

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012792	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/13/2017
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NAME OF PROVIDER OR SUPPLIER FAIRFAX BEHAVIORAL HEALTH MONROE	STREET ADDRESS, CITY, STATE, ZIP CODE 14701 179TH AVE SE MONROE, WA 98272
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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), Chapter 246-320 WAC Hospital Licensing Regulations, conducted this health and safety complaint investigation.</p> <p>Onsite dates: 12/13/17 Examination number: 2017-14324 Intake number: 77516</p> <p>The investigation was conducted by: Surveyor #27347</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		

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