

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013299	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WELLFOUND BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>STATE COMPLAINT INVESTIGATION</p> <p>The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC) 246-322 State Private Psychiatric and Alcoholism Hospital Licensing Regulations, conducted this complaint investigation.</p> <p>Investigation Onsite Date: 04/26/22</p> <p>Investigation Offsite Dates: 04/27/22, and 04/29/22</p> <p>Intake Numbers: 100543, 100800, 100982</p> <p>Case Numbers: 2020-6595, 2020-6822, 2020-7262</p> <p>No citations were determined for the complaints.</p>	L 000		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE