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 _____	C 03/05/2020

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

(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) COMPLETE DATE
L 000	INITIAL COMMENTS STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC) 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation. On site date: 01/28/21 Off-site dates: 01/27/21-03/05/21 Case number: 2020-2702 Intake number: 98075 There were violations found pertinent to this complaint. .	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. The Plan of Correction is due on 03/31/21 4. Sign and return the Statement of Deficiencies via email as directed in the cover letter.	
L 315	322-035.1C POLICIES-TREATMENT 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: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: .	L 315	322-035 1C Policies – Treatment Item #1 How: The Chief Nursing Officer educated all RNs on Nursing Standard for Patient Care Policy, nursing assessment/reassessment, documentation of provider notification of change in condition, active medical problems, documentation of patient assessment each shift or whenever there is a change in patient's condition using the Nursing Assessment/reassessment form and a progress note.	

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L 315	Continued From page 1 Based on interview, document review, and review of policy and procedure, the hospital failed ensure implementation of the policy and procedure for nursing assessment/reassessment (Item #1); (Patient #1, #2, #3). Failure to implement policies for providing or arranging for the care and safety of patients places patients at risk for physical and mental harm, and can result in poor outcomes. Findings included: Item #1 Assessment/Reassessment 1. Review of the facility policy, "Nursing Standards for Patient Care", #PC.N.200 Reviewed 01/2018, showed that "Patients are reassessed as indicated by the patient's care needs and condition, or unit specific requirements.", and "All significant changes in the patient's clinical condition will be communicated by the nurse to the responsible physician in a timely manner". 2. Record review of Patient #1's medical record showed that: a. On 12/05/19 at 3:00 PM, a nurse documented in the skin portion of an assessment a new bruise on Patient #1's left collar bone and an abrasion on the left side of her head. There was no documentation of provider notification of this change in condition. b. On 12/05/19 at 8:00 PM, a nurse documented in the skin portion of an assessment that Patient #1's skin was normal but that a left arm skin tear was present. There was no documentation of	L 315	Continued From page 1 Who: Chief Nursing Officer What: Chief Nursing Officer completed trainings for RNs on 02/04/2021 and 3/11/2021. The Chief Nursing Officer implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocols are reviewed to ensure medical needs of the patients are addressed immediately. When: Chief Nursing Officer and or designee is auditing five Medical records with patients with medical needs to ensure, nursing assessment/reassessment, documentation of provider notification of change in condition, active medical problems, documentation of patient assessment each shift or whenever there is a change in patient's condition are being completed within the guidelines of the hospital Nursing assessment and reassessment policy. All deficiencies are corrected immediately. Staff not in compliance will receive re-education and or corrective action as necessary. Audit results will be submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained.	05/31/2021

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L 315	Continued From page 2 provider notification of this change in condition. c. On 12/06/19 at 10:00 AM, a nurse documented in the skin portion of an assessment that a left shoulder bruise was present. There was no documentation of provider notification of this change in condition. 3. Record review of Patient #2's medical record showed that: a. On 01/22/21 at 12:00 PM, a nurse documented in the Medical/Physical Update portion of an assessment that Patient #2 had "no active medical problems" as well as "active medical problems". The skin portion of the assessment indicates bilateral great toe gangrene. b.On 01/22/21 at 3:00 PM, a nurse documented nothing in the behavior portion and "no active medical problems" in the Medical/Physical update. c. On 01/27/21 at 3:00 PM, a nurse documented "no active medical problems" in the Medical/Physical update portion of the Nursing Reassessment. 4. Record review of Patient #3's medical record showed that: a. On 01/23/21, no time documented, a nurse documented nothing in the Behavior portion and nothing in the Thought Processes portion of the Nursing Reassessment. b. On no date, no time documented, a nurse did not document any portion of the nursing assessment for Patient #3. The evening assessment dated 01/24/21 at 9:00 PM on the	L 315		

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L 315	Continued From page 3 same page was completed. 5. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff # 4 and Staff #5) showed that all RNs are expected to assess patients each shift or whenever there is a change in a patient's condition using the Nursing Assessment/reassessment form and a progress note, and that nurses are expected to notify a provider as soon as possible in person or by telephone, of changes in a patient's condition. Based on interview, document review, and review of policy and procedure, the hospital failed ensure implementation of the policy and procedure for Fall Risk Assessment and Prevention and failed to document individualized fall precaution interventions for 2 of 2 patients reviewed (Item #2). Failure to implement and document fall risk prevention procedures risks patient safety and can result in adverse outcomes for patients. Item #2 Fall Risk Interventions 1. Review of the facility policy, "Fall Risk Assessment and Prevention", #PC.F.100 Reviewed 03/19, showed that patients are to be assessed for fall risk using the Morse Fall scale. The policy further states that Interventions will be initiated or changed based on the Morse Fall Risk Assessment score, and will be documented on the interdisciplinary treatment plan and daily on the Nursing Reassessment form. The policy further states that a Post Fall Assessment Form will be completed on all patients after any fall and placed in the medical record. The "Potential for	L 315	Item #2 Fall Risk Interventions How: Chief Nursing Officer completed trainings to RNs on facility Fall Risk Assessment and Prevention Policy. Who: Chief Nursing Officer What: Chief Nursing Officer completed trainings to all RNs on facility Fall Risk assessment policy on 2/4/2021 and 3/11/2021. Training included: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the	

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L 315	Continued From page 4 Injury Related to Falls" document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: a. On 11/28/19 at 8:00 PM, a nurse documented in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 had a fall risk score of 65, which indicated that Patient #1 was at high risk to fall. b. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Master Treatment plan that the fall prevention interventions indicated were "apply wrist band", "comfort rounds", "bed in low position", "apply bed alarms", "apply chair alarms" and "reassess fall risk". No further documentation was found in nursing reassessments to indicate that the specific and individualized precautions were implemented. 3. Record review of Patient #3's medical record showed that: a. On 1/23/21, no time documented, a nurse documented in the Falls portion of the Nursing Reassessment that the patient's gait was both unsteady and steady, that the patient used a front wheel walker, and that no fall precautions were in place. b. On 1/23/21 at 11:00 PM, a nurse documented that the patient had an unsteady gait, used a front	L 315	Continued From page 4 Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocols are reviewed to ensure Fall Risk Interventions are completed in a timely manner. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs are following facility specific Falls policy. Falls Audit includes but not limited to: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. Falls Audit is being submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained. Staff not in compliance will receive re-education and or corrective action as necessary.	5/31/2021 and Ongoing

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L 315	Continued From page 5 wheel walker and neither yes nor no in the Fall Precaution portion of the Nursing Reassessment. 3. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff #4 and Staff #5) showed that none were aware of an expectation that individual fall prevention interventions were to be documented daily on the nursing reassessment form or progress note.	L 315		
L1070	322-170.2F PHYSICIAN ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (f) Physician orders for drug prescriptions, medical treatments and discharge; This Washington Administrative Code is not met as evidenced by: Based on interview, record review, and review of hospital policy and procedure, the hospital failed to implement and ensure staff followed the order reconciliation process for 2 of 2 patients reviewed (Patient #1, #4). Failure to implement and ensure order reconciliation places patients at risk for delayed or incomplete orders. Delayed or incomplete orders place patients at risk for physical and emotional harm and may lead to adverse outcomes.	L1070	322-170.2F Physician Orders How: The Chief Nursing Officer educated all RNs on following the physician order reconciliation process and avoid delay or incomplete orders. Who: The Chief Nursing Officer How: The Chief Nursing Officer educated all RNs on following physician order reconciliation process and avoid delays or incomplete orders on 2/4//2021. The Chief Nursing Officer has implemented 24 hour chart check form and revised the 24 hour chart check process to reflect completion of physician orders. When: The Chief Nursing Officer or designee is auditing five charts per unit to ensure all physician orders and order reconciliation process is being followed per hospital policy. Audit results will be submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained. Staff not in compliance will receive re-education and or corrective action as necessary.	05/31/2021 and Ongoing

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L1070	Continued From page 6 Findings included: 1. Review of the facility policy, "Noting and Transcribing Physician Orders", #PC.M.110, revised 02/19, shows that the purpose of the policy is to "Transcribe medication orders from doctor's order form accurately and as soon as possible for timely implementation." and that "The licensed nurse will review the orders to ensure that they have been accurately transcribed to the MAR, and that any appropriate notifications have been made (Pharmacy, Lab, etc.), and that "By indicating 'Noted' and signing the order, the nurse is attesting that the order has been accurately and completely transcribed, and that the appropriate steps have been taken to implement the order. 2. Record review of Patient #1's medical record showed that: a. On 12/02/19 at 11:40 a provider wrote an order for a urinalysis to rule out organic causes of Patient #1's increasing confusion. On 12/2/19 the order was transcribed to the medication administration record (MAR) and every subsequent day until 12/09/19. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. b. On 12/10/19, eight days after the order was placed, a Lab Result document indicated that urine had been collected on 12/09 and results were positive for 100.000+ escherichia coli. 3. Record review of Patient #4's medical record showed that:	L1070		

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L1070	Continued From page 7 a. On 01/19/21 a provider placed an order to obtain EKG results for QTc ASAP. The order was transcribed to the MAR on 1/19/21 and every subsequent day as of 01/28/21. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. 4. On 02/25/21 at 2:00 PM an interview with two RNs (Staff # 4 and Staff #5) showed that orders of all types are routinely transcribed to the MAR. Staff #4 and Staff #5 were unsure of the process to indicate or communicate that an order other than a medication order, had or had not been completed. .	L1070		
L1665	322-260.2 ADVERSE HEALTH EVENTS The National Quality Forum identifies and defines twenty-nine serious reportable events (adverse health events) as updated and adopted in 2011. (2) Psychiatric hospitals must comply with the reporting requirements under chapter246-302 WAC. This Washington Administrative Code is not met as evidenced by: . Based on interview and document review the hospital failed to report an Adverse Event within 48 hours of confirmation for one of one patients reviewed. Failure to report a serious adverse event to the DOH may cause delays in reviewing and	L1665	322-260.2 Adverse Health Events How: The Director of Risk educated all leadership team the hospital specific Adverse Health Events policy. Who: Director of Risk What: The Director of Risk educated all leadership team on hospital specific adverse health events policy on 2/2/2021. When: The Director of Risk will audit all serious adverse events for notification of DOH and to ensure hospital Sentinel Adverse Events policy is followed. Audit results will be submitted to monthly quality and medical executive committee and quarterly governing body until 100% compliance is achieved and sustained.	05/31/2021

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L1665	Continued From page 8 analyzing the adverse event. Findings included: 1. Review of the facility policy titled, "Sentinel and Adverse Events, "Policy No. ADM.S.300 Revised 02/20, showed that "In the event it is believed that a reportable event has occurred, the Director of Risk Management will report the event to the Department of Health per regulations. The event will be reported using the internet reporting system within forty-eight hours of confirming an adverse event..." 2. Review of a document showed that the patient fall incident was confirmed on 12/07/19. A DOH report of the incident was submitted on 12/15/19, 8 days after confirming the incident. 3. On 3/3/21 at 11:30 AM, an interview with a Risk Manager showed that the event report was made by the former Director of Risk Management and the reason for the late submission is unclear. .	L1665		

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PR RECEIVED 05/04/21 RLR
PR APPROVED 05/04/21

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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 315	Continued From page 3 same page was completed. 5. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff # 4 and Staff #5) showed that all RNs are expected to assess patients each shift or whenever there is a change in a patient's condition using the Nursing Assessment/reassessment form and a progress note, and that nurses are expected to notify a provider as soon as possible in person or by telephone, of changes in a patient's condition. Based on interview, document review, and review of policy and procedure, the hospital failed ensure implementation of the policy and procedure for Fall Risk Assessment and Prevention and failed to document individualized fall precaution interventions for 2 of 2 patients reviewed (Item #2). Failure to implement and document fall risk prevention procedures risks patient safety and can result in adverse outcomes for patients. Item #2 Fall Risk Interventions 1. Review of the facility policy, "Fall Risk Assessment and Prevention", #PC.F.100 Reviewed 03/19, showed that patients are to be assessed for fall risk using the Morse Fall scale. The policy further states that Interventions will be initiated or changed based on the Morse Fall Risk Assessment score, and will be documented on the interdisciplinary treatment plan and daily on the Nursing Reassessment form. The policy further states that a Post Fall Assessment Form will be completed on all patients after any fall and placed in the medical record. The "Potential for	L 315	Item #2 Fall Risk Interventions How: Chief Nursing Officer completed trainings to RNs on facility Fall Risk Assessment and Prevention Policy. Who: Chief Nursing Officer What: Chief Nursing Officer completed trainings to all RNs on facility Fall Risk assessment policy on 2/4/2021 and 3/11/2021. Training included: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the	

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L 315	Continued From page 4 Injury Related to Falls" document referenced on the Morse fall risk sheet was not mentioned in this policy. 2. Record review of Patient #1's medical record showed that: a. On 11/28/19 at 8:00 PM, a nurse documented in the Morse Fall Risk Assessment portion of the initial Nursing Assessment that Patient #1 had a fall risk score of 65, which indicated that Patient #1 was at high risk to fall. b. On 11/28/19 at 5:00 PM a nurse did not document on the High Risk Notification form that Patient #1 was a fall risk. c. On 11/28/19 a nurse documented in the Potential for Injury related to Fall section of the Master Treatment plan that the fall prevention interventions indicated were "apply wrist band", "comfort rounds", "bed in low position", "apply bed alarms", "apply chair alarms" and "reassess fall risk". No further documentation was found in nursing reassessments to indicate that the specific and individualized precautions were implemented. 3. Record review of Patient #3's medical record showed that: a. On 1/23/21, no time documented, a nurse documented in the Falls portion of the Nursing Reassessment that the patient's gait was both unsteady and steady, that the patient used a front wheel walker, and that no fall precautions were in place. b. On 1/23/21 at 11:00 PM, a nurse documented that the patient had an unsteady gait, used a front	L 315	Continued From page 4 Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. The Chief Nursing Officer Implemented daily morning meetings with each unit, Attendees in the meeting include the Chief Nursing Officer, Nurse Managers, House supervisor, Charge Nurse of each unit in the hospital, Infection Control Nurse and Director of Risk and Quality. During these meetings, treatment plans, care management and protocols are reviewed to ensure Fall Risk Interventions are completed in a timely manner. When: The Chief Nursing Officer and or designee is auditing all Falls to ensure all RNs are following facility specific Falls policy. Falls Audit includes but not limited to: Morse Fall Scale, interventions initiated or changed based on the Morse Fall Risk Assessment Score and documentation on the Interdisciplinary treatment plan, Fall interventions, and daily nursing reassessment form. Falls Audit is being submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained. Staff not in compliance will receive re-education and or corrective action as necessary. Audit results for March 85%, April 91% and May 92%.	5/31/2021 and Ongoing

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L 315	Continued From page 5 wheel walker and neither yes nor no in the Fall Precaution portion of the Nursing Reassessment. 3. On 01/28/21 at 1:30 PM an interview with the Director of Nursing (DON) (Staff #2) and two RNs (Staff #4 and Staff #5) showed that none were aware of an expectation that individual fall prevention interventions were to be documented daily on the nursing reassessment form or progress note. .	L 315		
L1070	322-170.2F PHYSICIAN ORDERS WAC 246-322-170 Patient Care Services. (2) The licensee shall provide medical supervision and treatment, transfer, and discharge planning for each patient admitted or retained, including but not limited to: (f) Physician orders for drug prescriptions, medical treatments and discharge; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policy and procedure, the hospital failed to implement and ensure staff followed the order reconciliation process for 2 of 2 patients reviewed (Patient #1, #4). Failure to implement and ensure order reconciliation places patients at risk for delayed or incomplete orders. Delayed or incomplete orders place patients at risk for physical and emotional harm and may lead to adverse outcomes.	L1070	322-170.2F Physician Orders How: The Chief Nursing Officer educated all RNs on following the physician order reconciliation process and avoid delay or incomplete orders. Who: The Chief Nursing Officer How: The Chief Nursing Officer educated all RNs on following physician order reconciliation process and avoid delays or incomplete orders on 2/4//2021. The Chief Nursing Officer has implemented 24 hour chart check form and revised the 24 hour chart check process to reflect completion of physician orders. When: The Chief Nursing Officer or designee is auditing five charts per unit to ensure all physician orders and order reconciliation process is being followed per hospital policy. Audit results will be submitted for three consecutive months to monthly quality meetings and governing body quarterly until 90% compliance is achieve and sustained. Staff not in compliance will receive re-education and or corrective action as necessary.	

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L1070	Continued From page 6 Findings included: 1. Review of the facility policy, "Noting and Transcribing Physician Orders", #PC.M.110, revised 02/19, shows that the purpose of the policy is to "Transcribe medication orders from doctor's order form accurately and as soon as possible for timely implementation." and that "The licensed nurse will review the orders to ensure that they have been accurately transcribed to the MAR, and that any appropriate notifications have been made (Pharmacy, Lab, etc.), and that "By indicating 'Noted' and signing the order, the nurse is attesting that the order has been accurately and completely transcribed, and that the appropriate steps have been taken to implement the order. 2. Record review of Patient #1's medical record showed that: a. On 12/02/19 at 11:40 a provider wrote an order for a urinalysis to rule out organic causes of Patient #1's increasing confusion. On 12/2/19 the order was transcribed to the medication administration record (MAR) and every subsequent day until 12/09/19. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. b. On 12/10/19, eight days after the order was placed, a Lab Result document indicated that urine had been collected on 12/09 and results were positive for 100.000+ escherichia coli. 3. Record review of Patient #4's medical record showed that:	L1070	Continued From page 6 Audit results: March 83%, April 90% and May 92%	05/31/2021 and Ongoing

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L1070	Continued From page 7 a. On 01/19/21 a provider placed an order to obtain EKG results for QTc ASAP. The order was transcribed to the MAR on 1/19/21 and every subsequent day as of 01/28/21. No MAR documentation was found to indicate that the order had been completed, and no documentation of provider notification of a delay in order completion was found. 4. On 02/25/21 at 2:00 PM an interview with two RNs (Staff # 4 and Staff #5) showed that orders of all types are routinely transcribed to the MAR. Staff #4 and Staff #5 were unsure of the process to indicate or communicate that an order other than a medication order, had or had not been completed. .	L1070		
L1665	322-260.2 ADVERSE HEALTH EVENTS The National Quality Forum identifies and defines twenty-nine serious reportable events (adverse health events) as updated and adopted in 2011. (2) Psychiatric hospitals must comply with the reporting requirements under chapter246-302 WAC. This Washington Administrative Code is not met as evidenced by: . Based on interview and document review the hospital failed to report an Adverse Event within 48 hours of confirmation for one of one patients reviewed. Failure to report a serious adverse event to the DOH may cause delays in reviewing and	L1665	322-260.2 Adverse Health Events How: The Director of Risk educated all leadership team the hospital specific Adverse Health Events policy. Who: Director of Risk What: The Director of Risk educated all leadership team on hospital specific adverse health events policy on 2/2/2021. When: The Director of Risk will audit all serious adverse events for notification of DOH and to ensure hospital Sentinel Adverse Events policy is followed. Audit results will be submitted to monthly quality and medical executive committee and quarterly governing body until 100% compliance is achieved and sustained.	

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L1665	Continued From page 8 analyzing the adverse event. Findings included: 1. Review of the facility policy titled, "Sentinel and Adverse Events, "Policy No. ADM.S.300 Revised 02/20, showed that "In the event it is believed that a reportable event has occurred, the Director of Risk Management will report the event to the Department of Health per regulations. The event will be reported using the internet reporting system within forty-eight hours of confirming an adverse event..." 2. Review of a document showed that the patient fall incident was confirmed on 12/07/19. A DOH report of the incident was submitted on 12/15/19, 8 days after confirming the incident. 3. On 3/3/21 at 11:30 AM, an interview with a Risk Manager showed that the event report was made by the former Director of Risk Management and the reason for the late submission is unclear.	L1665	Continued From page 8 Audit results March: 90%; April 91% and May 93%.	05/31/2021

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

June 29, 2021

Cascade Behavioral Health Hospital
12844 Military Road South
Tukwila, WA 98168

RE: 98075 /2020- 2702

Hello Meghna.

I conducted a state hospital licensing complaint investigation at Cascade Behavioral Hospital in January and February 2021. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 04/17/21.

The former risk manager sent a Progress Report dated 05/04/21 that indicates all deficiencies have been corrected. The Department of Health accepts Cascade Behavioral Health Hospital's attestation that it will correct all deficiencies cited at Chapter 246-322 WAC.

We sincerely appreciate your cooperation and hard work during the investigation process.

Sincerely,

Robin Shabica BSN, RN
DOH Nurse Investigator