<table>
<thead>
<tr>
<th>ID</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 000</td>
<td>State Complaint Investigation Survey</td>
</tr>
<tr>
<td></td>
<td>This State psychiatric hospital administrative complaint investigation survey was conducted by Mary Wood, MN, BSN, RN on March 1, 2016, in response to complaint # 63334.</td>
</tr>
<tr>
<td></td>
<td>There were no deficient findings per WAC 246-322 pertinent to this complaint.</td>
</tr>
<tr>
<td></td>
<td>Shell # BBUU11</td>
</tr>
</tbody>
</table>

State of Washington
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000102

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: 
B. WING 

(X3) DATE SURVEY COMPLETED: C
03/01/2016

NAME OF PROVIDER OR SUPPLIER: BHC FAIRFAX HOSPITAL
STREET ADDRESS, CITY, STATE, ZIP CODE: 10200 NE 132ND STREET, KIRKLAND, WA 98034

(X4) ID PREFIX TAG
L 000

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
L 000

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BBUU11
TITLE: 
(X6) DATE: If continuation sheet 1 of 1