State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60429197	A. BUILDING: _____ B. WING _____	07/26/2019

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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L 000	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this health and safety survey. Onsite dates: 07/23/19 - 07/26/19. Examination number: 2019-691 The survey was conducted by: Surveyor #6 Surveyor #10 The Washington Fire Protection Bureau conducted the fire life safety inspection. During the course of the survey, surveyors assessed issues related to complaint 2019-2838 HPSY.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction; WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by August 16, 2019. 4. Return the ORIGINAL REPORT with the required signatures.	
L 070	322-025.1A RESP & RIGHTS-COMPLIANCE WAC 246-322-025 Responsibilities and Rights - Licensee and Department. (1) The licensee shall: (a) Comply with the provisions of chapter 71.12 RCW and this chapter; This Washington Administrative Code is not met	L 070		

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L 070	Continued From page 1 as evidenced by: . Based on observation and record review, the hospital failed to submit its policy for charity care within 30 days of adoption to the Washington Department of Health (Item #1); and failed to make the policy available on the hospital's public website (Item #2). Failure to provide patient rights policies to the public risks patients' ability to make informed decisions regarding access to care. Reference: RCW 70.170.060 - Current versions of the hospital's charity care policy, a plain language summary of the hospital's charity care policy, and the hospital's charity care application for must be available on the hospital's web site. WAC 246-453-070 (1) Each hospital shall develop, and submit to the department, charity care policies, procedures, and sliding fee schedules consistent with the requirements included in WAC 246-453-020, 246-453-030, 246-452-040, and 246-453-050. Any subsequent modifications to those policies, procedures, and sliding fee schedules must be submitted to the department no later than thirty days prior to their adoption by the hospital. Findings included: Item #1 Policy update 1. Review of the hospital policies posted on the Washington State Department of Health (DOH) internet website showed that the hospital's un-dated, un-numbered policy titled "Financial Assistance and Charity Care," was most recently updated with DOH in January 2014.	L 070		

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L 070	Continued From page 2 2. On 07/25/19 at 3:15 PM, the Director of Risk & Quality (Staff #601) provided Surveyor #6 with the hospital's policy number ADM.C.300, titled "Charity Care," approved 02/19. Staff #601 stated it was the current policy for charity care. Item #2 Charity care access 1. Review of the hospital's internet website showed that neither a policy for charity care, nor an application for charity care was available or referenced. 2. On 05/26/19 at 2:00 PM, during the surveyors' exit conference, the Director of Risk & Quality (Staff #601) confirmed the hospital's internet website had not been updated to include the current policy for charity care.	L 070		
L 335	322-035.1G POLICIES-EMERGENCY CARE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (g) Emergency medical care, including: (i) Physician orders; (ii) Staff actions in the absence of a physician; (iii) Storing and accessing emergency supplies and equipment; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and review of hospital policies and procedures, the hospital failed to ensure staff checked and verified the	L 335		

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L 335	Continued From page 3 correct serial-numbered lock when performing a daily Emergency Crash Cart Equipment Checklist. Failure to verify the correct serial-numbered lock on the emergency cart could result in a cart without the supplies listed within that could risk potential delays in providing emergency care. Findings included: 1. Review of the hospital's policy and procedure titled, "Emergency Cart" policy number PC.C.110, reviewed 01/19, showed that there are seven (7) emergency carts in the hospital and checked nightly by the Charge Nurse. A log for documenting daily checks is located on the cart includes: date, lock serial number, locked Y/N, suction checked Y/N, back board, and signature of the staff member checking the cart. 2. On 07/24/19 at 2:00 PM, Surveyor #10 inspected the emergency cart located on the 3rd floor North Unit. A review of the emergency cart checklist for July 2019 showed a lock serial number #154254 entered for the last 24 days, on the list. A closer look at the actual red serial lock showed a lock number #326884. 3. During an interview on 07/24/19 at 3:50 PM, the North Unit Nurse Manager (Staff #1001) confirmed the incorrect checklist entry.	L 335		
L 410	322-035.1V POLICIES-FOOD SERVICE WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures	L 410		

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L 410	Continued From page 4 consistent with this chapter and services provided: (v) Food service consistent with chapter 246-215 WAC and WAC 246-322-230. This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to develop and implement policies and procedure to ensure compliance with the Washington State Retail Food Code (Chapter 246-215 WAC). Failure to develop food service policies that direct food preparation and service in compliance with food safety standards places patients and staff at risk from food borne illness. Findings included: 1. On 07/24/19 between 9:00 AM and 10:15 AM, Surveyor #6 toured the kitchen and dining room with the Dietary Services Director (Staff #602). During the tour, the surveyor requested a copy of the hospital's policy for cooling potentially hazardous foods (PHF). Staff #602 provided an information sheet copied from the New York State Department of Health's public website. 2. On 07/24/19 at 2:00 PM, during an interview with the Director of Risk & Quality (Staff #601), Surveyor #6 requested copies of all food service policies. At 3:15 PM Staff #601 provided copies of temperature logs, food storage logs, sanitizer logs, and food safety information handouts. Staff #601 stated that she was not able to locate any approved policies related to food service.	L 410		

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L 420	Continued From page 5	L 420		
L 420	322-040.1 ADMIN-ADOPT POLICIES WAC 246-322-040 Governing Body and Administration. The governing body shall: (1) Adopt written policies concerning the purposes, operation and maintenance of the hospital, and the safety, care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, medical record review, and review of the hospital's policies and procedures, the hospital failed to assure that policies and procedures were reviewed and revised to reflect current clinical practice. Failure to review and revise policies to reflect current practice prevents the hospital staff from carrying out all of the functions of the organization and risks unsafe, inconsistent patient care. Findings included: 1. Record review of the hospital's policy and procedure titled, "Policies and Procedures," policy #ADM.P.500 reviewed 05/19, showed that the hospital will have policies and procedures in place that will reflect evidence-based practice and guide staff to carry out all of the functions of the hospital to promote safe, consistent, high-quality care. a. Record review of the hospital's policy and procedure titled, "Diabetes: Patient Care," policy #PC.D.200 reviewed 02/19, showed that staff will treat a blood sugar level below 70 by following the hypoglycemia protocol and staff will not withhold scheduled insulin doses. For treatment of high or	L 420		

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L 420	Continued From page 6 low blood sugar levels, staff will follow physician orders and/or Cascade Behavioral Hospital nursing procedure. b. Record review of the hospital's pharmacy policy and procedure titled, "Intravenous Therapy," policy #MM.05.01.07 reviewed 05/18, showed that the hospital offers no intravenous therapy services (no IV solutions or supplies) and a home health agency will administer all intravenous medication on site. 2. Review of Patient #1001's medical record on 07/24/19 at 1:25 PM, showed a pre-printed order sheet to guide staff on the treatment of the patient's blood glucose levels. Review of the order form showed it was labeled with the patient's ID stamp and a hand written note showing orders were faxed to pharmacy. The top of the form showed orders for monitoring the patient's blood glucose (before meals & at bedtime), showed Regimen #1 and #2 guidelines for supplemental insulin according to the current patient's blood glucose level, and the bottom of the form showed the hypoglycemia protocol. The hypoglycemia protocol provides steps that staff will follow to treat a diabetic patient with a blood glucose level <70mg/dl and includes treatment for a patient who is conscious or treatment for a patient who is unconscious. For treatment of an unconscious patient with a blood glucose of 50-69mg/dl, staff will administer 25ml of D50W intravenous and repeat a blood glucose level in 15 minutes. Review of the Patient #1001's blood glucose levels showed an average level of 170-200 and he was administered Humalog insulin according to Regimen #2 guidelines.	L 420		

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L 420	Continued From page 7 3. During an interview on 07/24/19 at 2:00 PM, the Chief Nursing Officer [CNO] (Staff #1002) confirmed that the hospital does not provide staff supplies or medications to administer medication intravenously. The CNO was asked how staff could follow the hypoglycemia protocol for Patient #1001 if the hospital does not provide intravenous services. The CNO stated that if the patient's blood glucose level reaches a critical point and becomes unconscious, then staff are to call 911. 4. During an interview on 07/25/19 at 1:00 PM, the hospital's Pharmacist (Staff #1003) reviewed Patient #1001's blood glucose order form and revealed that the form's approval date (showed in the footer) was 05/18. The Pharmacist also stated that the hospital does not stock D50W intravenous solutions and it is not available. He stated that the pre-printed blood glucose order form will need to be reviewed and revised by the P & T committee.	L 420		
L 715	322-100.1E INFECT CONTROL-PROVISIONS WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which includes at a minimum: (f) Provisions for: (i) Providing consultation regarding patient care practices, equipment and supplies which may influence the risk of infection; (ii) Providing consultation regarding appropriate procedures and products for cleaning, disinfecting and sterilizing; (iii) Providing infection	L 715		

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L 715	Continued From page 8 control information for orientation and in-service education for staff providing direct patient care; (iv) Making recommendations, consistent with federal, state, and local laws and rules, for methods of safe and sanitary disposal of: (A) Sewage; (B) Solid and liquid wastes; and (C) Infectious wastes including safe management of sharps; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to implement an effective procedure to monitor the physical environment for situations that support the growth of microorganisms that could spread infectious disease. Failure to prevent the growth and spread of waterborne pathogens places patients, staff, and visitors at risk for infections. Reference: CDC Legionella Toolkit, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings; A Practical Guide to Implementing Industry Standards, updated 05/15/17. Elements of an effective water management program include identification of areas where water could pool and stagnate, apply and monitor control measures, establish corrective actions to intervene when controls are not met, evaluate the program's effectiveness, and document the activities. Findings included: 1. Document review of the hospital's policy titled, "Water Management Plan," Policy #F.WMP.100	L 715		

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L 715	Continued From page 9 approved 11/18, showed that ice/water dispenser drain lines are not identified as areas where water could pool and stagnate; control measures/limits, including elimination of stagnant water and monitoring disinfectant levels are not identified; corrective actions do not address equipment drain lines; and the verification process (evaluation) refers to semiannual testing without identifying testing protocols. Document review of Follett Symphony series Ice and Water Dispensers Installation, Operation and Service Manual showed that drains must maintain at least ¼-inch per foot of slope on horizontal runs. 2. During the survey, Surveyor #6 made the following observations of 6 ice/water dispensers: a. On 07/23/19 at 2:00 PM, Surveyor #6 toured Unit 2-W with the Chief Nursing Officer (CNO) (Staff #603). Surveyor #6 observed a Follett brand Symphony series ice/water dispenser in the dining room. The ice/water dispenser's drain line ran horizontally with a dip that allowed water to pool. The drain line did not maintain the required slope. b. On 07/24/19 at 10:10 AM, Surveyor #6 toured the hospital's kitchen and cafeteria with the Dietary Director (Staff #609). Surveyor #6 observed a Hoshizaki brand ice/water dispenser with a clear PVC (polyvinyl chloride) drain hose that rested horizontally across the flat surface of a cabinet for a length of approximately 2-feet. The drain hose showed significant black slime accumulation indicating bacterial growth. c. On 07/24/19 at 10:55 AM, Surveyor #6 toured Unit 2-N with the Nurse Manager (Staff #609).	L 715		

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L 715	Continued From page 10 Surveyor #6 observed a Follett brand Symphony series ice/water dispenser in the Day Room. The ice/water dispenser's drain line ran horizontally with a dip that allowed water to pool. The drain line did not maintain the required slope. d. On 07/25/19 at 10:50 AM, Surveyor #6 toured Unit 3-N with the Nurse Manager (Staff #610) and the Director of Facilities (Staff #606). Surveyor #6 observed a Follett brand Symphony series ice/water dispenser in the Clean Utility room. The ice/water dispenser's drain line ran through an opening in the countertop and was not visible. Staff #606 stated that special tools were required to access the space below the countertop and that the drain line installation was the same as other countertop ice/water dispensers. Staff #606 stated he did not know whether the drain line maintained the required slope. e. On 07/25/19 at 11:30 AM, Surveyor #6 toured Unit 3-W with the Nurse Manager (Staff #611) and the Director of Facilities (Staff #606). Surveyor #6 observed a Follett brand Symphony series ice/water dispenser in the pantry for the dining room. The ice/water dispenser's drain line ran through an opening in the countertop and was not visible. Staff #606 stated that special tools were required to access the space below the countertop and that the drain line installation was the same as other countertop ice/water dispensers. Staff #606 stated he did not know whether the drain line maintained the required slope. f. On 07/25/19 at 11:45 AM, Surveyor #6 toured Unit 4-W with the Nurse Manager (Staff #611) and the Director of Facilities (Staff #606). Surveyor #6 observed a Follett brand Symphony series ice/water dispenser in the Clean Utility	L 715		

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L 715	Continued From page 11 room. The ice/water dispenser's drip tray was full of water (not draining). The drain line ran through an opening in the countertop and was not visible. Staff #606 stated that special tools were required to access the space below the countertop and that the drain line installation was the same as other ice/water dispensers. Staff #606 stated he did not know whether the drain line maintained the required slope.	L 715		
L 815	322-120.7 MAINTENANCE P&P WAC 246-322-120 Physical Environment. The licensee shall: (7) Implement current, written policies, procedures, and schedules for maintenance and housekeeping functions; This Washington Administrative Code is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure that staff members properly performed housekeeping functions, including failure to maintain a clean environment (1), failure to maintain environmental surfaces in smooth, non-absorbent, and easily cleanable condition (2), and failure to adequately and effectively disinfect environmental surfaces in patient rooms (3). Failure to properly perform housekeeping functions places patients, staff, and visitors at risk of increased exposure to allergens and harmful microorganisms. Findings included: Item #1 - Clean environment	L 815		

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L 815	Continued From page 12 Reference: Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC), 2003; updated July 2019. Pg. 147. E Recommendations - Environmental Services; subsection E. Keep housekeeping surfaces (e.g., floors, walls, and tabletops) visibly clean on a regular basis and clean up spills promptly. 1. Document review of the hospital's policy titled, "Belongings (Patient)," policy #PC.B.100 reviewed 02/19, showed that the hospital should provide for safe and appropriate management of patients' personal belongings. Document review of the hospital's document titled, "Quick Reference: Environmental Cleaning," revised 10/17, showed that equipment with visibly soiled surfaces should be scrubbed with a cleaner/detergent or disinfectant. 2. On 07/23/19 from 10:50 AM to 3:10 PM, Surveyor #6 toured patient care areas with the Chief Nursing Officer (CNO) (Staff #603). The observations showed unclean areas, excessive amounts of dirt, dust, and debris, and items/areas whose readiness for use could not be determined: a. Room #103 (used for video court) - patient care equipment that could not be identified as clean or disinfected, or whether it had been used: a wheelchair, a disposable, cone-style face mask hanging from a push handle of the wheelchair, 2 sets of cloth restraints lying on the seat of the wheelchair, 2 Ambu® disposable face masks loose in a drawer. b. Assessment Room #4 (used for medical/vital	L 815		

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L 815	Continued From page 13 signs assessment) - no sanitizer/disinfectant was available for sanitizing patient care items after use. There was no indicator that informed staff whether the room was ready for use. c. Assessment Room #2 - contained soiled clothing and discarded paper products. There was no indicator that informed staff whether the room was ready for use. d. Patient Belongings Storage (Room 4 in the "old surgical suite") - over-flowing garbage bin, trash on the floor throughout the room, disorganized storage of patient belongings on the floor and shelves intermingled with debris. e. Soiled Utility on Unit 2-W - stained surface under the sink, dirt & debris along floor coving. f. An Office/Visitation Room on Unit 2-W - dirt & debris on the floor. 3. On 07/23/19 at 11:15 AM, Surveyor #6 interviewed Staff #603 and a Milieu Specialist (Staff #605) about the patient care items listed in Room #103. Staff #605 stated that the wheelchair should have been disinfected after patient use, but that she did not know whether that had been done. Staff #605 stated she did not know of a policy or procedure to launder cloth restraints, and that they might have been used up to 5 times in the past year without being cleaned or sanitized after patient use. Staff #603 stated that the Ambu® bags were probably left over from a previous hospital facility. 4. On 07/24/19 from 10:40 AM to 1:45 PM, Surveyor #6 toured patient care areas with the Director of Risk & Quality (Staff #601). The observation showed unclean areas and	L 815		

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	60429197	A. BUILDING: _____ B. WING _____	07/26/2019

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L 815	Continued From page 14 accumulation of dirt, dust, and debris: a. Clean Utility on Unit 2-N - an electric razor blade guard was covered with whisker debris, the emergency cart had a layer of dust on the top surface, 2 bladder scanners and a patient vital signs monitor had dried debris on the housing surfaces; 3 rolling stands for patient care equipment had dust and debris on their surfaces. b. Seclusion room on Unit 2-N - accumulation of dust in the corners & along the bed pedestal. c. Shower/toilet Room #386 on Unit 3-S -significant dust accumulation on exhaust fan cover. Item #2 - Cleanable surfaces 1. On 07/23/19 at 12:00 PM, during a tour of patient intake areas with the CNO (Staff #603), Surveyor #6 observed a couch in Assessment Room 2 with a tear in the vinyl upholstery such that the cloth padding was exposed. Cloth is absorbent and not a cleanable surface. 2. At the time of the observation, the surveyor asked Staff #603 about the torn vinyl. Staff #603 stated that a repair request would be made immediately. 3. On 07/24/19 at 10:55 AM, during a tour of patient care areas with the Director of Risk & Quality (Staff #601), Surveyor #6 observed uncleanable surfaces in the Unit 2-N Dayroom: a. Five chairs with worn vinyl upholstery such that the structural mesh fabric was exposed. The mesh fabric is absorbent and not a cleanable surface.	L 815		

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L 815	Continued From page 15 b. Wall surfaces along the window and on a support column had deep gouges such that sheetrock was exposed. Sheetrock is absorbent and not a cleanable surface. 4. At the time of the observations, the surveyor asked Staff #601 about the worn vinyl and gouges in the wall. Staff #601 stated that those surfaces should be repaired. 5. On 07/25/19 at 11:45 AM, during a tour of patient care areas with the Director of Facilities (Staff #606), Surveyor #6 observed uncleanable surfaces in the Unit 4-W Clean Utility: a. Counter edges and cabinet doors had areas of broken and missing laminate such that particle board was exposed. Particle board is absorbent and not a cleanable surface. b. Drawers and cabinet surfaces had areas of swollen particle board. 6. At the time of the observations, the surveyor asked the Unit 4-W Nurse Manager (Staff #611) about the exposed and swollen particle board. Staff #611 stated that the surfaces were not cleanable. Item #3 - Disinfection of environmental surfaces 1. Reference Sheet Virex II 256 - EPA Reg. No. 70627-24 states that all surfaces must remain wet for 10 minutes. Document review of the hospital's policy titled, "Daily Cleaning of Toilet - Tub," Policy #ES.D.300 dated 06/19, showed that facility staff are to use Virex 256 disinfectant solution to clean toilet seat,	L 815		

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L 815	Continued From page 16 top, and underneath and around hinge. 2. On 07/25/19 at 10:30 PM, Surveyor #6 observed a housekeeper (Staff #607) perform a terminal cleaning of Patient Room #392 on Unit 3-N. During the process, the surveyor observed ineffective disinfectant use: a. Staff #607 used a wiping cloth that had been soaked in Virex II 256 (a quaternary disinfectant solution) to wipe surfaces around the room. When disinfecting the door handles and mirror, Staff #607 wiped the surfaces with the disinfectant cloth and then immediately wiped the surfaces with a dry cloth. b. Staff #607 used a disinfectant soaked cloth to wipe the toilet bowl but used a dry cloth to wipe the toilet seat, top, and underneath. 3. At the time of the observations, Surveyor #6 asked Staff #607 about the disinfectant solution. Staff #607 stated that the solution was Virex and that surfaces must remain wet 10 minute for the disinfectant to be effective.	L 815		
L1485	322-230.1 FOOD SERVICE REGS WAC 246-322-230 Food and Dietary Services. The licensee shall: (1) Comply with chapters 246-215 and 246-217 WAC, food service; This Washington Administrative Code is not met as evidenced by: Based on observation, interview, and document review, the hospital failed to implement policies and procedures consistent with the Washington State Retail Food Code (Chapter 246-215 WAC).	L1485		

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L1485	Continued From page 17 Failure to follow food safety standards places patients at risk from food borne illness. Findings included: Item #1 Potentially Hazardous Foods (PHF) temperature control 1. On 07/24/19 between 9:10 AM and 10:30 AM, Surveyor #6 toured the hospital's kitchen and cafeteria with the Dietary Director (Staff #609). Surveyor #6 requested a copy of the hospital's policy for cooling potentially hazardous foods (PHF). Staff #609 provided an information sheet titled, "Cooling and Reheating of Potentially Hazardous Foods." Review of the information sheet showed that it is a page from the New York State Department of Health's public website. The document directs that PHFs must be cooled to 45 degrees Fahrenheit. Washington State Retail Food Code requires PHFs to be cooled to 41 degrees Fahrenheit. Reference: Washington State Retail Food Code (WAC) 246-215-03515; WAC 246-215-03520 2. During the survey, Surveyor #6 made the following observations of phf cold holding temperatures that exceeded the required maximum of 41 degrees Fahrenheit: a. Unit 2-W pantry: ½ pint milk - 45.4 degrees Fahrenheit; 6-oz container of yogurt - 49.1 degrees Fahrenheit; b. Unit 3-W pantry: ½ pint milk - 45 degrees Fahrenheit; cheese stick - 51 degrees Fahrenheit.	L1485		

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L1485	Continued From page 18 Reference: Washington State Retail Food Code 246-215-03525 Item #2 Handwashing sink 3. On 07/24/19 at 10:10 AM, Surveyor #6 inspected the cafeteria. The surveyor observed there was no handwashing sink near the cafeteria tray line, where staff plate and serve ready-to-eat food. 4. At the time of the observation, Surveyor #6 interviewed a food service worker (Staff #612) about handwashing during food service at the tray line. Staff #612 stated that staff could use a handwashing sink in the kitchen. The nearest handwashing sink to the cafeteria is through a latching door, across a hallway, and through another doorway. The nearest handwashing sink does not allow convenient use by food employees, as required. Reference: Washington State Retail Food Code 246-215-05255	L1485		
L1565	322-240.4A LAUNDRY-WATER TEMPERATURE WAC 246-322-240 Laundry. The licensee shall provide: (4) When laundry is washed on the premises: (a) An adequate water supply and a minimum water temperature of 140 F in washing machines; This Washington Administrative Code is not met as evidenced by: Based on observation and interview, the hospital failed to ensure the water supply used for on-site	L1565		

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L1565	Continued From page 19 patient laundry services reaches a minimum temperature of 140 degrees Fahrenheit. Failure to use sufficiently hot wash water places patients at risk of illness due to insufficient reduction of microbial contamination in patient laundry. Findings included: 1. On 07/24/19 at 9:10 AM, Surveyor #6 used an instant read thermometer to assess the temperature of hot water at a handwashing sink in the hospital kitchen. The temperature was assessed at 116.8 degrees Fahrenheit after 90 seconds. At 11:05 AM, Surveyor #6 used an instant read thermometer to assess the temperature of hot water at the service sink in the Soiled Utility room on Unit 2-N. The temperature was assessed at 104.1 degrees Fahrenheit after 3 minutes. 2. On 07/25/19 at 10:00 AM, Surveyor #6 interviewed the Facilities Director (Staff #606) and the CNO (Staff #603) about hot water temperature available to the on-site washing machines for patient laundry. Staff #606 stated that each patient unit had a domestic washing machine and that the hot water source for each machine was the same system that serves the rest of the hospital. Staff #606 stated that none of the washing machines had heat boosters to raise the water temperature to the required minimum temperature of 140 degrees Fahrenheit.	L1565		

RECEIVED
AUG 16 2019
Office of Health Systems Oversight

CASCADE BEHAVIORAL HEALTH
Plan of Correction for
State Licensing Survey
July 23 – 26, 2019

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 070	**Charity Care policy:** The Chief Financial Officer revised the current Charity Care policy ADM.C.300 and submitted it to the Department of Health. It will be uploaded to Cascades website by 8/30/19.	Chief Financial Officer	8/14/19 submitted to Department of Health 8/30/19 upload to Cascade's website.	The Chief Financial Officer will be responsible for ensuring the Department of Health has the most current copy of the hospital's Charity Care policy annually. Cascade's website will reflect the same policy as well as an application for charity care. Target for compliance is 8/30/19
L 335	**Crash Cart:** A new log will be implemented by 8/23/19 on all crash carts. All crash carts will be opened, expiration dates noted on all supplies in the carts and carts will be re-locked on 8/23/19. All nursing staff will be educated on the new logs and how to complete them properly on 8/29/19. Follow up education will be provided to those who do not attend the 8/29/19 nursing staff meeting.	Chief Nursing Officer	New logs and audits will begin on 8/23/19 and continue for a minimum of 3 months to ensure sustained compliance.	Nursing Supervisors will audit the crash carts and the logs on a daily basis to ensure sustained compliance. Any deficiencies will be corrected immediately and staff will be re-educated if necessary. Target for compliance is 8/23/19
L 410	**Foodborne Illness policy:** The hospital's policies on foodborne illness were not located at the time of survey. Policies were subsequently located and placed in the proper location on our public drive. **Cooling foods policy:** A policy for cooling potentially hazardous foods will be developed. All dietary staff will be educated on this policy. This policy will be submitted for approval by Quality Council and the Medical Executive	Dietary Manager Dietary Manager	8/16/19 9/13/19	Dietary Manager re-educated regarding policy location and content. Kitchen staff will be educated on the Cooling Foods policy. New staff will receive education upon hire. Dietary Manager will continue to monitor the temperatures and timeframes while cooling foods.

2019-2838

	Committee during their August monthly meetings.			
L 420	**Intravenous Fluids:** Both the pharmacy and hospital policies will be revised to remove instructions on treatment with intravenous fluids. The policy changes will go through The Pharmacy and Therapeutics Committee, Quality Council and Medical Executive Committee at their regularly scheduled August meetings. All clinical staff will be educated regarding the changes in the policies after final approval by the above committees.	Chief Medical Officer, Lead Pharmacist & Chief Nursing Officer	8/30/19	New polices will be approved and clinical staff will be educated by August 30th, 2019. The Chief Nursing Officer, Chief Medical Officer and Lead Pharmacist reviewed all other policies to ensure no others mentioned intravenous therapy.
L 715	**Water Management plan:** The Water Management policy will be revised to include the identification of ice/water drain lines as a place where water could stagnate; control measures/limits including the elimination of stagnant water and the monitoring of disinfectant levels. Verification process during semiannual testing identifies testing protocols and parameters.	Director of Facilities	9/27/19	The Water Management monitoring procedure will be developed and implemented by 9/27/19. Director of Facilities will report water management activities monthly to CEO moving forward.
	Ice Machines: All ice machines drain lines were inspected and adjusted to meet the standard slope requirement on 8/5/19. 2W drain line was reinstalled, kitchen line was replaced and reinstalled, 2N reinstalled, 3N checked and was at the appropriate slope, 3W checked and was at the appropriate slope, 4W checked and was at the appropriate slope. Additionally, all the ice machines have a built in drain separation inside the units themselves to prevent backfill of any kind.	Director of Facilities	8/5/19	Inspected/corrected 8/5/19. Monthly inspections of ice machine drain lines for any buildup, blockage and for correct slope by the Director of Facilities will begin 9/2/19.

L 815	**Clean Environment:** Belongings room Housekeeping staff completed a deep clean of the belongings room on 8/5/19. Housekeeping staff will clean this area daily moving forward.	Director of Facilities	8/5/19	Deep cleaning occurred on 8/5/19. Daily cleaning began 8/6/19. Director of Facilities will monitor this area weekly for cleanliness.
	Clean Environment: Court Wheel chair for court was cleaned. Cleaning/disinfecting wipes were stocked in the court area. Ambu bags were disposed of. Cloth Restraints were laundered. Nursing and court staff were educated on the mandatory cleaning of these items after each patient use: wheelchair, restraints and any other items that are used on a patient. A clipboard with a log was implemented to demonstrate that these items are cleaned after every patient use.	Director of Facilities	8/5/19	Director of Facilities will include the monitoring of the cleaning and completion of the log on his monthly rounds beginning 9/2/19.
	Clean environment: Assessment rooms Staff have been provided with wipes for cleaning equipment and other surfaces between patients. A clipboard is posted to demonstrate when each room was last cleaned. The Dynamap (vital sign machine) was relocated to the admissions area and staff were trained regarding the new location for its storage and cleaning. All staff who discharge or admit patients in these rooms have been instructed to clean the room after the patient has discharged and document the cleaning on the clipboard. The Director of Facilities is researching options for indicators to be placed outside the doors of these rooms to indicate if the room is in use/dirty or	Chief Nursing Officer, Director of Intake, Director of Facilities & Infection Control Nurse	8/30/19	Intake staff and Nurse Supervisors will assess all of the rooms daily at random intervals for maintained compliance starting 8/30/19. Any rooms found out of compliance will be immediately cleaned and staff responsible will receive 1:1 on the spot re-education. Infection Control nurse will add these rooms to their monthly rounding and report any findings to CNO, Director of Intake and Director of Facilities starting 8/30/19.

	available/clean to install by 9/30/19. Housekeeping staff thoroughly clean all assessment rooms in the intake areas once daily.			
	Clean environment: 2N Clean utility room. Electric trimmer was removed and discarded. Disposable trimmers were purchased last year, staff reminded to use only those trimmers with the disposable heads and to clean the base between each patient use. No other reusable trimmers remain at Cascade. Housekeeping staff were re-educated on cleaning all surfaces to include the crash cart tops. Nursing staff educated to clean all patient care equipment after each patients use and if the item needs a more thorough clean on the bases or stands, they are to inform the Director of Facilities.	Director of Nursing Director of Facilities Infection Control Nurse	8/6/19	Infection Control has added patient care equipment to their monthly rounds and will notify Director of Nursing and the Director of Facilities if any items are in need of cleaning. Monthly rounding begins in August 2019.
	Clean Environment; Cleanable Surfaces A complete hospital inspection was completed on furniture in patient care areas. Chairs were removed from the units, soiled or damaged coverings were replaced with replaced with new vinyl on 8/2/19. The couch in assessment room 2 was sent out for repair and replaced with additional chairs until its return. Wall surface damage has been repaired and repainted in 2N. 4 west utility room broken and missing laminate on counter edges, cabinet doors and drawers are scheduled to be	Director of Facilities Infection Control Nurse	9/25/19	Infection Control has added the inspection of all furniture to their monthly rounds and will report any findings or soiled or damaged furniture to the Director of Facilities monthly for immediate removal or repair. Monthly rounding begins in August 2019. Infection control will also monitor all cleanable surfaces to include cabinets, countertops, walls and floors on their monthly rounds for any damage and inform the Director of Facilities immediately, if discovered, to initiate a work order for repair.

	repaired/replaced by an external vendor on 9/25/19 **Clean Environment:** 2W soiled utility room, 2N seclusion room & office/visitation room have been deep cleaned. Housekeeping was re-educated about getting floor corners cleaned in all areas of the hospital. The area below the sink on 2W has been cleaned and secured closed with screws.	Director of Facilities Infection Control Nurse	8/16/19	Director of Facilities and Infection Control will round monthly to assess the cleanliness of these areas. Any accumulation of dust, dirt or debris will be reported to Housekeeping to address immediately. Specialized training with cleaning vendor is scheduled on 8/22/19 for all housekeeping staff. Director of Facilities will follow up with individual staff regarding job performance.
	Clean Environment: Shower/toilet exhaust fans: All exhaust fans have been cleaned. They will be externally cleaned by housekeeping daily moving forward. Preventative maintenance is performed every 3 months where the exhaust fans are opened, assessed for proper functionality, oiled & deep cleaned.	Director of Facilities Infection Control Nurse	8/16/19	The Director of Facilities and Infection Control have added the inspection of shower/toilet exhaust fans to their monthly rounds for inspection. Any findings will be reported for immediate attention.
	Clean Environment: Ineffective disinfectant use. All Housekeeping staff attended mandatory training on Cleaning Procedures and proper disinfectant use on 8/9/19. They will also receive additional training from the cleaning vendor on 8/22/19 on disinfectant dwell times and cleaning procedures.	Director of Facilities Infection Control Nurse	8/22/19	The Director of Facilities will observe housekeeping staff during his monthly rounds and provide immediate 1:1 correction if needed. The Infection Control will observe a minimum of one housekeeper monthly during their surveillance rounds and report any deviation from proper process to the Director of Facilities.
L 1485	**Potentially Hazardous Foods:** A policy for cooling potentially hazardous foods will be developed and implemented by 9/13/19. All dietary staff will be educated on this policy. This policy will be formally approved in Quality Council and the Medical Executive Committee during their August monthly meetings.	Dietary Manager Director of Facilities Infection Control Nurse	9/13/19	Dietary Manager will ensure all new staff are trained on this policy upon hire. Random spot checks of appropriate temperatures will occur monthly by the Dietary Manager and the Infection Control Nurse. All findings will be reported to the Director of Nursing as well as the Director of Risk & Quality with an expected compliance of 100%. This will be

				followed for 3 months to ensure sustained compliance. Target date 9/13/19 to develop and implement policy as well as train staff.
	Patient refrigerators: All patient refrigerators were inspected by the Director of Facilities by 8/16/19 and were found to be in good working order. It was determined that dietary staff were allowing nursing to stock the refrigerators and staff have been stocking the patient refrigerators excessively. Nursing staff have been instructed to call the kitchen if they run out of a particular item prior to the next delivery.	Dietary Manager Director of Facilities	8/16/19	Moving forward only dietary staff will stock a smaller par level of supplies in all of the patient refrigerators on the units. This will prevent overstocking and maintain temperature control inside the refrigerators. Refrigerator temperatures are monitored monthly by Infection Control, daily by Director of Dietary and monthly by the Director of Facilities. Any deviation outside the acceptable temperature range will immediately be reported to the Director of Facilities.
	Handwashing sink in Cafeteria: A new handwashing sink will be installed in the cafeteria. This will require coordination with the Department of Health Construction Review Service and installation of new plumbing.	Director of Facilities	1/26/20	Working with Department of Health Construction Review. Mitigation plan until construction is complete: a portable handwashing station will be purchased and placed in the cafeteria.
L1565	**Laundry water temperature:** New hot water boosters will be ordered to bring the temperature of the water in all patient washing machines to 140 F. This will require major work pertaining to the instillation of dedicated electrical and plumbing to all patient units as coordination with the Department of Health Construction Review Service. .	Director of Facilities	5/26/20	Working with Department of Health Construction Review Service. Mitigation plan until construction is complete: Patient laundry will contain a chemical additive to decrease the risk of illness due to insufficient reduction of microbial contamination until hot water boosters are installed.