DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/04/2020 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION INTERPRETATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		504016	B. WING _			04/	07/2020
	ROVIDER OR SUPPLIER	TH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3402 S 19TH ST TACOMA, WA 98405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 000	INITIAL COMMENTS		A	000	0		
	MEDICARE COMPLA	AINT INVESTIGATION					
	(DOH) in accordance Participation set forth	e Department of Health with Medicare Conditions of in 42 CFR 482 for this complaint investigation.					
	Investigation dates: 0 04/07/20	4/01/20 - 04/03/20 &					
	Intake number: #9886	67					
	Examination number:	2020-5203					
	The investigation was	conducted by:					
	Investigator #2 Investigator #3 Investigator #11						
	Body, 42 CFR 482.13 482.23 Nursing Servi	FR 482.12, Governing B Patient Rights, 42 CFR ces, and 42 CFR 482.42 and Control and Antibiotic as, Conditions of nose standard-level					
A 175	PATIENT RIGHTS: R SECLUSION CFR(s): 482.13(e)(10		Α.	17	5		
	secluded must be mo	natient who is restrained or nitored by a physician, other or trained staff that have					
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

06/02/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		504016	B. WING	····	04/07/2020		
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
A 175	paragraph (f) of this determined by hosp This STANDARD is This STANDARD is Based on record re the hospital's policie hospital failed to en followed the hospital procedure for docur records reviewed (Failure to follow est procedures places psychological harm patient rights. Findings included: 1. Document review "Use of Seclusion a number, approved assess the patient f seclusion at regular patient's safety. The assessments shoul minutes. 2. On 04/03/20 at 8 the Chief Nursing C the medical records placed in seclusion The review showed in seclusion for kick	ing criteria specified in a section at an interval policy. In section at an interval policy is not met as evidenced by: view, interview, and review of the sand procedures, the sure that staff members all's seclusion policy and mentation in 1 of 3 seclusion Patient #301). In ablished policies and patients at risk of physical and and possible violation of a vof the hospital's policy titled, and Restraint," no policy 10/19, showed that staff will for readiness to discontinue intervals to ensure the	A 17	75			
	review showed no o seclusion observati	l3/16/20 at 2:25 PM. The documentation on the on monitoring flowsheet to lembers had assessed the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		504016	B. WING		04/07/2020		
NAME OF PROVIDER OR SUPPLIER WELLFOUND BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 3402 S 19TH ST TACOMA, WA 98405		1 340112020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
A 175	minutes. 3. At the time of the Nursing Officer (State	ge 2 If until 2:25 PM, a period of 40 record review, the Chief If #301) acknowledged that build be found for that period	A 175				
A 405	administered in according specified under §482 standards of practicording standards of practicording administered on the not specified under §482 practitioners are actillaw, including scope policies, and medicaregulations. (2) All drugs and bio administered by, or or other personnel in and State laws and applicable licensing accordance with the policies and procedulations. Based on record reviously in a policy and policy an	picals must be prepared and ordance with Federal and res of the practitioner or sible for the patient's care as 2.12(c), and accepted e. cals may be prepared and orders of other practitioners §482.12(c) only if such ing in accordance with State of practice laws, hospital al staff bylaws, rules, and logicals must be under supervision of, nursing accordance with Federal regulations, including requirements, and in approved medical staff	A 405				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED	
		504016	B. WING _			04/07/2020
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 405	electronic Medication (eMAR) for 2 of 5 per (Patients #302, #30). Failure to provide an eMAR, of the medication errors and Findings included: 1. Document review procedure titled, "M Documentation: Genumber, approved licensed staff member medication shall record (eMAR) after also showed that stroute, and any other necessary. 2. On 04/02/20, Inventor 15 per	ations in the hospital's on Administration Record atient records reviewed 3). ccurate documentation in the cations patients received risks	A 4	·		
	Quality (Staff #302) medication adminis five patients. The real a. Patient #302 was mg (an antipsychotic AM. The eMAR on received the medical AM. Similarly, the preceive Baclofen 20 medication) at 1:30	reviewed the electronic tration records (eMARs) of eview showed: to receive Chlorpromazine 25 c medication) daily at 8:30 03/30/20 showed the patient ation at 9:27 AM and 11:48 atient was scheduled to mg (a muscle relaxant PM. The eMAR on 03/30/20 cient received this medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 3402 S 19TH ST TACOMA, WA 98405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 405	b. Patient #303 was (an antidepressant in The eMAR on 03/27 received the medical PM. 3. On 04/02/20 betwoeld in the Pharmacist about the multiple do in the eMARs of Patmedications administ time. The PIC (Staff documentation from (automated dispensionally once from the Experiods. The investigentries in the eMAR that the issue appear training/knowledge pages in the email of the periods.	to receive Sertraline 200 mg medication) daily at 12:00 PM. 7/20 showed the patient stion at 12:03 PM and 12:05 veen 11:00 AM and 3:00 PM, viewed the CNO (Staff #301) in Charge (PIC) (Staff #303) ocumented entries identified stient #302 and #303 for stered around a scheduled the Pyxis machine ing system) which showed ved the selected medications Pyxis during those time gator asked how the duplicate occurred. The CNO stated	A 4	05		

Plan of Correction received 05/01/2020 Plan of Correction approved 05/08/2020 Palmkalton, MN, MM

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

		How the Deficiency Will Be	Responsible	Estimated	Target for	1
CMS Reference	Washington State Reference	Corrected	Individual(s)	Date of	Compliance	
		70 (Correction	-	
7000	L000	No issues identified with 42CFR 482.	12, governing Boo	ly and 42 CFR	482.42 Infecti	on
MEDICARE COMPLAINT INVESTIGATION	STATE COMPLAINT INVESTIGATION	Prevention and Control and Antibiot				
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: 94/81/20 - 64/83/20 & 64/87/20 Intake number: #98867 Examination number: 2020-5203 The investigation was conducted by. Investigator #2 Investigator #2 Investigator #2 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.	The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 248-322 Private Psychiatric and Alcoholism Hospitals, conducted this complaint investigation. Investigation dates: 04/01/20 - 04/03/20 & 04/07/20 Intake number: #98587 Examination numbers: 2020-5293 The investigation was conducted by: Investigator #2 Investigator #3 Investigator #11 There were violations found pertinent to this complaint.					

Tag Number	Tag Number	How the Deficiency Will Be	Responsible	Estimated	Target for
CMS Reference	Washington State Reference	Corrected	Individual(s)	Date of	Compliance
	3			Correction	Compliance
A175	L1145				
PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(st. 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	322-190.1C RESTRAINT OBSERVATIONS WAC 246-321-190 Patient Safety and Seclusion Care. (1) The Boensee 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				
completed the training onteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by:	observe any patient in restraint or sectusion at least every fifteen moutes, intervening as necessory and recording observations and interventions in the clinical				
Based on record review, interview, and review of the hosp talls policies and procedures, the hospital failed to ensure that staff members	record. This Washington Administrative Code is not met as evidenced by:				
followed the hospital's seclusion policy and procedure for documentation in 1 of 3 seclusion records reviewed (Patient #301).	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 sectusion policy and				
Failure to follow established policies and procedures places patients at his of physical and psychological harm and possible violation of	procedure for opcumentation in 1 of 3 sectusion records reviewed (Patient #301).				
patient rights. Findings included:	Failure to foliow established policies and procedures places patients at hisk of physical and psychological harm and possible wolation of patient rights.				
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.	Findings included 1. Document review of the hospital's policy titled, Tuse of Sedusion and Restrant," no policy number, approved 16/19, showed that staff will assess the patient for readiness to discontinue sedusion at regular intervals to ensure the patient's safety. The intervals between assessments should not be longer than 15 minutes.	1) Education discussion with specific staff member regarding still need to document Q15 min observations even when pt. is with provider post	CNO	5/1/2020	5/1/2020
2. On 04°03°00 at 8:80 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	2. On 04/03/20 at 8/30 AM, Investigator #3 and the Chief Nursing Officer (Staff #201) reviewed the medical records of three patients who were placed in seclusion during their hosp talization.	seclusion in confidential window conference room as in this example			
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	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	Seclusion and Restraint procedure was reshared with all clinical staff to include additional scenario to	CNO	5/8/2020	5/8/2020

patient from 1:45 PM until 2:25 PM, a period of 48 minutes. 3. At the time of the record review, the Chief Nursing Officer (Staff #381) 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	Quality Dept	8/1/2020	8/1/2020
		longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter			

A405	L1375		ľ	1	· · · · · · · · · · · · · · · · · · ·
ADMINISTRATION OF DRUGS CFR(s): 482.23(e)(1), (e)(1)() \$ (e)(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. (ii) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such	322-218.3C PROCEDURES-ADM:NISTER MEDS WAC 246-321-218 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)				
practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bytaws, rules, and regulations	Administering crugs: This Washington Administrative Code is not met as evidenced by:				
(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 ficensing 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 falled 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).				
Based on record review, interview, and review of hospital policy and procedures, hospital staff falled to provide accurate documentation of	Failure to provide accurate documentation in the eMARL of the medications patients received risks medication errors and patient narm				
administered medicabons in the hospital's electronic Medication Administration Record (eMAR) for 2 of 5 patient records reviewed (Patients #302, #303).		Medication Administration	Pharmacy	4/28/2020	4/28/2020
Failure to provide accurate documentation in the eMAR, of the medications patients received hisks medication errors and patient narm. Findings included:	Findings included 1. Document review of the hospital policy and procedure titled, "Medication Administration and Documentation: General Guidelines," no policy	and Documentation Policy was reviewed and supports medication administration time is to be within hour	director and CNO		
1. Document review of the hosp tal 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	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	prior to or after standard ordered administration. No changes needed to policy			
patient's electronic medication administration record (eMAR) after the medication is given, it also showed that staff should diclument the time, route, and any other specific information as necessary.	also showed that staff should document the time, route, and any other specific information as necessary.	2) Pharmacy director reviewed EMR reports looking for discrepancies between potential multiple medication scanning entries	Pharmacy director	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. Papent #302 was to receive Chlorpromazine 25 mg (an antipsychotic medication) daily at 8:30 AM. The eMAR on 03/02/20 showed the patient received the medication at 9.27 AM and 11.43 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 Sertraine 200 mg (an antidepressant medication) daily at 12:08 PM. The eMAR on 03/27/20 showed the patient received the medication at 12:03 PM and 12:05 PM.	2. On 04/02/20, Investigator #3, the Chief Nursing Officer (CNO) (Staff #301), and the Director of Quakry (Staff #302) reviewed the electronic medication administration records (eMARs) of five patients. The review showed: a. Patient #302 was to receive Chiorpromazine 25 mg (an antipsychotic medication) daily at 9:30 AM. The eMAR on 03/20/20 showed the patient received the medication at 9:27 AM and 11:43 AM. Similarly, the patient was scheduled to receive Baclofen 20 mg (a muscle relaxant medication) at 1:30 PM. The eMAR on 02/30/20 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 12:09 PM. The eMAR on 03/27/20 showed the patient received the medication at 12:03 PM and 12:05 PM.	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.	Quality Director	4/30/2020	4/30/2020
3. On 04/02/20 between 11 89 AM and 3:00 PM, Investigator #3 interviewed the CNO (Staff #301) and the Pharmadist in Charge (PIC) (Staff #303) about the multiple dodumented enthes identified in the eMARs of Patient #302 and #303 for medications administered ground 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 dublicate entities 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 barooding system.	3. On 04/32/20 between 11 00 AM and 3:00 PM, Investigation #3 interviewed the CNO (Staff #301) and the Pharmacist in Charge (PIC) (Staff #303) about the multiple documented enthes certified 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 fin estigator asked how the dublicate entries in the eMAR occurred. The CNO stated that the issue appears to be a staff transing/Anowledge problem with the use of the medication administration barcoding system.	 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 Pharmacist	5/8/2020 8/1/2020	5/15/2020 8/1/2020

	No.		Price Read Rained Objection
	Wellfound Behavioral H	lealth Hospital	Progress Report received 06/30/2020 Progress Report approved 07/07/2020 2020- #98867/2020-5203 (6/30/2020) Poplet
	ogress Report for Anonymous Complaint Investigation on April 1-	3, 2020 & April 7, 2	2020- #98867/2020-5203 (6/30/2020)
Tag Number	How Corrected	Date Completed/Current Progress	Results of Monitoring
A175/ L1145 Restraint Observation Documentation	 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 Seclusion and Restraint procedure was reshared with 	5/1/2020	Specific individual education was completed on cases reviewed during audit as learning opportunity. Seclusion and restraint procedure documentation was reinforced to all clinical staff focusing on fact that the
	all clinical staff to include additional scenario to reinforce documentation requirement.3) Weekly audits for all seclusion and restraint situations		process steps are standardized to ensure patient safety and to reinforce compliance.
	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	 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 Pharmacy director reviewed EMR reports looking for discrepancies between potential multiple medication scanning entries compared to medication pulled from 	4/28/2020	Policy Review Completed EMR report reviews Completed
	 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. 	4/30/2020	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 5) Weekly sudite of medication administration shorts leaking for	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