

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 04/04/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WELLFOUND BEHAVIORAL HEALTH HOSPITA	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>STATE COMPLAINT INVESTIGATION</p> <p>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 investigation.</p> <p>On-site dates: 04/04/24</p> <p>Case numbers: 2024-2790</p> <p>Intake numbers: 138696</p> <p>The investigation was conducted by:</p> <p>Investigator #1</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		
-------	---	-------	--	--

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE