

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/30/2023
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NAME OF PROVIDER OR SUPPLIER WELLFOUND BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 3402 S 19TH ST TACOMA, WA 98405
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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
L 000	<p>INITIAL COMMENTS</p> <p>STATE COMPLAINT INVESTIGATION</p> <p>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.</p> <p>On-site date: 06/29/23-06/30/23; 08/15/23-08/16/23 Off-site: 07/07-07/18/23, 08/17/23-08/18/23, 08/21/23, 08/23/23, 08/28/23-08/30/23 Case number: 2022-10266 Intake number: 125027</p> <p>Investigation was conducted by investigator #19</p> <p>There were violations found pertinent to this complaint.</p>	L 000	<p>1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies.</p> <p>2. EACH plan of correction statement must include the following:</p> <p>The regulation number and/or the tag number;</p> <p>HOW the deficiency will be corrected;</p> <p>WHO is responsible for making the correction;</p> <p>WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and</p> <p>WHEN the correction will be completed.</p> <p>3. Your PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plan of Correction is due on 09/22/23.</p> <p>4. Return the ORIGINAL REPORT via email with the required signatures.</p>	
L1105	<p>322-170.3C NURSING SERVICES</p> <p>WAC 246-322-170 Patient Care Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff,</p>	L1105		

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



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L1105	<p>Continued From page 1</p> <p>including: (c) Nursing services, including: (i) A psychiatric nurse, employed full time, responsible for directing nursing services twenty-four hours per day; and (ii) One or more registered nurses on duty within the hospital at all times to supervise nursing care;</p> <p>This Washington Administrative Code is not met as evidenced by:</p> <p>Based on interview, record review, and review of hospital policies and procedures, the hospital failed to provide medical supervision by either neglecting to ensure vital signs were obtained and documented per the provider's order or by neglecting to document patient refusal for 3 of 6 patients (Patients #1, #2, and #3).</p> <p>Failure to obtain and document vital signs as ordered can lead to exacerbation of existing medical conditions or lack of recognition of emerging medical conditions.</p> <p>Findings included:</p> <ol style="list-style-type: none"> 1. Review of the hospital policy titled, "Standards of Care," #11847809, last approved 06/22, showed that vital signs are to be obtained at least upon admission and daily. 2. Review of the hospital policy titled, "Patient Assessment and Reassessment-Inpatient," #11847883, last approved 07/22, showed that vital signs are to be done at least once per day and more often if the provider orders more frequent assessments on a case-by-case basis. 3. Review of an annual competency document for nursing staff titled, "Wellfound Required 	L1105		

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L1105	<p>Continued From page 2</p> <p>Validation Form; Manual/Automatic Vital Signs Evaluation Competency," last updated 07/22, showed that vital signs that are outside of normal parameters are reported to the provider. The document defines parameters for normal vital signs as between 90/60 to 120/80. Patient refusals to allow vital signs to be obtained should be documented in a nurse's note.</p> <p>Patient #1</p> <p>5. Patient #1 was a 54-year-old woman admitted involuntarily on 05/13/22 with a history of schizoaffective disorder. She had multiple medical conditions documented on admission, including obstructive sleep apnea (OSA), hypertension (HTN), and insulin-dependent Diabetes Mellitus.</p> <p>a. Review of Patient #1's medical record showed that the patient's vital signs were not consistently taken as ordered by the provider or daily as baseline protocol dictates. Multiple vital signs were not documented.</p> <p>b. On two dates, no vital signs were documented for Patient #1: 05/16/22 and 06/20/22. On the following dates, vital signs were ordered twice per day and were documented only once: 05/18/22-05/20/22; 05/22/22; 05/24/22; 05/28/22-05/30/22; 06/02/22-06/03/22; 06/05/22-06/12/22; 06/14/22; 06/15/22; 06/18/22-06/19/22; 06/21/22-; 06/22/22-06/30/22; 07/03/22; 07/07/22-07/10/22; 07/12/22; 07/14/22-07/15/22; 07/20/22-07/21/22; 07/25/22-07/27/22, 07/29/22, 07/31/22, 08/04/22; 08/05/22-08/07/22; 08/10/22-08/15/22; and 08/20/22. On the following dates, vital signs were ordered three times per day and were documented less</p>	L1105		

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L1105	<p>Continued From page 3</p> <p>frequently than were ordered: 08/23/22-08/26/22; 08/28/22-09/03/22; 09/05/22-09/06/22.</p> <p>c. No refusals were documented correlating to the dates listed.</p> <p>Patient #2</p> <p>6. Patient #2 was a 62-year-old woman admitted on 03/17/22 involuntarily for schizoaffective disorder. She had a diagnosis of hypertension that was documented at admission in her History and Physical, dated 03/18/22.</p> <p>a. Review of the medical record showed that Patient #2, who had an order for daily vital signs and an order for PRN (as needed) blood pressure medication, did not have vital signs documented on the following dates: 03/22/22-03/23/22; 03/25/22-03/26/22; 04/01/22-04/02/22; 04/18/22-04/21/22; 05/02/22-05/03/22; 05/16/22; 05/28/22; 06/07/22; 06/10/22; and 06/15/22.</p> <p>b. No refusals were documented correlating to the dates listed.</p> <p>Patient #3</p> <p>7. Patient #3 was a 64-year-old man admitted involuntarily on 08/10/22 for schizophrenia. He had multiple medical conditions documented on admission, including alcohol use disorder, erosive esophagus with previous perforation and surgery, upper gastrointestinal (GI) bleed, Mallory Weis tear (a tear of the tissue of the lower esophagus), variceal bleeding (bleeding of varices found in the GI tract), Hepatitis C, previous cardiac arrest, and chronic obstructive pulmonary disorder (COPD).</p> <p>b. On the following dates, Patient #3, who had an</p>	L1105		

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L1105	<p>Continued From page 4</p> <p>order for once daily vital signs, did not have any vital signs documented: 08/14/22; 08/16/22; 08/20/22-08/22/22; 08/25/22; and 08/31/22-09/01/22.</p> <p>c. No refusals were documented correlating to the dates listed.</p> <p>8. Interviews with 4 Registered Nurses (RNs), on 06/30/23 at 3:20 PM (Staff #4), 3:35 PM (Staff #6), and 4:00 PM (Staff #7), respectively, and again on 08/15/23 at 3:50 PM (Staff #4, second interview) and 4:40 PM (Staff #11), showed that RNs contact the provider for vital signs outside of normal limits per the provider's orders or baseline policy. The RNs stated that Mental Health Technicians (MHTs) frequently take vitals and that MHTs have a "badge buddy" with their identification badge that gives parameters for which they need to notify the nurse. They stated that the vital signs taken by the MHT are checked by the nurse to ensure they are completed and within normal limits.</p> <p>9. Interviews with 2 MHTs (Staff #5 and #13), on 06/30/23 at 3:25 PM and on 08/15/23 at 11:45 AM, respectively, showed that the MHTs will get vitals on all patients at least daily unless the patient refuses and will provide the vital signs to the nurse or inform the nurse of the patient's refusal. Both MHTs referred to their "badge buddy" for parameters.</p> <p>8. Interviews with the Chief Nursing Officer (CNO) (Staff #3), on 06/30/23 at 1:30 PM and again on 08/17/23 at 11:00 AM, and the Infection Control and Wellness Manager (Staff #15), on 08/21/23 at 9:30 AM, showed that both confirmed that multiple vital signs were missing for many dates for Patients #1, #2, and #3. They confirmed that if</p>	L1105		

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L1105	Continued From page 5 the patient had refused to allow assessment, the refusal should be documented.	L1105			

Wellfound Behavioral Hospital

Plan of Correction for
State & CMS Health Investigation
(Case #2022-10266)

*POC received
08/22/23
approved 09/24/23*

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure & Target for Compliance
L1105	All RNs and MHTs will be trained in person and online (on the learning system) with a signed attestation to the requirements to obtain and document vital signs as ordered (at admission and daily at minimum). Training will include the requirement to document refusals.	Alexis Johnson, CNO	10/29/2023	Compliance with this will be monitored by completing a tracer on 5 charts weekly. Monitoring will continue until 8 weeks of consecutive compliance is met at ≥95%.



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47874 • Olympia, Washington 98504-7874

Angie Naylor, CEO
Wellfound Behavioral Health Hospital
3402 S. 19th St., Tacoma, WA 98405

Re: Complaint 2022-10266

Dear Ms. Angie Naylor, CEO:

I conducted a state hospital licensing complaint investigation at Wellfound Behavioral Hospital on onsite: 06/29/23-06/30/23; 08/15/23-08/16/23; off-site: 07/07/23-07/18/23, 08/17/23-08/18/23, 08/21/23, 08/23/23, and 08/28/23-08/30/23. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 09/22/23.

Hospital staff members sent a Progress Report dated 11/02/23 that indicates all deficiencies have been corrected. The Department of Health accepts Wellfound Behavior Hospital's attestation that it has corrected all deficiencies cited under WAC 246-322.

We sincerely appreciate you and your staff's cooperation and hard work during the investigation process.

Sincerely,

Mary D'Avanzo, MN/BSN/RN
Nurse Investigator