State of Washington

STATEMENT OF DEFICIFNCIFS AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	013299	A. BUILDING: _____ B. WING _____	C 12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	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 COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric & Alcoholism Hospitals Regulations, conducted this health and safety investigation. Onsite date: 12/09/19 & 12/18/19 Case number: 2019-16774 Intake number: 95435 The investigation was conducted by: Surveyor #1 & Surveyor #2 There were violations found pertinent to this complaint. .	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 PLAN OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. PLAN OF CORRECTION DUE: JANUARY 13, 2019 4. The Administrator or Representative's signature is required on the first page of the original. 5. Return the original report with the required signatures.	
L 340	322-035.1H PROCEDURES-BEHAVIOR 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: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards;	L 340		

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L 340	Continued From page 1 (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to implement its policies and procedures for the use of restraints/seclusion for 1 of 2 sampled patients. Failure to implement their policies puts patients at risk for physiological or psychological harm. Findings included: 1. The hospital policy titled "Use of Seclusion and Restraint", approved 10/19, showed that use of physical holds and the use of locked seclusion were only to be used when other least restrictive measures had been ineffective. 2. Review of Patient #1's medical record showed: a) The patient was brought to the hospital by their parents for the assessment of the patient's agitation and paranoia on 11/18/19 at 3:10 PM. While the staff were attempting to assess the patient for a mental health emergency the patient eloped from the intake unit. The parents stated the patient had a history of drug abuse. b) The patient eloped from the hospital intake unit at 3:23 PM while the staff were attempting to assess the patient for a mental health emergency. Staff called 911. The patient's mother was upset and asked for the Chief Nursing Officer (CNO) to run after the patient as the patient was reported running out in traffic. c) The patient was escorted back to the hospital	L 340		

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L 340	Continued From page 2 lobby at 3:54 PM by the CNO. The patient was put in a 3-person physical hold at 3:59 PM to prevent the patient from running out of the hopsital. the patient was escorted into the unit and placed in an unlocked seclusion room at 4:00 PM. d) Every 15 minute checks were done on the patient while the patient was in unlocked seclusion from 4:00 to 4:30 PM. The patient was documented as agitated with paranoia. There was no documentation that the patient was being physically asaultive towards them self or staff. The patient was not verbalizing wanting to harm them self or others. e) A medical screening exam determined the patient had "acute intoxication" and needed to be transferred to the emergency department (ED) that could provide further medical treatment. The patient was given medication Zyprexa (antipsychotic) and Ativan (medication used to treat anxiety) at 4:30 PM by the registered nurse (RN) that was ordered by the licensed independent practitioner (LIP). f) Documentation revealed the patient was placed in locked seclusion at 4:30 PM after being given an IM injection for their "methamphetamine intoxication". g) Documentation of every 15 minute checks from 4:30 PM to 6:41 PM showed the patient was interactive, calm, and quiet while in a locked seclusion room. At 6:41 PM the patient was taken out of locked seclusion after being assessed by the RN. h) The patient was transferred to the medical ED at 6:46 PM by ambulance. The patient received	L 340		

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L 340	Continued From page 3 medical treatment for their acute intoxication in the medical ED. 3. On 12/09/19 at 12:42 PM, the investigators interviewed a licensed nurse (Staff #10). Staff #10 stated that the patient was informed of the medication that was ordered by the LIP. The patient consented to the medication. After the patient received the medication the patient was placed in locked seclusion. 4. On 12/09/19 at 2:45 PM, the investigators interviewed the CNO (Staff #3). Staff #3 stated seclusion and restraints was not to be used unless a patient was danger to them self or others. .	L 340		
L 580	322-050.6H ORIENTATION-PATIENT BEHAV WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (h) Managing patient behavior; This Washington Administrative Code is not met as evidenced by: . Based on interview and document review, the hospital failed to ensure that all staff that interacted with patients or supervised patient care had the required training to manage aggressive patients for 1 of 4 staff records reviewed. Failure to ensure that staff have the required training to manage aggressive patients puts patients at risk for substandard care and adverse outcomes.	L 580		

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L 580	Continued From page 4 Findings included: 1. Review of the hospital policy titled"Scope of Service: Admission, Tranfer and Discharge Criteria", approved 10/02/19 showed that staff that provided direct patient care or were supervising the direct care were to have restraint and de-escalation training. This included the Chief Nursing Officer (CNO). 2. Review of employee records showed that: a) The CNO did not have the hospital required training for Management of Aggressive Behavior (MOAB). 3. On 12/09/19 at 2:45 PM, the investigators interviewed the CNO (Staff #3). Staff #3 verified the above information. .	L 580		
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: . Based on observation and interview, the hospital failed to have a secured door from the reception desk to the nursing station's intake assessment area. Failure to have a secured door puts patients, staff and visitors at risk for harm when patient care	L 780		

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L 760	Continued From page 5 areas are not secured from unauthorized entry. Findings included: 1. On 12/09/19 at 0830 AM, the investigators observed that the receptionist desk had an open barn style door that was open to the hospital's intake/assessment unit. The door did not have a way to be locked so that the intake/assessment area was secured. 2. On 12/20/19 at 0830 AM, investigator #2 observed that the receptionist desk had an open barn style door that was open to the hospital's intake/assessment unit. The door did not have a way to be locked so that the intake/assessment area was secured. 3. On 12/20/19 at 9:00 AM, investigator #2 interviewed the Chief Nursing Officer (Staff #3) and the Chief Executive Officer (Staff #12) about the unsecured door. Staff #3 and Staff #12 stated that the hospital was aware of the potential for patients to elope through the unsecured door and were looking to replace the door with a secured locking door.	L 780		
L1285	322-200.3J RECORDS-THERAPIES WAC 246-322-200 Clinical Records. (3) The licensee shall ensure prompt entry and filing of the following data into the clinical record for each period a patient receives inpatient or outpatient services: (j) Description of therapies administered, including drug therapies;	L1285		

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L1285	Continued From page 6 This Washington Administrative Code is not met as evidenced by: . Based on interview and record review the hospital failed to document the reasons why a patient was given an emergency dose of an antipsychotic medication for 1 of 2 patient records reviewed (Patient #1). Failure to state the reasons why a patient was given a medication put patients at risk for substandard care. Findings included: 1. The hospital policy titled "Involuntary Administration of Antipsychotic Medication in Emergency Situations", approved 10/02/19 showed that all patients getting an emergency antipsychotic medication needed this to be documented on the form labeled "Emergency Administration of Antipsychotic Medication". The form also needed to specify why the medication was ordered and to have the licensed independent practitioner (LIP) sign this form. It was also required to have second LIP review the reason why the medication was given and whether the second LIP agreed with the ordering LIP. 2. Review of Patient #1's medical record showed: a) Patient #1 was ordered Zyprexa (antipsychotic) on 11/18/19.The form for the administration of involuntary antipsychotic medications was not in the patient's record. There was no reason documented as to why the patient was prescribed the Zyprexa from the ordering LIP or documentation from a second LIP indicating agreement with the reason for the ordered	L1285		

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L1285	Continued From page 7 antipsychotic medication for Patient #1. 3. On 12/09/19 at 12:05 PM, the investigators interviewed the LIP (Staff #1) that had prescribed the medication. Staff #1 stated that the medication was ordered for a medical emergency due to acute intoxication from drug use. 4. On 12/09/19 at 2:45 PM, the investigators verified the above information with the Chief Nursing Officer (Staff #3). .	L1285		

Plan of Correction for Wellfound Behavioral Health Hospital
Washington State DOH Hospital Complaint Survey
12/09/2019 and 12/18/2019

	Tag Number	How the Deficiency Will Be Corrected	Who Responsible Individual(s)	When Estimated Date of Correction	What Monitoring procedure; Target for Compliance
1	L 340	Regarding the finding related to hospital implementation of the policy and procedures involving the use of seclusion and restraint, specifically related to adequate documentation surrounding the required elements of uses of seclusion and restraint and proper use of seclusion and restraint for patient in management of assaultive, self-destructive, or out of control behavior as outlined in WAC 246-322-180. A seclusion and restraint documentation packet were created to encompass all required elements of documentation related to seclusion and restraint use. The packet will be piloted until approval during January 2020 medical executive committee. Education to all appropriate staff on the proper use, new seclusion and restraint packet and documentation of patient management involving seclusion and restraint will be completed by 1/10/2019.	Kimberly Buckner, CNO	01/10/2019	The CNO will conduct a record review of 100 % of patient charts equal to 10 or less or 50% of charts up to 30 charts whichever is greater of those charts identified to have use of seclusion and/or restraint beginning on 1/2/2020. Once tracer compliance of 95% or greater has been sustained for three consecutive months, ongoing tracers will be completed monthly. If compliance falls below 95%, the Chief Nursing Officer or designee will provide retraining to nursing staff and resume weekly tracers until compliance returns to 95%. Results of tracer auditing will be reported to Quality Committee monthly.

	Tag Number	How the Deficiency Will Be Corrected	Who Responsible Individual(s)	When Estimated Date of Correction	What Monitoring procedure; Target for Compliance
2	L 580	Regarding the finding related to hospital training and documentation of training for management of patient behavior, specifically related to all care staff and those providing supervision of care staff will complete and have documentation of completed Management of Aggressive Behavior (MOAB). Leadership team managing clinical staff will complete MOAB training and provide documentation within the human resources chart by 01/10/2020.	Kimberly Buckner, CNO	01/10/2020	CNO or designee with human resources will audit as part of the onboarding process for all employees; effective 01/03/2019. Staff who meet these criteria will not be allowed to start work independently until the training has been completed.
3	L 780	Regarding the finding related to the hospital providing a safe environment for patients, staff, and visitors, specifically related to door between reception desk and intake nursing station not having the ability to secure and lock. Chief Operating Officer and facilities manager have met 01/10/2020 to formulate a plan to replace the current door and system. Formal plans indicate an expected completion of replacement to be completed within an eleven week timeline, 03/27/2020.	Chris Rakunas, COO	03/27/2020	COO and facilities manager will oversee the plan and replacement of the current door for a system that can secure and lock. Mitigation until the replacement is complete will include staff being present to ensure the door is closed when patients or visitors are present in the lobby or in the intake and assessment area.

	Tag Number	How the Deficiency Will Be Corrected	Who Responsible Individual(s)	When Estimated Date of Correction	What Monitoring procedure; Target for Compliance
4	L 1285 #1	Regarding the finding related to the hospital providing prompt entry of documentation into a clinical record, specifically related to documentation of therapies administered; including drug therapies and administration of emergency medications. Provider staff will be provided education on the necessary elements of documentation when ordering emergency medications for a behavioral health emergency with documentation of proof education by 01/17/2020.	Colin Daniels, CMO	01/17/2020	The CMO or designee will conduct a record review of 100 % of patient charts equal to 10 or less or 50% of charts up to 30 charts whichever is greater of those patients receiving an emergency medication to assure that the proper documentation is included in the provider documentation beginning on 01/10/2019. Once tracer compliance of 95% or greater has been sustained for three consecutive months, ongoing tracers will be completed monthly. If compliance falls below 95%, the Chief Medical Officer or designee will provide retraining to provider staff and resume weekly tracers until compliance returns to 95%. Results of tracer auditing will be reported to Quality Committee monthly.

	Tag Number	How the Deficiency Will Be Corrected	Who Responsible Individual(s)	When Estimated Date of Correction	What Monitoring procedure; Target for Compliance
5	L 1285 #2	Regarding the finding related to the hospital providing prompt entry of documentation into a clinical record, specifically related to documentation of therapies administered; including drug therapies and administration of emergency medications. Provider staff will be provided education on the necessary use of the "Emergency Administration of Antipsychotic Medication Form" that includes a second provider review and signature with each situation requiring administration of emergency medications for a behavioral health emergency, education will be completed by 01/17/2020.	Colin Daniels, CMO	01/10/2020	The CMO or designee will conduct a record review of 100 % of patient charts equal to 10 or less or 50% of charts up to 30 charts whichever is greater of those patients receiving an emergency medication to assure that the approved formed is included in the provider documentation beginning on 01/10/2019. Once tracer compliance of 95% or greater has been sustained for three consecutive months, ongoing tracers will be completed monthly. If compliance falls below 95%, the Chief Medical Officer or designee will provide retraining to provider staff and resume weekly tracers until compliance returns to 95%. Results of tracer auditing will be reported to Quality Committee monthly.

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

January 13, 2020

Kimberly Buckner, Chief Nursing Officer
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, WA 98405

Dear Ms. Buckner,

An investigator from the Washington State Department of Health conducted a state complaint investigation at Wellfound Behavioral Health Hospital on 12/09/19 & 12/18/19. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 01/13/20.

The Department of Health accepts Wellfound Behavioral Health Hospital attestation that it will correct all deficiencies cited at Chapter 246-322 WAC.

This letter is notification that the case has been forwarded to the Department of Health state agency for closure.

Thank you for the assistance and cooperation extended to me by your staff during the course of my visit. If you have any questions, please contact me at (360) 236-4696 or Ms. Elizabeth Gordon, MN, RN, Hospital Investigation Manager at (360) 236-2925.

Sincerely,

Deborah Barrette

Deborah Barrette, RN
Complaint Investigator