



STATE OF WASHINGTON
DEPARTMENT OF HEALTH

November 25, 2019

Michael Uradnik, Administrator
Acadia Healthcare
830 Crescent Centre Drive, Suite 610
Franklin, TN 37067

Re: Investigation #**WA00094626** / Case #**2019-14150**

Dear Michael Uradnik:

This letter informs you of the outcome of the completed complaint investigation conducted on November 19, 2019. After reviewing the complaint investigation, we determined there were no deficiencies pertinent to this complaint under WAC and/or 42 CFR regulations.

Enclosed is your copy of the Statement of No Deficiencies. If you have any questions regarding the process or results of this investigation you may contact our office at 360-236-4735. Please include the investigation number of the facility.

Sincerely,

Valerie Vajda, Case Manager
Office of Health Systems Oversight
P.O. Box 47874
Olympia, WA 98504-7874

Enclosures

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60429197	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2019
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NAME OF PROVIDER OR SUPPLIER CASCADE BEHAVIORAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 12844 MILITARY ROAD SOUTH TUKWILA, WA 98168
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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
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L 000	<p>INITIAL COMMENTS</p> <p>STATE COMPLAINT INVESTIGATION</p> <p>The Washington State Department of Health (DOH) in accordance with the Washington Administrative Code (WAC) 246-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation.</p> <p>Onsite date: 11/19/19 Case number: 2019-14150 Intake number: 94626</p> <p>The investigation was conducted by: Investigator #37242</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		
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State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____