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 _____	C 05/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLFOUND BEHAVIORAL HEALTH HOSPITAL	3402 S 19TH ST TACOMA, WA 98405

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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 and Alcoholism Hospitals, conducted this health and safety investigation. On site dates: 05/19/21 and 05/21/21 Case numbers: 2021-4819 and 2021-2697 Intake numbers: 111640 and 110514 The investigation was conducted by: Investigator #15 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 PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the emailed Statement of Deficiencies. Your Plans of Correction must be emailed by June 17, 2021. 4. Return the ORIGINAL REPORT via email with the required signatures. .	
L1110	322-170.3D SOCIAL WORK SERVICES WAC 246-322-170 Patient Care Services. (3) The licensee shall	L1110		

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L1110	Continued From page 1 provide, or arrange for, diagnostic and therapeutic services prescribed by the attending professional staff, including: (d) Social work services coordinated and supervised by a social worker with experience working with psychiatric patients, responsible for: (i) Reviewing social work activities; (ii) Integrating social work services into the comprehensive treatment plan; and (iii) Coordinating discharge with community resources; This Washington Administrative Code is not met as evidenced by: . Based on interview, record review, and review of hospital policies and procedures, the hospital failed to ensure a safe discharge plan by coordinating with community resources and/or receiving facilities regarding the patient's discharge, as demonstrated by 2 of 4 records reviewed (Patient #1501 and #1503). Failure to ensure coordination and communication with community resources and receiving facilities in transitioning the patient to a different level of care may lead to inadequate continuity of care, patient harm, and adverse events. Findings included: 1. Document review of the hospital's policy titled, "Discharge Planning (Transition Planning)," policy number 9244752, reviewed 03/21, showed the following: a. Discharge Planning (Transition Planning) recognizes the shared responsibility of healthcare	L1110		

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L1110	Continued From page 2 professionals and post-acute services/facilities, as well as patients and their support persons throughout the continuum of care. b. Continued assessment and coordination occurs throughout the hospital stay to ensure that the appropriate referrals are initiated to achieve an adequate, timely discharge (transition). c. The Care Coordinator (CC) or Social Worker (SW) team will incorporate the receiving facility's specific referral process in the patient's transition of care. d. The CC screens all inpatients for discharge needs as part of the discharge evaluation process, which includes the patient's discharge goals and preferences, pre-admission functional status, cognitive ability, living situation, social supports, financial resources, discharge barriers, post discharge needs and risk for readmission. e. The CC will participate in all phases of the discharge planning process, including early identification of high-risk cases and involvement of the family/collaterals. f. The patient's discharge (transition) evaluation and plan will be documented in the patient's medical record. Patient #1501 2. On 05/19/21 at 1:00 PM, Investigator #15 and the Director of Clinical Services (Staff #1506) reviewed the medical record for Patient #1501, a 59-year-old male admitted on 01/28/21, on an involuntary detainment due to Grave Disability and Danger to Others/Property, with an admission diagnosis of Unspecified	L1110		

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L1110	Continued From page 3 Schizophrenia spectrum. Prior to detention, Patient #1501 was living in an assisted living facility, however his symptoms had been worsening for an unknown period due to substance use and noncompliance with treatment. Review of the medical record showed the following: a. The Initial Psychiatric Evaluation, dated 01/28/21, showed that Patient #1501 received services from the Home and Community Services (HCS) Governor's Opportunity for Supporting Housing (GOSH) program, which provided discharge and diversion options for Aging and Long-term Support Administration (ALSTA) clients, to provide housing and intensive services and various community supports, and resources to support independent living. b. On 02/09/21, the Care Coordinator (CC) documented on an Ancillary Note, that the HCS outpatient housing coordinator (Contact #1501) reported that Patient #1501 had been kicked out of his apartment because "he scared them so bad during the decompensation." Staff documented that the outpatient housing coordinator reported that the patient "was very vulnerable on the streets." Patient #1501 also received outpatient services from Lewis Mason & Thurston Area Agency on Aging and was part of the Community Options Program Entry System Waiver (COPES) and the Community First Choice (CFC) Program. c. Staff documented on the Treatment Plan Update, dated 02/14/21, that the outpatient housing provider was working with the patient to find appropriate housing. The 14-day civil commitment was granted on 02/10/21 and the next court hearing was scheduled for 02/24/21.	L1110		

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L1110	Continued From page 4 d. On 02/14/21, the Social Worker (SW) documented on a Weekly Progress Note, that the plan was for the Social Worker to continue to work with CC and the patient's outpatient team to find him appropriate housing and outpatient services to discharge safely. e. On 02/16/21, the CC documented on an Ancillary Note, that the outpatient housing coordinator reported that she submitted a referral for housing, which would take a minimum of one week. She requested that Patient #1501 remain at Wellfound until he has stable housing, allowing ease of accessibility to community resources. The anticipated discharge date was 02/24/21. f. On 02/17/21, the CC documented a phone call between the Patient, the outpatient housing coordinator (Contact #1501), the Agency on Aging outpatient services case manager (Contact #2) and herself. The outpatient services providers reported concerns about discharging the patient currently because he was not at his baseline and he needed support in the outpatient setting, including stable housing and assistance for ADL's and medication management. They stated that they were looking into the Housing and Recovery through Peer Services (HARPS) program to pay for a hotel until the patient gets placed somewhere. The CC documented that she would look into homeless shelters in Olympia to send the patient to on a temporary basis. Staff documented that Patient #1501 was worried about discharging back to his apartment. He stated, "I feel like I might do something bad if I go back there." g. On 02/18/21, the patient was discharged from Wellfound Behavioral Health Hospital. The	L1110		

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L1110	Continued From page 5 provider documented on the Discharge Summary, dated 02/18/21, that the patient was being discharged "home" and on the day of discharge the patient "presented in good behavioral control." At discharge, the provider documented the patient's functional condition as "no significant deficits in hearing, activities of daily living (ADL), fall risks or home safety issues. Able to perform all ADLs without limitations." Investigator #15 found no evidence that Patient #1501's activities of daily living and home safety issues were documented as addressed, and could be maintained independently based on the housing and community support services (HCS, COPES, and CFC) that he received prior to his admission to the hospital. h. On 02/18/21, the CC documented on the Case Management Discharge Summary that Patient #1501 was discharged via Saferide (Non-emergency medical transportation) to the Salvation Army Shelter located at 1505 4th Avenue East in Olympia, WA. 3. On 05/06/21 at 10:10 AM, during an interview with Investigator #15, the HCS outpatient housing coordinator (Contact #1501) reported that Patient #1501 was discharged to the Thurston County Salvation Army Shelter in Olympia on 02/18/21. Contact #1501 reported that the shelter had not operated as a drop-in shelter for several months. She stated that she had reported to the CC that the patient was not ready for discharge and was not at his baseline. Contact #1501 stated that Patient #1501 met their criteria for a "vulnerable adult" and received outpatient services through Home and Community Services (HCS). When Contact #1501 had not heard from Patient #1501 one week after discharge, she initiated an alert	L1110		

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L1110	Continued From page 6 within the crisis system. As of 05/06/21, Patient #1501 has not been located. 4. During the interview with Investigator #15, Contact #1501 reported that on 05/03/21, she contacted Wellfound's Staff #1506 regarding Patient #1501. Contact #1501 reported that she advised the facility that the Thurston County Salvation Army Shelter had not been operating as a drop-in shelter for several months and the patient was missing. She reported that Staff #1506 stated that when patients are discharged to a shelter, it is not necessary to verify with the shelter prior to discharge. 5. On 05/19/21, at 1:15 PM, during an interview with Investigator #15, Staff #1506 verified that there was no evidence of documentation verifying the shelter had been contacted prior to Patient #1501's discharge. Staff #1506 verified via Saferide, that the patient had been dropped off at the intended discharge location on 02/18/21 at 11:46 AM. Staff #1506 reported that the CC typically contacts the receiving facility, but that communication is not documented. She stated that the CC does not always call a receiving shelter, especially if it is a facility that they are "used to dealing with and already know the process." 6. On 05/19/21, at 3:35 PM, during an interview with Investigator #15, Care Coordinator (CC) (Staff #1507) stated that some shelters require coordination before the patient is discharged. The CC is responsible for contacting the receiving facility prior to discharge. Some shelters, like the Tacoma Rescue Mission, do not require coordination before discharging a patient, because Wellfound is familiar with their process. Staff #1507 stated that she did contact the	L1110		

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L1110	Continued From page 7 Thurston County Salvation Army prior to discharging Patient #1501 and that they were aware of Patient #1501's discharge to their facility. Staff #1507 stated that the outpatient services case manager was meeting the patient at the shelter once they were discharged. Investigator #15 found no evidence that staff documented communication with the receiving facility, the Thurston County Salvation Army or the outpatient services case manager for discharge arrangements. 7. On 05/26/21, Investigator #15 spoke to the Office Manager (Contact #3) at the Salvation Army. She reported that the Thurston Salvation Army - 1505 4th Avenue location that Patient #1501 was discharged to, had not been operating shelter services or drop-in emergency services since November of 2020. 8. On 05/26/21 at 10:15 AM, during an interview with Investigator #15, the HCS outpatient community services case manager (Contact #1502) reported that during a conference call on 02/17/21, with the outpatient housing coordinator Contact #1501), the Patient and Staff #1501, Patient #1501 exhibited behavior that was "not at his baseline." She stated that during the call the Patient was mumbling and delusional, unable to form a cohesive sentence, and had a tangential thought process. Contact #1502 stated that the plan was to coordinate the Patient's outpatient support services while the Patient was admitted to the hospital. After the phone call, the outpatient service providers received an email from Staff #1507 stating that the medical providers are not willing to keep the Patient any longer and he would be discharging the next day, 02/18/21. The CC stated that per the provider, the Patient was	L1110		

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L1110	Continued From page 8 stable, and the facility would not keep him based on housing needs. Contact #1502 stated that she did not arrange to meet the Patient at the Salvation Army on 02/18/21, "they are not even allowed to meet clients right now." She stated that the Patient was discharged without a phone, identification, or access to his money. 9. Investigator #15 found no evidence that staff ensured a safe discharge by evaluating Patient #1501's discharge goals and preferences, pre-admission functional status, cognitive ability, living situation, social supports, financial resources, discharge barriers, post discharge needs and risk for readmission. Patient #1503 10. On 05/19/21 at 1:45 PM, Investigator #15 and the Director of Clinical Services (Staff #1506) reviewed the medical records for Patient #1503, a 58-year-old male admitted on 04/03/21, on an involuntary detainment due to Grave Disability, with an admission diagnosis of Schizoaffective Disorder, Bipolar Type. Patient #1503 was living at an adult family home, where he assaulted another resident at the home. The patient presented as paranoid with grandiose ideation. Review of the medical records showed the following: a. The Initial Psychiatric Evaluation, dated 04/03/21, showed that Patient #1503 was admitted after assaulting another resident of the adult family home where he resided. The Patient presented as grandiose, and stated he had a large amount of money and could go wherever he wanted. The provider documented that Patient	L1110		

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L1110	Continued From page 9 #1503 reported that he "could take care of his own needs" even though it has been assessed that he cannot. The provider documented the patient's limitations as "dependent on others for completion of ADL's and negative coping skills." Active hospital problems noted upon admission included Diabetes and Dementia. b. The Petition for a 14 Day Commitment Order, dated 04/05/21, showed that the Social Worker (SW) documented that the initial Involuntary Treatment Act (ITA) referral was made due to the Patient refusing to return to his adult family home (AFH) and the report from his outpatient service provider that he is unable to manage his medications appropriately. The SW documented that Patient #1503's risk factors included a history of noncompliance with medications and lack of engagement in outpatient services to include medication management. The petition hearing was scheduled for 04/07/21. c. The Psychosocial Assessment, dated 04/05/21, showed that the SW documented the Patient's limitations included poor physical health, resistant to treatment, unstable housing, and needing another living arrangement. The Patient reported that he was concerned about where he was going to discharge to. The SW documented that the Patient stated he was not able to return to the AFH due to an Order of Protection. d. The Master Treatment Plan, dated 04/05/21, showed that staff documented the Patient's challenges to include dependent on others for Activities of Daily Living (ADL's) and negative coping skills. Investigator #15 found no evidence that the Patient's Chronic/Stable medical problems included Dementia, which was identified during the Patient's admission and the	L1110		

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L1110	Continued From page 10 Patient was actively being treatment with Nameda. Staff documented the Patient's anticipated discharge date as 04/12/21. e. The Case Manager/Care Coordinator Note, dated 04/06/21, showed that staff documented an attempt to discuss discharge goals with Patient #1503. The CC documented that the Patient did not want to live in an adult family home but wanted to live on his own. The Patient reported that he makes $5000 a month and can take care of himself. Patient #1501 stated that he will stay in a hotel until he had his own place. The CC documented contacting Home and Community Services (HCS) to find the Patient's current case manager. Investigator #15 found no evidence that staff documented communication with the Patient's current HCS case manager, or provided notification of the Patient's admission to the hospital, or attempted to coordinate outpatient care. f. On 04/08/21, the CC documented a phone conversation with the case manager who previously provided Patient #1503's outpatient services. The previouse outside services case manager stated that the Patient had been talking about getting his own place for a year now and he did not have a lot of insight. g. On 04/09/21, the CC documented on an Ancillary Note that the adult family home that Patient #1503 was living at when admitted, was inquiring about dropping off the Patients belongings. Because of the amount of the belongings, it was decided that the Patient would pick them up after he discharges.	L1110		

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L1110	Continued From page 11 h. On the Master Treatment Plan Update, dated 04/12/21, staff documented that the Patient had "a great deal of difficulty either understanding or remembering his various as-needed (PRN) medications." The Patient requested PRN medications frequently, and when the medications were not available to him, he became agitated. Staff documented that barriers to discharge include frequent agitation, verbal outbursts, loss of previous housing, and unwillingness to accept a referral to another AFH. The Discharge Plan is to discharge Patient #1503 with outpatient mental health services arranged. Staff documented that the Patient cannot return to previous living arrangement, "will need assistance with housing." i. On 04/14/21, Patient #1503 was discharged from Wellfound Behavioral Health Hospital. The Psychiatric Discharge Summary, dated 04/14/21, showed the following: i. The provider documented that the Patient was currently homeless but will be discharged to the (previous) AFH to pick up his belongings. ii. The discharge diagnosis included: Schizoaffective Disorder, Diabetes Mellitus-Type 2, Dementia, Post-Traumatic Stress Disorder and Gastroesophageal Reflux Disease (GERD). iii. The Mental Status Examination performed at discharge by the provider documented Patient #1503's thought process as disorganized, his thought content as persecutory delusions, and insight as fair. The Patient was partially able to demonstrate awareness of symptoms and partially recognized the need for treatment. iv. The provider documented the Patient's	L1110		

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L1110	Continued From page 12 Psychiatric Condition at Discharge as "resolution of behavioral disturbance and resolution of psychotic symptoms, and is sufficiently stable and improved, no longer gravelly disabled, as defined by RCW 71.05, such that transition to a less restrictive level of care is clinically indicated and appropriate." v. Discharge instruction included directions for the Patient to pick up 20 medication in Kent, WA, which is approximately 25 miles from Lakewood, where the patient was discharged to. 11. On 05/04/21 at 3:50 PM, during an Interview with Investigator #15, the HCS outpatient community services case manager (Contact #1504) stated that Patient #1503, was diagnosed with Schizoaffective Disorder and Dementia, received services from Home and Community Services (HCS), and was enrolled in the Specialized Behavior Support (SBS) program and required one-to-one (1:1) supervision. Contact #1504 stated that she did not receive notification from the hospital of the Patient's admission or discharge. The outpatient services case manager received a call from the care provider at the adult family home on 04/14/21, who reported that the Patient arrived to pick up his belongings and appeared actively psychotic. The outpatient services case manager attempted to talk to the Patient over the phone, but the Patient was psychotic and rambling. Law enforcement was called, and they took the Patient to a bus stop and gave him a bus pass, a Subway coupon, and left him. Contact #1504 contacted Wellfound regarding the discharge for Patient #1503 and failed to receive a phone call back from the hospital.	L1110		

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L1110	Continued From page 13 12. On 05/19/21 at 3:40 PM, during an interview with Investigator #15, the Care Coordinator (Staff #1507) stated that the care provider at the adult family home was aware that Patient #1503 would pick up his belongings when he discharges, and reported that he would have Patient #1503's belongings ready for him. The CC stated that she received a call from the care provider at the adult family home after Patient #1503's discharge via Saferide/Uber. The care provider reported that Patient #1503 arrived at the adult family home and refused to leave with his belongings. The stated that the AFH care provider contacted law enforcement and the designated crisis responder (DCR) to evaluate and transport the Patient to an Emergency Department. 13. On 05/19/21 at 3:40 PM, during an interview with Investigator #15, Staff #1507 stated that she thought that the discharge plan for the Patient was to go to a hotel, "because he had money" and he didn't want to go to an adult family home. Staff #1507 stated that she had not communicated with the Patient's outpatient community services case manager and was not aware of the services Patient #1503 received in the community. Staff #1507 verified that Patient #1503 had no medication upon discharge, no means of transportation to leave the adult family home with his belongings, no ability to pay for transportation or housing, no ability to obtain his medications, and was not connected to community resources.	L1110		

Wellfound Behavioral Health Hospital
Plan of Correction for
State Investigation
(Case #2021-4819 and Case #2021-2697)

	Tag Number	How the Deficiency Will Be Corrected	Responsible Individual	Estimated Date of Correction	Monitoring Procedure; Target for Compliance
1	L1110	Regarding the finding related to the failure to properly document the assessment of the patients pre- admission function status, cognitive ability, living situation, social supports, financial resources, discharge barriers, post- discharge needs, ability to maintain his activities of daily living independently, coordination with community care providers and coordination for discharge arrangements, Social Work leadership will develop updated electronic medical record templates and documentation standards that are inclusive of preadmission level of functioning, identification of high risk issues or barriers that may impact the type and timeliness of discharge, and documentation of interdisciplinary treatment team discussion sand decision making related to discharge. Electronic medical record template updates will be made available for staff use no later than June 25, 2021. All ~~appropriate~~ Care Coordinator and Social Work staff will be educated to these standards no later than June 25, 2021. POC Recieved 6/23/21 (updated POC) POC Approved 7/15/21	Amanda Bieber-Mayberry, LICSW, Director of Clinical Services	06/25/2021	Weekly tracers of ~~100% of~~ discharged patients charts equal to ~~10 or less charts or 30% of~~40 patients charts ~~up to 30 charts whichever is greater~~ will be conducted to ensure patients are provided an appropriate, safe discharge and documentation of adequate assessment and decision making is completed in accordance with expectations will begin on June 28, 2021. Once 95%

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	Tag Number	How the Deficiency Will Be Corrected	Responsible Individual	Estimated Date of Correction	Monitoring Procedure; Target for Compliance
					or greater compliance has been sustained for three consecutive months, ongoing tracers will be completed monthly. If compliance falls below 95%, the Director of Clinical Services or designee will provide re-training to clinical staff and resume weekly tracers until compliance returns to 95%. Results of tracer auditing will be reported to Quality Committee monthly

Wellfound Behavioral Health Hospital
Progress Report for
State Psychiatric Hospital Complaint Investigation (Case #2021-4819 and #2021-2697)
05/19/21 and 05/21/21

Tag Number	How Corrected	Date Completed	Results of Monitoring
L1110	Regarding the finding related to the failure to properly document the assessment of the patients pre- admission function status, cognitive ability, living situation, social supports, financial resources, discharge barriers, post- discharge needs, ability to maintain his activities of daily living independently, coordination with community care providers and coordination for discharge arrangements, Social Work leadership developed updated electronic medical record templates and documentation standards that are inclusive of preadmission level of functioning, identification of high risk issues or barriers that may impact the type and timeliness of discharge, and documentation of interdisciplinary treatment team discussions and decision making related to discharge. Electronic medical record template updates were created and made available for use and all care coordinators and social workers were trained on their use on June 23, 2021.	06/23/2021	**Record review for July 2021:** 75% compliance for discharge records reviewed (30/40). 80% of out of compliance (8/10) records were admitted prior to the adoption of the new electronic medical record template. By excluding charts admitted prior to the plan of correction, the compliance rate is 93% (30/32) **Record review for August 2021:** 85 compliance for discharge records reviewed (34/40). 85% of out of compliance (5/6) records were admitted prior to the adoption of the new electronic medical record template. By excluding charts admitted prior to the implementation of the plan of correction, the compliance rate is 97% (34/35).

STATE OF WASHINGTON
DEPARTMENT OF HEALTH

09/14/21

Angela Naylor
Chief Executive Officer
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, WA 98405

RE: Complaint #110514/Case #2021-2697 and
Complaint #111640/Case #2021-4819

Dear Ms. Naylor,

This letter contains information regarding the recent complaint investigation conducted by the Washington State Department of Health on 05/19/21. This investigation was completed on 05/21/21. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on 07/15/21.

Hospital staff members sent a Progress Report dated 08/18/21, that indicates all deficiencies have been corrected. The Department of Health accepts Wellfound Behavioral Health Hospital's attestation that it will correct all deficiencies cited in Chapter 246-322 WAC.

Your cooperation and hard work during the investigation is sincerely appreciated.

Sincerely,

Mary New

Mary New, MSN, RN
Nurse Consultant