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	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 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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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 08-01-2017
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 , 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