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

(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 and Alcoholism Hospitals, conducted this health and safety investigation. On site dates: 05/19/21 and 05/21/21 Case numbers: 2021-5238 Intake numbers: 112162 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 provide, or arrange for, diagnostic and therapeutic services prescribed by	L1110		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matt Crockett | TITLE: CEO | (X6) DATE: 6-17-21

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L1110	Continued From page 1 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 implement a safe discharge plan to ensure public safety by coordination with law enforcement personnel and notification of a potential victim, identified by a Protection Order, of a patient's discharge from the facility, for 1 of 4 patients reviewed (Patient #1504). Failure to communicate with law enforcement personnel or notify a potential victim, identified by a Protection Order, of a patient's discharge from the facility may lead to compromised public safety, potential harm and/or adverse outcomes. Reference: Revised Code of Washington (RCW) 71.05.120 Exemptions from Liability This section does not relieve a person from giving the required notices under RCW 71.05.330 (2) or 71.05.340 (1) (b), or the duty to warn or take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat or physical	L1110		

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L1110	Continued From page 2 violence against a reasonable victim or victims. The duty to warn or take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel. Washington Courts - Domestic Protection Order Definition: A domestic violence order for protection is a civil order from the court telling the household member who threatened you or assaulted you not to harm you again. A protection order can: a. Order the Respondent not to threaten or hurt you. b. Order the Respondent not to enter your residence. Findings included: 1. Document review of the hospital's policy titled, "Duty of Warn," policy number 8665205 reviewed 03/21, showed that when applying the standards of RCW 71.05.120, hospital providers are expected to conduct an assessment of the client's risk of violence or aggressive behavior towards themselves and others. When the client endorses past or current risk of harm to others, the following should be documented: a. Specific plans and access to means. b. Intention to act on plan/ideation. c. Protective factors. d. Natural/professional supports the person is	L1110		

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L1110	Continued From page 3 willing to access to support safety. e. Client commitment or lack of commitment to safety plan/no harm. f. Document a handoff, if possible. g. Risk assessment should be monitored throughout the inpatient stay. h. If assessment constitutes an actual threat of serious physical violence at the time the patient is released, consult with supervisor before taking any action and document this consultation in the electronic health record (EHR). If there is a concurrence to report, inform the law enforcement and inform the potential victim of the threat and document in the client's EHR. This call should be made prior to the patient's release if possible. 2. On 05/19/21 at 3:55 PM, Investigator #15 and the Director of Clinical Services (Staff #1506) reviewed the medical records for Patient #1504, a 35-year-old male admitted on 04/07/21, on an involuntary detainment due to homicidal threats and physical violence towards his mother and brother which required Emergency Medical Services (EMS) intervention. Patient #1504 had an admission diagnosis of Schizoaffective Disorder, Bipolar Type. Patient #1504 was living at home with his parents and brother. Patient #1504 had recently been discharged from an inpatient psychiatric hospital after a 30 day stay, but upon discharge he was noncompliant with medications and began drinking alcohol. Review of the medical records showed the following: a. The Initial Psychiatric Evaluation, dated 04/07/21, showed that the provider documented	L1110		

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L1110	Continued From page 4 that the Patient had a history of violence and aggressive behavior. Admission documents showed that he had legal problems and incarcerations for his violent behavior. Patient #1504 was recently released from jail after assaulting his brother and was reportedly dragging his mother around the house a few weeks ago. The provider noted that the family was seeking an order of protection due to the recent episode of violence. Discharge criteria included the Patient no longer being a danger to others. b. On 04/08/21, the provider documented on the Psychiatric Progress Note that the Patient was recently discharged from Cascade Behavioral health on 03/26/21. He was allegedly detained for homicidal threats to family. c. On the Psychosocial Assessment, dated 04/10/21, the staff documented that the Patient had a history of violence against family members and that the family was filing a restraining order (Order of Protection) against him. The patient reported to staff that he considered himself homeless and was unsure if he would be allowed to return home. The social worker's (SW) plan of care for the Patient included assistance from the Care Coordinator (CC) in locating housing, due to recent violence against mother and brother. d. The Master Treatment Plan, dated 04/10/21, showed that staff documented the Patient's challenges to include lack of stable housing. Interventions included the CC to provide information regarding housing resources available in the community. The Discharge Plan was to discharge to a shelter or structured placement with outpatient mental health services arranged.	L1110		

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L1110	Continued From page 5 e. On 04/12/21, staff documented on an Involuntary Treatment Note that the Designated Crisis Responder (DCR) stated that the Patient had been threatening to burn down the house and threatened to slit his brother's throat. Staff documented speaking with the Patient's mother who reported that he is not able to return home. A temporary (14 day) protection order was granted, and there was a hearing on 04/22/21 to extend it. Staff documented that the Patient was aware that his mother had obtained an order of protection. f. The Treatment Plan Update, dated 04/17/21, showed that staff documented that the Patient had limited insight to his psychosis or violent posturing that led up to his hospitalization. g. On 04/21/21, the provider documented on the Psychiatric Progress Note that the Patient remained easily triggered by "family." h. On 04/22/21, the CC documented speaking to the Patient regarding his discharge plan. The Care Coordinator (Staff #1507)confirmed with the Patient that the discharge address would be his home address, where he was previously living with his family. Staff #1507 documented that the Patient was aware that he would be transported back to his family home via Lyft. Investigator #15 found no evidence of documentation from the CC or Social Worker (SW) related to discharge planning for the Patient prior to the 04/22/21 documentation. Investigator #15 found no evidence of documentation explaining the change from the initial discharge plan to discharge to a shelter, based on the Patient's inability to discharge back to his family home.	L1110		

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L1110	Continued From page 6 Investigator #15 found no evidence of discharge planning documentation from staff regarding the Order of Protection between the Patient and his family. Based on the Patient's history of violence directed towards his family, Investigator #15 found no evidence of documentation of notification to his family of the patient's discharge back to the family home. i. On 04/23/21, the provider documented on the Discharge Summary that the Patient was to be discharged home. The provider reported that the Patient's condition at discharge was that the Patient was no longer threatening the physical safety of another. Investigator #15 failed to find evidence of documentation regarding the Protection Order against the Patient, in the Discharge Summary. j. On 04/23/21, the CC documented that the Patient was discharged on 04/23/21 to his home address via Saferide-Lyft (Non-Emergency Medical Transport). 3. On 05/19/21 at 3:55 PM, during an interview with Investigator #15, the Director of Clinical Services (Staff #1506) verified that the facility did not contact the family prior to sending the Patient back to the family home. Staff #1506 stated that "you have to be able to discharge a patient to their home." Investigator #15 clarified with the staff about their policies regarding discharging patients to a location that may be a violation of an Order of Protection. Staff #1506 reported that the facility had a Duty to Warn Policy but stated that the facility did not know "if there was a restraining order in place."	L1110		

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L1110	Continued From page 7 Investigator #15 found evidence of multiple staff documentations within the medical record that the family did obtain an Order of Protection against the Patient. 4. On 05/19/21 at 3:40 PM, during an interview with Investigator #15, the Care Coordinator CC (Staff #1507) stated that the discharge plan was for the Patient to go home to pick up his belongs. The Patient had requested a police escort at the house while picking up his belongings. Staff #1507 reported that this was not something that the facility could arrange for him. The CC advised the Patient to call law enforcement when he arrived home. Staff #1507 stated that she was not aware that the Patient's mother had obtained an Order of Protection against the Patient. Investigator #15 clarified the Patient's housing upon discharge with Staff #1507. She stated, "maybe a shelter, I am not sure." 5. On 05/20/21 at 1:15 PM, during an interview with Investigator #15, the Patient's mother stated that she had reached out to the hospital 3 times via phone and once by email, regarding the Order of Protection. She did not receive a response back from the facility regarding the Order of Protection or when the Patient would be discharging. She reported that she told the facility that she was not requesting information regarding her son's status, because she was aware there was no Release of Information (ROI) in place, but that she wanted to make the facility aware of the Protection Order and that she requested notice of his discharge prior to his release from the hospital. She reported that the Lake Stevens Police Department contacted the hospital regarding service of the Order of Protection. The	L1110		

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L1110	Continued From page 8 receptionist at the hospital told the law enforcement agency that "they could not assist with that." The Patient's mother stated that on 04/23/21, the Patient "just showed up and walked right into the house." The Patient's mother reported that he was acting crazy, like when he left, ranting, raving and hostile." Law enforcement was called, and they responded to the home, served the Patient with the Order of Protection, stood by while the Patient with gathered his belongings, and ensured that the Patient left the property. 6. Investigator #15 found no evidence that staff ensured a safe discharge for Patient #1504 by providing notification, ensuring an appropriate discharge disposition, and taking precautions to protect the patient's and public's safety.	L1110		

Plan of Correction
Recieved · 6·17·21 – revised 6·23·21
Approved · 7·15·21
Mary Drew DOH

Wellfound Behavioral Health Hospital
Plan of Correction for
State Investigation
(Case #2021-5238)

	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 risk related to the no contact order and notification to the family of the patients planned discharge to the community, 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 (including the existence of a protection order and potential need to notify community members of release) or barriers that may impact the type and timeliness of discharge, coordination with community partners and documentation of interdisciplinary treatment team discussion and 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, Social Work and staff will be educated to these standards no later than June 25, 2021. All ~~appropriate~~ Social Work, Provider and Care Coordinator staff will be re-educated on the obligations to assess risk and complete proper notification under Duty to Warn. This education will be completed by June 25, 2021.	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%

	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

Progress Report
Recieved: 08/18/21
Approved: 09/14/21
Mary Mew DOH

Wellfound Behavioral Health Hospital
Progress Report for
State Psychiatric Hospital Complaint Investigation (Case #2021-5238)
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 risk related to the no contact order and notification to the family of the patients planned discharge to the community, 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 (including the existence of a protection order and potential need to notify community members of release) or barriers that may impact the type and timeliness of discharge, coordination with community partners and documentation of interdisciplinary treatment team discussion and decision making related to discharge. Electronic medical record template was created and made available for use on June 25, 2021. All Care Coordinator and Social Work were educated to these standards no later than June 23, 2021. All Social Work, Provider and Care Coordinator staff have been re-educated on the obligations to assess risk and complete proper notification under Duty to Warn. This education was provided to staff on June 25, 2021. All staff attestations were completed by July 16, 2021.	06/25/2021	**Record review for July 2021:** 100% compliance for discharge record reviews (40/40). 100% of records with high risk issues identified at admission were addressed at discharge (14/14). **Record review for August 2021:** 100% compliance for discharge record reviews (40/40). 100% of records with high risk issues identified at admission were addressed at discharge (16/16). **Staff Training Attestation Compliance by Discipline:** Social Work: 100% Care Coordinator: 100% Provider: 100%

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 #112162/Case #2021-5238

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