State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013299	A. BUILDING: _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	3402 S 19TH ST TACOMA, WA 98405

(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 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. On site dates: 04/20/22 - 04/22/22 Examination number: 2022-260 The survey was conducted by: Surveyor #3 Surveyor #6 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection. During the survey, surveyors assessed issues related to complaints #2022-3008 and 2022-4356.	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 May 20, 2022. 4. Sign and return the Statement of Deficiencies and Plans of Correction 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	L 315		

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L 315	Continued From page 1 services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff perform daily shift suicide risk assessments according to policy for 2 of 4 records reviewed (Patient #301, #302). Failure to assess patients for suicide risk places them at risk for serious injury and harm. Findings included: 1. Document review of the hospital policy and procedure titled, "Suicide Assessment and Intervention," PolicyStat ID # 10608878, last approved 02/22, showed that a suicide risk screening assessment is performed at least once per shift. 2. On 04/21/22 at 1:00 PM, Surveyor #3 and the Clinical Nursing Supevisor (Staff #301) reviewed the medical records of 4 patients who admitted to the hospital. The review showed: a. Patient #301 is a 62-year-old who was admitted on 03/25/22 involuntarily due to history of suicide ideation with plan to jump off a bridge. The surveyor found no documentation that a "day shift" suicide risk assessment screening was performed on 04/14/22 resulting in a period of 23 hours without an assessment being performed. Further, no suicide risk assessment screening was documented by the nursing staff on 04/15/22 (missing both day and night shifts) resulting in a period of 37 hours without an assessment being	L 315		

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L 315	Continued From page 2 performed. b. Patient #302 is a 26-year-old who was admitted on 04/29/22 due to auditory hallucinations telling her to kill herself. The surveyor found no documentation that a "day shift" suicide risk assessment screening was performed on 04/14/22 and 04/15/22. Further, no suicide risk assessment screening was documented by the nursing staff on 04/16/22 (missing both day and night shifts) resulting in a period of 35 hours without an assessment being performed. 3. On 04/21/22 at 2:30 PM, Surveyor #3 interviewed the Clinical Nuring Supevisor (Staff #301) about suicide risk assessments. Staff #301 stated that suicide risk assessments are performed at least once per shift by the nursing staff. She confirmed that the findings noted above that staff had not followed the hospital policy. .	L 315		
L 670	322-050.12G RECORDS-PERFORM EVALS WAC 246-322-050 Staff. The licensee shall: (12) Maintain a record on the hospital premises for each staff person, during employment and for two years following termination of employment, including, but not limited to: (g) Annual performance evaluations. This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to develop an effective process to	L 670		

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L 670	Continued From page 3 ensure annual performance evaluations were conducted and records retained for 6 of 12 staff human resource records reviewed (Staff #604, #607, #608, #609, #610, and #611). Failure to conduct annual performance evaluations limits the hospital's ability to ensure satisfactory staff performance of required duties. Findings included: 1. Document review of the hospital's policy titled, "Staff Competency," PolicyStat ID# 9565400, approved 04/21, showed that staff competency is a assured through annual performance evaluations by supervisors. 2. On 04/21/22 at 1:15 PM, Surveyor #6 and the Senior Human Resources Consultant (Staff #606) reviewed human resources records for 12 staff members. Review of annual performance evaluations showed: a. a Registered Nurse (RN) (Staff #607), hired 02/20, did not have an annual performance evaluation; b. a Mental Health Technician (MHT) (Staff #608), hired 01/19, did not have an annual performance evaluation; c. a Housekeeper (Staff #604), hired 06/19, did not have an annual performance evaluation; d. a Recreational Therapist (Staff #609), hired 11/20, did not have an annual performance evaluation; e. a Care Consultant (Staff #610), hired 02/19, did not have an annual performance evaluation;	L 670		

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L 670	Continued From page 4 f. a Health Unit Coordinator (HUC) (Staff #611), hired 11/20, did not have an annual performance evaluation. 3. At the time of the review, Staff #606 stated that performance evaluations had been delayed several times due to delays in patient services, the COVID-19 Pandemic, executive staff changes, and legal concerns during staff unionization petitions. Staff #606 stated that performance evaluations are currently scheduled. .	L 670		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This Washington Administrative Code is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to provide a clean and sanitary exam environment for patient examinations. Failure to maintain a clean and sanitary physical environment puts patients at risk of increased exposure to harmful contaminants. Findings included: 1. Document review of Environmental Services - Housekeeping Checklists for the occupied patient units for 04/19/22 and 04/20/22 showed that an Environmental Services staff member (Staff #604) was assigned to clean the clinical inpatient	L 780		

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L 780	Continued From page 5 "Dock Unit" on both days. The checklist for 04/19/22, which had pre-printed rooms listed, did not have either of the 2 Consultation Rooms (no room numbers listed) marked as cleaned that day. The checklist for 04/20/22, which had hand-written rooms listed, showed "exam room" marked as cleaned. 2. On 04/20/22 at 9:20 AM, Surveyor #6 toured Consultation Room #1410 on the Dock Unit with a Quality & Compliance Officer (Staff #601) and the Chief Clinical Officer (Staff #602). The observation showed that Room #1410 was not available for a patient exam: a. the medical exam table paper was wrinkled and torn, having the appearance of previous use; b. a pull-out padded surface at the foot of the exam table was gritty with debris; c. the garbage from a previous exam had not been removed from the room. 3. On 04/20/22 at 10:00 AM, Surveyor #6 interviewed an Environmental Services staff member (Staff #604) about the daily cleaning of Consultation Room #1410. Staff #604 stated she had cleaned Room #1410 on 04/19/22 around 11:00 AM. Staff #604 stated that the daily cleaning of the exam room includes wiping all surfaces of the exam table, including the pull-out surface, with a disinfectant solution. She stated that the provider changes the medical exam table paper but that the EVS staff should remove the garbage. At the time of the interview, Surveyor #6 requested information regarding the last use of Room #1410 for a patient exam. Surveyor #7 did	L 780		

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L 780	Continued From page 6 not receive information regarding when Room #1410 was last used prior to the observation. 4. On 04/21/22 at 11:00 AM, during an interview with the Chief Operations Officer (Staff #605), Surveyor #7 requested the policy or procedure information about cleaning exam rooms. Staff #605 stated there was not a separate policy or procedure for common areas including exam rooms, but EVS staff use EVS Housekeeping Checklists that include exam rooms and other common areas. .	L 780		
L1040	322-170.1C TRANSFER PATIENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval by the receiving facility prior to transfer; and (iii) Immediately notifying the patient's family. This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure staff completed the documentation for transfer in 1 of 3 medical records reviewed (Patient #901). Failure to complete transfer documentation promotes lack of care continuity and places patients at risk for sub-optimal care.	L1040		

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L1040	Continued From page 7 Findings included: 1. Document review of the hospital's policy and procedure titled, "Transfer of Patients for Medical Stabilization," Policy Stat ID # 1078690, approved 02/22, showed that the nurse is responsible for documenting handoff communication with the receiving facility and contacting the patients family to notify them of the change in condition and transfer of care. 2. On 04/21/22 at 2:00 PM, Surveyor #9 and Director of Utilization Management (Staff #903), reviewed the medical record for Patient #901. A provider note showed that Patient #901 was transferred to Allenmore Hospital on 11/27/21. The surveyor could not find evidence of a note to indicate a nurse to nurse hand off or family notification had been completed. 3. On 04/21/22 at 2:20 PM, Surveyor #9 interviewed Staff #903 about the transfer documentation. Staff #903 was unable to locate the nurse to nurse hand off or the family notification and agreed that the information was missing.	L1040		
L1155	322-180.1E SECLUSION EXAM WAC 246-322-180 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (e) A physician shall examine each restrained or	L1155		

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L1155	Continued From page 8 secluded patient and renew the order for every twenty-four continuous hours of restraint and seclusion; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital's seclusion policy and procedure for documentation in 1 of 2 seclusion records reviewed (Patient #902). Failure to follow approved policies and procedures for seclusion risks physical and psychological harm, loss of dignity, and violation of patient rights. Item #1 Face to Face Evaluation Findings included: 1. Document review of the hospital's policy titled, "Use of Seclusion and Restraint," Policy Stat ID #10533122, last approved 12/21, showed that a face to face evaluation of the patient within 1 hour by a licensed provider or a Registered Nurse (RN) within the Behavioral Health Unit is required. The face to face must include the patient's immediate situation, the reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or discontinue the restraint or seclusion. Review of document titled "Seclusion and Restraint Documentation," updated 10/21 showed that a face to face must be completed by an RN within 1 hour of restrictive intervention. 2. On 04/21/22 from 12:30 PM to 3:00 PM,	L1155		

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L1155	Continued From page 9 Surveyor #9 and Director of Utilization Management (Staff #903), reviewed the medical record of Patient #902. The review showed: a. Patient #902 was admitted on 02/05/22 for treatment of bipolar disorder with psychosis. A seclusion order was placed for Patient #902 on 02/07/22 at 4:19 AM. Patient #902 was placed in seclusion on 02/07/22 at 4:15 AM for self-destructive behavior jeopardizing their immediate safety. b. The restraint monitoring flowsheet showed that a second order for seclusion was placed for Patient #902 on 02/07/22 at 8:15 AM and a face to face was completed by a licensed provider. Patient #902 remained in seclusion. The surveyor could find no evidence of an order or face to face nursing assessment within 1 hour. c. A third order for seclusion was placed for Patient #902 on 02/07/22 at 1:10 PM. The surveyor could find no evidence of a face to face nursing assessment within 1 hour. Patient #902 was released from seclusion on 02/07/22 at 2:27 PM. 3. At the time of the review, Staff #903 confirmed the findings. Item #2 Care Plan Findings included: 1. Review of document titled "Seclusion and Restraint Documentation," updated 10/21, showed that the care plan must be updated as soon as possible after initiating restraint or seclusion.	L1155		

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L1155	Continued From page 10 2. On 04/21/22 from 12:30 PM to 3:00 PM, Surveyor #9 and Director of Utilization Management (Staff #903), reviewed the medical record of Patient #902. The review showed: a. Patient #902 was admitted on 02/05/22 for treatment of bipolar disorder with psychosis. A seclusion order was placed for Patient #902 on 02/07/22 at 4:19 AM. Patient #902 was placed in seclusion on 02/07/22 at 4:15 AM for self-destructive behavior jeopardizing their immediate safety. b. The restraint monitoring flowsheet showed that a second order for seclusion was placed for Patient #902 on 02/07/22 at 8:15 AM. The surveyor could find no evidence of an updated care plan note. c. A third order for seclusion was placed for Patient #902 on 02/07/22 at 1:10 PM. The surveyor could find no evidence of an updated care plan note. Patient #902 was released from seclusion on 02/07/22 at 2:27 PM. 3. At the time of the review, Staff #903 confirmed the findings.	L1155		
L1375	322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing, and administering medications according to state and federal laws and rules, including: (c)	L1375		

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L1375	Continued From page 11 Administering drugs; This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedures, the hospital failed to ensure staff members completed and documented reassessments after each "as needed" (PRN) medication intervention for 3 of 4 medical records reviewed (Patient #303, #304, and #305). Failure to reassess patients after PRN medication administration risks inconsistent, inadequate, or delayed relief of symptoms including insomnia, and anxiety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Medication Administration and Documentation: General Guidelines," PolicyStat ID #10599409, last approved 10/21, showed that staff should document the effects of medications to include response to PRN medications. 2. On 04/21/22, Surveyor #3 reviewed the medical records for 4 patients who received PRN medications while hospitalized. The review showed: a. Patient #303 was medicated with trazodone (a medication used to treat insomnia) 50 mg by mouth for insomnia on 04/18/22, 04/19/22, and 04/20/22. Surveyor #3 found no evidence that hospital staff reassessed the patient to determine the effectiveness of the as needed medication. b. Patient #304 was medicated with lorazepam (a medication used to treat anxiety) 2 mg by mouth	L1375		

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L1375	Continued From page 12 for anxiety on 04/19/22 and 04/21/22. Surveyor #3 found no evidence that hospital staff reassessed the patient to determine the effectiveness of the as needed medication. c. Patient #305 was medicated with hydroxyzine pamoate (a medication used to treat anxiety) 50 mg by mouth for anxiety on 04/19/22. Surveyor #3 found no evidence that hospital staff reassessed the patient to determine the effectiveness of the as needed medication. 3. On 04/21/22 at 2:30 PM, Surveyor #3 interviewed the Clinical Nursing Supervisor (Staff #301) about the process for how nursing staff document their reassessments when administering PRN medications. Staff #301 stated that nursing staff were to either document the effectiveness of the medication in their daily shift assessment or by entering a comment in the medication administration record. She confirmed the above findings that staff did not followed the hospital policy for reassessing the patient after administering PRN medications.	L1375		
L1470	322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services. The licensee shall: (1) Provide access to laboratory services to meet emergency and routine needs of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure laboratory testing supplies did not exceed their designated expiration date.	L1470		

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L1470	Continued From page 13 Failure to ensure testing supplies do not exceed their expiration date places patients at risk for inadequate medical treatment due to unreliable test results. Findings included: 1. Document review of the hospital's policy titled, "Stock Rotation and Expiration Policy," PolicyStat ID #10437519, approved 10/21, showed that staff are to conduct quarterly tracers to audit expiration dates and ensure staff compliance of expiration dates. 2. On 04/20/22 at 9:20 AM, Surveyor #6 toured the clinical "Dock Unit" with a Quality & Compliance Officer (Staff #601) and the Chief Clinical Officer (Staff #602). The observation showed the following expired supplies in an exam table in Consultation Room #1410: 2 culture swab kits with expiration dates of 08/31/19 and 02/28/21; 8 packets of lubricating jelly with an expiration date of 11/21. 3. At the time of the observation Staff #601 and Staff #602 verified the finding and removed the items. 4. On 04/20/22 at 9:40 AM, Surveyor #9 toured the clinical "Flag Unit" with a Nurse Manager (Staff #901). The observation showed the following expired supplies in the medication room: 18 vacutainer blood collection tubes with expiration dates of 03/22, 03/22, and 01/22. 5. At the time of the observation, Staff #901 verified the finding and removed the items. 6. On 04/20/22 at 10:45 AM, Surveyor #6 toured	L1470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L1470	Continued From page 14 the clinical "Compass Unit" with a Quality & Compliance Officer (Staff #601) and the Chief Clinical Officer (Staff #602). The observation showed the following expired supplies in Exam Room #1311: 3 boxes of vacutainer blood collection tubes with expiration dates of 04/30/20 and 3 vacutainer blood collection tubes with an expiration date of 08/31/20. 7. At the time of the observation Staff #601 and Staff #602 verified the finding and removed the items. 8. On 04/20/22 at 12:15 PM, Surveyor #9 toured the clinical "Dock Unit" with a Quality Representative (Staff #902). The observation showed the following expired supplies in the medication room: 4 vacutainer blood collection tubes with expiration dates of 03/22 and 12/21. 9. At the time of the observation Staff #902 verified the finding and removed the items. 10. On 04/20/22 at 1:15 PM, Surveyor #9 toured the the clinial "Compass Unit" with a Quality Representative (Staff #902). The observation showed the following expired supplies in the medication room: 1 vacutainer blood collection tube with an expiration date of 03/22. 11. At the time of the observation Staff #902 verified the finding and removed the items. 12. On 04/20/22 at 2:45 PM, Surveyor #6 toured the the clinical "Beacon Unit" with a Quality & Compliance Officer (Staff #601) and the Environmental Services Supervisor (Staff #603). The observation showed the following expired supplies in the Clean Utility Room: 2 boxes (150 count) bacteriostatic lubricating jelly packets with	L1470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013299	A. BUILDING: _____ B. WING _____	04/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	3402 S 19TH ST TACOMA, WA 98405

(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
L1470	Continued From page 15 expiration dates of 11/21 and 10/21 and approximately 40 microtainer tubes with an expiration date of 03/31/21. 13. At the time of the observation Staff #601 and Staff #603 verified the finding and removed the items. THIS IS A REPEAT FINDING - PEVIOUSLY CITED SEPTEMBER 2021 .	L1470		

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013299	A. BUILDING: 03 B. WING _____	04/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	3402 S 19TH ST TACOMA, WA 98405

(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
S 000	INITIAL COMMENTS This report is the result of an unannounced Fire and Life Safety state survey conducted at the Wellfound Behavioral Health Hospital on April 20, 2022, by a team of representatives of the Washington State Patrol, Fire Protection Bureau. The survey was conducted in concert with the Washington State Department of Health Services (DOH) health survey teams. The facility has a total of 120 beds and at the time of this survey the census was 51. The existing section of the 2012 Life Safety Code was used in accordance with 42 CFR 482.41. The facility is a Type 1 construction with exits to grade. The facility is protected by a Type 13 fire sprinkler system throughout and an automatic fire alarm system with corridor smoke detection. All exits are to grade with paved exit discharges to the public way. The facility is in substantial compliance with the 2012 Life Safety Code as adopted by the Centers for Medicare & Medicaid Services. The surveyor was: Lysandra Davis Deputy State Fire Marshal State Fire Marshal's Office 2502 112th St E Tacoma, WA 98445 Life Safety Code Surveyor - 41257	S 000		

State Form 2567

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

Plan of Correction received
05/20/2022
Plan of Correction approved
06/13/2022
Paul M Leonhardt RN, MSN

Wellfound Behavioral Health Hospital
Plan of Correction for
State Licensing Survey
April 20-22, 2022

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L315	The Daily Shift Suicide Risk screening tool has been reassigned to Mental Health Technicians (MHTs); education and training has been completed and the new procedure is in place. The Nurse (RN) is responsible for using the data collected in the screening tool as a piece of the daily assessment for risk of suicide. The RNs must co-sign on the tool completed by the MHT. The Suicide Risk Assessment policy to be updated to reflect these changes. The Daily Shift Suicide Risk screening will be completed for all patients on every shift.	AVP of Nursing-Angie Conklin	06/24/2022	Completion of Daily Shift Suicide Risk screening will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks. Completion of co-signature by RNs will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks.
L670	Annual Staff Evaluations are in progress for all staff. Annual evaluations will be scheduled during Quarter 2 moving forward each year for all staff.	Mgr Human Resources & Labor Relations-Sarah Hermann	06/24/2022	Completion of Annual Staff Evaluations will be monitored by report being run weekly in June to ensure target will be met of ≥95% evaluations completed by 06/24/2022.
L780	All EVS staff will be educated on cleaning Consult Rooms. MHT/RNs will be educated on cleaning Consult Rooms between patients. The policy "Environmental Services- Daily Cleaning, Discharges, and Transfers" will be updated to include cleaning the Consult Room.	EVS Supervisor-Ashley Jackson AVP of Nursing-Angie Conklin	06/20/2022	Verification of Consult Rooms being clean and sanitary will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks.
L1040	The "Transfer of Patients for Medical Stabilization" policy to be updated to indicate that the SW is responsible for communicating with the Patient's family on weekdays; RN will complete on weekends.	AVP of Nursing-Angie Conklin	06/20/2022	Completion of family notification and nurse-to-nurse handoff will be monitored via Tracer until

	All RNs and SWs will be trained on the updated policy. All RNs will be trained on completing the nurse-to-nurse handoff. All SWs will be trained on completing the family notification. For every patient transferred out of the facility, a family notification will be completed (dependent on ROI). For every patient transferred out of the facility, a nurse-to-nurse handoff will be completed.	Chief Clinical Officer-Rhiannon Service		≥95% compliant for 8 consecutive weeks.
L1155	All RNs will be educated on completing the face-to-face nursing assessment within 1 hour and updating the care plan. A Provider or LPN will perform and document a face-to-face assessment within one hour of initiation of restraint or seclusion for all patients.	AVP of Nursing-Angie Conklin	06/20/2022	Completion of face-to-face nursing assessment and updated care plan will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks.
L1375	All RNs will be educated on completing the reassessments after PRN medications are administered. Reassessments will be completed for all patients by RNs after a PRN is administered.	AVP of Nursing-Angie Conklin	06/20/2022	Completion of reassessments for PRNs will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks.
L1470	All Leadership, RNs and MHTs will be educated on the removal of expired supplies. A weekly ongoing tracer will be created to ensure staff members are checking all units for expired supplies (outside of the compliance/monitoring procedure).	AVP of Nursing-Angie Conklin	06/20/2022	Verification that there are no expired supplies will be monitored via Tracer until ≥95% compliant for 8 consecutive weeks. This tracer will be completed weekly and will have a monthly cross-check completed by leadership (Angie Conklin).

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

June 17, 2022

Ms. Angela Naylor, CEO
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, Washington 98405

Dear Ms. Naylor,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state hospital licensing survey at Wellfound Behavioral Health Hospital on April 20-22, 2022. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on June 13, 2022.

A Progress Report is due on or before **July 21, 2022** when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please email this progress report to me at the following email address:

Paul.kondrat@doh.wa.gov

Please contact me if you have any questions. I may be reached at (360) 236–2911. I am also available by email.

Sincerely,

Paul Kondrat

Paul Kondrat, RN, MN, MHA
Survey Team Leader

Wellfound Behavioral Health Hospital
Progress Report for
State Licensing Survey
Onsite: 4/20/22 and 4/22/22

Progress Report received 07/21/2022
Progress Report approved 07/25/2022
Paul Leitman, MN MD 07/25/22

Tag #	How Corrected	Date Corrected	Results of Monitoring
L315	The Daily Shift Suicide Risk screening tool has been reassigned to Mental Health Technicians (MHTs); education and training has been completed and the new procedure is in place. The Nurse (RN) is responsible for using the data collected in the screening tool as a piece of the daily assessment for risk of suicide. The RNs must co-sign on the tool completed by the MHT. The Suicide Risk Assessment policy to be updated to reflect these changes. The Daily Shift Suicide Risk screening will be completed for all patients on every shift.	Ongoing	A tracer reviewing the completion of the Daily Shift Suicide Risk screening has been ongoing. In the past 8 weeks of completing the tracer, the reviewed charts have only been at ≥95% compliance for 3 non-consecutive weeks. As part of this Plan of Correction (POC), the MHTs were trained on completing the Daily Shift Suicide Risk screening tool with RNs co-signing. However, this did not improve compliance. This coupled with feedback from staff resulted in returning to the RNs completing the screening. Upon monitoring with RNs resuming this duty, we still did not see steady compliance changes. Due to already providing education and feedback to staff, we are now moving forward with individualized disciplinary action. Nursing leadership is communicating with each RN when a missed screening is identified and following up as appropriate per disciplinary protocol. We will continue this tracer until we are able to meet our 8-week compliance goal of ≥95%.
L670	Annual Staff Evaluations are in progress for all staff. Annual evaluations will be scheduled during Quarter 2 moving forward each year for all staff.	06/24/2022	Annual staff evaluations were completed at the goal of ≥95%.
L780	All EVS staff will be educated on cleaning Consult Rooms. MHT/RNs will be educated on cleaning Consult Rooms between patients.	Ongoing	All EVS staff completed the new education on cleaning Consult Rooms. RNs and MHTs were provided education on cleaning Consult Rooms between patients.

	The policy "Environmental Services- Daily Cleaning, Discharges, and Transfers" will be updated to include cleaning the Consult Room.		The policy "Environmental Services- Daily Cleaning, Discharges, and Transfers" was updated. For the past 8 weeks of monitoring via tracer, the Consult Rooms have been at ≥95% except for one week (week of June 12th). We will continue monitoring this via tracer until we have 8 consecutive weeks of compliance.
L1040	The "Transfer of Patients for Medical Stabilization" policy to be updated to indicate that the SW is responsible for communicating with the Patient's family on weekdays; RN will complete on weekends. All RNs and SWs will be trained on the updated policy. All RNs will be trained on completing the nurse-to-nurse handoff. All SWs will be trained on completing the family notification. For every patient transferred out of the facility, a family notification will be completed (dependent on ROI). For every patient transferred out of the facility, a nurse-to-nurse handoff will be completed.	Ongoing	Training was completed for RNs and SWs. The policy was updated. A tracer was completed for the past 8 weeks regarding the family notification and nurse-to-nurse handoff completion. For the past 8 weeks, a tracer has been completed. Compliance was ≥95% for 5 non-consecutive weeks for notifying the family. Compliance was ≥95% for only 2 weeks for completing the nurse-to-nurse handoff. Due to already providing training on this topic, other action items are being conducted. Nursing leadership is working to develop a prompt within the electronic health record to help with documentation of the nurse-to-nurse handoff. There will also be follow-up by leadership within 24-hours on each transfer to review completion of all tasks. Furthermore, individual follow-up with staff members who are not completing this is occurring along with disciplinary measures. The tracer will continue until we have 8 consecutive weeks of compliance at ≥95%.
L1155	All RNs will be educated on completing the face-to-face nursing assessment within 1 hour and updating the care plan. A Provider or LPN will perform and document a face-to-face assessment within one hour of initiation of restraint or seclusion for all patients.	Ongoing	RNS were educated on completion of the face-to-face nursing assessment within 1 hour and updating the care plan. For the past 8 weeks, a tracer has been completed. Compliance was ≥95% for 5 non-consecutive weeks. Individual follow-up has been ongoing when this is found to not be completed during the tracer. Due to education and individual follow-up already taking place, disciplinary action will be occurring for staff

			members who are not completing the assessment. There will also be follow-up by leadership within 24-hours on each transfer to review completion of all tasks. The tracer will continue until 8 consecutive weeks of compliance at ≥95% is maintained.
L1375	All RNs will be educated on completing the reassessments after PRN medications are administered. Reassessments will be completed for all patients by RNs after a PRN is administered.	Ongoing	Education was provided to staff members on PRN reassessments. A tracer was conducted on this and was only in compliance at ≥95% for 1 week. At this time, individual communication is going out to each RN listing the missed assessments. Nursing leadership is following-up with disciplinary action for RNs who continue to not complete reassessments. The tracer will continue until 8 consecutive weeks of compliance at ≥95% is maintained.
L1470	All Leadership, RNs and MHTs will be educated on the removal of expired supplies. A weekly ongoing tracer will be created to ensure staff members are checking all units for expired supplies (outside of the compliance/monitoring procedure).	Ongoing	Education and information was provided to all staff and leadership on expired supplies. A weekly tracer has been conducted along with a cross-check for expired supplies. The tracer has only been in compliance at ≥95% on the 8th week. Leadership reviewed the expired supplies discovered on the units each week. A review of all med rooms and consult rooms and closed units was done to ensure all expired supplies were out of the facility. Leadership communicated with the supplier and ensured no expired supplies were being stocked. At this time, a check for expired supplies is being completed multiple times a week. Leadership has also rounded with staff to discuss the importance of not using expired supplies. The tracer will continue until 8 consecutive weeks of compliance at ≥95% is maintained.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

May 10, 2022

Ms. Angela Naylor, CEO
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, Washington 98405

Dear Ms. Naylor,

This letter contains information regarding the recent survey of Wellfound Behavioral Health Hospital by the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau. Your state licensing survey was completed on April 22, 2022.

During the survey, deficient practice was found in the areas listed on the attached Statements of Deficiencies (CMS 2567). A written Plan of Correction is required for each deficiency listed on the Statement of Deficiencies and will be due 10 days after you receive this letter. All corrections for the **Health survey** findings must be completed within **60 days** of the survey exit date (June 21, 2022) and **Fire Life Safety** findings must be completed within **35 days** of the survey exit date (May 27, 2022).

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;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring procedure including time frame, number of planned observations and the target for compliance.

A sample Plan of Correction has been enclosed for reference. You are not required to write the Plan of Correction on the Statement of Deficiencies form.

Please sign and return a scanned copy of the original reports and Plans of Correction to me at the following email address:

paul.kondrat@doh.wa.gov

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

August 1, 2022

Ms. Angela Naylor, CEO
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, Washington 98405

Dear Ms. Naylor,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Wellfound Behavioral Health Hospital on April 20-22, 2022. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on June 13, 2022.

Hospital staff members sent a Progress Report dated July 21, 2022, that indicates all deficiencies have been corrected. The Department of Health accepts Wellfound Behavioral Health Hospital's attestation to be in compliance with Chapter 246-322 WAC.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Paul Kondrat

Paul Kondrat, RN, MN, MHA
Survey Team Leader