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 ______	09/09/2021

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 LICENSING SURVEY 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 survey. Onsite dates: 09/07/21 to 09/09/21 Examination number: 2021-766 The survey was conducted by: Surveyor #6 Surveyor #7 Surveyor #8 The Washington Fire Protection Bureau conducted the Fire Life Safety inspection.	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. The Plan of Correction is due on October 1, 2021. 4. Sign and return the Statement of Deficiencies and Plans of Correction via email as directed in the cover letter.	
L 690	322-100.1A INFECT CONTROL-P&P WAC 246-322-100 Infection Control. The licensee shall: (1) Establish and implement an effective hospital-wide infection control program, which	L 690		10/26/21

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Interim CEO (X6) DATE: 12/14/2021

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 ______	09/09/2021

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 690	Continued From page 1 includes at a minimum: (a) Written policies and procedures describing: (i) Types of surveillance used to monitor rates of nosocomial infections; (ii) Systems to collect and analyze data; and (iii) Activities to prevent and control infections; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview, and document review, the hospital failed to implement and maintain active surveillance to prevent and control exposure to infectious diseases. Failure to implement an active and appropriate hospital surveillance program puts patients, staff, and visitors at risk from communicable diseases. Reference: Centers for Disease Control and Prevention (CDC), "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, " updated 09/21. 1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic; Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has symptoms of COVID-19 so that they can be properly managed. Findings included: 1. Document review of the hospital's policy titled, "Covid-19 Policy," PolicyStat ID: 9987712, approved 06/21, showed that one point of entry through Beacon Unit had been identified for employees, vendors, and business visitors. Vendor or operational visitors are required to wear a tight fitted mask. The policy described	L 690		

am 12/14/21

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 ______	09/09/2021

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 690	Continued From page 2 screening procedures for patients & staff. The policy did not include visitor screening procedures. The policy cited references including CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Covid 19 pandemic. 2. On 09/07/21 at 8:00 AM, Surveyor #6 and Surveyor #7 arrived together at the hospital. Both surveyors were escorted directly to the reception area. Neither surveyor was screened for symptoms of COVID-19. At 9:00 AM, Surveyor #8 arrived at the hospital and recieved a temperature screening before signing the visitor log at Beacon. Surveyor #8 was not screened for other COVID-19 symptoms. 3. On 09/08/21 at 8:00 AM, Surveyors #6, #7, & #8 arrived at the hospital and received a temperature screening before signing the visitor log at Beacon. None of the surveyors were screened for other COVID-19 symptoms. 4. On 09/09/21 at 8:00 AM, Surveyors #6, #7, & #8 arrived at the hospital and received a temperature screening before signing the visitor log at Beacon. None of the surveyors were screened for other COVID-19 symptoms. 5. On 09/09/21 at 10:30 AM Surveyors #6, #7, & #8 conducted an Infection Control meeting including the Infection Preventionist Consultant (Staff #603) and the Interim CEO (Staff #604). During the meeting the investigators asked about the COVID-19 screening procedure for entrance to the hospital. Both Staff #603 and Staff #604 stated that everyone who enters the hospital is required to have a temperature check and should be asked whether they're experiencing any COVID-19 symptoms (i.e. fever or chills, cough,	L 690		

an 12/14/21

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 ______	09/09/2021

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 690	Continued From page 3 shortness of breath or difficulty breathing, new loss of taste or smell, etc.). .	L 690		
L1040	322-170.1C TRANSFER PATIENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval by the receiving facility prior to transfer; and (iii) Immediately notifying the patient's family. 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 staff completed the transfer form in 3 of 4 transfer records reviewed (Patients#705, #706, and #707). Failure to complete the transfer document promotes lack of care continuity and places patients at risk for sub-optimal care. Findings included: 1. Document review of the hospital's policy titled "Transfer of Patients for Medical Stabilization," PolicyStat ID: 8676123, approved 10/20, showed that both the nurse and provider are responsible for documenting the decision to transfer and all handoff communication with the receiving facility on the transfer form.	L1040		10/31/21

an 12/14/21

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 ______	09/09/2021

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
L1040	Continued From page 4 2. On 09/08/21 at 2:12 PM, Surveyor #7 and a Nurse Manager (Staff #701) reviewed the medical record for Patient #705. A chart note showed Patient #705 was transferred to Tacoma General Hospital on 08/28/21. The medical record did not contain a transfer document. 3. On 09/08/21 at 2:20 PM, Surveyor #7 interviewed the Chief Medical Officer (Staff #709) and the Director of Quality Behavioral Health (Staff #703) about the use of transfer documentation. Staff #709 and #703 stated there should be a transfer sheet and that they were unable to locate transfer documentation for Patient #705. 4. On 09/09/21 at 9:47 AM, Surveyor #7 and a Nurse Manager (Staff #701), reviewed the medical record for Patient #706. The medical record did not include a transfer sheet showing the location where Patient #706 was transferred. 5. At the time of the review, Staff #701 and Staff #703 agreed that the transfer sheet should show a location that Patient #706 was being sent to and agreed that the information was missing. 6. On 09/09/21 at 10:03 AM, Surveyor #7 and a Nurse Manager (Staff #701) reviewed the medical record for Patient #707. The transfer sheet showed that Patient #707 was transfered to St. Joseph Hospital but no Unit or Area was documented. 7. At the time of the review, Staff #701 agreeed with the finding that the transfer sheet did not note the Unit or Area that Patent #707 was to be sent to and that that information should be included on the document.	L1040		

ar 12/14/21

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 ____	09/09/2021

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
L1040	Continued From page 5 .	L1040		
L1065	322-170.2E TREATMENT PLAN-COMPREHENS 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: (e) A comprehensive treatment plan developed within seventy-two hours following admission: (i) Developed by a multi-disciplinary treatment team with input, when appropriate, by the patient, family, and other agencies; (ii) Reviewed and modified by a mental health professional as indicated by the patient's clinical condition; (iii) Interpreted to staff, patient, and, when possible and appropriate, to family; and (iv) Implemented by persons designated in the plan; This Washington Administrative Code is not met as evidenced by: . Based record review and interview, the hospital failed to ensure that staff members completed the Comprehensive Treatment Plan to include date and time for 4 of 4 records reviewed (Patients #701, #702, #703, and #704). Failure to ensure the development of a complete Comprehensive Treatment Plan for behavioral and medical problems put patients at risk for inappropriate, inconsistent, and delayed treatment.	L1065		10/31/21

am 12/14/21

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 ______	09/09/2021

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
L1065	Continued From page 6 Findings included: 1. On 09/07/21 at 3:06 PM, Surveyor #7, a Nurse Manager (Staff #701), and the Director of Quality Behavioral Health (Staff #703), reviewed the medical record of Patient #701. Patient #701 was an involuntary admit for self-cutting, with recent suicidal ideation. Patient #701 had a Master Treatment Plan (MTP) dated 09/12//21, that did not included time or date documentation for patient refusal to sign. The MTP update on 09/19/21 did not include the time of the provider/staff signature, and did not include the date or time of the patient signature. 2. On 09/08/21 at 8:41 AM, Surveyor #7, a Nurse Manager (Staff #701), and the Director of Quality Behavioral Health (Staff #703), reviewed the medical record of Patient #702. Patient #702 was a self-admit, seeking help with medications on 03/08/21. Patient #702 had a Master Treatment Plan (MTP) on 03/24/21 that did not record the time of the provider signature. 3. On 09/08/21 at 10:00 AM, Surveyor #7, a Nurse Manager (Staff #701), and the Director of Quality Behavioral Health (Staff# 703), reviewed the medical record of Patient #703. Patient #703 was admitted on 04/29/21 at 4:43 PM for manic behaviors with suicidal ideation, and discharged on 05/27/21. Patient #703 had a Master Treatment Plan (MTP) that showed a date of 05/02/21 with no time documented. Subsequent MTP documented on 05/09/21, 05/16/21, and 05/23/21 did not record the time of the provider/staff signature. 4. On 09/08/21 at 1:11 PM, Surveyor #7 and a Nurse Manager (Staff #701) reviewed the medical record of Patient #704. Patient #704 was a	L1065		

an
12/14/2

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 ____	09/09/2021

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
L1065	Continued From page 7 voluntary admit on 09/08/20 at 5:28 PM for medication management help. Patient #704 had a MTP from 09/11/20 that showed Patient #704 had refused to sign. The date and time of the patient's refusal to sign were not recorded. 5. At the time of the review, Surveyor #7 interviewed Staff #701 and Staff #703 about the hospital's expectation for date and time documentation on Comprehensive Treatment Plans. Staff #701 and Staff #703 verified the date and time were not recored in the treatment plans for Patients #701, #702, #703 and #704, and that those elements should always be documented. .	L1065		
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 document review and interviews, the hospital failed to ensure they had a sufficient number of trained nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained staff risks patient safety and delays in care and treatment.	L1165		10/31/21

an 12/14/21

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 ______	09/09/2021

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
L1165	Continued From page 8 Findings included: 1. Document review of the hospital's policy titled, "Code Blue- Rapid Response Team," PolicyStat ID 8665207, approved 10/20, showed that staff should follow BLS CAB-D (Basic Life Support Circulation, Airway, Breathing - Defibrillation) in accordance with approved training standards when a patient is discovered down and unresponsive. Document review of the hospital's training titled, "Sample BLS Renewal Course Agenda Without Optional Lessons," showed Lesson #2, part 3 AD Practice part 4: Bag-Mask Device. 2. On 09/08/21 at 11:06 AM, Surveyor #7 and a Nurse Manager (Staff #701), toured the Flag Unit. Surveyor #7 interviewed a Registered Nurse (Staff #705) about location of oxygen and the artificial manual breathing unit (AMBU bag), a bag mask devise, in relation to a code situation. Staff #705 located the emergency cart in the Galleon Unit. Staff #705 and Staff #701 could not locate the ambu bag and stated that there was no ambu bag. The House Supervisor (Staff #706) located the ambu bag which was locked inside the emergency cart. 3. On 09/09/21 at 8:34 AM, Surveyor #7 interviewed the Nurse Manager responsible for BLS renewal training (Staff #707) and the Director of Quality (Staff #703). Staff #703 and Staff #707 stated that the BLS training was the only training staff received in relation to Code Blue and AMBU bag training. Staff #703 and #707 stated the facility did not conduct Code Blue drills. .	L1165		

am 12/14/21

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 ______	09/09/2021

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
L1470	Continued From page 9	L1470		
L1470	322-220.1 LAB ACCESS WAC 246-322-220 Laboratory Services. The licensee shall: (1) Provide access to laboratory services to meet emergency and routine needs of patients; This Washington Administrative Code is not met as evidenced by: . Based on observation, document review, and interview, the hospital failed to ensure laboratory testing supplies did not exceed their designated expiration date. Failure to ensure testing supplies do not exceed their expiration date places patients at risk for inadequate medical treatment due to unreliable test results. Findings included: 1. Document review of the hospital's policy titled, "Stock Rotation and Expiration Policy," PolicyStat ID: 8451650, approved 09/20, showed that staff are to perform quarterly expiration checks and rotate stock, and to remove stock that expires within the next calendar month. 2. On 09/07/21 at 11:07 AM, Surveyor #7 toured the Galleon Unit with a Nurse Manager (Staff #701) and the Quality Manager (Staff #702). Surveyor #7 observed 1 of 4 bottles of wound cleanser had an expiration date of 04/21. 3. At the time of the observation Staff #701 and Staff #702 agreed the wound cleanser was expired and removed the item.	L1470		10/31/21

an 12/14/21

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 ______	09/09/2021

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
L1470	Continued From page 10 4. On 09/07/21 at 3:10 PM, Surveyor #6 inspected Exam Room #2311 on the Galleon Unit with the hospital's Business Operations Consultant (Staff #601) and the Clinical Supervisor of Patient Services (Staff #602). The observation showed the following items: a. 8 of 8 BBL Culture Swab packages; one with an expiration date of 12/31/20, 7 with an expiration date of 02/28/21 b. approximately 60 BD Vacutainer Serum Blood Collection Tubes (100% of available tubes) with an expiration date of 03/31/20. 5. At the time of the observation Surveyor #6 asked Staff #601 & #602 about the hospital policy for expired supplies. Staff #601 stated they did not know the policy but would provide it. Staff #602 removed the expired supplies. .	L1470		

an
12/14/21

Munroe, Robin L (DOH)

From: Chris Rakunas <Chris.Rakunas@wellfound.org>
Sent: Monday, December 13, 2021 1:17 PM
To: Munroe, Robin L (DOH); Angela Naylor; Shikha Gapsch
Subject: RE: Wellfound licensing survey 2021-766 Statement of Deficiency

External Email

Thank you for sending this over, Robin. We really appreciate it! I will make sure Angie gets a chance to sign this tomorrow and we'll send it right back.

Thank you again, and I hope you have a wonderful holiday!

From: Munroe, Robin L (DOH) <robin.munroe@doh.wa.gov>
Sent: Monday, December 13, 2021 12:54 PM
To: Angela Naylor <Angela.Naylor@multicare.org>; Shikha Gapsch <Shikha.Gapsch@wellfound.org>
Cc: Chris Rakunas <Chris.Rakunas@wellfound.org>
Subject: Wellfound licensing survey 2021-766 Statement of Deficiency

CAUTION: This message originated from an outside source. Do not click links or open attachments unless you recognize the sender, are expecting something from them, and know the content is safe. Please send spam & phishing emails to SPAM.Email@multicare.org as an attachment.

Good afternoon,

The attached Statement of Deficiency (SOD) had the Laundry deficiency removed (WAC 246-322-240). I know Shikha has been in contact with our Survey Manager regarding removal of the requirement.

Please sign and return the SOD to me so that we can complete the survey. Thank you for your patience through this process, I hope it wasn't too disruptive.

Please let me know if you have any questions or concerns.

Sincerely,

Robin Munroe, RS
Clinical Care Environmental Consultant
Office of Health Systems Oversight
Health Systems Quality Assurance
Washington State Department of Health
robin.munroe@doh.wa.gov
360-236-2914 | www.doh.wa.gov

Sign up for the Power of Providers Initiative :: Washington State Department of Health

POC received 10/01/21
approved 10/12/21
[signature] 12Oct21
TL Robin Munroe

Wellfound Behavioral Health Hospital
Plan of Correction for
WAC 246-322 Re-Licensing Survey
Exam #2021-766 | September 7 – 9, 2021

Tag Number	Finding	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L 690	Hospital failed to implement and maintain active surveillance to prevent and control exposure to infectious disease	1. The Covid-19 screening protocols will be updated to include visitor screening (currently only employees and vendor screening processes called out in policy).	1.Renee Espinosa	October 15, 2021	1. Policy Updates • The Covid Screening policy, protocols and related tools will be updated to include screening of visitors by October 15, 2021
		2. Staff will be trained on screening policy, protocol, and related responsibilities	2. Dasha Flameqvist	October 26th, 2021	2. Screening Education • staff with screening related responsibilities will be trained on the updated COVID Screening Policy by October 26, 2021. Evidence of training and related competence will be documented in Health Stream.
		3. All employees, vendors and visitors will enter through Beacon unit. Each will be screened:	3.Renee Espinosa	Screening Audits to begin	3. Screening • A Cross check of the visitor/vendor log with visitors will be completed

		• provided a mask • requested to screen for Covid symptoms • required to sign screening log to provide evidence of completed screening process		October 15, 2021	weekly to ensure screenings are occurring. • Results of cross check will be provided weekly as a compliance percentage to the CNO and reviewed monthly in QIC until 95% compliant for 60 consecutive days
		4. Appropriate signage from policy regarding steps and process for screening will be present and visible at Beacon unit for all employees, vendors, and visitors.	4.Renee Espinosa	October 15, 2021	4. Signage • Presence and visibility reviewed monthly via EOC Tracer until 95% compliant for 60 consecutive days.

L 1040	Based on record review, interview and review of hospital policy, the hospital failed to ensure staff completed the transfer form in 3 of 4 transfer records. Failure to complete the transfer documentation promotes lack of care continuity and places patients at risk for sub-optimal care.	1. Staff will be re-educated on Transfer documentation/Certificate of Transfer requirements through policy review. 2. Transfer Documentation Form/Certificate of Transfer to be completed for every patient transferred out of the facility.	Dr. Brian Neal, Renee Espinosa, Angie Naylor Renee Espinosa	October 31, 2021 Transfer Audits to begin October 31, 2021	1. Transfer Education • Transfer/Certificate of Transfer policy and protocols will be reviewed with each Wellfound staff (nursing and providers) who complete the Transfer Documentation Form to ensure competence for completion of required elements by October 31st. 2. Transfer Documentation • 100% of Transfer documentation /Certificates of Transfer will be audited for use and completion until 95% compliance is achieved with use and completion for 60 consecutive days.
L 1065	Based on record review and interview, the hospital failed to ensure that staff members completed the Comprehensive Treatment Plan to include date and time which put	1. Treatment Plan policy will be reviewed with appropriate staff to ensure awareness of need for inclusion of both date and time for each Treatment Plan and Treatment Summary, including all signatures of staff and patient as appropriate.	Dr. Brian Neal/Renee Espinosa	October 31, 2021	1. Treatment Plan Completion Education • All staff involved in the treatment planning processes and Treatment Summaries will be trained to the required elements of the Comprehensive Treatment Plan to ensure competence for completion of required elements by October 31st.

	patients at risk for inappropriate, inconsistent, and delayed treatment.	2. Treatment Plan documentation will be reviewed to ensure inclusion of both date and time for each Treatment Plan and Treatment Summary, including all signatures of staff and patient as appropriate.			2. Treatment Plan Completion Documentation • 25% of Treatment Plans will be audited weekly until 95% compliance is achieved with both date and time for 60 consecutive days.
L1165	Based on document review and interviews, the hospital failed to ensure they had a sufficient number of trained nursing personnel to provide safe and effective care to patients. Failure to provide an adequate number of trained staff risks patient safety and delays in care and treatment.	1. Code Blue/Rapid Response policies, protocols, and related training curriculum will be reviewed to ensure inclusion of adequate explanatory information as to location of items on response cart, expected response, responsibilities of team members, etc. 2. All staff involved in Code Blue will be trained in the processes and protocols for a code. • Code Blue – Rapid Response Team training, including policy/protocol review • Ambu Bag/manual resuscitator Training	1.Renee Espinosa and Jeff Bryant 2.Jeff Bryant, and Dasha Flameqvist – policy	Monthly drills to begin by October 31, 2021 October 31, 2021	1. Code Blue/Rapid Response policies, protocols, and related training curriculum • will be reviewed initially by October 15th to ensure inclusion of adequate explanatory information as to location of items on response cart, expected response, responsibilities of team members, etc. 2. Code Blue/Rapid Response Training Staff will receive: • Training on updated/current Code Blue/Rapid Response Policy and Protocols, including use of Ambu Bag/manual resuscitator to ensure competence for Code Blue and Rapid Response

		3. Code Blue Drills will be completed to ensure ongoing staff knowledge and capacity for timely response to these infrequent care events	3.ReneeEspinosa and Jeff Bryant	Drills to begin by October 31, 2021	processes and equipment by October 31st. • Label carts (completed 9/28/2021) 3. Code Blue Drills • will be completed monthly on alternating shifts and units to include at a minimum of one drill per shift per quarter. • Code Blue Drill records will be reviewed and reported monthly in QAPI x 90 days or when 100% compliance for completion has been reached for 90 consecutive days and then quarterly or per Quality Plan.
L 1470	Based on observation, document review and staff interview, the hospital failed to ensure laboratory testing supplies did not exceed	1. Stock Rotation and Expiration Policy to be followed for all supplies. Specifically: • Wound Cleaner • POCT Supplies • Culture Swab packages • Blood Draw vacutainer serum blood collection tubes	1.Renee Espinosa	October 31, 2021	1. Staff Training on Stock Currency • All staff involved in laboratory stock oversight will be re-educated on the Stock Rotation and Expiration Policy to ensure competence for required processed and procedures by October 31st.

	their designated expiration date.	2. Staff will be retrained on monitoring process to ensure currency of laboratory supplies	2.Renee Espinosa	Stock Audits to begin before October 31, 2021	2. Stock Audits • Laboratory testing supplies will be audited weekly until 95% compliance with no expired supplies is achieved for 60 consecutive days.

L 1565	Based on observation and document review, the hospital failed to ensure a minimum water temperature of 140 degrees Fahrenheit to patient washing machines.	1. Washer will be connected to the hot water. 2. Temperatures will be monitored using the Infection Control and Prevention Laundry Log Audit.	1.Chris Rakunas 2.Renee Espinosa	October 31, 2021 Temp. audits to begin by October 31, 2021	1. Hot Water Connection • All washing machines on patient units will be connected to hot water by October 31, 2021 2. Temperature Monitoring • Laundry Logs will be audited weekly to ensure o Completion o Temperatures in desired range o Appropriate action taken when temperature not within range until 95% achievement of compliance goals is maintained for 60 consecutive days • Audit results will be reviewed monthly in QAPI to monitor progress toward goals until 95% achievement of compliance goal is maintained for 60 consecutive days.

		3. Training will be completed for all staff involved in patient laundry on use of log and required water temperatures	3.Dasha Flameqvist	October 31, 2021	3. Training
					• Training will be completed by October 15, 2021, for all staff involved in patient by laundry on
					  ○ use of log,
					  ○ required water temperatures,
					  ○ actions to take when temperature is out of range
					• Laundry temperature and related responsibilities to be included in the initial competency checklist for each Mental Health Technician by 10/31/2021