

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/27/2023</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BHC FAIRFAX HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10200 NE 132ND ST KIRKLAND, WA 98034</b>
---	--

(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)	(X6) COMPLETE DATE
L 000	<p><b>INITIAL COMMENTS</b></p> <p><b>STATE COMPLAINT INVESTIGATION</b></p> <p>The Washington State Department of Health (DOH), in accordance with Washington Administrative Code (WAC), 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation.</p> <p>On site dates: 02/28/23, 03/16/23, and 03/27/23</p> <p>Case number: 2023-1866</p> <p>Intake number: 128821</p> <p>This investigation was conducted by Investigator #1</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------