

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/08/2017
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NAME OF PROVIDER OR SUPPLIER BHC FAIRFAX HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 10200 NE 132ND ST KIRKLAND, WA 98034
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(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 STATE COMPLAINT INVESTIGATION</p> <p>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.</p> <p>Onsite dates: 9/8/17 Examination number: 2017 - 7332 Intake number: 74247</p> <p>The survey was conducted by: Rosie Tillotson, RN, MSN</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		

State Form 2567
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____