additionally, daily audits are being conducted throughout the hospital, observing housekeepers in their daily routines. Staff education is in process. The facilities director will be responsible for monitoring real-time compliance related to procedures when cleaning patient rooms. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

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A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael J Ure	CEO	1.20.2017

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A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment Shell # 27QV11	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. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. . 3. Failure to protect and promote each patient ' s rights. . 4, Failure to maintain the condition of the physical plant and the overall hospital environment of care. . Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. . Cross-Reference: Tags A0115, A0263, A0490, A0700 .	A 043		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: Based on observation, interview, document 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, privacy, dignity, and psychological harm. Findings: 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. 4. Failure to investigate patient complaints prior to closure of the complaint. 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 A0123, A0129, A0164, A0174	A 115	**See A 0123, A 0129, A 0164, A 0174**	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). . Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. . Findings: . 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." . 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present the grievance log and grievance responses to the monthly PI and quarterly MEC and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients' concern had been addressed or resolved. Staff Member #7 confirmed this observation.	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. Failure to allow patients the right to refuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. Findings: 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129		

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A 129	Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff. 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.	A 129		

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A 164	Continued From page 9 482.13(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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. Findings: 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 or seclusion used must be the least restrictive	A 164	**A 0164 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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.	A 164		
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). . Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. . Findings: . 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." . 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. . 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.	A 174		

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	**See A0273, A0286, A0309, A0490, A0700**	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and.... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint andseclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273		

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273	A 286 Corrective Actions	
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 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:	A 286	1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286		

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405		

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses.	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings: . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verifiedby a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units,	A 490	**See Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: . Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought in with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initialing of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.58 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a period of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493		

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units.	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: . Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. . Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. . Findings: . 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	**A 0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation.	A 500		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700	**See Tags A0701, A0710, A0724, A0726**	

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701		

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms. .	A 701		
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings. .	2/10/17

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tipped applicators with an expiration date of 2/2016. d. One box of sterile cotton-tipped applicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of 10/2016. f. One 14 french Foley urethral catheter with an expiration date of 7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724		

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A 724	Continued From page 44 inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderrm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detoxunit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Operations Director/designee will perform monthly inspections of all ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

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A 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for thepasta. Reference: Washington State Retail Food Code WAC 246-215-03515, FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	**A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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	504011	A. BUILDING _____ B. WING _____	12/21/2016

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749		

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

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K 000	INITIAL COMMENTS This report is the result of an unannounced Fire and Life Safety re-certification survey conducted at Cascade Behavioral Hospital on 12/14/2-16 by a representative of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health (DOH) health survey teams. The facility has a total of 135 beds and at the time of this survey the census was 107. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 483.70. The facility is a 4 story structure of Type 1-fr construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is not in compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Donald L West Deputy State Fire Marshal	K 000	Upon completion of the survey, the CEO, COO/CNO, PI/RM Director, and Plant Operations Director reviewed the findings and immediately formulated a corrective action plan. A monitoring plan was implemented in order to ensure compliance with the corrective actions.	
K 161	NFPA 101 Building Construction Type and Height Building Construction Type and Height	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J. Lucas — TITLE: CEO — (X6) DATE: 1.20.2017

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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K 161	Continued From page 1 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This STANDARD is not met as evidenced by:	K 161	**K 161 Corrective Actions** The Plant Operations Director replaced the noted ceiling tile in the Two West soiled linen room. Person Responsible: Plant Operations Director Monitoring On the monthly basis, the Plant Operations Director/designee will conduct monthly environmental rounds to assess for intact ceiling tiles. Any damaged ceiling tiles will be promptly remedied. Results of the environmental rounds will be reported in the monthly Safety/EOC and PI committee meetings.	1/12/17

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K 161	Continued From page 2 Based upon observations and staff interviews on 12/14/2016 between approximately 0800 and 1115 hours the facility has failed to maintain fire resistive construction of the building capable of resisting the passage of smoke and fire into other compartments. This could allow the toxic product of combustion to move out of a room and into the exit access corridor and the smoke compartment which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. On Two west by the soiled linen room there is a ceiling tile in the corridor with a large hole in it. The above was discussed and acknowledged by the Facilities director.	K 161		
K 291	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.1.8.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based upon observations and staff interviews on 12/14/2016 between approximately 0800 and 1115 hours the facility has failed to maintain records of testing for the emergency battery backup lighting. This could result in the failure of the battery powered backup lighting in the event of a power outage and render the means of egress dark. This could result in tripping and fall injuries to residents, staff and/or visitors. The findings include, but are not limited to: 1. The emergency egress light in the Fire alarm	K 291	**K 291 Corrective Actions** The Plant Operations Director installed new batteries for the emergency lighting. In addition, the Plant Operations Director tested the emergency egress lighting with satisfactory performance documented. Person Responsible Plant Operations Director Monitoring On a monthly and annual basis, the Plant Operations Director/designee will monitor the testing of emergency egress lighting. Monitor results will be reported in the monthly Safety/EOC and PI committees.	1/11/17

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K 291	Continued From page 3 panel room failed to function on battery back-up power. The above was discussed and acknowledged by the facilities director.	K 291	**K 311 Corrective Actions**	
K 311	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is not met as evidenced by: Based upon observations and staff interviews on 12/14/2016 between approximately 0800 and 1115 hours the facility has failed to maintain vertical openings between floors with a construction having a fire resistive rating of at least one hour. This could result in the passage of toxic products of combustion from one floor to another which would endanger the residents, staff and/or visitors within the facility. The findings include, but are not limited to: 1. The door to the stairwell by room #361 has been damaged and does not seal tight to the frame. The above was discussed and acknowledged by the facilities director.	K 311	The Director of Plant Operations submitted a capital equipment request to replace the stairwell door. The capital request was approved and sent to the contractor on 1/17/2017. Door replacement is scheduled for 2/17/17. The Plant Operations Director trained hospital staff on the proper latching of the door. A positive closure test will be performed weekly until door is replaced. If any issues are identified during testing, interim life safety measures will be immediately implemented. Person Responsible: Plant Operations Director Monitor In addition to the above monitoring, the Plant Operations Director/designee will test all rated doors for proper closure and damage on a semi-annual basis. Monitoring results will be reported semi-annually to the Safety/EOC and PI meetings. If any interim life safety measures are used, the measures will be reported monthly to the Safety/EOC and PI meetings until resolved.	1/17/17 2/17/17

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A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J Uhle | TITLE: CEO | (X8) DATE: 1.20.2017

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A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment Shell # 27QV11	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. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. 3. Failure to protect and promote each patient ' s rights. 4. Failure to maintain the condition of the physical plant and the overall hospital environment of care. Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A0115, A0263, A0490, A0700	A 043		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: Based on observation, interview, document 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, privacy, dignity, and psychological harm. Findings: 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. 4. Failure to investigate patient complaints prior to closure of the complaint. 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 A0123, A0129, A0164, A0174	A 115	**See A 0123, A 0129, A 0164, A 0174**	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). . Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. . Findings: . 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." . 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present the grievance log and grievance responses to the monthly PI and quarterly MEC and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients' concern had been addressed or resolved. Staff Member #7 confirmed this observation.	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. Failure to allow patients the right torefuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. Findings: 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129		

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A 129	Continued From page 8 coughing is no longer part of the process. . 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. . 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff . . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required. .	A 129		

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A 164	Continued From page 9 482.13(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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 or seclusion used must be the least restrictive	A 164	**A 0164 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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.	A 164		
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). . Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. . Findings: . 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." . 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. . 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.	A 174		

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	**See A0273, A0286, A0309, A0490, A0700**	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service andoperations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and.... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint andseclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273		

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273	A 286 Corrective Actions	
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 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:	A 286	1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286		

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager Investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405		

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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses. .	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings: . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verified by a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units,	A 490	**See Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: . Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought in with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initialing of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.68 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a period of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493		

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units. .	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: . Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. . Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. . Findings: . 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	**A 0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation.	A 500		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700	**See Tags A0701, A0710, A0724, A0726**	

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: . Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726 .	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701		

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.	A 701		
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings. .	2/10/17
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724		

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tipped applicators with an expiration date of 2/2016. d. One box of sterile cotton-tipped applicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of 10/2016. f. One 14 french Foley urethral catheter with an expiration date of 7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724		

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A 724	Continued From page 44 inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Operations Director/designee will perform monthly inspections of all ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

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A 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	**A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

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A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749		

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

Cascade Behavioral Health Hospital

Plan of Correction Review

2nd Revision

A0500 – The plan does not address the deficiency (uncontrolled distribution of medications in accordance with applicable standards of practice, consistent with Federal and State law). Current plan of correction is incongruent with state WAC 246-873-080 (6) which states ". . . A pharmacist shall review the original order or direct copy thereof, prior to dispensing any drug, except for emergency use". Upon approval of the override list, will the automated dispensing machine (ADM) restrict access to nursing personnel to medications that have not had a prospective pharmacy review? If not, what is the plan to ensure pharmacy review of provider orders prior to medication administration?

A0701 – The plan of correction does not address the second room with skylights. Will the second room continue to be utilized as an outpatient room? If the vented windows cannot be completed by day 45 (exceeds required date of compliance), then a extension waiver will need to be submitted. A process and or a policy needs to be developed to guide staff when classes need to be relocated.

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A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

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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	504011	A. BUILDING _____ B. WING _____	12/21/2016

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A 000	Continued From page 1 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment Shell # 27QV11	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. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring Systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. 3. Failure to protect and promote each patient ' s rights. 4. Failure to maintain the condition of the physical plant and the overall hospital environment of care. Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A0115, A0263, A0490, A0700	A 043	Amendment 2/1/2017: The CEO will issue weekly reports to the Governing Board related to the hospital's ongoing efforts toward compliance for all citations. Conference calls will be held as needed for dialogue. The target compliance is 90% for all standards cited. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: . Based on observation, interview, document 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, privacy, dignity, and psychological harm. . Findings: . 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. . 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. . 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. . 4. Failure to investigate patient complaints prior to closure of the complaint. . 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 A0123, A0129, A0164, A0174 .	A 115	**See A 0123, A 0129, A 0164, A 0174**	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). . Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. . Findings: . 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." . 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Amendment 2/1/2017: The hospital's grievance policy, log for grievances, and letters that are to be mailed to patients have all been revised and will be presented at the weekly PI Committee on Thursday, February 9, 2017 for approval. From there, they will go the Medical Executive Committee on February 9, 2017 and Governing Board at its next meeting thereafter. Weekly data toward compliance in the new processes is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present an analysis of the grievance log and grievance responses to the monthly PI and quarterly MEC (next meeting is Feb 9, 2017) and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. . 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. . 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation. .	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: . Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. . Failure to allow patients the right torefuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. . Findings: . 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." . "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." . 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." . 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129	Amendment 2/1/2017: The hospital's skin check/contraband policy has been revised to remove the administrative discharge for patients who refuse the skin check process. Staff education has been conducted related to this change. Daily audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 129	Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.	A 129		

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A 164	Continued From page 9	A 164	**A 0164 Corrective Actions**	
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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 or seclusion used must be the least restrictive	A 164	The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." . 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. . 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. . 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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. .	A 164	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: . Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). . Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. . Findings: . 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." . 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. . 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.	A 174	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. . 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review. .	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: . Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	**See A0273, A0286, A0309, A0490, A0700**	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service andoperations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and.... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: . Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint and seclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273	Amendment 2/1/2017: The 2016 data for grievances, anticoagulants, restraints & seclusions, elopements, medication consultations, Pharmacy & Therapeutics indicators, and contracted services have been abstracted and analyzed and will go the PI Committee on or before Thursday, February 9, 2017 and then to the Medical Executive Committee on Thursday, February 9, 2017 and Governing Board thereafter. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273	A 286 Corrective Actions	
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 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:	A 286	1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286	Amendment 2/1/2017: Going forward, the PI Committee will receive action plans for each Root Cause Analysis conducted along with a time frame for the completion of those action items. The PI Committee will add those items to minutes and receive follow-up at each of its meetings until all items are resolved. Action items will typically be resolved within 90 days, some sooner, depending on the urgency associated with that action item. The target compliance is 90% of all items completed with 90 days. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues	

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities for improvement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: . Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405	Amendment 2/1/2017: CIWA protocols are currently being audited daily by the Nursing Director of CD Services. Analysis of the audits will go to the PI Committee at each weekly PI Committee starting Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Once several weeks of compliance is achieved, monitoring will become monthly with the same targets.	

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses. .	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings: . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verifiedby a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units,	A 490	**See Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. . The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. . Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. . Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: . Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought In with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initialing of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings. Amendment 2/1/2017: The pharmacy director is auditing 100% of home medications and will first report his findings to the weekly PI Committee on Wednesday, February 1, 2017, to the Medical Executive Committee on February 9, 2017 and to the Governing Board thereafter. Audits will continue until several weeks of compliance at or greater than 90% has been achieved and sustained. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. . Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. . Findings: . 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.58 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. . 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a period of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493	Addendum 2/1/2017: Pharmacy has increased its hours of coverage in the evening hours. Overrides are being tracked daily and analyzed for time of day, type of drug, and reason for the override. The PI Director and Pharmacy Director will formally present their findings at the weekly PI Committee meeting beginning Wednesday, February 1, 2017. Pharmacy hours will continue to be adjusted as necessary to minimize the use of the override process. The facility will continue to evaluate hours needed by the pharmacy through recommendations by the contracted provider, number of over-rides due to lack of pharmacist to conduct the first dose review, and medication errors related to overrides.	

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units.	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. Findings: 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	**A 0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 86 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation.	A 500	Amendment 2/1/2017: The medical staff will develop a list of medications which may be overridden. That list is due to the COO/CNO by Tuesday, February 7, 2017 at which time an educational event will be held for nursing staff. Overrides will continue to be monitored daily and trended weekly & presented to the PI Committee weekly, quarterly P&T Committee, quarterly Medical Executive Committee (next meeting February 9, 2017) & Governing Board thereafter. The target compliance is 90% of all medications overridden will be from the approved list. An incident report will be written by the pharmacist for any meds removed that are not from the approved override list and the Nursing Director will follow up with the employee and medical provider as indicated. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Patient care will not be restricted because of this imposition. It is expected to see a steady decline of medication overrides week by week.	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700		

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: . Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726 .	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701	Amendment 2/1/2017: The pipes were occluded by temporary obstructions and have been assessed by an independent, professional plumber. The pipes have no on-going needs except routine cleaning and maintenance. To improve cleaning and maintenance, the hospital purchased distinct brushes to scour the drain pipes to remove hair and other debris. This cleaning will occur monthly and as needed and has been added to facility and housekeeping rounds. The hospital has switched to psych-safe paper towels that dissolve when wet to address drain clogging issues. The hospital will install vented skylight windows in the outpatient group room. Bids from window vendors are being obtained, with a capital expense requisition to be processed as soon as possible. The work is expected to be completed within the next 60 days, depending on vendor availability. In a worst-case scenario, the outpatient services will be relocated to other areas in the hospital. A thermometer will also be installed in the outpatient department, alerting staff if the temperature is excessive. On a day-by-day basis, these services can easily be relocated to another area in the hospital that is air conditioned.	

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.	A 701		
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings. .	2/10/17

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tipped applicators with an expiration date of 2/2016. d. One box of sterile cotton-tipped applicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of 10/2016. f. One 14 french Foley urethral catheter with an expiration date of 7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724	Amendment 2/1/2017: Daily audits are being conducted on each of the units. Unit champions are responsible for checking the ice machine logs to make sure the cleanings are happening at least weekly. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90% per unit. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 724	Continued From page 44 Inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderrm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Operations Director/designee will perform monthly inspections of all ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	12/21/2016

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 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for thepasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	Amendment 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to food temperatures throughout the department. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. **A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

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A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749	Addendum 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision and will be presented to the PI Committee for approval on February 17, 2017. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to proper sanitation throughout the department. The COO/CNO will double check staff's compliance related to the use of chlorine solution, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 8, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Additionally, daily audits are being conducted throughout the hospital, observing housekeepers in their daily routines. Staff education is in process. The facilities director will be responsible for monitoring real-time compliance related to procedures when cleaning patient rooms. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

- override

Automatic Despensig Device

on call pharmacist.- pharmacist -> come in for home med verification

24/7

REMOVAL PLAN RECEIVED 12/20/2016

PRESENTED BY JOHN BEALL, CNO, COO MIKE URADNIK, CEO

Cascade Behavioral Health

Date: 12/20/2016

To: Paul Kondrat, RN, MN, Washington State Department of Health Survey Team Leader

From: John Beall, COO/CNO and Michael Uradnik, CEO, Cascade Behavioral Health

Re: Response to NOTICE OF IMMEDIATE JEOPARDY

Finding	Response	Responsible Party
• Medications being administered to patients prior to pharmacy verification of orders resulting in a high number of automatic dispensing machine overrides	• Cascade Behavioral Health (CBH) will increase pharmacy hours by two hours per day (in the evening) so that pharmacists can review orders and profile medications in the medication dispensing machines.	• Dale Cary, Pharmacy Director
	• Nurses will not administer medications that have not been reviewed by pharmacy **unless** the medication has been identified by the physician as a critical medication which must be administered in a timely fashion in which case:	• John Beall, CNO & Swapna Vaidya, Medical Director
	• Two nurses will verify medication dispensing machine overrides prior to administering the medication to the patient.	• John Beall, CNO

Medication variances (errors) resulting from medication overrides.	• Nursing will no longer override unless a physician has determined it is a critical medication. If/when that happens, two nurses will perform the override, verifying the 5 rights of medication administration.	• John Beall, CNO & Swapna Vaidya, Medical Director
Patient home medications not being verified by a pharmacist prior to administering	• Home medications will no longer be administered until reviewed by a pharmacist **unless** a physician determines the medication to be critical in nature, in which case: • A nursing supervisor, specifically trained in home medication review, will verify the accuracy of the critical home medication to be administered.	• John Beall, CNO must be a pharmacist. • Dale Cary, Pharmacy Director & Janet Huff, Nurse Educator
Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.	• Two additional hours per day of pharmacist review of orders will be added immediately for increased evening-hour coverage ~~based on admission trends~~.	• Dale Cary, Pharmacy Director

If we can be of any further assistance, please do not hesitate to contact us at 206-248-4550.

Sincerely,

John Beall, RN, DNP, NEA-BC
Chief Operating Officer/Chief Nursing Officer

Michael Uradnik
Chief Executive Officer

Nursing Supervisor Patient Home Medication Verification Competency

Purpose:

- To ensure that medications brought in by the patient are utilized during their stay, disposed of properly or stored properly in a manner consistent with State and Federal law, Joint Commission Standards, and professional practice.
- To ensure proper dispensing and administration, all medications brought in by patients will be examined by the Pharmacist for identification and labeling (when on duty)
- To contribute to the process of reconciliation of all medication across the continuum of care.
- Patient's own medications may be used during their stay in the facility for the following reasons: 1) To avoid interruption in therapy, 2) If the patient is taking a non-formulary medication, and 3) If there is a lack of alternatives to a patient's personal medication. While the physician is required to write an order that a patient may use their own medications, facility policy states that patient's own medications may be used.

Procedure Requirement	Step completed yes/no	Pharmacist initials
The Nursing Supervisor has received an order from the physician stating the medication needs to be given to the patient prior to Pharmacys normal operating hours		
Nursing Supervisor has determined the patients home medication is not available in the Med Dispense (non-formulary).		
Name of the patient matches the name on the prescription bottle exactly.		
Check prescription label for description of medication (Small, white, oval #234 imprinted, etc). Does it match?		
If no descriptors on medication label go to www.drugs.com/imprints.php. Type in name & strength of medication. Check photos for exact match with what is in prescription bottle.		
If medication is verified, Nursing Supervisor signs Medication Verification Form, applies patients identification sticker on the form and faxes it to the pharmacy. Nursing Supervisor will file form in patients medical record.		
Nursing Supervisor has read Pharmacy policy # PHR-118 *Medications Brought In With Patients*		

Nursing Supervisor Name (Print):_____
Nursing Supervisor Signature: _____
Pharmacist performing competency sign off (print): _____
Pharmacist signature: _____
Date Competency Performed: _____

ADVANCED PHARMACEUTICAL CONSULTANTS, INC. MEDICATION MANAGEMENT	
POLICY AND PROCEDURE MANUAL POLICY NUMBER – PHR-118 TJC: MM.03.01.03 MM.05.01.13	PAGE: ONE OF TWO Origination Date: 02/2014
CASCADE BEHAVIORAL HOSPITAL TITLE: MEDICATIONS BROUGHT IN WITH PATIENTS	Annual Review: 05/2015 Revised/Effective: 04/2014

1.0 STATEMENT OF PURPOSE:

1.1 To ensure that medications brought in by the patient are utilized during their stay, disposed of properly or stored properly in a manner consistent with State and Federal law, Joint Commission Standards, and professional practice.

1.2 To ensure proper dispensing and administration, all medications brought in by patients will be examined by the Pharmacist for identification and labeling (when on duty)

1.3 To contribute to the process of reconciliation of all medication across the continuum of care.

2.0 STATEMENT OF POLICY:

2.1 Patient's own medications may be used during their stay in the facility for the following reasons: 1) To avoid interruption in therapy, 2) If the patient is taking a non-formulary medication, and 3) If there is a lack of alternatives to a patient's personal medication. While the physician is required to write an order that a patient may use their own medications, facility policy states that patient's own medications may be used. Patient's using their own medications will not be charged for medications. Medications will be returned to patient upon discharge if warranted by the physician.

2.2 Nonprescription nasal sprays and eye drops will not be used for patients on the Dual Diagnosis Program or Drug Detoxification programs except upon the order of a Facility Prescriber.

2.3 Herbal non-formulary medications may only be used if the patient has a new sealed bottle, the medication is in date, the herbal medication does not interact with any other medication the client is prescribed, and the physician writes an order to use their own herbal medication with the instructions for use.

3.0 SCOPE OF POLICY:

Admissions
Clinical Staff
Medical Staff
Pharmacy

4.0 PROCEDURE:

4.1 The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form.

4.2 The medication order will be reviewed by the pharmacist.

4.3 When the pharmacist is on duty, for those medications that will be used by the patient during their admission at the facility, the medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence that the medication has been verified. In addition pharmacy will notify the physician and patient (per MD approval) if the medications are not acceptable for use or it is recommended that they should not be returned. When the pharmacist is not on duty, but home medications are to be used, the nurse or physician is responsible for identifying the medication. This can be done by: (i) calling poison control (800-222-1222), (ii) comparing the medication to the identification label listed on the Rx bottle, (iii) calling the dispensing pharmacy for assistance or (iv) positive identification using drugs.com or epocrates.com to verify the tablet/capsule markings.

4.4 If the use of the medication is not warranted, then the following procedure should be used:

4.4.1 All medications are given back to the patient's family to be taken home if possible.

4.4.2 If the patient's family cannot be notified, then all medications are placed in a tamper resistant sealed bag. A list of the medications will be written on the approved inventory form by the Admissions staff or nurse in charge and will include the patient's name and list of medications. Controlled substances that cannot be returned to the family must be counted with the quantity noted on the inventory sheet. The patient and staff member receiving medications will sign the form. The entire bag with the Inventory form will be secured under lock in the medication room on the unit where the patient is located or other designated area. Tamper resistant tape shall be used to seal the bag. If the pharmacy has to check a medication for use in house, the pharmacy will remove the medication and reseal the bag. No meds will be stored in the pharmacy dept. Copies of the inventory form are kept with the bag of medications and in the patient's record.

4.4.3 When the patient is discharged, the medications will be returned as indicated by the physician. If a patient has controlled substances being returned at discharge, the quantity being returned to the patient must be noted by the nurse (and witness if available) on the Controlled Drug Record form. The patient or care giver must also verify that the count is correct.

4.4.4 No medication will be returned which does not meet proper labeling requirements, is mixed with other tablets, or is adulterated in any way as defined in the Drug Product Defect Policy PHR-108.

4.4.5 If the physician has agreed to release the medication to the patient and the patient does not pick them up at the time of discharge, the medications will be held for thirty (30) days post-discharge prior to destroying in accordance with DEA requirements. The pharmacy dept will be responsible for placing the meds in quarantine until removal from hospital by a licensed reverse drug distributor.

All medication documentation regarding disposition of medications must be clearly marked and maintained for a period of two years.

Cascade
Behavioral Health

Nursing Supervisor Home Medication Verification Form

Patient label here

Name of medication verified: _____
Strength: _____ Directions: _____

Name of medication verified: _____
Strength: _____ Directions: _____

Name of medication verified: _____
Strength: _____ Directions: _____

1. Medication order has been obtained by physician and is in the chart.
2. Medication is not on formulary (not in Med dispense)
3. Medication has been determined by physician as a critical medication and must be given prior to pharmacists regular hours of operation.

Name of Verifying Nursing Supervisor:
Print: _____ Signature: _____

Faxed to Pharmacy:
Date: _____ Time: _____

Please place completed form in patients medical record.

Washington State Department of Health

NOTICE OF IMMEDIATE JEOPARDY

On 12/20/2016 at 10:30 AM, Washington State Department of Health surveyors determined that a condition existed at **Cascade Behavioral Health Hospital that posed an immediate and serious threat to patient safety.**

The facility failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served.

This posed a serious risk of harm due to:

- Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides risking patient safety
- Medication variances (errors) resulting from medication overrides
- Patient home medications not being verified by a pharmacist prior to administering
- Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.

Notice of a determination of Immediate Jeopardy was made on behalf of CMS to:

Cascade Behavioral Health Hospital on December 20, 2016 at 1145 (AM)/PM. **The facility needs to respond by developing an effective system-wide plan to remove the immediate risk of harm to patients.**

A state of Immediate Jeopardy will remain in effect until the corrections are completed and accepted by the Washington Department of Health.

Paul M Kordut RN/MN/MBA 12/20/2016 1145 AM

Survey team leader Date/Time

Michael J Lane 12/20/2016 1147 AM

Facility representative Date/Time

Washington State Department of Health

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Paul M Kanbar RN MN MHA 12/20/2016 1145 AM

Survey team leader Date/Time

Michael Mc 12/20/2016 1147 AM

Facility representative Date/Time

PROFILE OVERRIDE HISTORY From: 12/20/2016 6:00:00 PM To: 12/21/2016 6:59:00 AM

Type	Quantity/Item Number	Common Name / Brand Name	Operator Name	Witness Name	Patient Name	Entry Date
3 NORTH						
DSO	1 16758	CLONIDINE 0.1 MG TAB CATAPRES TAB 0.1 MG	WSELASSIE, TIGIST		SNIDER, JEREMIAH	12/20/2016 9:30:49P
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229040
DSO	1 75251	DICYCLOMINE 20 MG TAB BENTYL TAB 20 MG	WSELASSIE, TIGIST		SNIDER, JEREMIAH	12/20/2016 9:30:58P
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229042
DSO	1 68187	HALOPERIDOL TAB 5 MG HALDOL TAB 5 MG	HAY, THOMAS		SNIDER, JEREMIAH	12/21/2016 12:02:54A
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229492
DSO	1 33653	DIPHENHYDRAMINE 25 MG CAP BENADRYL CAP 25 MG	HAY, THOMAS		SNIDER, JEREMIAH	12/21/2016 12:03:02A
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229494
DSO	1 142800	TRAZODONE TAB 50 MG DESYREL TAB 50 MG	HAY, THOMAS		SNIDER, JEREMIAH	12/21/2016 12:03:17A
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229496
DSO	1 16759	CLONIDINE TAB 0.2 MG CATAPRES TAB 0.2 MG	KUNGU, HELEN		GARRIS, ISAAC	12/21/2016 2:00:01A
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229570
DSO	1 2629	HYDROXYZINE 50 MG CAP VISTARIL CAP 50 MG	KUNGU, HELEN		GAYNOR, JULES	12/21/2016 2:29:07A
	Notes	**Override Reason: First dose needed. Verified no allergies/contraindications** **Nursing Notes:**				TranID 3229602

Approved Removal plan
12/20/2016 4:55 PM
Paul Kondrat, RN, MN
TM Leader

Cascade
Behavioral Health

Date: 12/20/2016

To: Paul Kondrat, RN, MN, Washington State Department of Health Survey Team Leader

From: John Beall, COO/CNO and Michael Uradnik, CEO, Cascade Behavioral Health

Re: Response to NOTICE OF IMMEDIATE JEOPARDY

Finding	Response	Responsible Party
• Medications being administered to patients prior to pharmacy verification of orders resulting in a high number of automatic dispensing machine overrides	• Cascade Behavioral Health (CBH) will increase pharmacy hours by two hours per day (in the evening) so that pharmacists can review orders and profile medications in the medication dispensing machines.	• Dale Cary, Pharmacy Director
	• Nurses will not administer medications that have not been reviewed by pharmacy **unless** the medication has been identified by the physician as a critical medication which must be administered in a timely fashion in which case:	• John Beall, CNO & Swapna Vaidya, Medical Director
	• Two nurses will verify medication dispensing machine overrides prior to administering the medication to the patient.	• John Beall, CNO

Medication variances (errors) resulting from medication overrides.	• Nursing will no longer override unless a physician has determined it is a critical medication. If/when that happens, two nurses will perform the override, verifying the 5 rights of medication administration.	• John Beall, CNO & Swapna Vaidya, Medical Director
Patient home medications not being verified by a pharmacist prior to administering.	• Home medications will no longer be administered until reviewed by a pharmacist.	• John Beall, CNO & • Dale Cary, Pharmacy Director
Expansion of hospital services with corresponding increase in average daily census without a comparable increase in pharmacy hours or personnel.	• Two additional hours per day of pharmacist review of orders will be added immediately. Coverage is currently 70 hours/week and will be increased to 84 hours/week. • An on-call pharmacist will be available 24 hours/day for consultation and/or to come to the hospital, should the need arise.	• Dale Cary, Pharmacy Director

If we can be of any further assistance, please do not hesitate to contact us at 206-248-4550.

Sincerely,

John Beall, RN, DNP, NEA-BC
Chief Operating Officer/Chief Nursing Officer

Michael Uradnik
Chief Executive Officer

Immediate Jeopardy

Removal Plan Verification Inspection

Clinical Units –

Interview 2 licensed nursing staff

Interview 1 medical staff provider

Nursing –

When retrieving medications for a patient, what do you do if recently ordered medications are not visible on the ADM for selection?

Under what circumstances, may a nursing staff member perform a medication override?

Describe the process of performing a medication override?

If you have pharmacy questions when the pharmacy is closed, what do you do?

What is the process for using a patient's home medications in the hospital? Can they be given without pharmacy verification?

Medical Staff –

What steps or process must be taken when pharmacy verification of provider orders has not taken place?

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	504011	A. BUILDING _____ B. WING _____	12/21/2016

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CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA 98168

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A 000	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY This Medicare hospital complaint survey was conducted on the following dates: 12/12-16/2016 and 12/19-21/2016 by Washington State Department of Health surveyors: Paul Kondrat, RN, MN, MHA; Elizabeth Gordon, RN, MN; Valerie Walsh RN, MS; Alex Giel, REHS, PHA and Joy Williams, RN, BSN. The Fire Life Safety (F/L/S) inspection was conducted on 12/14/2016 by Washington State Patrol Deputy Fire Marshal Donald West (See F/L/S inspection report). Surveyors assessed issues related to the following MEDICARE complaints: #69120; #69393; #70129; #70130; #70131; #70133; and #70136. During the course of this survey, the DOH surveyors determined that there was a high risk of serious harm, injury, and death due to the extent of deficiencies. This resulted in one finding of IMMEDIATE JEOPARDY in the following area: Failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. The hospital initiated corrective actions on 12/20/2016 but surveyors were unable to verify the plan's implementation developed by the hospital for the IMMEDIATE JEOPARDY and the state of IMMEDIATE JEOPARDY remained in place at the time of survey team exit. Removal of the state of IMMEDIATE JEOPARDY	A 000	Submission of this plan of correction is not an admission that the citations are true or that the hospital violated the rules. **A 000: Response to Medicare Hospital Complaint Survey** As noted, an action plan was submitted and accepted in response to the immediate jeopardy finding. Corrective actions included: -Analysis and reduction of overrides in the medication dispensing devices; -Pharmacy staffing increases; -Physician order requirements for overrides; -Two nurse verification for overrides; -After-hour pharmacist verification process revision; -Pharmacy policy revision relative to overrides and home medications.	2/10/17

Michael J Madia, CEO 2/18/17

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 was verified on a revisit on 12/29/2016 at 12:30 PM by Paul Kondrat, RN, MN, MHA and Joy Williams, RN, BSN. Cascade Behavioral Hospital is NOT IN COMPLIANCE with Medicare Hospital Conditions of Participation: 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 Environment Shell # 27QV11	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. Failure to meet patient rights, quality assessment and performance improvement, pharmaceutical services and physical environment requirements	A 043	Upon completion of the survey, the CEO, Medical Director, COO/CNO, Governing Board members, and PI/RM Director reviewed the findings and began formulation of the Plan of Correction. The Governing Board delegated responsibility of ensuring completion of all corrective actions to the CEO. The CEO is responsible for reporting the results of the corrective actions and use of monitoring Systems to the Governing Board. **See A0115, A0263, A0490, A0700**	2/10/17

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A 043	Continued From page 2 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 12/20/2016 for failure to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. 2. Failure to provide oversight of the Performance Improvement Program delegated to the Medical Staff. 3. Failure to protect and promote each patient ' s rights. 4. Failure to maintain the condition of thephysical plant and the overall hospital environment of care. Due to the scope and severity of deficiencies detailed under 42 CFR 482.13 Condition of Participation for Patient Rights; 42 CFR 482.21 Condition of Participation for Quality Assessment and Performance Improvement; 42 CFR 482.25 Pharmaceutical Services; and 42 CFR 482.41 Condition of Participation for Physical Environment, the Condition of Participation for Governing Body was NOT MET. Cross-Reference: Tags A0115, A0263, A0490, A0700	A 043	Amendment 2/1/2017: The CEO will issue weekly reports to the Governing Board related to the hospital's ongoing efforts toward compliance for all citations. Conference calls will be held as needed for dialogue. The target compliance is 90% for all standards cited. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the	A 084		

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A 084	Continued From page 3 services performed under a contract are provided in a safe and effective manner. This Standard is not met as evidenced by: . Based on interview and review of hospital documents, the hospital failed to ensure that its quality assurance and performance improvement (QAPI) processes included a systematic review of contracted patient care services. Failure to develop a process to oversee the performance of all contracted patient care services places patients at risk for provision of improper or inadequate care and adverse patient outcomes. Findings: On 12/20/2016 at 9:00 AM, during a discussion of the hospital's quality program with Director of Risk and Quality (Staff Member #12), Surveyor #2 reviewed the hospital's process for evaluating the performance of contracted health services. In reviewing the contracted services documents, Surveyor #2 found there was no evidence that the following contracted services had ever been formally reviewed as part of the QAPI program for quality of services provided: -Universal Hospital - R&M Equip, Biomed -Advanced Pharmaceutical - Pharmacy Services -Dietician Services -Highline Physical Therapy - Physical Therapy -Northwest Healthcare - Linen Services .	A 084	**A084 Corrective Actions:** 1. The department heads responsible for contracts evaluated all contracted patient care services and submitted those evaluations to the Medical Executive Committee for review and approval. 2. The PI/RM Director revised the QAPI process for contract evaluation as: a. The PI/RM Director will calendar review dates to ensure timeliness. b. The Department Head responsible for oversight of the contracted clinical service will review the contract and complete the evaluation. c. If there are service concerns, the Department Head will discuss those concerns with the clinical contracted service and develop a plan of improvement in order to ensure patient care needs are met. d. Annually, all evaluations for contracted clinical services will be forwarded to the Medical Executive Committee for review. **Responsible Person:** PI/RM Director **Monitor** On an annual basis, the PI/RM Director will present the list of contracted patient care services with completed evaluations by the assigned department head in the MEC meeting. The evaluations will include any service concerns with related plan of improvement. Committee minutes will reflect the review and any actions taken on patient care contracts.	2/10/17
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights.	A 115		

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A 115	Continued From page 4 This Condition is not met as evidenced by: . Based on observation, interview, document 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, privacy, dignity, and psychological harm. . Findings: . 1. Failure to allow patients the right to exercise their rights to privacy and refuse treatment. . 2. Failure to utilize the least restrictive alternative to the use of seclusion and restraints. . 3. Failure to release the patient from seclusion at the earliest possible time when documentation reflected no imminent risk of danger. . 4. Failure to investigate patient complaints prior to closure of the complaint. . 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 A0123, A0129, A0164, A0174	A 115	**See A 0123, A 0129, A 0164, A 0174**	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION	A 123		

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A 123	Continued From page 5 At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This Standard is not met as evidenced by: Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were provided with a written response to their grievances for 1 of 4 grievances reviewed (Patients #2). Failure to provide patients with a written response to their grievance violates their right to be informed of how the hospital investigated and resolved the grievance. Findings: 1. The hospital's policy and procedure titled "Patient Grievance Policy" (Revised 10/2015; Policy # G.1001) read in part: "The Patient Advocate will: Review results of the preliminary investigation. . . Complete a written report on the Grievance Resolution Form . . . Give written report to patient for review, comments and signature." 2. Four patient complaints were selected for review of process and resolution. Sources included the patient complaint log. Each was reviewed for evidence of receipt, hospital review, investigation, findings, and resolution of the grievance issue with the findings reviewed with	A 123	**A 0123 Corrective Actions** The Patient Advocate reviewed the Patient Grievance Policy on the requirement of providing a written response to a grievance. The Clinical Educator reeducated the clinical staff on the grievance process with written responses provided to the patient. Education was provided in staff meetings through written and verbal communication. Amendment 2/1/2017: The hospital's grievance policy, log for grievances, and letters that are to be mailed to patients have all been revised and will be presented at the weekly PI Committee on Thursday, February 9, 2017 for approval. From there, they will go the Medical Executive Committee on February 9, 2017 and Governing Board at its next meeting thereafter. Weekly data toward compliance in the new processes is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Persons Responsible: Patient Advocate PI/RM Director Monitoring: The Patient Advocate will present an analysis of the grievance log and grievance responses to the monthly PI and quarterly MEC (next meeting is Feb 9, 2017) and Governing Board meetings. Any issues requiring immediate attention will be addressed by the appropriate department head.	2/10/17

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A 123	Continued From page 6 the patient who filed the grievance. . 3. Patient #2 filed a patient concern notification on 6/3/2016 making allegations of inadequate cleaning of the patient rooms, patient kitchen area, shower and bathrooms. A review of the grievance log indicated the complaint was closed. . 4. On 12/15/2016 at 2:30 PM, Surveyor #3 interviewed the Patient Advocate (Staff Member #7) about the hospital grievance process. While reviewing the complaint log for Patient #2, no action was documented indicating the patients concern had been addressed or resolved. Staff Member #7 confirmed this observation. .	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This Standard is not met as evidenced by: . Based on observation, interviews, document review, and review of hospital policy and procedures, the hospital failed to protect patient rights. . Failure to allow patients the right torefuse skin/clothing checks risks patient's loss of personal dignity, privacy, and respect. . Findings: . 1. The hospital's policy titled "Patient Rights and Responsibilities" (Reviewed 10/2016; Policy # ADM.P.300) under the section "PURPOSE" read: "To assure that a patient is informed of his or her rights and responsibilities upon receiving care and service from Cascade Behavioral Hospital	A 129	**A 129 Corrective Actions** The Clinical Educator reeducated the nursing staff on the policy titled Skin/Clothing Check. Education included an emphasis on the proper procedure for assessing patients and procedure for patient's refusal. Education was provided during staff meetings through verbal and written communication with competency testing. Person Responsible: COO/CNO Patient Advocate Monitoring: The PI/RM Director/designee will perform at least 30 random audits per month to ensure compliance of 90% or above for at least 3 consecutive months. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 129	Continued From page 7 and to assure that these rights are known by hospital staff, physicians and other health care providers." "B. The list of patient rights shall include but are not limited to the following: . . . 4. The right to personal privacy, and to be protected from invasion of privacy, PROVIDED, that reasonable searches may be conducted or other means used to detect and prevent contraband from being possessed or used on the premises. . . 13. The right to care that is considerate and respectful of your personal culture, values, beliefs, and preferences and to be treated in a manner promoting dignity and self-respect." 2. The hospital's policy titled "Skin/Clothing Check" (Reviewed 10/2016) read in part: "Voluntary psychiatric patients who are not voicing or exhibiting self-harm behaviors, who refuse the skin/clothing check, will be given referral information and administratively discharged from the hospital." 3. On 12/14/2016 at 12:00 PM, Surveyor #3 observed Patient #1 being admitted to the hospital. During the skin/clothing check process, Patient #1 was asked to change into a hospital gown and hand his clothing over to a nursing supervisor (Staff Member #1) to be checked for contraband (hospital prohibited items). Patient #1 agreed but stated, I am not taking my underwear off, I am here voluntarily and am not going to do that. The other registered nurse in attendance (Staff Member #2) informed Patient #1 that was acceptable. After Patient #1's clothing had been searched for contraband, Staff Member #1 asked the patient to squat and cough so they could check further for contraband. Staff Member #2 informed Staff Member #1 that squatting and	A 129	Amendment 2/1/2017: The hospital's skin check/contraband policy has been revised to remove the administrative discharge for patients who refuse the skin check process. Staff education has been conducted related to this change. Daily audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 129	Continued From page 8 coughing is no longer part of the process. 4. On 12/14/2016 at 1:37 PM, Surveyor #2 interviewed a registered nurse (Staff Member #3) about the skin/clothing check done at admission. Staff Member #3 confirmed that part of the process included having the patient squat and cough and then checking for any visible contraband. Surveyor #2 found similar understanding of the process while interviewing two other registered nurses (Staff Member #4, Staff Member #5) on the chemical dependency and rehabilitative units. 5. On 12/12/2016 at 2:30 PM, Surveyor #2 interviewed the Clinical Director of Adult Psychiatric Services (Staff Member #6) about the skin/clothing check procedure process. Staff Member #6 explained the hospital had received complaints about the skin/clothing check procedure and had recently changed their policy about a month ago. The new policy no longer required the patient to squat and cough and now allowed the patient to refuse the skin check. The surveyor asked Staff Member #6 to explain why the current policy directed staff to administratively discharge voluntary patients who refused the skin/clothing check process. S/he acknowledged being unaware of that aspect of the policy. Staff Member #6 stated that each clinical director was responsible for disseminating the new policy information to their respective clinical staff . 6. On 12/20/2016 at 1:50 PM, Surveyor #3 conducted a review of the hospital's human resource training files. Three of the four nursing staff members (Staff Members #1, #3, # 4) reviewed had no record of completing the new Skin/Clothing Check Competency as required.	A 129		

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A 164	Continued From page 9	A 164	**A 0164 Corrective Actions**	
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, interview, and review of hospital policies and procedures, the hospital staff failed to consider the effectiveness of less restrictive interventions before applying both restraints and seclusion for 2 of 6 patients (Patients #4, #6). . Failure to utilize less restrictive alternatives to using both restraints and seclusion simultaneously puts patients at risk for loss of personal freedom and dignity. . Findings: . 1. The hospital policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R.100) under the section "Policy" read in part: "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 "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 or seclusion used must be the least restrictive	A 164	The Clinical Educator reeducated nursing staff on the requirement of using less restrictive interventions prior to restraint and seclusion in protecting patients, staff, and/or others from harm. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during staff meetings through the use of verbal and written communication with return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions to determine appropriateness of use with less restrictive interventions. Any clinical issues requiring corrective actions will be promptly addressed by the COO/CNO. The PI/RM Director will report audit results in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 164	Continued From page 10 intervention that will be effective to protect the patient, a staff member, or others from harm." 2. On 12/12/2016 at 2:30 PM, Surveyor #3 reviewed the hospital's pre-printed restraint and seclusion order sheet for Patient #5 observing that under the section titled "Type", the box labeled "Mechanical Restraints (wrist, ankle, chest)" does not specify how many restraints are to be applied by the hospital staff. 3. On 12/15/2016 at 2:00 PM, Surveyor #3 interviewed the hospital ' s primary restraint educator (Staff Member #7) about how many restraints are to be used when physical restraints are ordered by a physician. Staff Member #7 indicated that the registered nurse determines how many restraints are initially used. The staff member acknowledged that hospital staff generally start with restraining both the arms and legs. The chest restraint is only used in rare occasions. 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed the seclusion/restraint records of Patients #4 and #6 noting that hospital staff placed Patients #4 and #6 in both physical restraints and seclusion simultaneously on 8/12/2016 and 9/29/2016 respectively based upon a physician order. 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.	A 164	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length	A 174		

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A 174	Continued From page 11 of time identified in the order. This Standard is not met as evidenced by: Based on record review, interview, and review of hospital policies and procedures, the hospital failed to ensure that patients were released from seclusion at the earliest possible time for 3 of 6 patients reviewed (Patients #3, #4 and #5). Failure to remove patients from seclusion at the earliest possible time puts patients at risk for psychological harm, loss of dignity, and personal freedom. Findings: 1. The hospital's policy and procedure titled "Seclusion and Physical & Mechanical Restraint" (Revised 2/2016; Policy # PC.R. 100) under the section "PATIENT RIGHTS" read in part: "Restraints or seclusion shall be ended at the earliest possible time." 2. On 12/15/2016 at 1:15 PM, Surveyor #3 interviewed the hospital's principal trainer/educator for staff on the use of seclusion and restraints (Staff Member #7). The surveyor asked Staff Member #7 when a patient should be released from seclusion. Staff Member #7 acknowledged that the trained registered nurse or physician would review and assess the patient's behavior to determine if seclusion or restraints could be discontinued. When asked by the surveyor what should happen if the documented behavior was described as sleeping, s/he indicated the door should be unlocked and the patient released from seclusion. 3. On 12/13/2016 at 11:30 AM in the adult	A 174	**A 0174 Corrective Actions** The Clinical Educator reeducated nursing staff on the requirement of releasing patients from seclusion and restraint at the earliest possible time. The education included an emphasis on de-escalation techniques as well as other therapeutic interventions. The Clinical Educator provided the education during Nursing staff meetings through the use of written communication and return demonstration. Person Responsible: PI/RM Director COO/CNO Monitoring: The PI/RM Director/designee will audit all restraints and seclusions for release at the earlies possible time. Any clinical issues related to length of use requiring corrective actions will be addressed by the COO/CNO. Results of the audit will be reported by the PI/RM Director in the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 174	Continued From page 12 psychiatric unit (2 West), Surveyor #3 reviewed the medical record of Patient #3 who was placed into seclusion on 12/1/2016 at 8:30 AM and released from seclusion at 11:30 AM. The patient was placed in seclusion after being observed grabbing a food cart and running down a hallway repeatedly striking the cart against the wall. Documentation on the seclusion flow sheet indicated the patient's observable behavior as "resting" or "sleeping" from 9:00 AM to 10:30 AM, a period of 90 minutes. A progress note written at 10:30 AM indicated the patient was resting on the bed with eyes closed and verbalized understanding for the need for seclusion. "Will discontinue seclusion when staffing allows for 1 to 1 support." 4. On 12/14/2016 and 12/15/2016, Surveyor #3 reviewed seclusion/restraint flowsheet records of Patients #4 and #5 and noted the following: a. Hospital staff placed Patient #4 in seclusion and restraint on 9/29/2016 and did not release him/her from seclusion until 9/30/2016, a period of 28 hours. Surveyor #3 noted the patient's observed documented behavior of sleeping or resting for the following periods: --From 9/29/2016 at 6:45 PM until 9:30 PM, a period of 2 hours and 45 minutes. --From 9/29/2016 at 10:45 PM until 9/30/2016 at 7:45 AM, a period of 9 hours. --From 9/30/2016 at 8:45 AM until 10:45 AM, a period of 2 hours. --From 9/30/2016 at 12:30 PM until 3:30 PM, a period of 3 hours.	A 174	Amendment 2/1/2017: Seclusion & restraint forms were changed to comply with standards and staff were educated on those changes. Audits are already in progress and the results of which will be shared at the weekly PI Committee to be held Wednesday, February 1, 2017 and to the Medical Executive Committee on Thursday, February 9, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. 100% of all restraint charts are being audited.	

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A 174	Continued From page 13 b. Hospital staff placed Patient #5 in seclusion on 12/11/2016 at 10:30 PM and was released from seclusion on 12/12/2016 at 7:15 AM. Surveyor #3 noted the patient's observed documented behavior on the seclusion flow sheet as "sleeping" from 11:35 PM until 7:15 AM, a period of 7 hours and 40 minutes. The surveyor found no evidence in the seclusion documentation to indicate the hospital staff considered removing the patient from seclusion early. 5. The director of adult psychiatric services (Staff Member #6) confirmed the findings at the time of review.	A 174		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This Condition is not met as evidenced by: Based on observation, interview, record review, and review of the hospital's quality program and quality documentation, the hospital failed to	A 263	**See A0273, A0286, A0309, A0490, A0700**	

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A 263	Continued From page 14 develop and implement a hospital-wide, data-driven quality assessment and performance improvement (QAPI) program. Failure to systematically collect and analyze hospital-wide performance data and to develop action plans to improve performance based on that data limited the hospitals ability to identify problems and formulate action plans. Findings: Failure to identify pharmaceutical services lacking sufficient personnel to meet the scope, complexity, and needs of the patients served. Failure to provide oversight of the Performance Improvement Program; Failure to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016; Failure to measure, analyze and track adverse patient events; Failure to develop a process for identifying and reviewing reportable adverse events; Failure to ensure completion of action plans developed during review of adverse events; Failure to ensure and monitor the overall hospital environment was maintained in such a manner that the safety and well being of patients was protected.	A 263		

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A 263	Continued From page 15 The cumulative effect of these systemic problems resulted in the hospital's inability to identify opportunities to improve patient care, safety and outcomes of care. Due to the scope and severity of deficiencies cited under 42 CFR 482.21, the Condition of Participation for Quality Assurance and Performance Improvement Program was NOT MET. Cross Reference: A-0273, A-0286, A-0309, A0490, A0700	A 263		
A 273	482.21(a), (b)(1),(b)(2)(i), (b)(3) DATA COLLECTION & ANALYSIS (a) 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 improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service andoperations. (b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and.... (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	**A 0273 Corrective Actions** The PI Director reviewed the list of performance indicators, assigned by the Governing Body, PI Committee, and Medical Staff for 2016. Of note, the following clinical data was aggregated, analyzed, and presented to the PI and MEC committees for assessment of patient care processes. -Grievances -Anticoagulation therapy and medication reconciliation upon admission and discharge -Restraint/Seclusion -Elopement rates and medication variances -Medical consultations/treatment -Contracted Services -Pharmacy and Therapeutics (drug utilization, medication variances, adverse drug reactions, antibiotic usage, and nursing unit/med room checks)	2/10/17

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A 273	Continued From page 16 This Standard is not met as evidenced by: Based on interview and review of the hospital's quality program and quality documents, the hospital failed to collect and analyze data for performance measures assigned by the Governing Body, Performance Improvement Committee and the Medical Staff for the year 2016. Failure to measure, analyze and track data related to performance measures as assigned leaves the hospital unable to identify areas of concern that may require improvement. Findings: 1. Review of the Performance Improvement Plan (Approved 12/2015) and a document titled " Performance Database - 2016 " revealed that the hospital was to collect and analyze data for 16 different performance measures. Each performance measure was assigned to a specific person for data collection and analysis, and the reporting frequency was defined. The Governing Board was to review the performance measures on a quarterly basis. 2. Surveyor #2 interviewed the Director of Clinical Services (Staff Member #13) about Performance Measure data collection, analysis and reporting on 12/16/2016 at 1:45 PM. The interview revealed the following: a. The Performance Measure titled "Patient Rights and Grievances" was to measure grievance process compliance and number of	A 273	Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of performance measures for presentation to the PI committee. Committee members will implement action plans as documented in meeting minutes. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program.	2/10/17

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A 273	Continued From page 17 grievances. The information was to be collected and analyzed by the Performance Improvement Director and the Patient Advocate, and reported to the Performance Improvement Committee monthly. There was no report containing this information presented for surveyor review. The Director stated that the grievance committee had not been meeting and that the data was not being collected or analyzed. b. The Performance Measure titled "National Patient Safety Goals" listed 5 goals that the hospital was to collect and analyze data for, two were reviewed by Surveyor #2: 1) Reduce likelihood of patient harm associated with anticoagulant therapy (Warfarin), and 2) Medication Reconciliation upon admission and discharge. The Chief Nursing Officer and the Risk Manager were responsible for data collection and analysis, and for reporting to the PI Committee and the Governing Board monthly. There was no report containing this information presented for surveyor review. c. The Performance Measure titled "Restraint/Seclusion" was to measure proper documentation of restraint and seclusion. The Directors of Nursing and the Risk Manager were responsible for the data collection and analysis, and for reporting monthly to the PI Committee and Governing Board. While the number of patients placed in restraint and seclusion were reported by the Performance Improvement Committee to the Governing Board, there was no report available for review related to proper documentation of restraint andseclusion. d. The Performance Measure titled "Risk Management/Patient Safety/Quality" was to measure suicides/suicide attempts, falls,	A 273	Amendment 2/1/2017: The 2016 data for grievances, anticoagulants, restraints & seclusions, elopements, medication consultations, Pharmacy & Therapeutics indicators, and contracted services have been abstracted and analyzed and will go the PI Committee on or before Thursday, February 9, 2017 and then to the Medical Executive Committee on Thursday, February 9, 2017 and Governing Board thereafter. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 273	Continued From page 18 medication variances, elopements, contraband and patient satisfaction. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting monthly to the Performance Improvement Committee and Governing Board. The surveyor requested to review the data collection and analysis for medication variances and elopement. While there was data presented to the surveyor for elopement and medication variances, there was no report containing analysis of the data. e. The Performance Measure titled "Medical Consultations/Treatment" was to measure medical consultation for timeliness and appropriateness to the patient's individual needs. The Risk Manager and Chief Nursing Officer were responsible for data collection and analysis, and for reporting the information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. f. The Performance Measure titled "Contracted Services" referred to the Contract log for scope of service and quality measures. The Risk Manager and Chief Executive Officer were responsible for data collection and analysis, and for reporting this information annually to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review. Cross-reference: Tag A-0084 g. The Performance Measure titled "Pharmacy and Therapeutics" was to measure drug utilization, medication variances, adverse drug	A 273		

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A 273	Continued From page 19 reactions, antibiotic usage and nursing unit/med room checks. The Pharmacist was responsible for data collection and analysis, and for reporting this information quarterly to the Performance Improvement Committee and the Medical Executive Committee. There was no report containing this information presented for surveyor review.	A 273		
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 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:	A 286	A 286 Corrective Actions 1) Analysis and Tracking of Adverse Patient Events All elements of the PI plan and 2016 performance improvement activities were reviewed by senior leadership, the Performance Improvement Committee (1/11/17) and the Medical Staff committees (1/10/17 and 1/11/17). The processes for adverse event analysis and tracking including the Root Cause Analysis process was highlighted. 2016 data analysis and recommendations for action were reviewed by PI and MEC committees. Persons Responsible: PI Director COO/CNO Medical Director Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for adverse events for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of adverse event data analysis and tracking on a quarterly basis to ensure implementation of the performance improvement program.	2/10/17

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A 286	Continued From page 20 ITEM #1 - Analysis and Tracking of Adverse Patient Events Based on interview, record review and review of quality documents, the hospital failed to measure, analyze and track adverse patient events. Failure to analyze aggregate data related to adverse patient events risks the hospital's ability to identify root causes and develop action plans and may contribute to an unsafe patient care environment. Findings: 1. Review of the hospital policy and procedure titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) revealed that the hospital's Risk Manager was responsible for collecting incident report data for statistical analysis and trending. Review of the hospital's Performance Improvement Plan (Policy #RM.300; Approved 12/2015) revealed that it was the responsibility of the Medical Executive Committee and the Performance Improvement Committee to review risk management activities by analyzing the results of incident reports, patient surveys and patient complaints to determine patterns of patient care occurrences and ensure that corrective action is or has been taken to the extent possible. 2. An interview with the Manager of Risk and Quality (Staff Member #12) on 12/14/2016 at 1:04 PM and 12/20/2016 at 1:20 PM, and the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:45 PM revealed the following:	A 286	Amendment 2/1/2017: Going forward, the PI Committee will receive action plans for each Root Cause Analysis conducted along with a time frame for the completion of those action items. The PI Committee will add those items to minutes and receive follow-up at each of its meetings until all items are resolved. Action items will typically be resolved within 90 days, some sooner, depending on the urgency associated with that action item. The target compliance is 90% of all items completed with 90 days. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues	

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A 286	Continued From page 21 a. Incident reports were reviewed individually by the Risk Manager and other managers as needed but the data was not reviewed in aggregate looking for patterns, trends and opportunities for improvement. b. Patient grievances were logged and reviewed individually but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. c. The number of patients requiring a medical transfer were reported to the Governing Board quarterly but the data was not analyzed in aggregate looking for patterns, trends and opportunities forimprovement. d. Hospital code data was not being collected or analyzed for the purpose of looking for patterns, trends and opportunities for improvement. ITEM #2 - Reportable Adverse Events Based on interview, record review and review of hospital policies and procedures, the hospital failed to develop a process for identifying and reviewing reportable adverse events. Failure to recognize reportable adverse events inhibits the hospitals ability to perform in-depth review of the events and develop action plans. This failure places patients at risk for care in an unsafe environment. Reference: WAC 246-302-010 Definitions "Adverse health event" or "adverse event" means the list of twenty-nine serious reportable events updated and adopted by the National Quality	A 286	ITEM #2 – Reportable Adverse Events The COO/CNO has educated the PI Director on the requirements of WAC246-302-010. All reportable events outlined in the NQF list of reportable adverse events, the requirement for reporting adverse events and elements of submitting a root cause analysis were discussed. All reportable adverse events will be reported in a timely manner in accordance with WAC246-302-010.	2/10/17

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A 286	Continued From page 22 Forum in 2011, in its consensus report on serious reportable events in health care including all appendices. WAC 246-302-020 How and When to Report (1) Notify the department that an adverse health event has occurred within forty-eight hours of confirmation of the adverse health event ... (2) Submit a report to the department within forty-five days of the confirmation of the adverse health event. The report must include a root cause analysis and corrective action plan ... Reference: The National Quality Forum (NQF) identifies and defines twenty-nine serious reportable events. The twenty-nine adverse health events including but not limited to: (7) Potential criminal events: (d) Death or serious injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting. Findings: 1. The Hospital policy titled "Incident Reporting" (Policy #RM.200; Approved 12/2013) stated that "In States where the facility is required to report Tragic/Serious incidents to the State, it must be done within the State requirements and notification of completion to Corporate Risk Management and Clinical Services Departments." The same policy stated that "All Level I and II incidents require a Risk Manager investigation and completion of the Investigation Chronology and Incident Recap Analysis."	A 286	ITEM #2 continued Persons Responsible: PI Director COO/CNO Monitoring On a monthly basis, the PI/RM Director will report all adverse events reported per WAC 246-302-020 to the PI committee and MEC and Governing Board quarterly.	

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A 286	Continued From page 23 The policy did not include the NQF list of reportable adverse events nor did it include the requirement for reporting adverse events and submitting a root cause analysis. 2. Surveyor #2 reviewed a report of a patient to patient assault resulting in a serious patient injury. The patient was transferred to the emergency room for care and required follow-up specialty health care appointments for his/her injuries. The incident was reviewed by the Manager of Risk and Quality (Staff Member #12), and the Investigation Chronology and Incident Recap was completed with recommendations for improvement based on the investigation. 3. An interview with the Manager of Risk and Quality (Staff Member #12) by Surveyor #2 on 12/20/2016 at 2:12 PM about the patient to patient assault revealed that Staff Member #12 was unaware that this particular incident was considered an adverse event by NQF. Staff Member #12 stated that a root cause analysis had not been completed nor had the incident been reported to the State as required by hospital policy. ITEM #3 - Completion of Action Plans Based on interview and document review, the hospital failed to ensure completion of action plans developed during review of adverse events. Failure to ensure completion of action plans limits the hospitals ability to correct systemic problems placing patients at risk for harm. Findings:	A 286	A 286 Item #3- Completion of Action Plans The COO/CNO and PI Director were trained on analysis of adverse events and credible root cause analysis elements by the Regional Clinical Director. Adverse reportable events will be reviewed with credible action plans formulated and implemented in a timely manner. Persons Responsible: PI Director Monitoring On a monthly basis, the PI/RM Director will present action plans based on analysis of adverse events to the PI committee. Action plans will include date/s actions taken and persons responsible for action. The Medical Staff and Governing Board will be informed of actions taken in response to adverse events on a quarterly basis to ensure implementation of the analysis and actions taken in response to adverse events.	2/10/17

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A 286	Continued From page 24 1. Surveyor #2 reviewed the root cause analysis for 3 adverse events with the Director of Clinical Services (Staff Member #13) on 12/16/2016 at 1:25 PM and with the Manager of Risk and Quality (Staff Member #12) on 12/20/2016 at 9:20 AM. Review of the action plans developed to correct identified issues revealed the following: a. For the elopement issue, the action item to change the policy "Code Amber" (used to alert staff of a patient who has wandered away from the nursing unit) to "Code E" had not been completed although staff were trained and Code E was being used by the hospital. b. For the sexual assault issue, one of the action items was a change to an assessment form followed by audits to ensure that assessments were properly conducted, documented, and risk reduction precautions were implemented. Staff Member #12 stated that the audits had not been done.	A 286		
A 309	482.21(e)(1), (e)(2), (e)(5) QAPI EXECUTIVE RESPONSIBILITIES The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: 1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained . (2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient	A 309	A 309 Corrective Actions The PI Director and Medical Director reviewed all elements of the PI plan and 2016 performance improvement activities with the Medical Staff and MEC committees (1/10/17 and 1/11/17). The processes for clinical and non-clinical analysis and tracking were highlighted. 2016 data analysis and recommendations for action were reviewed by the MEC. The Medical Staff assigned physician representation to the Infection Control, Pharmacy & Therapeutics, EOC, Safety and Performance Improvement committees. These committee participants will report committee activities to the MEC at least quarterly.	2/10/17

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A 309	Continued From page 25 safety and that all improvement actions are evaluated. (5) That the determination of the number of distinct improvement projects is conducted annually. This Standard is not met as evidenced by: Based on interview and review of the hospital's performance improvement plan, the hospital's Governing Body failed to provide oversight to ensure that the quality assessment and performance improvement (QAPI) plan was fully implemented. Failure to provide oversight of the Quality Assessment and Performance Improvement program to ensure full implementation of the performance Improvement plan limited the hospital's ability to identify systemic problems and develop action plans to improve patient care and ensure safety. Findings: 1. The hospital's Performance Improvement Plan (Policy #RM. 300; Approved 12/2015) stated that "Medical staff and management staff provide leadership for and actively participate in performance improvement activities and establish criteria for measuring, assessing and improving organization performance of both clinical and non-clinical processes and patient outcomes. They assure implementation of appropriate quality assessment and improvement activities and report the results to the Board through the Medical Executive Committee and Performance Improvement Committee.	A 309	The MEC reviewed the 2017 PI Plan and recommended priorities for quality and performance improvement activities. Persons Responsible: Medical Director President of the Medical Staff Monitoring On a monthly basis, the PI/RM Director will facilitate the tracking and analysis of PI measures for presentation to the PI and MEC committees. Negative or undesired trends will be discussed by the committee for initiation of performance improvement actions as needed. The Medical Staff and Governing Board will be informed of data analysis and PI initiatives on a quarterly basis to ensure implementation of the quality and performance improvement program	2/10/17

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A 309	Continued From page 26 The Medical Executive Committee is delegated the Authority and Accountability necessary for the delivery and assessment of all processes that contribute to the prevention of problems and the continual improvement of the quality, appropriateness and efficiency of patient care outcomes. Medical Executive Committee responsibilities, duty and authority for performance improvement activities are defined in the Medical Staff Bylaws." The hospital's Medical Staff Bylaws (dated 12/1/2013) under the section titled "Medical Executive Committee" read in part 11.4.1 Quality Management: (a) The duties involved in overseeing quality assessment and performance improvement are to ...perform at least an annual evaluation of the quality management program to assure its comprehensiveness and effectiveness, and document improvement in patient care and patient outcome studies; and ...document performance of this function in a report on at least a quarterly basis. 2. An interview with the Manager of Risk and Quality (Staff Member #12) and the Director of Clinical Services (Staff Member #13) revealed that the Medical Director is a member of the Performance Improvement Committee but does not participate in performance improvement activities other than those that have to do with credentialing and privileging of medical staff . The Manager of Risk and Quality stated that the Performance Improvement Program has never been formally evaluated as required by the Medical Staff Bylaws. Cross Reference: A-0273, A-0286	A 309		

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A 405	Continued From page 27	A 405	**A 0405 Corrective Actions**	
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This Standard is not met as evidenced by: Based on record review, interview, and review of policy and procedure, the hospital failed to ensure that nursing staff followed physician orders for treatment of alcohol withdrawal for 1 of 3 patients reviewed (Patient #7). Failure to follow such orders risks patients receiving inadequate or improper treatment, which may result in patient harm. Findings:	A 405	The Clinical Educator reeducated the nursing staff on the requirement of administrating medications as ordered for the treatment of alcohol withdrawal. The Clinical Educator provided education during Nursing staff meetings through verbal and written communication. Person Responsible: COO/CNO Monitoring The PI/RM Director/designee will perform a random audit of at least 30 records per month to ensure compliance of 90% or above for four consecutive months. Any deficiencies will be promptly addressed. Audit results will be presented to the monthly PI and quarterly MEC and Governing Board meetings.	2/10/17

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A 405	Continued From page 28 1. The hospital's policy and procedure titled "CIWA" [Clinical Institute Withdrawal Assessment] (Policy #AR.C.210; Approved 12/2013) established how often a patient was to be assessed for symptoms of alcohol withdrawal; how the patient's symptoms were to be scored using a withdrawal assessment scale and how medications were to be administered according to the patient's score. The policy included a pre-printed order set titled "Lorazepam Orders for Alcohol Withdrawal" (dated 5/15/2014) used by physicians to order specific dosages of medications to be administered based on the patient's withdrawal assessment score. 2. Review of the medical records of three patients who experienced symptoms of alcohol withdrawal during their hospital stay revealed the following: a. Patient #7 was a 59 year-old patient who was admitted on 12/10/2016 for treatment of alcohol withdrawal. On 12/10/2016 at 9:30 PM the patient's physician ordered the Alcohol Withdrawal Protocol initiating treatment for alcohol withdrawal symptoms. Review of the medication administration record for Patient #7 revealed that on 12/10/2016 the patient received 1 mg of Lorazepam at 9:40 AM and 1 mg of Lorazepam at 2:20 PM. An interview by Surveyor #2 with a Registered Nurse (Staff Member #4) during review of the patients alcohol withdrawal scores and administered medications revealed that based on the score assigned at 9:00 AM and 2:00 PM the patient's dose of Lorazepam should have been 0.5 mg at 9:40 AM and 0.5 mg at 2:20 PM. Staff	A 405	Amendment 2/1/2017: CIWA protocols are currently being audited daily by the Nursing Director of CD Services. Analysis of the audits will go to the PI Committee at each weekly PI Committee starting Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Once several weeks of compliance is achieved, monitoring will become monthly with the same targets.	

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A 405	Continued From page 29 Member #4 did not know why nursing staff administered the higher doses. .	A 405		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This Condition is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to provide sufficient pharmaceutical services to meet the scope, complexity, and needs of the patients served. . Failure to provide adequate pharmacy services risks patient safety and safe medication administration practices. . Findings: . 1. Medications being administered to patients prior to pharmacy verification of orders resulting in high number of automatic dispensing machine overrides. . 2. Patient home medications not being verified by a pharmacist prior to being administered. . 3. Medication errors resulting from medication overrides of the automatic dispensing machines. . 4. Expansion of hospital services, clinical units,	A 490	**See Tags A0491, A0493, A0500**	

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A 490	Continued From page 30 and patient census without a comparable increase in pharmacy services coverage. The cumulative effect of these systemic problems resulted in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. Due to the scope and severity of deficiencies under 42 CFR 482.25, the Condition of Participation for Pharmaceutical Services was NOT MET. Cross Reference: Tags A0491, A0493, A0500	A 490		
A 491	482.25(a) PHARMACY ADMINISTRATION The pharmacy or drug storage area must be administered in accordance with accepted professional principles. This Standard is not met as evidenced by: Based on observation, interview, and review of policy and procedure, the hospital failed to ensure that hospital staff followed hospital procedures for use of a patient's own medications. Failure of staff to follow procedures for use of a patient's own medications places patients at risk for harm due to medication errors. Findings: 1. The hospital policy and procedure titled "Medications Brought in with Patients" (Policy # PHR-118; Revised 4/2014) read as follows: "...for those medications that will be used by the patient during their admission at the facility, the	A 491	**A 0491 Corrective Actions** The Clinical Educator reeducated the nursing staff on policy titled "Medications Brought In with Patients." Education was provided during Nursing staff meetings through verbal and written communication. Education included: -Use of home medications only after the verification process is complete. -Proper labeling and initialing of the verification process on home medication bottles. -Physician orders needed for use of home medications. The medical staff were educated on the requirement of documenting dosages for home medication administration and ordering allowance of patient home medications. Education was provided through written and verbal communication. Persons Responsible Medical Director Pharmacy Director COO/CNO	2/10/17

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A 491	Continued From page 31 medications will be inspected for proper identification, labeling, and visual evaluation as part of the pharmacist verification process. Once a medication is verified, the pharmacist will place a sticker on the packaging with the pharmacist's initials and date the medication as evidence the medication has been verified ..." "The order for a patient to take his/her own medication must be written by the attending physician on the Physician's Order form." 2. A tour of the medication room of three patient care units (Gero-psych, Rehab and Detox) on 12/19/2016 between 2:00 PM and 3:00 PM revealed the following: a. One bottle of home medication, Latuda 120 mg tablets, was found for Patient #8 in the patient's medication tray in the Rehab unit medication room. The pharmacist attached a white printer label to the medication bottle with "verified" written on the label along with the date (12/17/2016) and initials of the pharmacist. Staff administered the medication at 9:00 PM on 12/15/2016 and 12/16/2016 prior to pharmacist verification. b. Two bottles of home medications, Provastatin Sodium 40 mg tablets and Dilt [Diltiazem] XR SR 180 mg capsules, were found for Patient #9 in the patient's medication tray in the Rehab medication room. The pharmacist verified and labeled the medications using a "date opened/expiration date" label rather than the pharmacy medication verification label. Staff administered the medications on 12/18/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medications.	A 491	Monitoring The PI/RM Director/designee will perform a random audit of at least 30 patient's own medication orders to ensure compliance with the verification process. Any deficiencies will be addressed promptly. Audit results will be reported in the monthly PI and quarterly MEC and Governing Board meetings. Amendment 2/1/2017: The pharmacy director is auditing 100% of home medications and will first report his findings to the weekly PI Committee on Wednesday, February 1, 2017, to the Medical Executive Committee on February 9, 2017 and to the Governing Board thereafter. Audits will continue until several weeks of compliance at or greater than 90% has been achieved and sustained. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 491	Continued From page 32 c. Three bottles of home medications, Rayataz 300 mg capsules, Norvir 100 mg tablets and Truvada 200 mg tablets, were found for Patient #10 in the patient's medication tray in the Rehab medication room. There was an initial and date written directly on the medication bottle label (for the Rayataz and Truvada) but the surveyor was unable to tell if the initials and dates were evidence of pharmacist verification. There were no pharmacist verification labels on the two medication bottles. The Norvir medication had no label with date and signature indicating pharmacist verification. All of these medications were in a plastic bag placed in the patient's medication tray. Two notes were found in the bag, one stated that the pharmacist verified Truvada and the other note stated the pharmacist had verified Norvir. The notes were not attached in any way to the bottles of medication. Staff administered all three medications on 12/19/2016 at 9:00 AM. There was a physician order for administration of the patient's own medications but the order did not include specific dosages. d. One bottle of home medication, Dilantin 30 mg capsules, was found for Patient #11 in the patient's medication tray in the Gero-psych unit medication room. The pharmacist verified and labeled the medication. Staff administered the medication on 12/19/2016 at 9:00 AM. There was no physician order for the patient to take his/her own medication.	A 491		
A 493	482.25(a)(2) PHARMACY PERSONNEL The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.	A 493		

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A 493	Continued From page 33 This Standard is not met as evidenced by: Based on document review and interview, the hospital failed to ensure the pharmacy was staffed with sufficient number of personnel to provide quality pharmaceutical services in order to meet the needs of the patients and the staff providing care. Failure to provide sufficient pharmacy staff to provide accurate and timely order processing and medication delivery places patients at risk of harm due to medication errors. Findings: 1. The hospital expanded its overall bed capacity by 42 beds within the past 12 months. During that period, two additional nursing units were opened (2 North - 18 beds; 2 West - 24 beds). Prior to the expansion, the hospital's average daily census (ADC) was 66.58 patients. This year's current ADC is 104.41 which represents a 57% increase or an additional 37.58 patients per day. The hospital pharmacy staffing or coverage did not increase correspondingly despite the increased workload. 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captures a variety of key quality workload elements. The surveyor noted that the average number of medication doses administered monthly increased by over 12,000 doses since the beginning of the year. The total number of medication overrides performed by nurses averaged 2,593 per month or nearly 87 per day. Similarly, the "inventory count off" in the automatic dispensing machines monthly totals reflect non-controlled substances discrepancies have increased to a monthly	A 493	**A 0493 Corrective Actions** Upon completion of the survey, the CEO, COO/CNO, Pharmacy Director, and Regional Clinical Director reviewed pharmacy staffing in order to ensure a sufficient number of personnel. Effective 12/20/16, the Pharmacy Director increased pharmacy staffing hours by two (2) additional evening hours, seven days per week. The increase in pharmacy hours are prioritized on verification of new orders and order entry. Persons Responsible: Pharmacy Director CEO Monitoring The Director of Pharmacy will track use of the additional staffing hours and report utilization in the monthly PI and quarterly MEC and Governing Board meetings for a period of 3 months. Any related deficiencies will be addressed promptly.	2/10/17

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A 493	Continued From page 34 average of 685 items. 3. On 12/14/2016 at 11:30 AM, Surveyor #3 interviewed a pharmacist (Staff Member #9) about the adequacy of pharmacy staffing compared to the current workload. Staff Member #9 acknowledged the pharmacy workload had substantially increased within the past year. S/he stated that since starting work at this facility almost a year ago, the hospital had added two more inpatient clinical units without a corresponding increase in pharmacy operating hours or personnel. Staff Member #9 indicated that the average turnaround time for verifying new medication orders was 30 minutes but may be delayed up to an hour depending on volume of new admissions. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 stated that he/she had only been a member of the hospital staff for "less than a month" but acknowledged the number of medication overrides was "high" indicating that pharmacy is only on-site during the day shift hours. Surveyor #3 asked Staff Member #8 if s/he had sufficient pharmacy resources. Staff Member #8 stated that "I don't have enough pharmacy staff to do what we should." The director of pharmacy indicated that he/she had worked over the contracted hours every week except for the first week when on orientation. 5. On 12/16/2016 at 11:00 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated	A 493	Addendum 2/1/2017: Pharmacy has increased its hours of coverage in the evening hours. Overrides are being tracked daily and analyzed for time of day, type of drug, and reason for the override. The PI Director and Pharmacy Director will formally present their findings at the weekly PI Committee meeting beginning Wednesday, February 1, 2017. Pharmacy hours will continue to be adjusted as necessary to minimize the use of the override process. The facility will continue to evaluate hours needed by the pharmacy through recommendations by the contracted provider, number of over-rides due to lack of pharmacist to conduct the first dose review, and medication errors related to overrides.	

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A 493	Continued From page 35 that medication overrides is a "problem" stating "I think medication overrides are dangerous." The staff member acknowledged that nurses were overriding because of how long it takes for orders to be verified in the system. Staff nurses have also complained they frequently run out of medications in the automatic dispensing machines on the weekends, "especially on Monday mornings" requiring nursing staff to search for medications on other clinical units. .	A 493		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This Standard is not met as evidenced by: . Based on document reviews, interviews, and review of hospital policies and procedures, the hospital failed to ensure drugs were controlled and distributed in accordance with applicable standards of practice. . Failure to have adequate processes in place for medication orders to be received and dispensed in a safe and timely manner risks patient safety and medication errors. . Findings: . 1. The hospital policy and procedure titled "After-Hour Medication Stock with or without Pharmacy Review" (Revised 4/2014; Policy # PHR-169l) under the section titled "Statement of Policy" read "The facility recognizes the importance of pharmacist review prior to initiation of new drug therapy. This review has been shown	A 500	**A 0500 Corrective Actions** The Pharmacy Director, COO/CNO, and PI/RM Director reviewed the process of medication overrides in the automated dispensing system. To ensure safe delivery of medications, the following system revisions were made: -Reasons for overrides -Two nurse witness system when overrides are needed -Weekly review of overrides to assess for trends, rationale, and any needed system improvements The Clinical Educator educated the nursing and medical staff on the revised system changes for oversight of the override system. Education was provided during Nursing and Medical Staff meetings through verbal and written communication. Persons Responsible: Medical Director Pharmacy Director COO/CNO PI/RM Director	2/10/17

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A 500	Continued From page 36 to decrease medication errors associated with the medication-use process. . .The hospital allows for an exception to pharmacist review of the medication order for certain situations when time does not permit pharmacist review. This often occurs in 'first doses' or 'emergency' situations. In such cases, an exception is allowed because significant patient harm could result in the delay involved for a pharmacist review of the medication order, and the potential harm would outweigh the benefits of a pharmacist review." 2. On 12/20/2016, Surveyor #3 reviewed a pharmacy document which captured a variety of key quality workload indicators that included medication variances and medication overrides. The surveyor noted the hospital had a total of 23,348 medication overrides performed by nurses in the first nine months of 2016. Prior to the expansion of the hospital bed capacity, the hospital average 2,221 medication overrides a month. With the opening of the two additional nursing units, the number of medication overrides had risen to a monthly average of 2,700 representing a 22% increase or 479 additional overrides. Similarly, the surveyor noted that the number of medication variances (potential errors) by physicians had increased by four fold since the beginning of the year. 3. On 12/19/2016 at 3:00 PM, Surveyor #3 reviewed the hospital medication override list for the period 12/16/2016 at 4:00 PM until 12/19/2016 at 7:00 AM (the weekend) in which the pharmacy in-house coverage is only 6 hours a day. During this time period, the hospital admitted 14 patients and there was a total of 236 medication overrides initiated by the nursing staff. Of the 236 medication overrides which occurred over the weekend, 85 of the overrides listed	A 500	Monitoring The Pharmacy Director/designee will report on the total number of overrides with aggregated trends, analysis, and system improvements to the monthly PI and quarterly Pharmacy and Therapeutics committees. Findings, recommendations and actions will be reviewed and reported at quarterly MEC and Governing Board meetings. Committee minutes will reflect data reporting, analysis, and system changes. **A500 Amendment 2/18/2017** Cascade Behavioral Health was cited for pharmaceutical services not meeting the needs of its patients. The cumulative effect of these systemic problems/findings results in the hospital's inability to provide for safe dispensing, use and administration, and tracking and control of medications. Immediate response included increased pharmacy hours by two (2) additional evening hours, seven (7) days per week. That staffing enhancement resulted in overrides being reduced to approximately 10 per day. Since then, the medical staff considered a night locker concept with a smaller inventory of medications but ultimately decided not to endorse this idea. Collectively, these systemic issues require additional time to implement process change, arrange additional pharmacy coverage, establish 24/7 coverage solution to review all orders, and eliminate nursing access and overrides.	

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A 500	Continued From page 37 "First Dose Needed" as the reason indicating the pharmacy had not yet verified the medication order in the automated dispensing system. Only 11 medication overrides listed "Emergency Use" as the reason for the override. 4. On 12/19/2016 at 2:30 PM, Surveyor #3 interviewed the Director of Pharmacy (Staff Member #8) about the high number of medication overrides occurring within the hospital. Staff Member #8 indicated that nursing personnel can override and obtain any and all medications in the hospital's automated dispensing machines. He/she acknowledged that the hospital's entire formulary was accessible to all nurses without any restriction. 5. On 12/20/2016 at 2:30 AM, Surveyor #3 interviewed the Director of Adult Psychiatric Nursing Services (Staff Member #6) about the high number of medication overrides occurring within the hospital. Staff Member #6 indicated that medication overrides is a long standing problem. The staff member confirmed that s/he was processing "too many medication error" incident reports. Staff Member #6 asked to be a member of the Pharmacy & Therapeutics Committee to see if some improvement or progress could be made on this issue. He/she acknowledged discussing medication overrides in meetings with the previous pharmacy director (Staff Member #10) former chief nursing officer (Staff Member #11) and the quality risk manager (Staff Member #12) and the decision was made to continue to monitor the situation.	A 500	**Proposed Interim Plan** Temporary night and weekend pharmacists to provide additional coverage will be in place by February 24, 2017. They will physically be present in the pharmacy to review and enter all new orders during their shift, just as the day-shift pharmacists currently do. The nurses' ability to override medications will be disabled permanently. All medication orders will be verified by a pharmacist prior to administration. **Responsible Person** Pharmacy Director (Pharmacist in Charge) **Proposed Long Term Plan** On or about April 1, 2017, the facility will transition pharmacist coverage to 24/7 through a combination of pharmacist on site and remote order entry. The Pharmacy Director, CEO and COO are evaluating options to obtain the necessary resources to establish this service within this expedited timeframe.	
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient,	A 700		

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A 700	Continued From page 38 and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This Condition is not met as evidenced by: Based on observations, document review, and staff interviews, the hospital failed to ensure the condition of the physical plant and the overall hospital environment was maintained in such a manner that the safety and well-being of patients was protected. Failure to maintain the structural integrity of the facility plumbing and ventilation system. Failure to follow manufacturer-recommended maintenance activities and schedule. Failure to remove ligature risks in patient care areas. Failure to monitor and provide appropriate food temperature devices to ensure food temperatures are maintained at the required levels. Due to the scope and severity of deficiencies cited under 42 CFR 482.41, the Condition of Participation for Physical Environment was NOT MET. Cross Reference: Tags A0701, A0710, A0724, A0726	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and	A 701	A 701 Corrective Actions 1. and 2. The Facilities Director reeducated staff on environmental factors contributing to ligature and self-harm risks particularly related to doors and handles. Training included mitigation strategies such as patient observation and	2/10/17

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A 701	Continued From page 39 well-being of patients are assured. This Standard is not met as evidenced by: . Based on observation, interview and record review the hospital failed to maintain the condition of the physical plant and the overall hospital environment of care. Failure to maintain the physical plant increases the risk of infection to patients, staff and visitors. Findings: 1. On 12/13/2016 at 10:00 AM Surveyor #1 observed the door in the sunroom in the Gero-psychiatric unit had a closure mechanism that posed a ligature risk. In review of the "Proactive Risk Assessment dated August 2016, the facility had identified door risks in geriatric unit and assessed it as "High" or "Severe Risk". The surveyor noted the columns labeled "What Action", "Time Frame", and "Intermediate Mediation Needed" for this item had limited or no information provided in these columns. 2. On 12/13/2016 at 10:00 AM Surveyor #1 observed that the handles on the small rectangular windows in the sunroom posed a ligature risk 3. On 12/13/2016 at 10:10 AM Surveyor #1 observed that the flooring in the bathroom on the adult psychiatric unit (3 West) was soft underneath the vinyl and that vinyl was rippled and not smooth. The bathroom was located next to 3 showers on 3 West. 4. On 12/13/2016 at 10:25 AM Surveyor #1 observed in the seclusion room on the adult	A 701	**A 0701 Corrective Action** Increased monitoring of high risk patients. Staff required to successfully complete post training test. 3. Bathroom flooring was repaired by (contractor) on 1-12-17. 4. Ceiling links were repaired by (contractor) on 1-12-17. 5. Occluded pipes were repaired by contractor 1-12-17 6. Ceiling tiles were changed 1-16-17 by Maintenance staff 7. Burnt outlet was replaced by Maintenance staff by 12/23/16 8. Shower mold was remediated, old caulk was removed and the area cleaned and re-caulked by Maintenance staff (1/9/17) 9. Oscillating fans have been installed in all PHP patient care areas. Permanent ventilation systems are being evaluated. Persons Responsible: Plant Operations Director CEO Monitoring: The Plant Operations Director/designee will perform environmental rounds of the patient care areas to monitor ligature risks, integrity of flooring/walls/ceilings, furnishings, finishes, cleanliness and structures. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	

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A 701	Continued From page 40 psychiatric unit (2 West) a large crack in the ceiling, the crack appeared to be wet with exposed dry wall where work had previously been done. On 12/14/2016 between the hours of 2:00 PM and 3:00 PM Surveyor #1 observed towels soaked in water on the floor in the same seclusion room on 2 West where the ceiling was actively leaking. Surveyor #1 went to 3 West to see what was above the seclusion room and found that the three showers previously stated above were located above the seclusion room, the surveyor observed that one of the showers was in use during the incident. 5. On 12/15/2016 between 9:00 AM and 10:00 AM Surveyor #1 observed flooding over the rim of the shower onto the floor on 3 West next to room 303. During the incident, the surveyor observed facility staff (Staff Member #17) "snake" the drain and pull out small amounts of hair. Surveyor #1 did a visual inspection of the pipes using a flashlight and found the pipes were occluded. 6. On 12/13/2016 between the hours of 10:25 AM and 11:00 AM Surveyor #1 observed water damage on a ceiling tile located in the Rehab unit laundry room. 7. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed a burnt outlet in the patient kitchen area in the Rehab unit, this is a potential fire hazard. 8. On 12/13/2016 between the hours of 10:25 and 11:00 AM Surveyor #1 observed mold underneath the caulking in the shower room in the rehab unit. 9. On 12/15/2016 between the hours of 1:30 PM and 3:00 PM Surveyor #1 entered into an outpatient building (PHP Building), the buildings	A 701	Amendment 2/1/2017: The pipes were occluded by temporary obstructions and have been assessed by an independent, professional plumber. The pipes have no on-going needs except routine cleaning and maintenance. To improve cleaning and maintenance, the hospital purchased distinct brushes to scour the drain pipes to remove hair and other debris. This cleaning will occur monthly and as needed and has been added to facility and housekeeping rounds. The hospital has switched to psych-safe paper towels that dissolve when wet to address drain clogging issues. **A701 Amendment 2/18/2017** We propose to cool, circulate, and dehumidify our outpatient/PHP rooms with two portable air conditioners designed for that purpose, one in each room where patient care is delivered. The rooms measure: 1) 19 feet by 19 feet (361 square feet) 2) 17 feet by 29 feet (493 square feet) Before the summer heat arrives, we will install two Honeywell model MM14CCS, or similar, units which are designed to cool 500 square feet. These quiet units provide 14,000 BTU cooling. They can be used to cool or use the fan and dehumidify the air. The units' venting kits would be installed for the air conditioner to operate properly.	

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A 701	Continued From page 41 ventilation system had not been replaced after a fire. Surveyor #1 observed 2 large rooms that are used for group sessions for patients, one room did not have any windows and the other room had skylights that did not open creating no means to ventilate in both rooms.	A 701	Between now and the installation of these units, ventilation of these patient care rooms will be accomplished by the fan-forced heaters currently in use and oscillating fans. No policy is needed for staff to turn on the air conditioning. This will be based on a consensus of the group of patients and staff at the time as it relates to comfort.	
A 710	482.41(b)(1)(2)(3) LIFE SAFETY FROM FIRE (1) Except as otherwise provided in this section- (i) The hospital must meet the applicable provisions of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR Part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospitals. (2) After consideration of State survey agency findings, CMS may waive specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the	A 710	**A 0710 Corrective Actions** The hospital will not require a waiver to comply with 482.41(b)(1)(2)(3).	

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A 710	Continued From page 42 facility, but only if the waiver does not adversely affect the health and safety of the patients . (3) The provisions of the Life Safety Code do not apply in a State where CMS finds that a fire and safety code imposed by State law adequately protects patients in hospitals. This Standard is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to meet the requirements of the Life Safety Code of the National Fire Protection Association (NFPA), 2012 edition. Findings: Refer to the deficiencies written on the Acute Care Hospital MEDICARE Life Safety inspection reports. .	A 710		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This Standard is not met as evidenced by: . Item #1 Medical Supplies Based on observation, interview, and record review, the hospital failed to ensure that patient care supplies did not exceed the manufacturer's designated expiration date. Failure to ensure patient care supplies do not exceed their expiration dates risks deteriorated and contaminated supplies being available for patient use.	A 724	**A 0724 Corrective Actions** #1- Medical Supplies The COO/CNO directed/delegated monthly inspections by the Materials Department staff, Nursing staff and Pharmacy staff to ensure that all supplies and medications are not expired and within date specified on the manufacturers labeling. Expired/nearing expiration products will be properly disposed of timely. All expired supplies and medications were removed and discarded on 12/21/16. Person Responsible: COO/CNO Monitoring: The COO/designee will perform environmental rounds of the patient care areas to monitor integrity of products, supplies and medications. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings. .	2/10/17

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A 724	Continued From page 43 Findings: 1. On 12/12/2016 at 11:00 AM during a tour of 3 West adult psychiatric unit, Surveyor #3 found the following items in the wound supplies cabinet: a. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 4/2016. b. One 500 ml bottle of 0.9% Sodium Chloride for Irrigation with an expiration date of 9/2016. c. One box of sterile cotton-tipped applicators with an expiration date of 2/2016. d. One box of sterile cotton-tipped applicators with an expiration date of 9/2016. e. One box of povidone-iodine swabsticks with an expiration date of 10/2016. f. One 14 french Foley urethral catheter with an expiration date of 7/2016. 2. On 12/12/2016 at 1:00 PM, Surveyor #3 inspected the 3 West emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride Intravenous fluids with an expiration date of 5/2016. b. Five 10 ml 0.9 % Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. One 60 ml bottle of povidone-iodine solution with an expiration date of 7/2016. 3. On 12/13/2016 at 1:35 PM Surveyor #4	A 724	Amendment 2/1/2017: Daily audits are being conducted on each of the units. Unit champions are responsible for checking the ice machine logs to make sure the cleanings are happening at least weekly. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90% per unit. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 724	Continued From page 44 inspected the gero-psychiatric unit (4 West) emergency cart and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. c. Five Tegaderm intravenous site dressings with expiration dates of 11/2015 and 4/2016. 4. On 12/13/2016 at 1:11 PM Surveyor #2 toured the medication room on the Detox Unit and found three 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. a. On 12/14/2016 between the hours of 1:00 PM and 2:25 PM Surveyor #1 found Tegaderm (transparent adhesive film dressing) with an expiration date 4/2016 in the crash cart located on the Detox unit. 5. On 12/13/2016 at 1:30 PM Surveyor #2 inspected the emergency cart on the Rehab Unit and found the following: a. Two 1000 ml 0.9% Sodium Chloride intravenous fluids with an expiration date of 5/2016. b. Nine 10 ml 0.9% Sodium Chloride pre-filled syringes with an expiration date of 5/2016. 6. On 12/14/2016 between the hours of 1:00 and 2:25 PM Surveyor #1 interviewed central supply staff (Staff Member #18). During the course of the interview Surveyor #1 asked how often the supplies in the crash carts are checked. The	A 724		

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A 724	Continued From page 45 central supply person was unaware that it was part of his/her responsibilities to check the crash carts monthly. He/she stated that he/she had checked the crash carts 4 months previously. Item #2 Ice Machines Based on observation, document review and interview the hospital failed to follow manufacturer's instruction for preventive maintenance, installation and routine cleaning of its ice machine. Failure to follow manufacturer's instruction for preventive maintenance, routine cleaning and installation, promotes the growth of microorganisms, which places patients health at risk. Reference: Follett Series/W, MCD400A/W, R400A/W, MFD400A/W, D400A/W Ice Machines Installation, Operation and Service Manual Serial numbers above D25455 stated on page 15 provided a diagram of incorrect installation. Information on incorrect installation as followed: Dips in tube where water can collect Splice or tight bend that restricts ice flow Uninsulated tube that results in wet ice and potential dispensing problems Reference: Follett Symphony Plus: On page 4 the following was noted: "Water shut-off recommended within 10 ft. (3 m) of dispenser. Drain to be hard-piped and insulated. Maintain that at least 1/4" per foot (20 mm per 1 m) run of slope." Reference: Follett Ice machine 400 Series and Follett Symphony Ice Machine Manual stated the	A 724	A724 **#2 Ice Machines** The Plant Operations Director has obtained a certified contractor to perform the manufacturer recommended maintenance and cleaning for the Ice machines. All machines were serviced during the week of 1/16/17 to 1/20/17.This certified contractor will also train Plant Operations Staff on proper cleaning techniques. Person Responsible: Director of Plant Operations Monitoring: The Plant Operations Director/designee will perform monthly inspections of all Ice machines to monitor cleanliness and operations. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 724	Continued From page 46 following cleaning frequency for both models on page 14 and 17: "the frequency in cleaning and sanitizing ice machine according to the schedule below:" Semi-annually preventive maintenance Drain Line - weekly Drain Pan/Drip Pan -weekly Findings: 1. On 12/13/2016 between the hours of 1:00PM and 1:45PM Surveyor #1 observed a drain-line from a Follett Ice Machine was not slope to grade to the floor drain. The ice machine was located in the patient kitchen area on the Rehab unit. The preventive maintenance sticker was past due 9/2016 and the grate on the drip pan had residue build-up. 2. On 12/14/2016 between the hours of 8:30 AM and 10:00 AM, Surveyor #1 interviewed the hospital plant manager (Staff Member #19). Staff Member #19 stated in part that the ice machine maintenance was behind so they contracted with a company to get them caught up. When asked how often they get preventive maintenance, he/she said, annually. In review of work orders from the company, "MacDonald-Miller" it showed several machines received preventive maintenance between the months of July through September but the work order did not indicate which machines were done and what was included in the preventive maintenance. In addition, Surveyor #1 reviewed a work order generated from the hospital system that indicated a "Follett" ice machine on 3-North unit was scheduled for preventive maintenance on 2/11/2015, was crossed out and a hand written date of 8/10/16 was provided to indicate when the	A 724		

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A 724	Continued From page 47 work was done. 3. On 12/14/2016 between the hours of 1:00 PM and 2:45 PM Surveyor #1 observed soil buildup on the drip pan and drain line of the ice machine located in the Detox unit.	A 724		
A 726	482.41(c)(4) VENTILATION, LIGHT, TEMPERATURE CONTROLS There must be proper ventilation, light, and temperature controls in pharmaceutical, food preparation, and other appropriate areas. This Standard is not met as evidenced by: Based on observation, the hospital staff failed to implement policies and procedures consistent with the Washington State Retail Food Code, WAC 246-215 and Federal Food and Drug Administration. Failure to follow the food code places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM, Surveyor #1 observed two containers of pasta greater than 2 inches in the walk-in cooling refrigerator. For foods with a depth greater than 2 inches, staff must document temperature dates and times to ensure foods cool within the required cooling time-frame as specified by Washington State Retail Food Code. The hospital did not document cooling times for the pasta. Reference: Washington State Retail Food Code WAC 246-215-03515. FDA Food Code 3-501.14 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed dietary staff (Staff	A 726	**A 0726 Corrective Actions** The Dietary Manager purchased new digital thermometers and provided training on use of the new thermometers. The Dietary Manager reeducated all dietary staff on the proper techniques and requirements of obtaining food temperatures and maintaining refrigerator and freezer temperatures. All required temperature requirements will be logged daily. Person Responsible: Director of Dietary Monitoring: The Dietary Director/designee will perform weekly inspections of all food, refrigerator, and freezer temperatures logs to monitor adherence to the WAC 246-215-03515 and FDA3-501.14 codes. The Dietary Director/designee will perform weekly random observation monitors of staff performing temperature checks. Any deficiencies will be promptly addressed during the monitor. Results of the both monitors will be reported in the monthly PI committee and quarterly MEC meetings.	2/10/17

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A 726	Continued From page 48 Member #20) using a food probe thermometer inaccurately when taking the temperature of a "Ruben Sandwich". The thermometer temperature indicator is located half way up the stem; the staff inserted only the tip into the sandwich thereby potentially giving an inaccurate reading. The type of thermometer used by the staff was not designed to temp thin foods such as meat patties, fish fillets, and other thin food items. In addition, Surveyor #1 checked to see the thermometer's accuracy by placing the thermometer with 2 other thermometers in an ice-bath registered at 32 degrees Fahrenheit. The thermometer used to temp the "Ruben Sandwich" registered at 20 degrees Fahrenheit, 12 degrees off calibration. Dietary staff (Staff Member #20) confirmed this. Reference: Washington State Retail Food Code, WAC 246-215-04335 Reference: Washington State Retail Food Code, WAC 246-215-04580	A 726	Amendment 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to food temperatures throughout the department. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. **A 0749 Corrective Actions** 1) The Infection Control Practitioner reeducated the nursing staff on the importance of hand hygiene per policy during medication administration. Education was provided during staff meetings through verbal and written communication. Persons Responsible: Infection Control Practitioner Monitoring On a monthly basis, the Infection Control Practitioner/designee will monitor hand hygiene during medication administration with a minimum of 10 medication passes per unit. Any deficiencies will be addressed during the medication pass. Monitoring results will be reported during the monthly PI and quarterly MEC meetings.	2/10/17
A 749	482.42(a)(1) INFECTION CONTROL PROGRAM The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This Standard is not met as evidenced by: Item #1 Hand Hygiene Based on observation and review of hospital policy and procedure, staff failed to perform hand hygiene prior to and after administering	A 749		

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A 749	Continued From page 49 medications Failure to perform hand hygiene puts patients and staff at risk for infection. Findings: 1. Facility policy titled "Hand Hygiene", #IC.HH.100, reviewed 10/2016 read in part: "... III. INDICATIONS FOR HANDWASHING AND ANTISEPSIS... C. Decontaminate hands before having direct or indirect contact with patients... F. Decontaminate hands after contact with a patient's intact skin... G. Decontaminate hands after contact with body fluids or excretions, mucous membranes..." 2. On 12/13/2016 at 9:00 AM Surveyor #4 observed a registered nurse (Staff Member #14) administer oral medications to a patient. S/he did not perform hand hygiene (HH) before preparing the medications, and though s/he came in contact with the patient's oral secretions during administration, did not perform HH afterward. 3. On 12/13/2016 at 9:45 AM Surveyor #4 observed a registered nurse (Staff Member #15) administer oral medications to a patient. S/he did not perform HH prior to or following administration, despite numerous contacts with the patient's skin. Item #2 Dietary Sanitation Based on observation, the hospital failed to implement policies and procedures to ensure compliance with the Washington State Retail Food Code (246-215 WAC) and the Federal Food and Drug Administration.	A 749	2) The Dietary Manager obtained new thermometers designed to measure food temperatures properly. The Dietary Manager educated the dietary staff on the proper use of the food thermometers with an emphasis on accurate insertion. The education was provided during staff meetings with the use of verbal and written communications Person Responsible: Dietary Manager Monitoring The Dietary Manager will perform a minimum of 30 random audits per month x 3 months to ensure proper temperature monitoring. Any deficiency will be promptly addressed. Results of the audit will be reported in the monthly PI and quarterly MEC meetings. 3) The Infection Control Practitioner reeducated the housekeeping staff on the following procedures for proper cleaning of patient care areas: -Allowing for a 10-minute contact time when using Virex 256 disinfectant solution. -Avoidance of cross-contamination when using cleaning brushes. -Proper dusting procedures to avoid patient exposure. -Maintaining possession of carts at all times. Person Responsible: Plant Operations Director	

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A 749	Continued From page 50 Failure to follow best food practices places patients, staff, and visitors at risk for foodborne illness. Findings: 1. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 used a chlorine indicator test paper to evaluate the chlorine concentration level in the sanitizer bucket for in-use wiping cloths. The chlorine exceeded the tolerance limit of 200 parts-per-million (ppm) for sanitizer. Reference: Washington State Retail Food Code, WAC 246-215-03339(2) (2009 FDA Food Code 3-304.14) 2. On 12/12/2016 between 11:00 AM and 12:15 PM Surveyor #1 observed signs of algae growth on the interior plastic panel of the ice machine located in the main kitchen. Reference: Washington State Retail Food Code, WAC 246-215-04605(5)(d)(ii) Item #3 Housekeeping Cleaning Based on observation, review of hospital's policy and manufacturer's instructions for use, the hospital staff failed to follow procedures when cleaning patient rooms. Failure to follow manufacturer's instructions for use and hospital polices and procedures increases the risk of infection/illness to patients, staff and visitors. Reference: Virex II 256 Diversey: "Apply use solution to hard, non-porous environmental surfaces. All surfaces must remain wet for 10	A 749	Monitoring The Plant Operations Director will perform monthly environmental rounds of the patient care units to monitor contact times, proper use of cleaning brushes and dusting, and maintenance of cleaning carts. Any deficiencies will be promptly addressed during the environmental round. Results of the environmental rounds will be reported in the monthly to EOC and PI committees and quarterly MEC meetings.	

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A 749	Continued From page 51 minutes. Wipe surfaces and let air dry." Findings: 1. In review of hospital's policy and procedure titled: "Daily Cleaning of Patient Area" (Revised 8/2016) stated in part III, "Take cart with you into the room to clean. Cart should be within eyesight at all times." 2. On 12/13/2016 at 8:30 AM Surveyor #1 observed a housekeeper (Staff Member #21) during a daily clean of a patient room, applied "Virex 256 disinfectant solution" on a patients hand sink then proceeded to wipe it off with a dry cloth. The housekeeper did not allow 10-minute contact time as required per manufacturer's instruction for use. 3. On 12/13/2016 at 9:38 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper use a brush to clean a shower floor after cleaning a toilet with the same brush. 4. On 12/13/2016 at 9:45 AM Surveyor #1 observed a housekeeper (Staff Member #22) during a daily clean of a patient room. The surveyor observed the housekeeper dusting a light fixture over the patient's head while a patient was sleeping, potentially exposing the patient to dust particles. 5. On 12/13/2016 at 9:50 AM Surveyor #1 observed housekeeper (Staff Member #21) enter a patient room at the end of the hallway leaving the housekeeping cart in the hallway unattended. 6. On 12/15/2016 at 4:00 PM, Surveyor #1	A 749	Addendum 2/1/2017: Daily audits are being conducted in the kitchen. The policy is under revision and will be presented to the PI Committee for approval on February 17, 2017. Staff education is in process. The dietary manager will be responsible for monitoring real-time compliance related to proper sanitation throughout the department. The COO/CNO will double check staff's compliance related to the use of chlorine solution, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 8, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues. Additionally, daily audits are being conducted throughout the hospital, observing housekeepers in their daily routines. Staff education is in process. The facilities director will be responsible for monitoring real-time compliance related to procedures when cleaning patient rooms. The Infection Control nurse will double check, on a weekly basis, to make sure staff are complying with standards. The results of those audits first go to the weekly PI Committee on Wednesday, February 1, 2017. The target compliance is 90%. Any score below 90% will require remediation with the affected employee and/or further analysis of possible system issues.	

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A 749	Continued From page 52 reviewed a facility document titled, "Infection Prevention" the document provides a line list of indicators for 2016. One of the Indicators identified was Patient Room Cleaning with a "Target" of success of 95% or better. For the entire year of 2016, January through November, no observations were made.	A 749		

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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: 08/29/17 This survey was conducted by: Paul Kondrat, RN, MN, MHA Joy Williams, RN, BSN This visit was to verify correction of Condition-Level deficiencies found during the hospital complaint survey follow-up visit on 07/19/17 to 07/21/17 in which the facility was found not in compliance with: 42 CFR 482.12 Governing Body 42 CFR 482.13 Patient Rights DOH staff found the facility has substantially corrected all Condition-level deficiencies cited during the 07/19/17 - 07/21/17 hospital complaint survey follow-up visit. The facility is now in substantial compliance with all Medicare Conditions of Participation set forth in 42 CFR, Acute Care Hospitals.	{A 000}		

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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}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT 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. During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539. 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: 42:CFR 482.12 Governing Body 42 CFR 482.12 Patient Rights 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: Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation. 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. The hospital remains NOT IN COMPLIANCE with	{A 000}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	Continued From page 1 Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13	{A 000}	**A 023 482.11 (c) Licensure of Personnel** Corrective Action: All personnel have been audited for current licensure and other applicable standards that are required by state and local laws. All new staff members will be validated for licensure and certification prior to starting employment at Cascade Behavioral Hospital. Monitoring Plan: The director of human resources will be responsible for the auditing of all existing employees for licensure and certification monthly. All findings will be reported out monthly to the CBH Performance Improvement Committee, and quarterly to the MEC and Governing Board. Persons Responsible: CEO Director Human Resources PI/Risk Manager	All corrective actions will be completed by June 30, 2017
A 023	482.11(c) LICENSURE OF PERSONNEL The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This Standard is not met as evidenced by: 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. Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff. Findings: 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." 2. On 5/4/2017 at 1:00 PM Surveyor #1 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	A 023		

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	504011	A. BUILDING _____ B. WING _____	R 05/05/2017

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A 023	Continued From page 2 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}	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 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. 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	{A 043}	**A043 482.12 Governing Board** Immediately following the exit summation the CEO, Governing Board Members, CNO, 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 the responsibility of ensuring completion of all corrective action action to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO/ Designee is responsible for reporting the results of corrective actions and use the 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. This increased monitoring will continue until compliance is obtained and sustained for two reporting periods.	

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{A 043}	Continued From page 3 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. Cross- Reference: Tags A093	{A 043}	**A 045 482.12 (a)(1) Medical Staff** **Corrective Action:** The CBH Policy "Physician Assistant Privileges" (Policy No: MS.P.310)' will be updated to reflect the scope of practice contained in the physician assistant collateral agreement. Evaluations will be performed in accordance with the OPPE/FPPE policy. **Monitoring Plan:** Evaluation Results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. **Persons Responsible:** Chief Medical Officer	All corrective actions will be completed by June 30, 2017
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, 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 agreement and to provide polices that are consistent with physician assistant practice, places patients' safety and health at risk. Findings 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	A 045		

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A 045	Continued From page 4 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." 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. 3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a 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	482.12(f)(2) EMERGENCY SERVICES 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,	A 093		

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A 093	Continued From page 5 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 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 occured 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	A 093	**A 093 482.12 (f)(2) Emergency Services** **Corrective Action:** All clinical staff will be trained to the standards of healthcare provider AHA BLS prior to assuming their role on shift. A checklist is provided to all CNA staff and nursing stations regarding the emergency notification procedure. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. **Persons Responsible:** CEO Director of Nursing PI/Risk Manager	All corrective actions will be completed by June 30, 2017

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A 093	Continued From page 6 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. 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	A 093		

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A 093	Continued From page 7 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 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. 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	A 093		

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A 093	Continued From page 8 whether the CPR [cardiopulmonary resuscitation] was uninterrupted and high quality. 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. 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 indicated that mock code drills for the facility were scheduled to begin in two weeks. REVIEW OF CODE #2 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	A 093		

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A 093	Continued From page 9 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. 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. b. An interview with the Director of Clinical 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	482.23(b)(4) NURSING CARE PLAN 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	A 396		

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A 396	Continued From page 10 (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." 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	**A 396 482.23 (b)(4) Nursing Care Plan** **Corrective Action:** All clinical staff will be trained to the standards of the Suicide Risk Assessment, and that the Suicide Risk Assessment be completed at a minimum of 2 hours from admission. If any suicide risk assessment renders information that has the potential to immediately affect patient safety and/or results in a score of High or Severe, the psychiatrist shall be contacted immediately. The Directors of Nursing will perform 30 random chart audits for timeliness of suicide risk assessments and the completion of the Intake to Nursing Communication Hand Off. The Director of Intake/Chief Nursing Office (CNO) will be informed regarding of any initial suicide risk assessment renders information that has potential to immediately affect patient safety. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. Audit results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. The intake director will inform leadership daily of any failure in hand-off communication regarding any initial suicide risk assessment that renders information for a potential to immediately affect patient safety. **Persons Responsible:** CEO CNO Director of Intake Director of Nursing PI/RM Director	All corrective actions will be completed by June 30, 2017

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{A 000}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT 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. During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539. 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: 42:CFR 482.12 Governing Body 42 CFR 482.12 Patient Rights 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: Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation. 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. The hospital remains NOT IN COMPLIANCE with	{A 000}		

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

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{A 000}	Continued From page 1 Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13	{A 000}	**A 023 482.11 (c) Licensure of Personnel** Corrective Action: All personnel have been audited for current licensure and other applicable standards that are required by state and local laws. All new staff members will be validated for licensure and certification prior to starting employment at Cascade Behavioral Hospital. Monitoring Plan: The director of human resources will be responsible for the auditing of all existing employees for licensure and certification monthly. All findings will be reported out monthly to the CBH Performance Improvement Committee, and quarterly to the MEC and Governing Board. Persons Responsible: CEO Director Human Resources PI/Risk Manager	All corrective actions will be completed by 08-01-2017
A 023	482.11(c) LICENSURE OF PERSONNEL The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This Standard is not met as evidenced by: 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. Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff. Findings: 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." 2. On 5/4/2017 at 1:00 PM Surveyor #1 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	A 023		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 023	Continued From page 2 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}	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 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. 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	{A 043}	**A043 482.12 Governing Board** Immediately following the exit summation the CEO, Governing Board Members, CNO, 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 the responsibility of ensuring completion of all corrective action action to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO/ Designee is responsible for reporting the results of corrective actions and use the 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. This increased monitoring will continue until compliance is obtained and sustained for two reporting periods.	

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{A 043}	Continued From page 3 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. Cross- Reference: Tags A093	{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, 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 agreement and to provide polices that are consistent with physician assistant practice, places patients' safety and health at risk. Findings 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	A 045	**A 045 482.12 (a)(1) Medical Staff** **Corrective Action:** The CBH Policy "Physician Assistant Privileges" (Policy No: MS.P.310)' will be updated to reflect the scope of practice contained in the physician assistant collateral agreement. Evaluations will be performed in accordance with the OPPE/FPPE policy. **Monitoring Plan:** Evaluation Results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. **Persons Responsible:** Chief Medical Officer	All corrective actions will be completed by 08-01-2017

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A 045	Continued From page 4 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." 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. 3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a 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	482.12(f)(2) EMERGENCY SERVICES 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,	A 093		

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A 093	Continued From page 5 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 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 occured 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	A 093	**A 093 482.12 (f)(2) Emergency Services** **Corrective Action:** All clinical staff will be trained to the standards of healthcare provider AHA BLS , emergency notification, and emergency code response procedures prior to assuming their role on shift. Mock Code/Hands On training will be conducted annually for all clinical employees, and during new employee orientation. A checklist is provided to all CNA staff and nursing stations regarding the emergency notification procedure. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. All code blue documentation will be reviewed at the CBH monthly Performance Improvement (PI) meeting for action plan development, and reported out quarterly to the MEC and governing board. **Persons Responsible:** CEO Chief Nursing Officer PI/RM Director	All corrective actions will be completed by 08-01-2017

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A 093	Continued From page 6 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. 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	A 093		

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A 093	Continued From page 7 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 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. 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	A 093		

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A 093	Continued From page 8 whether the CPR [cardiopulmonary resuscitation] was uninterrupted and high quality. 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. 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 indicated that mock code drills for the facility were scheduled to begin in two weeks. REVIEW OF CODE #2 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	A 093		

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A 093	Continued From page 9 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. 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. b. An interview with the Director of Clinical 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	482.23(b)(4) NURSING CARE PLAN 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	A 396		

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A 396	Continued From page 10 (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." 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	**A 396 482.23 (b)(4) Nursing Care Plan** **Corrective Action:** All clinical staff will be trained to the standards of the Suicide Risk Assessment, and that the Suicide Risk Assessment be completed at a minimum of 2 hours from admission. If any suicide risk assessment renders information that has the potential to immediately affect patient safety and/or results in a score of High or Severe, the psychiatrist shall be contacted immediately. The Directors of Nursing will perform 30 random chart audits for timeliness of suicide risk assessments and the completion of the Intake to Nursing Communication Hand Off. The Director of Intake/Chief Nursing Office (CNO) will be informed regarding of any initial suicide risk assessment renders information that has potential to immediately affect patient safety. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. Audit results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. The intake director will inform leadership daily of any failure in hand-off communication regarding any initial suicide risk assessment that renders information for a potential to immediately affect patient safety. **Persons Responsible:** CEO CNO Director of Intake Director of Nursing PI/RM Director	All corrective actions will be completed by 08-01-2017

Kondrat, Paul M (DOH)

From:	Timothy Hall <Timothy.Hall@cascadebh.com>
Sent:	Tuesday, June 13, 2017 3:23 PM
To:	CMS_RO10_CEB@cms.hhs.gov
Cc:	Michael Uradnik; Jennifer Hamilton; Pat Brewer; Kondrat, Paul M (DOH)
Subject:	Attn: Karen Roe CMS POC Cascade Behavioral Health Hospital - Amendment
Attachments:	Cascade Behavioral Health CMS POC 06132017 Corrections.pdf
Importance:	High

Good afternoon -

This communication is in response to the deficiencies identified on the Plan of Correction Form CMS 2567.

Please see the attached plan of correction that was amended per our conversation this afternoon.

Timothy C. Hall
Director of Quality and Risk Management
Cascade Behavioral Health Hospital
12844 Military Rd S, Tukwila, WA 98168
(206) 248-4538

Priviledged and Confidential
Quality Assurance Related Document
Protected by RCW 70.41.200 & 70.41.230

Cascade
Behavioral Hospital

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{A 000}	INITIAL COMMENTS MEDICARE HOSPITAL COMPLAINT SURVEY FOLLOW-UP VISIT 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. During the survey, surveyors also assessed issues related to the following Medicare complaints: #72537 and 72539. 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: 42:CFR 482.12 Governing Body 42 CFR 482.12 Patient Rights 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: Failure to intervene when an emergency medical situation was identified requiring immediate action resulting in delay of cardiopulmonary resuscitation. 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. The hospital remains NOT IN COMPLIANCE with	{A 000}		

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

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{A 000}	Continued From page 1 Medicare Hospital Conditions for: 42 CFR 482.12 Governing Body Shell #27QV13	{A 000}	**A 023 482.11 (c) Licensure of Personnel** Corrective Action: All personnel have been audited for current licensure and other applicable standards that are required by state and local laws. All new staff members will be validated for licensure and certification prior to starting employment at Cascade Behavioral Hospital. Monitoring Plan: The director of human resources will be responsible for the auditing of all existing employees for licensure and certification monthly. All findings will be reported out monthly to the CBH Performance Improvement Committee, and quarterly to the MEC and Governing Board. Persons Responsible: CEO Director Human Resources PI/Risk Manager	All corrective actions will be completed by 06-30-2017
A 023	482.11(c) LICENSURE OF PERSONNEL The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws. This Standard is not met as evidenced by: 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. Failure to ensure that the hospital's staff is appropriately licensed prior to employment, places patients at risk for care provided by unqualified staff. Findings: 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." 2. On 5/4/2017 at 1:00 PM Surveyor #1 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	A 023		

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A 023	Continued From page 2 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}	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 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. 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	{A 043}	**A043 482.12 Governing Board** Immediately following the exit summation the CEO, Governing Board Members, CNO, 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 the responsibility of ensuring completion of all corrective action action to the CEO/Designee who along with the Medical Director is a member of the Governing Board. The CEO/ Designee is responsible for reporting the results of corrective actions and use the 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. This increased monitoring will continue until compliance is obtained and sustained for two reporting periods.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504011	A. BUILDING _____ B. WING _____	R 05/05/2017

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 043}	Continued From page 3 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. Cross- Reference: Tags A093	{A 043}	**A 045 482.12 (a)(1) Medical Staff** **Corrective Action:** The CBH Policy "Physician Assistant Privileges" (Policy No: MS.P.310)' will be updated to reflect the scope of practice contained in the physician assistant collateral agreement. Evaluations will be performed in accordance with the OPPE/FPPE policy. **Monitoring Plan:** Evaluation Results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. **Persons Responsible:** Chief Medical Officer	All corrective actions will be completed by 06-30-2017
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, 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 agreement and to provide polices that are consistent with physician assistant practice, places patients' safety and health at risk. Findings 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	A 045		

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A 045	Continued From page 4 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." 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. 3. On 5/4/2017 at 1:00 PM Surveyor #1 reviewed Patient #4's medical record which indicated that a 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	482.12(f)(2) EMERGENCY SERVICES 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,	A 093		

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A 093	Continued From page 5 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 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 occured 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	A 093	**A 093 482.12 (f)(2) Emergency Services** **Corrective Action:** All applicable clinical staff will be trained to the standards of healthcare provider AHA BLS, which includes hands-on training and skill validation of CPR competency using CBH equipment. All applicable clinical staff must complete the hands-on training provided in healthcare provider AHA BLS prior to assuming any direct patient care role at CBH. Mock Codes will be initiated at CBH starting 06-21-2017 and continue until all applicable clinical staff have participated in a mock code. (100 percent). All applicable clinical staff will receive mock code training annually thereafter. The educational content of the mock code training will include the appropriate response to a patient suicide in a hanging scenario. A checklist was provided to all CNA staff and nursing stations regarding the emergency notification procedure. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. These education results will detail the percentage of staff requiring AHA BLS training as well as those requiring mock code training. All code blue documentation will be reviewed at the CBH monthly Performance Improvement (PI) meeting for action plan development, and reported out quarterly to the MEC and governing board. **Persons Responsible:** CEO Chief Nursing Officer PI/RM Director	All corrective actions will be completed by 06-30-2017

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A 093	Continued From page 6 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. 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	A 093		

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A 093	Continued From page 7 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 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. 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	A 093		

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A 093	Continued From page 8 whether the CPR [cardiopulmonary resuscitation] was uninterrupted and high quality. 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. 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 indicated that mock code drills for the facility were scheduled to begin in two weeks. REVIEW OF CODE #2 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	A 093		

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A 093	Continued From page 9 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. 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. b. An interview with the Director of Clinical 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	482.23(b)(4) NURSING CARE PLAN 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	A 396		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 396	Continued From page 10 (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." 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	**A 396 482.23 (b)(4) Nursing Care Plan** **Corrective Action:** All clinical staff will be trained to the standards of the Suicide Risk Assessment, and that the Suicide Risk Assessment be completed at a minimum of 2 hours from admission. If any suicide risk assessment renders information that has the potential to immediately affect patient safety and/or results in a score of High or Severe, the psychiatrist shall be contacted immediately. The Directors of Nursing will perform 30 random chart audits for timeliness of suicide risk assessments and the completion of the Intake to Nursing Communication Hand Off. The Director of Intake/Chief Nursing Office (CNO) will be informed regarding of any initial suicide risk assessment renders information that has potential to immediately affect patient safety. **Monitoring Plan:** Education results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. Audit results will be reported out monthly to the CBH performance improvement committee, and quarterly to the MEC, and governing board. The intake director will inform leadership daily of any failure in hand-off communication regarding any initial suicide risk assessment that renders information for a potential to immediately affect patient safety. **Persons Responsible:** CEO CNO Director of Intake Director of Nursing PI/RM Director	All corrective actions will be completed by 06-30-2017

Cascade Behavioral Hospital
Plan of Correction
August 18, 2017

Tag Number A144	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC
Item One	All psychiatric admissions to Cascade Behavioral Hospital will have an initial assault/ violence assessment performed indicating the necessity for interventions be considered. All admissions will be audited for the presence of the assaultive/violence assessment. Data will be reported out weekly to governing board, monthly to Performance Improvement committee, and quarterly to Medical Executive Committee.	Chief Nursing Officer	08-28-2017	100%	90 % or below
Item Two	A policy will be created and implemented, "Assaultive Patient: Precaution and Treatment", outlining three intervention levels once a patient has been identified by the following criteria; A. Previous history of violence/assault B. Assessment results indicating a risk of violence/assault C. An allegation regarding the threat of violence/assault D. A verbal altercation/threat E. A physical confrontation of of violence/assault	Chief Nursing Officer	08-28-2017	Policy Approval	NA
Item Three	The procedure outlined in the policy, "Assaultive Patient: Precaution and Treatment", will outline the following three intervention levels (once a patient has been identified through assessment or action indicating assaultive/violent behavior). The interventions for each level are listed below: Level One: A patient that has had previous history of assault/violence and/or has an assessment result indicating a risk of violence/assault. Intervention: Patient is to be placed on assault precautions. Level Two: A patient has an allegation regarding the threat of violence/assault while staying at CBH. Intervention: Focused treatment team immediately following the threat of violence or assault with specific treatment plans. Medical interventions will be	Chief Nursing Officer	08-28-2017	100%	90 % or below

	assessed. Patient's observation levels will be evaluated. Daily assaultive/violence assessment to be conducted. Level Three: A patient that has had a physical confrontation of of violence/assault while staying at CBH. Intervention: Focused treatment team meeting immediately following the act of assault or violence to address specific treatment plans. Medical interventions will be assessed. Patient's observation level will be evaluated. Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use. Patient will be considered for hospital transfer based on acuity. An assaultive/violence assessment will be conducted every shift. All physical confrontation incident reports will be audited for the appropriate process steps outlined in the policy. Data will be reported out weekly to governing board, monthly to Performance Improvement Committee, and quarterly to Medical Executive Committee.				
Tag Number **A 043**	**How the Deficiency Will Be Corrected**	**Responsible Individual(s)**	**Estimated Date of Correction**	**Target for Compliance**	**Action Level Indicating Need for Change of POC**
Item One	CEO will communicate to governing board weekly the status of plan of correction beginning Thursday, August 17, 2017.	CEO	08-28-2017	100%	100%
Tag Number **A 045**	**How the Deficiency Will Be Corrected**	**Responsible Individual(s)**	**Estimated Date of Correction**	**Target for Compliance**	**Action Level Indicating Need for Change of POC**

Item One	Physician Assistant supervision will be documented according to delegation agreement by supervising physician. Compliance will be monitored weekly and reported to governing board starting week of August 21, 2017	CMO	08-28-2017	100%	100%
Tag Number **A 115**	**How the Deficiency Will Be Corrected**	**Responsible Individual(s)**	**Estimated Date of Correction**	**Target for Compliance**	**Action Level Indicating Need for Change of POC**
Item One	**Corrective Action:** All clinical staff will be educated regarding the finding of "PRN orders for restraints and seclusion". All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. Cascade no longer uses PRN orders for restrictive interventions. **Monitoring Plan:** Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and weekly to the Governing Board.	CMO/CNO	08-28-2017	100%	90%
Tag Number **A 169**	**How the Deficiency Will Be Corrected**	**Responsible Individual(s)**	**Estimated Date of Correction**	**Target for Compliance**	**Action Level Indicating Need for Change of POC**
Item One	All clinical staff will be educated regarding the appropriate use of restraint and seclusion (i.e.. orders for restraint and seclusion are not prn, least restrictive means must be used for seclusion and restraint, etc.) All restraints and seclusion performed at CBH will be audited by the house supervisor upon occurrence. Once audits have been completed they will then be reviewed by the PI/RM Director, and Chief Nursing Officer to ensure that requirements are met and if they require a focus review. **Monitoring Plan:** Audit results will be shared monthly to the performance improvement committee, and quarterly to the MEC and weekly to Governing Board.	CMO/CNO	08-28-2017	100%	90%

Cascade Behavioral Hospital
Plan of Correction
August 17, 2017

Tag Number A144	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC
Item One	All psychiatric admissions to Cascade Behavioral Hospital will have an initial assault/ violence assessment performed indicating the necessity for interventions be considered. All admissions will be audited for the presence of the assaultive/violence assessment. Data will be reported out weekly to governing board, monthly to Performance Improvement committee, and quarterly to Medical Executive Committee.	Chief Nursing Officer	09-11-2017	100%	90 % or below
Item Two	A policy will be created and implemented, "Assaultive Patient: Precaution and Treatment", outlining three intervention levels once a patient has been identified by the following criteria; A. Previous history of violence/assault B. Assessment results indicating a risk of violence/assault C. An allegation regarding the threat of violence/assault D. A verbal altercation/threat E. A physical confrontation of of violence/assault	Chief Nursing Officer	09-11-2017	Policy Approval	NA
Item Three	The procedure outlined in the policy, "Assaultive Patient: Precaution and Treatment", will outline the following three intervention levels (once a patient has been identified through assessment or action indicating assaultive/violent behavior). The interventions for each level are listed below: Level One: A patient that has had previous history of assault/violence and/or has an assessment result indicating a risk of violence/assault. Intervention: Patient is to be placed on assault precautions. Level Two: A patient has an allegation regarding the threat of violence/assault while staying at CBH. Intervention: Focused treatment team immediately following the threat of violence or assault with specific treatment plans. Medical interventions will be	Chief Nursing Officer	09-11-2017	100%	90 % or below

	assessed. Patient's observation levels will be evaluated. Daily assaultive/violence assessment to be conducted. Level Three: A patient that has had a physical confrontation of of violence/assault while staying at CBH. Intervention: Focused treatment team meeting immediately following the act of assault or violence to address specific treatment plans. Medical interventions will be assessed. Patient's observation level will be evaluated. Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use. Patient will be considered for hospital transfer based on acuity. An assaultive/violence assessment will be conducted every shift. All physical confrontation incident reports will be audited for the appropriate process steps outlined in the policy. Data will be reported out weekly to governing board, monthly to Performance Improvement Committee, and quarterly to Medical Executive Committee.				

Plan of Correction

Cascade Behavioral Hospital

Amended plan of correction date: **08-16-2017**

A 043 Governing Body

CEO will communicate to governing board weekly the status of plan of correction beginning Thursday, August 17, 2017.

A 045 Medical Staff

Physician Assistant supervision will be documented according to delegation agreement by supervising physician. Compliance will be monitored weekly and reported to governing board starting week of August 21, 2017.

A 144 Patient Rights: Care in Safe Setting

Plan of correction includes a focus on different levels of intervention for improving patient safety.

Admission criteria policy update, including a 'high risk' addendum to further identify patients who may pose a safety threat.

Admission communication that patients have been informed of patient rights will be audited daily upon admission.

Development of an assessment for assault risk, similar to suicide risk assessment. *It will be monitored through the current nursing admission audit.*

Implement assault precautions and treatment policy that addresses assaultive risk and interventions. Initial intervention includes identifying individual patient drivers/triggers and incorporating them into individual treatment plans. The second level of intervention for patient safety includes identifying threatening behavior and implementing medical and physical interventions. The third level of intervention includes Identifying a limited safe space for patient and others, including individual rooms, quiet and seclusion spaces, restraint use and transferring of the patient to a different facility.

Nursing admission audit will be utilized to monitor the identification of patient drivers/triggers and their incorporation into treatment plans. Action plans will be developed based on focused review to implement patient safety improvements for medical and physical interventions. Incident Reports related to assaults will be reviewed to ensure that the appropriate levels of intervention were in place or considered. After every assault, an audit process will be initiated immediately. Based upon the results of that audit, a focused review will be conducted directed by CNO or PI/Risk Director to determine if interventions were appropriate or needed to be adjusted. Data regarding audits will be reviewed weekly by governing board, monthly by PI Committee and quarterly by governing board and MEC.

Safety Huddle improvement to specifically emphasize high-assault-risk patients, done each shift and reviewed and audited daily.

Additional de-escalation training focusing on multiple levels of intervention and assault precautions and treatment.

CNO or designee will attend all emergency response (e.g. Code Grey) and review interventions, and assess need for increased, improved treatment.

Develop an assaultive patient taskforce focused on implementing and improving interventions.

Audit results will be shared weekly with governing board and monthly with Performance Improvement Committee and quarterly with Medical Executive Committee.

All corrective actions will be completed by September 11, 2017