STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504016	A. BUILDING _____ B. WING _____	04/07/2020

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) COMPLETION DATE
A 000	INITIAL COMMENTS . MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482 for Hospitals, conducted this complaint investigation. Investigation dates: 04/01/20 - 04/03/20 & 04/07/20 Intake number: #98867 Examination number: 2020-5203 The investigation was conducted by: Investigator #2 Investigator #3 Investigator #11 DOH staff found the facility in substantial compliance with 42 CFR 482.12, Governing Body, 42 CFR 482.13 Patient Rights, 42 CFR 482.23 Nursing Services, and 42 CFR 482.42 Infection Prevention and Control and Antibiotic Stewardship Programs, Conditions of Participation except those standard-level deficiencies listed below.	A 000		
A 175	. PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have	A 175		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 06/02/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 175	Continued From page 1 completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD 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 that staff members followed the hospital's seclusion policy and procedure for documentation in 1 of 3 seclusion records reviewed (Patient #301). Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. Findings included: 1. Document review of the hospital's policy titled, "Use of Seclusion and Restraint," no policy number, approved 10/19, showed that staff will assess the patient for readiness to discontinue seclusion at regular intervals to ensure the patient's safety. The intervals between assessments should not be longer than 15 minutes. 2. On 04/03/20 at 8:30 AM, Investigator #3 and the Chief Nursing Officer (Staff #301) reviewed the medical records of three patients who were placed in seclusion during their hospitalization. The review showed that Patient #301 was placed in seclusion for kicking and banging on walls at 11:23 AM on 03/16/20. The patient was released from seclusion on 03/16/20 at 2:25 PM. The review showed no documentation on the seclusion observation monitoring flowsheet to indicate that staff members had assessed the	A 175		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 175	Continued From page 2 patient from 1:45 PM until 2:25 PM, a period of 40 minutes. 3. At the time of the record review, the Chief Nursing Officer (Staff #301) acknowledged that no documentation could be found for that period of time. .	A 175		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedures, hospital staff failed to provide accurate documentation of	A 405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 405	Continued From page 3	A 405		

administered medications in the hospital's electronic Medication Administration Record (eMAR) for 2 of 5 patient records reviewed (Patients #302, #303).

Failure to provide accurate documentation in the eMAR, of the medications patients received risks medication errors and patient harm.

Findings included:

1. Document review of the hospital policy and procedure titled, "Medication Administration and Documentation: General Guidelines," no policy number, approved 10/19, showed that the licensed staff member who administers the medication shall record the administration in the patient's electronic medication administration record (eMAR) after the medication is given. It also showed that staff should document the time, route, and any other specific information as necessary.

2. On 04/02/20, Investigator #3, the Chief Nursing Officer (CNO) (Staff #301), and the Director of Quality (Staff #302) reviewed the electronic medication administration records (eMARs) of five patients. The review showed:

a. Patient #302 was to receive Chlorpromazine 25 mg (an antipsychotic medication) daily at 8:30 AM. The eMAR on 03/30/20 showed the patient received the medication at 9:27 AM and 11:48 AM. Similarly, the patient was scheduled to receive Baclofen 20 mg (a muscle relaxant medication) at 1:30 PM. The eMAR on 03/30/20 showed that the patient received this medication at 1:25 PM, and again at 1:41 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 405	Continued From page 4 b. Patient #303 was to receive Sertraline 200 mg (an antidepressant medication) daily at 12:00 PM. The eMAR on 03/27/20 showed the patient received the medication at 12:03 PM and 12:05 PM. 3. On 04/02/20 between 11:00 AM and 3:00 PM, Investigator #3 interviewed the CNO (Staff #301) and the Pharmacist in Charge (PIC) (Staff #303) about the multiple documented entries identified in the eMARs of Patient #302 and #303 for medications administered around a scheduled time. The PIC (Staff #303) provided documentation from the Pyxis machine (automated dispensing system) which showed that the nurse retrieved the selected medications only once from the Pyxis during those time periods. The investigator asked how the duplicate entries in the eMAR occurred. The CNO stated that the issue appears to be a staff training/knowledge problem with the use of the medication administration barcoding system.	A 405		

Plan of Correction received 05/01/2020
Plan of Correction approved 05/08/2020
Paul Kault RN, MN, MHA

Wellfound Behavioral Health Hospital
Plan of Correction for
State Complaint Investigation
April 1-3, 2020 and April 7, 2020

Tag Number CMS Reference	Tag Number Washington State Reference	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance
A000 MEDICARE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482 for Hospitals, conducted this complaint investigation. Investigation dates: 04/01/20 - 04/03/20 & 04/07/20 Intake number: #98867 Examination number: 2020-5203 The investigation was conducted by: Investigator #2 Investigator #3 Investigator #11 DOH staff found the facility in substantial compliance with 42 CFR 482.12, Governing Body, 42 CFR 482.13 Patient Rights, 42 CFR 482.23 Nursing Services, and 42 CFR 482.42 Infection Prevention and Control and Antibiotic Stewardship Programs. Conditions of Participation except those standard-level deficiencies listed below.	L000 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 complaint investigation. Investigation dates: 04/01/20 - 04/03/20 & 04/07/20 Intake number: #98867 Examination numbers: 2020-5203 The investigation was conducted by: Investigator #2 Investigator #3 Investigator #11 There were violations found pertinent to this complaint.	No issues identified with 42CFR 482.12, governing Body and 42 CFR 482.42 Infection Prevention and Control and Antibiotic Stewardship Programs Matt Crockett, CEO 5/1/2020			

Tag Number CMS Reference	Tag Number Washington State Reference	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	
A175 PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD 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 that staff members followed the hospital's seclusion policy and procedure for documentation in 1 of 3 seclusion records reviewed (Patient #301). Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. Findings included: 1. Document review of the hospital's policy titled, "Use of Seclusion and Restraint," no policy number, approved 10/19, showed that staff will assess the patient for readiness to discontinue seclusion at regular intervals to ensure the patient's safety. The intervals between assessments should not be longer than 15 minutes. 2. On 04/03/20 at 8:30 AM, Investigator #3 and the Chief Nursing Officer (Staff #301) reviewed the medical records of three patients who were placed in seclusion during their hospitalization. The review showed that Patient #301 was placed in seclusion for kicking and banging on walls at 11:23 AM on 03/16/20. The patient was released from seclusion on 03/16/20 at 2:25 PM. The review showed no documentation on the seclusion observation monitoring flowsheet to indicate that staff members had assessed the	L1145 322-160.1C RESTRAINT OBSERVATIONS WAC 246-322-160 Patient Safety and Seclusion Care. (1) The licensee shall assure seclusion and restraint are used only to the extent and duration necessary to ensure the safety of patients, staff, and property, as follows: (c) Staff shall observe any patient in restraint or seclusion at least every fifteen minutes, intervene as necessary, and recording observations and interventions in the clinical record. 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 that staff members followed the hospital's seclusion policy and procedure for documentation in 1 of 3 seclusion records reviewed (Patient #301). Failure to follow established policies and procedures places patients at risk of physical and psychological harm and possible violation of patient rights. Findings included: 1. Document review of the hospital's policy titled, "Use of Seclusion and Restraint," no policy number, approved 10/19, showed that staff will assess the patient for readiness to discontinue seclusion at regular intervals to ensure the patient's safety. The intervals between assessments should not be longer than 15 minutes. 2. On 04/03/20 at 8:30 AM, Investigator #3 and the Chief Nursing Officer (Staff #301) reviewed the medical records of three patients who were placed in seclusion during their hospitalization. The review showed that Patient #301 was placed in seclusion for kicking and banging on walls at 11:23 AM on 03/16/20 and was released from seclusion on 03/16/20 at 2:25 PM. The review showed no documentation on the seclusion observation monitoring flowsheet to indicate that	1) Education discussion with specific staff member regarding still need to document Q15 min observations even when pt. is with provider post seclusion in confidential window conference room as in this example 2) Seclusion and Restraint procedure was reshared with all clinical staff to include additional scenario to	CNO CNO	5/1/2020 5/8/2020	5/1/2020 5/8/2020	

patient from 1:45 PM until 2:25 PM, a period of 40 minutes. 3. At the time of the record review, the Chief Nursing Officer (Staff #301) acknowledged that no documentation could be found for that period of time.	staff members had assessed the patient from 1:45 PM until 2:25 PM, a period of 40 minutes. 3. At the time of the record review, the Chief Nursing Officer (Staff #301) acknowledged that no documentation could be found for that period of time.	reinforce documentation requirement. 3) Weekly audits for all seclusion and restraint situations assessing all related documentation for first 90 days or until 95% compliance with complete documentation whichever is longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter	Quality Dept	8/1/2020	8/1/2020	

A405 ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures This STANDARD is not met as evidenced by: Based on record review, interview, and review of hospital policy and procedures, hospital staff failed to provide accurate documentation of administered medications in the hospital's electronic Medication Administration Record (eMAR) for 2 of 5 patient records reviewed (Patients #302, #303). Failure to provide accurate documentation in the eMAR, of the medications patients received risks medication errors and patient harm Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration and Documentation: General Guidelines," no policy number, approved 10/19, showed that the licensed staff member who administers the medication shall record the administration in the patient's electronic medication administration record (eMAR) after the medication is given. It also showed that staff should document the time, route, and any other specific information as necessary.	L1375 322-210.3C PROCEDURES-ADMINISTER MEDS WAC 246-322-210 Pharmacy and Medication Services. The licensee shall: (3) Develop and implement procedures for prescribing, storing and administering medications according to state and federal laws and rules, including: (c) Administering drugs. This Washington Administrative Code is not met as evidenced by: . Based on record review, interview, and review of hospital policy and procedures, hospital staff failed to provide accurate documentation of administered medications in the hospital's electronic Medication Administration Record (eMAR) for 2 of 5 patient records reviewed (Patients #302, #303). Failure to provide accurate documentation in the eMAR, of the medications patients received risks medication errors and patient harm Findings included: 1. Document review of the hospital policy and procedure titled, "Medication Administration and Documentation: General Guidelines," no policy number, approved 10/19, showed that the licensed staff member who administers the medication shall record the administration in the patient's electronic medication administration record (eMAR) after the medication is given. It also showed that staff should document the time, route, and any other specific information as necessary.	1) Medication Administration and Documentation Policy was reviewed and supports medication administration time is to be within hour prior to or after standard ordered administration. No changes needed to policy 2) Pharmacy director reviewed EMR reports looking for discrepancies between potential multiple medication scanning entries	Pharmacy director and CNO Pharmacy director	4/28/2020 4/28/2020	4/28/2020 4/28/2020	

2. On 04/02/20, Investigator #3, the Chief Nursing Officer (CNO) (Staff #301), and the Director of Quality (Staff #302) reviewed the electronic medication administration records (eMARs) of five patients. The review showed: a. Patent #302 was to receive Chlorpromazine 25 mg (an antipsychotic medication) daily at 8:30 AM. The eMAR on 03/30/20 showed the patient received the medication at 9:27 AM and 11:48 AM. Similarly, the patient was scheduled to receive Baclofen 20 mg (a muscle relaxant medication) at 1:30 PM. The eMAR on 03/30/20 showed that the patent received this medication at 1:25 PM, and again at 1:41 PM. b. Patent #303 was to receive Sertraline 200 mg (an antidepressant medication) daily at 12:00 PM. The eMAR on 03/27/20 showed the patient received the medication at 12:03 PM and 12:05 PM. 3. On 04/02/20 between 11:00 AM and 3:00 PM, Investigator #3 interviewed the CNO (Staff #301) and the Pharmacist in Charge (PIC) (Staff #303) about the multiple documented entries identified in the eMARs of Patent #302 and #303 for medications administered around a scheduled time. The PIC (Staff #303) provided documentation from the Pyxis machine (automated dispensing system) which showed that the nurse retrieved the selected medications only once from the Pyxis during those time periods. The investigator asked how the duplicate entries in the eMAR occurred. The CNO stated that the issue appears to be a staff training/knowledge problem with the use of the medication administration barcoding system.	2. On 04/02/20, Investigator #3, the Chief Nursing Officer (CNO) (Staff #301), and the Director of Quality (Staff #302) reviewed the electronic medication administration records (eMARs) of five patients. The review showed: a. Patient #302 was to receive Chlorpromazine 25 mg (an antipsychotic medication) daily at 8:30 AM. The eMAR on 03/30/20 showed the patient received the medication at 9:27 AM and 11:48 AM. Similarly, the patient was scheduled to receive Baclofen 20 mg (a muscle relaxant medication) at 1:30 PM. The eMAR on 03/30/20 showed that the patient received this medication at 1:25 PM and again at 1:41 PM. b. Patient #303 was to receive Sertraline 200 mg (an antidepressant medication) daily at 12:00 PM. The eMAR on 03/27/20 showed the patient received the medication at 12:03 PM and 12:05 PM. 3. On 04/02/20 between 11:00 AM and 3:00 PM, Investigator #3 interviewed the CNO (Staff #301) and the Pharmacist in Charge (PIC) (Staff #303) about the multiple documented entries identified in the eMARs of Patent #302 and #303 for medications administered around a scheduled time. The PIC (Staff #303) provided documentation from the Pyxis machine (automated dispensing system) which showed that the nurse retrieved the selected medications only once from the Pyxis during those time periods. The investigator asked how the duplicate entries in the eMAR occurred. The CNO stated that the issue appears to be a staff training/knowledge problem with the use of the medication administration barcoding system	compared to medication pulled from pyxis as ordered. Reviews showed patients receiving medications as ordered. 3) Observations of medication passing and able to see how multiple medication scanning errors occurred when patient not ready for medication requiring nurse to reconnect with patient. Met with EMR informatics using scenarios and determined educational communication with screen shots for staff education. 4) Staff re-educated on medication scanning prior to administration process 5) Weekly audits of medication administration charts looking for medication documentation given for times outside established timelines for first 90 days or until 95% compliance with complete documentation whichever is longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter	Quality Director Quality Director Pharmacist	4/30/2020 5/8/2020 8/1/2020	4/30/2020 5/15/2020 8/1/2020	

Progress Report received 06/30/2020
Progress Report Approved 07/07/2020
Revised 07/07/2020

Wellfound Behavioral Health Hospital

Progress Report for Anonymous Complaint Investigation on April 1-3, 2020 & April 7, 2020- #98867/2020-5203 (6/30/2020)

Tag Number	How Corrected	Date Completed/Current Progress	Results of Monitoring
A175/ L1145 Restraint Observation Documentation	1) Education discussion with specific staff member regarding still need to document Q15 min observations even when pt. is with provider post seclusion in confidential window conference room as in this example	5/1/2020	Specific individual education was completed on cases reviewed during audit as learning opportunity.
	2) Seclusion and Restraint procedure was reshared with all clinical staff to include additional scenario to reinforce documentation requirement.	5/8/2020	Seclusion and restraint procedure documentation was reinforced to all clinical staff focusing on fact that the process steps are standardized to ensure patient safety and to reinforce compliance.
	3) Weekly audits for all seclusion and restraint situations assessing all related documentation for first 90 days or until 95% compliance with complete documentation whichever is longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter	6/30/2020	**100% Compliance**
A405/L1375 Standardization Procedure Administration Medication	1) Medication Administration and Documentation Policy was reviewed and supports medication administration time is to be within hour prior to or after standard ordered administration. No changes needed to policy	4/28/2020	Policy Review Completed
	2) Pharmacy director reviewed EMR reports looking for discrepancies between potential multiple medication scanning entries compared to medication pulled from pyxis as ordered. Reviews showed patients receiving medications as ordered.	4/28/2020	EMR report reviews Completed
	3) Observations of medication passing and able to see how multiple medication scanning errors occurred when patient not ready for medication requiring nurse to reconnect with patient. Met with EMR informatics using scenarios and determined educational communication with screen shots for staff education.	4/30/2020	Quality director observed medication passing process to include administrating med pass for medication earlier than hour earlier than ordered on day dinner trays per delivered early. Diabetic related medication. Quality director, pharmacist in charge, CNO met with EMR informatics staff to discuss scenarios to better understand what process steps are to be taken for correct documentation. EMR informatics provided documentation tips to be used for educating staff.
	4) Staff re-educated on medication scanning prior to administration process	6/3/2020	Education packets were shared with nursing staff. Supervisors helped with staff competencies and scenario discussions for EMR documentation.
	5) Weekly audits of medication administration charts looking for medication documentation given for times outside established timelines for first 90 days or until 95% compliance with complete documentation whichever is longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter	6/27/2020	**95.3% compliance**. Individual nurse education has been completed for fall outs.

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

May 8, 2020

Ms. Pamela Shotts, RN
Director of Quality
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, Washington 98405

Re: Complaint #98867/2020-5203

Dear Ms. Shotts,

Investigators from the Washington State Department of Health conducted a State hospital licensing and Medicare hospital complaint investigation at Wellfound Behavioral Health Hospital on April 1-3, 2020 and April 7, 2020. Hospital staff members developed a plan of correction to correct deficiencies cited during this investigation. This plan of correction was approved on May 8, 2020.

A Progress Report is due on or before **July 6, 2020** when all deficiencies have been corrected and monitoring for correction effectiveness has been completed. The Progress Report must address all items listed in the plan of correction, including the WAC reference numbers and letters, the actual correction completion dates, and the results of the monitoring processes identified in the Plan of Correction to verify the corrections have been effective. A sample progress report has been enclosed for reference.

Please send a scanned copy of this progress report to me at the following email address:

paul.kondrat@doh.wa.gov

Please contact me if you have any questions. I may be reached at (360) 790 - 7365. I am also available by email.

Sincerely,

Paul Kondrat
Investigation Team Leader