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 _____	09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITA	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) conducted this health and safety survey in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital Licensing Regulations. Onsite dates: 09/19/23 - 09/21/23 Examination number: X2023-603 The survey was conducted by: Surveyor #7 Surveyor #8 Surveyor #2 The Washington Fire Protection Bureau conducted the fire life safety inspection. See shell THRT21 .	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 PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be received electronically by Septeber 11th, 2023. 4. Return the REPORT electronically with the required signatures.	
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	L 315		

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L 315	Continued From page 1 or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policies and procedures, the hospital failed to ensure that patients were oriented to the unit during admission for 4 of 6 medical records reviewed (Patient #203, #204, #205, and #208). Failure to orient a patient to their environment places the patient at risk for a decreased level of understanding and safety and increased anxiety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Rights & Responsibilities," PolicyStat ID #11437226, last approved 09/22, showed the following: a. The following steps are to be followed to assure that the patient and families at Wellfound Behavioral Health Hospital (WBHH) are aware of their rights and responsibilities. b. At the time of admission, patients admitted to "inpatient" status will be provided a copy of the Patient Handbook that includes unit rules, patient rights, patient responsibilities, information on grievances and notice of privacy practices. 2. On 09/19/23 between 3:38 PM and 4:30 PM Surveyor #2 interviewed the Chief Clinical Officer (Staff #201) regarding patient orientation to the unit, Staff #201 explained there is a folder of information given to the patient when they are admitted to the unit. That folder contains a form titled "Patient Unit Orientation" and has areas to	L 315		

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L 315	Continued From page 2 check indicating the Mental Health Technician (MHT) will provide a tour of the unit, activity schedule (groups and attendance), Patient's Rights, unit rules, patient handbook, galley area, phone usage, medication times, and introduction to the assigned nurse. Additionally, there is an area in the electronic medical record (EMR) for the nurse to document in the nursing admission assessment unit orientation complete and room orientation complete. 3. On 09/19/23 between 3:38 PM and 4:30 PM Surveyor #2, the Chief Clinical Officer (Staff #201), and Health Information Manager (Staff #202) reviewed the medical records of Patient #203. Patient #203 was a 57-year-old female with an involvuntary admission on 07/30/23 for a diagnosis of schizophrenia. Surveyor #2 was unable to find evidence of patient orientation to the unit documented for Patient #203 either on the "Patient Unit Orientation" form from the MHT or the nursing admission assessment in the EMR. 4. At the time of the review, Staff #201 verified the missing patient orientation documentation. 5. On 09/20/23 between 9:00 AM and 11:35 AM Surveyor #2, the Director of Utilization Management (Staff #203), and Quality Manager (Staff #204) reviewed the medical records of Patient #204 and #205. The review showed the following: a. Patient #204 was a 27-year-old male admitted on 08/23/23 with a diagnosis of schizoaffective disorder and bipolar type. Surveyor #2 was an involvuntary admission on 07/30/23 for a unable to find evidence of patient orientation to the unit documented either on the "Patient Unit Orientation" form from the MHT or the nursing admission assessment in the EMR.	L 315		

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L 315	Continued From page 3 b. Patient #205 was a 24-year-old female admitted on 08/05/23 with a diagnosis of unspecified schizophrenia and other psychotic disorders. Surveyor #2 was unable to find evidence of patient orientation to the unit either on the "Patient Unit Orientation" form from the MHT or the nursing admission assessment form in the EMR. 6. At the time of the review, Staff #203 verified the missing patient orientation documentation. 7. On 09/20/23, between 1:04 PM and 3:20 PM, Surveyor #2, the Chief Clinical Officer (Staff #201), and the Director of Utilization Management (Staff #203) reviewed the medical record of Patient #208. Patient #208 was a 48-year-old male admitted on 06/19/23 with a diagnosis of schizoaffective disorder and bipolar type. Surveyor #2 was unable to find evidence of patient orientation to the unit on either the "Patient Unit Orientation" form from the MHT or the nursing admission assessment form in the EMR. 8. At the time of the review, Staff #203 verified the missing patient orientation documentation. .	L 315		
L 385	322-035.1Q POLICIES-PATIENT TRANSPORT 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: (q) Transporting patients for: (i) Diagnostic or	L 385		

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L 385	Continued From page 4 treatment activities; (ii) Hospital connected business and programs; (iii) Medical care services not provided by the hospital; This Washington Administrative Code is not met as evidenced by: . Based on observation, interviews, and document review, the hospital failed to ensure that 2 staff always remained with patients when off the unit. Failure to ensure 2 staff are with patients who are off the unit increases the risk of harm to staff, potential elopement risks, and negative outcomes for patients. Findings included: 1. Document review of the hospital policy titled, "Patient Movement Policy", PolicyStat #12456450, last approved 10/22 showed all patient movement requires 2 escorting staff. 2. Surveyor #7 interviewed the Chief Quality Officer (Staff #702) who stated the Patient Movement policy was the only policy that involved patients and staff off units. Staff #702 stated when staff and patients are in the outdoor area 2 staff must be always present. 3. On 09/19/23 at 12:18 PM, Surveyor #7 and the CEO (Staff #701) observed 2 staff members, a Mental Health Technician (Staff #703) and a group therapist (Staff #704) in the courtyard with patients from the Flag unit. 4. At 12:26 PM, Surveyor #7 observed Staff #703 enter the Flag unit with a patient. Surveyor #7 interviewed Staff #703 who advised Staff #704	L 385		

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L 385	Continued From page 5 was still in the courtyard alone with the patients. 5. At the time of the observation and interview Staff #701 verified Staff #704 was in the courtyard alone with patients. .	L 385		
L 415	322-035.2 P&P-ANNUAL REVIEW WAC 246-322-035 Policies and Procedures. (2) The licensee shall review and update the policies and procedures annually or more often as needed. This Washington Administrative Code is not met as evidenced by: . Based on record review and interview, the hospital failed to ensure that required policies and procedures were reviewed and updated annually. Failure to review and update policies annually prevents the facility from operating with up-to-date policies and procedures which could risk patient and staff safety. Findings included: 1. Document review of the hospital's policy and procedure titled, "Policy Development and Review," PolicyStat ID #13170909, last approved 04/23, showed that all policies must be reviewed every 1 year at minimum unless local, state, or federal regulations dictate otherwise. 2. Record review of the following policies showed that the hospital did not review all policies on an annual basis as required, including the following:	L 415		

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L 415	Continued From page 6 a. Background and Disclosure, PolicyStat ID #11279860, last approved 03/22. b. Patient Transportation Off Site, PolicyStat ID #14398844, has not been formally approved. c. Adult Alcohol Withdrawal Treatment Guideline, PolicyStat ID #11141057, last approved 02/22. d. Standards of Care, PolicyStat ID #11847809, last approved 06/22. 3. On 09/20/23 at 3:45 PM, Surveyor #2 interviewed Chief Quality Officer (Staff #205) regarding annual policy updates. Staff #205 verified the above listed policies are not current and stated that they are working on them. .	L 415		
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: . Item #1 Uncleanable surfaces Based on observation and interview, the hospital failed to implement systems to maintain a clean and sanitary environment for patients. Failure to maintain a clean and sanitary physical environment puts patients and staff at risk of harm from environmental contaminants. Findings included:	L 780		
L 780	322-120.1 SAFE ENVIRONMENT	L 780		

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L 780	Continued From page 7 1. On 09/19/23 at 11:00 PM, Surveyor #7 toured the Gallian Unit and observed damage to the walls in the patient care area in three places. The damage exposed the coarse and uncleanable surface of unpainted and paperless sheet rock. Observations in patient care areas included: a) An area along a wall about 12 inches off the floor the sheet rock paper was torn 1 inch by 12 inches. b) Letters carved into the sheet rock in a patient room. c) An area 12 inches from the floor exposing sheet rock with a damaged area of 4 inches by ½ inch. 2. On 09/20/23 between 8:50 AM and 9:30 AM, Surveyor #8 toured the facility with Operations Supervisor (Staff #802) and Facilities Manager (Staff #803). Every unit was observed including those unoccupied. Observations in patient care areas included: a) Dock Unit hallway had damage consisting of an indentation in the sheet rock wall of 1 ½ inch by 1 ½ inch. b) Flag Unit with wall damage 2 inches by ½ inch. c) Egret Unit with wall damage 1 inch by 1 inch. d) Staff #803 acknowledged the damage in each unit. Item #2 Door alarms. Based on observation and interviews the hospital	L 780		

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L 780	Continued From page 8 failed to ensure emergency exit doors had a properly functioning alarm system that would deliver notification in the event of exterior and exit doors being unlocked and exit doors being opened. Failure to receive notification when exterior doors are unlocked and opened can result in patient elopement and harm. Findings included: 1. Surveyor #7 requested all policies related to door alarms, notifications, processes, and security system testing and was informed that Wellfound follows its Life Safety policy, which focuses on fire alarms, and the patient movement policy. No other policies related to door alarms, notifications, processes, and security system testing were made available. 2. On 09/19/23 at 12:18 PM, Surveyor #7 and the CEO (Staff #701) unlocked the electronically locked egress door, that opens with direct access to the main road, in the patient courtyard. No notifications were sent to security, and no one responded to the open egress door. The door was re-secured. 3. On 09/19/23 between 2:00 and 2:07 PM, the egress doors were unlocked and accessed 2 more times. During this time and immediately after, no notifications were sent to security or the facility. 4. At 2:07 Surveyor #7 requested the Security Officer (Staff #706) contact the security department at Tacoma General (TG) and verify that an alarm had triggered and that the Wellfound facility had been notified. The call to	L 780		

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L 780	Continued From page 9 TG Security dispatch revealed there was no record of an alarm being triggered and thus no reason to send a notification. 5. Surveyor #7 and Staff #706 contacted the Lead Security Officer at TG (Staff #707) Surveyor #7 interviewed Staff #707 who stated the following: a. Staff #707 stated the alarm had triggered "multiple times today". b. Staff #707 stated he had attempted to contact the facility and was unable to connect to anyone at the preprogramed phone number, and no further attempt had been made.	L 780		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) 6. Surveyor #7 requested the alarm log and was informed there was no such document, that the alarms clear at TG when they are turned off at Wellfound, and no record is kept. 7. At the time of the interview Staff #706 verified Staff #707 had informed them the alarms had activated, one unsuccessful attempt was made to contact the facility, and that no log or record of the events was available from TG. 8. Surveyor #7 was informed by Staff #701 that the phone number provided by Staff #707 was not a Wellfound number. 9. Surveyor #7 requested a copy of the egress door alarm contract with the quality metrics and the last review. The Chief Quality Officer (Staff #702) sent an email with an attached contract with MultiCare (CareConnect Plus Services Agreement) signed 04/24/19, wherein MultiCare will provide a hosted electronic health record system as well as other software applications. To include IT infrastructure, equipment and	TAG	CROSS-REFERENCED TO THE APPROPRIATE	DATE

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L 780	Continued From page 10 implementation, maintenance, support, and hosting services to Wellfound. Surveyor #7 was unable to locate specific language within the contract pertaining to egress alarm monitoring and notifications. 10. Staff #702 verified this was the security monitoring contract and that there were no quality metric reviews available. .	L 780		
L 980	322-150.3A EXAM ROOM-TABLE WAC 246-322-150 Clinical facilities. The licensee shall provide: (3) One or more physical examination rooms, with or without an exterior window, equipped with: (a) An examination table; This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to provide a table in its patient examination room. Failure to provide an examination table in a patient examination room puts patients at risk of inadequate care. Findings included: 1. On 09/19/23 between 9:33 AM and 11:25 AM, Surveyor #8 toured all facility units with Quality Manager (Staff #801). During the tour Surveyor #8 did not find a room that contained all items necessary to be considered an examination room. The room was labeled an examination room and contained most items but was missing	L 980		

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L 980	Continued From page 11 a table. 2. On 09/19/23, Surveyor #7 toured all facility units and found a room that appeared to be used as an examination room but it did not have a sink, drying towels, soap, or sanitizer necessary for hand hygiene and to be considered an examination room. 3. On 09/20/23 at 12:35 PM, Surveyor #8 interviewed Staff #801 who confirmed that at the beginning of the inspection on 09/19/23, the facility had no room with all the items required to be an examination room. .	L 980		
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: . Item #1 Withdrawal assessment Based on observation, interview, and review of the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for safe medication administration for 1 of 2 patient records reviewed (Patient #208). Failure to follow safe medication administration	L1070		

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L1070	Continued From page 12 procedures puts patients at risk of receiving the wrong medications or unintended medication administration resulting in patient harm and/or death. Findings included: 1 Document review of the hospital's policy and procedure titled, "Adult Alcohol Withdrawal Treatment Guideline," PolicyStat ID #11141057, last approved 02/22, showed the following: a. The physician, nurse, and Social Work (SW) will carry out their clinical responsibilities within their professional scope of practice and adhere to this guideline as appropriate. b. The physician will obtain a history and assess for alcohol withdrawal risk, document in the patient's medical record, and initiate the alcohol withdrawal order set as appropriate. c. The RN will assess for alcohol history and withdrawal risk during admission screening, assure urine and/or blood toxicology samples are gathered as ordered and submitted to the laboratory, and perform patient assessment scales using Clinical Institute Withdrawal Assessment (CIWA)-Ar as well as administer medications as indicated per orders. 2. On 09/20/23, between 1:04 PM and 3:20 PM, Surveyor #2, the Chief Clinical Officer (Staff #201), and the Director of Utilization Management (Staff #203) reviewed the medical record of Patient #208. Patient #208 was a 48-year-old male admitted on 06/19/23 with a diagnosis of schizoaffective disorder and bipolar type. Patient #208 had a provider order written for CIWA protocol on 06/22/23 at 2:54 PM. The CIWA	L1070		

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L1070	Continued From page 13 protocol instructs nursing staff to perform a CIWA-Ar assessment every 4 hours and notify the provider if the patient scores greater than 21 on the protocol. Patient #208's first assessed CIWA-Ar score was on 06/23/22 at 8:55 AM and had a score of 4 (a period of approximately 18 hours after the order was written). The next assessed CIWA-Ar score was on 06/23/22 at 9:34 AM and had a score of 27. Surveyor #2 was unable to find documentation of provider notification in the medical record. 2. At the time of the review, Staff #204 verified the missing CIWA score assessments. Item #2 Precautions Based on observation, interview, and review of the hospital policy and procedures, the hospital failed to ensure staff members followed provider orders for implementing psychiatric precautions for 3 of 5 medical records reviewed. (Patient #203, #205, and #206) Failure to ensure specific psychiatric precautions are implemented puts patients at risk for inappropriate, inconsistent, and delayed treatment. Findings included: 1. Document review of the hospital's policy and procedure titled, "Assault Precautions," PolicyStat ID #13041823, last approved 08/23, showed the following: a. The Registered Nurse (RN) shall assess all newly admitted patients for potential assaultive behavior as soon as possible after admission by completing the "Risk to Others_ section of the	L1070		

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L1070	Continued From page 14 Violence Risk flow sheet. b. The RN shall review the results of the "Risk to Others" with the admitting physician when receiving admission orders. c. The patient will score either "High" or "Low". If the patient scores "High" the physician and RN will ensure all documentation is aligned on precautions (i.e.: treatment plan, rounding sheets (observation form), shift change report, EPIC orders, etc.). 2. Document review of the hospitals policy and procedure titled, "Sexual Safety Precautions Protocol," PolicyStat ID #13728621, last approved 07/23, showed the following: a. within 24 hours of admission and anytime following sexually inappropriate actions, the Registered Nurse (RN) will complete the "Sexual Safety Assessment" in EPIC. b. The RN shall review the results of the "Sexual Safety Assessment" with the admitting physician when receiving orders. c. The patient will score either "High" or "Low". If the patient scores "High", the physician and RN will determine if the patient needs to be placed on "Sexually Inappropriate Behavior (SIB)" precautions or "Sexually Vicitimization Precautions (SVP)". d. The physician and RN will ensure all documentation is aligned on precautions (i.e.: treatment plan, rounding sheets (observation form), shift change report, EPIC orders, etc.) 3. On 09/20/23, between 9:00 AM and 11:35 AM,	L1070		

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L1070	Continued From page 15 Surveyor #2 interviewed the Quality Manager who explained the process is the same for suicide and cheeking precautions. The physician will write the order for the precaution and nursing staff is responsible for getting the proper precautions on the observation form. 4. On 09/20/23, between 9:00 AM and 11:35 AM Surveyor #2, the Director of Utilization Management (Staff #203), and Quality Manager (Staff #204) reviewed the medical records of Patient #203 and #205. The review showed the following: a. Patient #203 was a 57-year-old female with an involuntary admission on 07/30/23 with a diagnosis of schizophrenia. Patient #203 had a provider order written on 07/31/23 for cheeking and assault precautions at 2:39 PM. The review showed the following: i. On 08/01/23, Patient #203's observation form had zero precautions checked for monitoring ii. On 08/02/23, Patient #203's observation form had assault precautions checked but no cheeking precaution checked. iii. On 08/04/23, Patient #203's observation form had no cheeking precautions checked. iv. On 08/05/23, Patient #203's observation form had no cheeking precautions checked. b. Patient #205 was a 24-year-old female admitted on 08/05/23 with a diagnosis of unspecified schizophrenia and other psychotic disorders. The review showed the following: i. Patient #205 had a provider order written on	L1070		

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L1070	Continued From page 16 08/12/23 for sexually inappropriate behavior precautions. ii. Patient #205 had a RN note in the medical record placed on 08/12/23 at 4:09 PM stating patient was put on assault precautions for threatening to harm the Nurse Practitioner. iii. On 08/13/23, Patient #205's observation form had no precautions checked. iv. On 08/14/23, Patient #205's observation form had no precautions checked. 5. At the time of the review, Staff #203 verified no precautions were checked on the patient's observation form. 6. On 09/20/23, between 1:04 PM and 3:20 PM, Surveyor #2, the Chief Clinical Officer (Staff #201), and the Director of Utilization Management (Staff #203) reviewed the medical record of Patient #206. The review showed the following: i. Patient #206 had a provider order written for assault and suicide precautions on 09/15/23 at 2:25 AM. ii. On 09/18/23, Patient #206's observation form had no precautions checked. 7. At the time of the review, Staff #203 verified no precautions were checked on the patient's observation form. .	L1070		
L1105	322-170.3C NURSING SERVICES [illegible] between 1:04 PM and 3:20 PM, WAC 246-322-170 Patient Care [illegible] officer (Staff	L1105		

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L1105	Continued From page 17 Services. (3) The licensee shall provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, 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; This Washington Administrative Code is not met as evidenced by: . Item #1 - Nursing shift assessments Based on interview, record review, and review of hospital's policies and procedures, the hospital failed to ensure staff completed nursing shift assessments for 4 of 8 patients (Patients #201, #208, #701 and #702). Failure to obtain and document shift assessments as ordered can lead to exacerbation of existing medical conditions or lack of recognition of emerging medical conditions. Findings included: 1. Document review of the hospital policy titled, "Patient Assessment and Reassessment - Inpatient," PolicyStat ID #14117968, last approved 07/23, showed that a physical assessment (nursing) is performed every shift and as needed. 2. On 09/19/23 between 11:05 AM and 12:15 PM Surveyor #2, the Chief Clinical Officer (Staff #201), and Health Information Manager (Staff	L1105		

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L1105	Continued From page 18 #202) reviewed the medical records of Patient #201. Patient #201 was a 42-year-old female with an involuntary admission on 08/04/23 with a diagnosis of schizoaffective disorder and bipolar type. The review showed Patient #201 had a physical shift assessment documented on 08/05/23 at 8:09 PM and the next physical shift assessment documented was on 08/07/23 at 8:00 AM (missing a period of approximately 35 hours or two shift assessments). Patient #201 had a physical shift assessment documented on 08/07/23 at 8:30 PM and the next documented physical assessment was on 08/08/23 at 8:08 PM (missing a period of approximately 23 hours or one shift assessment). 3. At the time of the review, Staff #201 verified the missing physical shift assessment documentation and stated the expectation is assessments are completed each shift. 4.On 09/20/23 between 8:38 AM to 3:35 PM, Surveyor #7 reviewed the medical records for Patients #701, and #702. The medical record review showed the following: a. Patient #701 was missing the following assessments: i. The head-to-toe night shift assessment on 09/12/23, and the day shift assessments on 09/14/23, 09/15/23, 09/17/23, 09/18/23, and 09/19/23. ii. The suicide shift screenings on 09/12/23 day shift and on 09/18/23 night shift. iii. The day shift pain assessments on 09/14/23, 09/15/23, 09/17/23, 09/18/23, and 09/19/23, and the night shift assessments on 09/12/23,	L1105		

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L1105	Continued From page 19 09/15/23, 09/16/23, and 09/17/23. b. Patient #702 was missing the following assessments: i. The head-to-toe night shift assessment on 09/07/23 and the day shift assessment on 09/11/23. ii. The suicide shift screenings on 09/07/23 night shift and on 09/11/23 day shift. Item #2 - Suicide assessments 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 medical records reviewed (Patient #208). 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 titled, "Patient Assessment and Reassessment," PolicyStat ID #14117968, last approved 07/23, showed suicide shift screening is performed every shift and while awake. 2.On 09/20/23 between 8:38 AM to 3:35 PM, Surveyor #7 reviewed the medical records for Patient #701 the medical record review showed Patient #701 was missing the suicide shift screenings on 09/12/23 day shift and on 09/18/23 night shift. 3. On 09/20/23, between 1:04 PM and 3:20 PM, Surveyor #2, the Chief Clinical Officer (Staff	L1105		

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L1105	Continued From page 20 #201), and the Director of Utilization Management (Staff #203) reviewed the medical record of Patient #208. Patient #208 was a 48-year-old male admitted on 06/19/23 with a diagnosis of schizoaffective disorder and bipolar type. The initial psychiatric history and physical indicated the patient cut his left wrist with a pop can in an attempt to kill himself. Surveyor #2 was unable to find evidence of a suicide shift assessment for the day shift on 06/21/23. Surveyor #2 was unable to find evidence of a suicide shift assessment for the day shift on 06/22/23. Surveyor #2 was unable to find evidence of a suicide shift assessment for the day shift on 06/26/23. Surveyor #2 was unable to find evidence of a suicide shift assessment for the day shift on 06/27/23. 4. At the time of the review, Staff #203 verified the missing suicide shift assessments. 5. On 09/20/23 between 8:38 AM to 3:35 PM, Surveyor #7 reviewed the medical records for Patient #701 the medical record review showed Patient #701 was missing the suicide shift screenings on 09/12/23 day shift and on 09/18/23 night shift. .	L1105		
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 21 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 record review, interview, and review of the hospital's policies and procedures, the hospital failed to ensure that staff members followed the hospital policy for restraints for 1 of 3 restraint records reviewed (Patient #205). Failure to follow approved policies and procedures for seclusion risks physical and psychological harm, loss of dignity, and violation of patient rights. Findings included: 1. Document review of the hospital's policy and procedure titled, "Use of Seclusion and Restraint", PolicyStat ID #13044702, last approved 05/23, showed the following: a. Documentation in the patient's medical record will include a one-hour face-to-face evaluation by a Licensed Independent Practitioner (LIP) if the restraint or seclusion is used to manage violent behavior. 2. On 09/20/23 between 9:00 AM and 11:35 AM, Surveyor #2, the Director of Utilization Management (Staff #203) and Quality Manager (Staff #204) reviewed the medical record of Patient #205 who was a 24-year-old female admitted on 08/05/23 with a diagnosis of unspecified schizophrenia and other psychotic disorders. The review showed on 08/09/23 at 12:40 PM, Patient #205 was placed in seclusion. Surveyor #2 was unable to find evidence of a	L1155		

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L1155	Continued From page 22 face-to-face evaluation. 3. At the time of the review, Staff #203 confirmed they were unable to locate face-to-face documentation in the medical record. .	L1155		
L1165	322-180.2 EMERGENCY SUPPLIES WAC 246-322-180 Patient Safety and Seclusion Care. (2) The licensee shall provide adequate emergency supplies and equipment, including airways, bag resuscitators, intravenous fluids, oxygen, sterile supplies, and other equipment identified in the policies and procedures, easily accessible to patient-care staff. This Washington Administrative Code is not met as evidenced by: . Based on observation and interview, the hospital failed to implement a quality control system to prevent the use of patient care equipment and supplies that were beyond the manufacturer's expiration date. Failure to monitor and establish a systematic process for ensuring patient care supplies do not exceed their expiration dates risks deteriorated, or potentially contaminated, supplies being available for patient use. 1. Document review of the MedGel Electrodes Frequently Asked Questions showed all Medline electrodes have a 30-day shelf life once opened. 2. On 09/19/23 between 10:02 and10:40 AM,	L1165		

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L1165	Continued From page 23 Surveyor #7, and the CEO (Staff #701), toured the Galleon and Flag units, Surveyor #7 made the following observations: a. Surveyor #7 observed 2 open and undated packages of Medline electrodes and 3 sheets of electrodes attached to the EKG leads in the EKG bag in the Galleon unit exam room. b. Surveyor #7 observed an open and undated package of Medline electrodes in the Flag unit medication room. 3. At the time of the observations Staff #701 verified the open electrodes were not dated and did not know when they had been opened. .	L1165		
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) 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 6 of 7 medical records reviewed for patients receiving PRN pain meds (Patient #202, #203, #206, #207,	L1375		

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L1375	Continued From page 24 #208, and #209). Failure to assess before PRN medication administration and reassess patients after PRN medication administration risks inconsistent, inadequate, or delayed relief of symptoms. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Assessment and Reassessment - Inpatient", PolicyStat ID #14117968, last revised 07/23, showed pain assessment/reassessment is assessed and documented once per shift, and if pain intervention is performed the reassessment should occur per policy. 2. Document review of the hospital's policy and procedure titled, "Standards of Care," PolicyStat ID #11847809, last approved 06/22, showed PRN pain medications are assessed prior to administration and all PRN's are reassessed within 60 minutes after administration. 3. On 09/19/23 between 1:57 PM and 4:15 PM Surveyor #2, the Chief Clinical Officer (Staff #201), and the Health Information Manager/Compliance Officer (Staff #202) reviewed the medical records of Patient #202 and #203. The review showed the following: a. Patient #202 was a 55-year-old female with a voluntary admission on 08/27/23 with a diagnosis of Bipolar II Disorder, Post Traumatic Stress Disorder, and Suicidal Ideation (passive). Patient #202 had a provider order for Tylenol 650 milligrams orally every six hours as needed for mild pain. On 09/17/23, at 3:15 PM Patient #202 received Tylenol for a 5/10 pain rating. Surveyor	L1375		

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L1375	Continued From page 25 #2 was unable to find evidence of a pain reassessment in the medical record. b. Patient #203 was a 57-year-old female with an involuntary admission on 07/30/23 with a diagnosis of Schizophrenia. Patient #207 had a provider order to receive Tylenol 650 milligrams orally every four hours as needed for mild pain. On 09/17/23 at 1:51 PM, Patient #203 received Tylenol for 8/10 shoulder pain. On 09/18/23 at 1:51 PM, Patient #203 received Tylenol for 4/10 headache pain. Surveyor #2 was unable to find evidence of a pain reassessment in the medical record on the above two pain medication administrations. On 09/18/23 at 6:28 PM, Patient #203 received Tylenol. On 09/19/23 at 9:39 AM, Patient #203 received Tylenol for a reported "headache". On 09/19/23 at 2:11 PM, Patient #203 received Tylenol. Surveyor #2 was unable to find evidence of a pain assessment or reassessment in the medical record. 4. At the time of the review, Staff #201 verified the missing pain assessments and reassessments. 5. On 09/20/23, between 1:04 PM and 3:20 PM, Surveyor #2, the Chief Clinical Officer (Staff #201), and the Director of Utilization Management (Staff #203) reviewed the medical records of Patient #206, #207, #208 and #209. The review showed the following: a. Patient #206 was a 43-year-old female with an involuntary admission on 09/08/23 with a diagnosis of Depression with Suicidal Ideation. Patient #206 had a provider order to receive Tylenol 650 milligrams orally every six hours as needed for mild pain. Patient #206 received Tylenol on 09/16/23 at 2:06 PM for "pain all over".	L1375		

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L1375	Continued From page 26 Surveyor #2 was unable to find evidence of a pain reassessment in the medical record. b. Patient #207 was a 66-year-old female with an involuntary admission on 08/21/23 with a diagnosis of Schizoaffective disorder. Patient #207 had a provider order to receive Tylenol 650 milligrams orally every six hours as needed for mild pain. Patient #207 received Tylenol on 08/24/23 at 3:56 AM. Patient #207 received Tylenol on 08/31/23 at 5:38 AM. Patient #207 received Tylenol on 09/02/23 at 8:44 PM. Surveyor #2 was unable to find a pain assessment or reassessment on the three listed pain medication administrations. c. Patient #208 was a 48-year-old male with an involuntary admission on 06/19/23 with a diagnosis of Schiozaffective disorder and bipolar type. Patient #208 had a provider order to receive Ibuprofen 600 milligrams orally AC (before meals) and HS (at bedtime) with the indication for pain. Surveyor #2 reviewed 10 consecutive pain medication administrations from 07/10/23 at 7:46 AM through 07/12/23 at 12:00 PM all of which had no pain assessment or pain reassessment in the medical record. d. Patient #209 was a 52-year-old with a voluntary admission on 08/18/23 with a diagnosis of depression with suicidal ideation. Patient #209 had a provider order to receive Ibuprofen 800 milligrams orally every six hours as needed for mild to moderate pain. Patient #209 received Ibuprofen 800 milligrams orally on 08/19/23 at 5:46 AM, 08/19/23 at 8:29 PM, on 08/20/23 at 4:48 AM, 08/20/23 at 1:15 PM, and on 08/20/23 at 9:52 PM. Surveyor #2 was unable to find evidence of pain assessment or reassessment for the five above mentioned pain medication	L1375		

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L1375	Continued From page 27 administrations in the medical record. 6. At the time of the review, Staff #203 verified the missing pain assessment and reassessment. .	L1375		

Rec: 10/13/23
App: 10/16/23

1/22/24 - Verified via email correspondence

Wellfound Behavioral Health Hospital
Plan of Correction for
State Licensing Survey
9/19/23 to 9/21/23

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L315	All RNs and MHTs will be educated on the process to orient patients to the unit and complete the form attesting that the process was completed.	Lisa Ault, Nurse Manager Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 5 charts will be reviewed weekly to ensure that the patient orientation was completed. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L385	The "Patient Movement" policy will be updated to clearly state that two staff members must be with patients during fresh air breaks and groups off the unit. All RNs, MHTs, and Group Therapists will be educated on this process.	Rhiannon Service, Chief Clinical Officer Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 5 patient movements will be observed weekly to ensure that the movement policy is being followed. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L415	All policies will complete their annual review and be approved. The policy software system will send reminders to policy owners when their policies are ready for annual review. All policy owners will be educated on regulations surrounding policies.	Shikha Gapsch, Chief Quality Officer	11/11/2023	A tracer will be completed wherein policies will be reviewed weekly to ensure that all policies are reviewed in the expected time frames. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L780	All damage has been repaired.	Ashley Escudero, Hospital Operations Supervisor	9/22/2023	A tracer will be completed weekly on open units to check for any damage to the facility and ensure repairs are being completed timely. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L780	The internal notification system has been updated with correct contact information to ensure alarms and follow-up calls are routed to correct departments.	Ashley Escudero, Hospital	11/11/2023	A system to test the alarms has been implemented with alarm testing taking place quarterly permanently.

		Operations Supervisor		
L980	Exam tables are stationed in the 2 (two) examination rooms with all items necessary for hand hygiene at this time.	Ashley Escudero, Hospital Operations Supervisor	9/21/2023	A tracer will be completed wherein the exam rooms are checked weekly to ensure that all necessary items are in place. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1070	All onboarding RNs will receive education in NEO (New Employee Orientation) on the procedure for CIWA-Ar assessments. All current RNs will receive training on the procedure for CIWA-Ar assessments.	Liz Yetter, Pharmacy Manager Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein charts for all patients who have CIWA orders will be reviewed to ensure CIWA assessments were completed per the order each week. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1070	RNs and MHTs will receive education on how to correctly identify and implement precautions on the observation sheets.	Amy von Borstel, Nurse Manager Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 10 charts of patients on precautions will be reviewed weekly to ensure observation sheets and orders align. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1105	All RNs will be educated on requirements for documenting pain assessments, suicide shift screenings, and head-to-toe assessments. A training will be added to NEO (New Employee Orientation) for all onboarding RNs regarding documentation expectations for these items.	Angie Naylor, CEO Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 5 charts are reviewed weekly to ensure all suicide assessments, pain assessments, and head-to-toe assessments have been completed timely. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1105	All RNs will be educated on requirements for documenting suicide shift screenings. A training will be added to NEO (New Employee Orientation) for all onboarding RNs regarding documentation expectations for suicide shift screenings.	Angie Naylor, CEO Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 5 charts are reviewed weekly to ensure all suicide assessments have been completed timely. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.

L1155	All RNs will be educated on requirements for face-to-face assessments and documentation. A training will be added to NEO (New Employee Orientation) for all onboarding RNs regarding documentation expectations for seclusion/restraint including the face-to-face assessment.	Angie Naylor, CEO Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein all seclusion/restraint incidents will be reviewed to ensure the face-to-face was completed per requirements. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1165	All RNs will be educated on the requirements for the use of electrodes and ensuring they are labeled with the expiration date. A quality control check will be implemented long term by adding this to our regular environment of care checks.	Amy von Borstel, Nurse Manager Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein all EKGs are checked weekly to ensure electrodes, if open, have been dated (and removed if past expiration date). This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
L1375	All RNs will be educated on requirements for pain and psychiatric PRN medication assessments and reassessments. A training will be added to NEO (New Employee Orientation) for all onboarding RNs regarding requirements for pain and psychiatric PRN medication assessments and reassessments.	Lisa Ault, Nurse Manager Paul Bridgeman, Educator	11/11/2023	A tracer will be completed wherein 5 charts will be reviewed weekly to ensure assessments and reassessments for pain and psych PRNs were completed and documented. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of ≥95%.
S351	The fire sprinkler is being installed per requirements.	Ashley Escudero, Hospital Operations Supervisor	11/30/2023	There will be an annual preventative maintenance work order to ensure all sprinklers are in place per the facility plans.
S355	Oxygen cylinders have been removed from that area and a 36 in clearance is being maintained.	Ashley Escudero, Hospital Operations Supervisor	9/22/2023	A tracer will be completed wherein the fire extinguisher cabinets will be observed weekly to ensure that the clearance is being maintained. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S372	All unsealed penetration has been fixed.	Ashley Escudero, Hospital	9/22/2023	A permanent review of this will become part of the quarterly building inspection to ensure long-term quality checks.

		Operations Supervisor		
S374	The center gap was corrected.	Ashley Escudero, Hospital Operations Supervisor	9/22/2023	A tracer will be completed wherein the double doors in the facility will be checked to ensure there are not excessive gaps per requirements. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S511	The combustible storage was removed from the main electrical room. A review of this will become a permanent part of the quarterly building inspection.	Ashley Escudero, Hospital Operations Supervisor	9/22/2023	A tracer will be completed wherein the electrical room will be checked to ensure combustible items are not being stored in there. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S711	The Emergency Response Plan Evacuation policy is being updated to reflect all 9 points of the NFPA 101, 18.7.2.2.	Ashley Escudero, Hospital Operations Supervisor	10/19/2023	Reviewing the fire plan against the NFPA will be a part of the annual review of this policy to ensure all components are included.
S712	All fire drills for Quarter 3 of 2023 have been completed and documented. A fire drill tracking spreadsheet has been developed to ensure all fire drills are completed timely.	Ashley Escudero, Hospital Operations Supervisor	10/11/2023	A tracer will be completed wherein a weekly check will be conducted to ensure the facility is in compliance with how many fire drills need to be completed given the time frame. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S914	Polarity, grounding, and tension testing will be completed by 10/19/2023.	Ashley Escudero, Hospital Operations Supervisor	10/19/2023	A recurring annual inspection preventive maintenance work order will be completed moving forward to ensure polarity, grounding, and tension testing is completed per requirements.
S918	The storage was removed from the area and a clearance area has been marked. A review of this will become a permanent part of the quarterly building inspection.	Ashley Escudero, Hospital Operations Supervisor	10/06/2023	A tracer will be completed wherein the access to the emergency generator shutoff button will be checked weekly to ensure a clearance is being maintained. This tracer

				will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S921	A policy is in place for Clinical Equipment maintenance with documentation of inspections and testing.	Ashley Escudero, Hospital Operations Supervisor	09/21/2023	A tracer will be completed weekly wherein the clinical equipment will be reviewed to ensure everything has been inspected per requirements. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.
S923	The oxygen cylinder tanks storage area has been cleared out and a clearance area has been marked. A review of this will become a permanent part of the quarterly building inspection.	Ashley Escudero, Hospital Operations Supervisor	10/06/2023	A tracer will be completed wherein the oxygen cylinder tanks will be assessed to ensure clearance is being maintained and combustible materials are not being kept in the same area. This tracer will continue until 8 consecutive weeks are maintained at a compliance level of 100%.

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
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January 5, 2024

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Re: State Relicensure Survey X2023-603 Closure

Dear Ms. Deana Altman,

Inspectors from the Washington State Department of Health conducted a hospital relicensing survey beginning September 19, 2023, and ending September 21, 2023. Hospital staff members developed a plan of correction for deficiencies cited during this inspection. This plan of correction was approved on October 16, 2023. This closure letter was pending approval of waivers and follow-up site inspection by the Fire Marshal which has now been completed and approved.

The Department of Health accepts Wellfound Behavioral Health Hospital attestation that they will correct all deficiencies cited under Chapter 246-322 WAC and deficiencies identified by Fire Marshals. We sincerely appreciate your cooperation and hard work during the survey process.

Sincerely,

/s/ Harold Ruppert

Harold Ruppert REHS/RS,
Clinical Care Environmental Consultant