Emailed 7/12/20. Kphelps RN

POC approved 7/20/20

PRINTED: 07/02/2020
FORM APPROVED

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 06/03/2020

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 Hospital, conducted this complaint investigation. Onsite dates: 06/02/20-06/03/20 Case number: 2020-7271 Intake number: 100825 The investigation was conducted by: Investigator #5 Investigator #6 There were violations found pertinent to these complaints. .	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 07/12/20. 4. Return the ORIGINAL REPORT via email with the required signatures.	
L 315	322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and	L 315		

State Form 2567

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Matt Crockett	CEO	7-12-2020

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L 315	Continued From page 1 treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policy and procedures, the hospital failed to implement policies for assessing and reassessing patients who are victims of physical assault while hospitalized for 1 of 2 assaultive patient incidents reviewed. Failure to assess and reassess patients following a physical assault can lead to patient harm and death. Findings included: 1. Document review of the hospital's policy and procedure titled, "Patient Assessment and Reassessment-Inpatient," policy number 7808121, revised 10/19 showed that nursing staff will document a physical and psychiatric assessment every shift and as needed and additional information for an "event" will be documented in the Nursing Note section of the patient medical record. Document review of the hospital's policy and procedure titled, "Record Completion, Retention, Destruction," policy number 7804408, revised 10/19 showed that the purpose of the medical record is to serve as a basis for planning patient care, for continuity of care, and to furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay. The medical record must include any findings of assessments and reassessments, any diagnosis, or conditions established during the patient's	L 315		

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L 315	Continued From page 2 course of care, treatment, and services, and any observations relevant to care, treatment and services. 2. On 06/02/20 from 9:00 AM until 3:00 PM during interviews with hospital staff, Staff #502, Staff #503, Staff #504, Staff #505, Staff #506, and Staff #507stated that Patient #501 had physically assaulted Patient #502. 3. On 06/03/20 at 4:10 PM, Investigator #5 and the Chief Nursing Officer (Staff #501) reviewed the medical records for Patient #501 and #502. The review showed the following: a. On 05/14/20 at 7:20 AM, a nursing note stated that while trying to move Patient #501 to a seclusion room, Patient #501 "attacked another patient, dragging the patient to the ground." b. On 05/14/20 at 1:13 PM, a provider note stated that Patient #501 had "attacked another patient, dragging that patient to the ground." c. During review of the medical record for Patient #502, Investigator #5 found no evidence that staff completed or documented an assessment or reassessment of the patient for injury or change in condition after the assault. 4. At the time of the observation, Staff #501 confirmed the finding and stated that staff should have documented an assessment of the patient after the incident.	L 315		
L 340	322-035.1H PROCEDURES-BEHAVIOR WAC 246-322-035 Policies and	L 340		

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L 340	Continued From page 3 Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on nterview, document review, and review of hospital policy and procedures showed that the hospital failed to implement its Code Gray Policy. Failure to implement documentation and reporting of the hospital's Code Gray Policy limits the hospitals ability to collect accurate data, identify trends and patterns, and implement process improvement. Findings included: 1. Document review of the hospital's policy titled, "Code Gray Policy," policy number 7808170, revised 10/19 showed the following: -A Debrief/Huddle form will be completed in a timely manner by the Code Gray team and will be submitted to the department supervisor. It will be used weekly during Harm Huddle Discussions, during Safely Committee meetings, and/or for supplemental injury investigations. -The Debrief/Huddle form may be reviewed by regulatory agencies.	L 340		

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L 340	Continued From page 4 -The team leader will complete an Incident Report. -Security will complete a Security Case Report, which will include the escalation level, the behavior exhibited, and the staff's response to the incident. -If it is a patient offense, the patient's medical record will be documented with the appropriate information related to the incident, by the medical personnel. 2. On 06/03/20 at 3:30 PM, Investigator #5 and the Chief Nursing Officer reviewed the hospital's Incident Report Log. At this time, Surveyor #5 asked to review the Code Gray Debrief for the event involving Patient #501 on 05/14/20. The incident included an assault on another patient. Investigator #5 was not provided with the debrief form for this incident or any others. During the investigation process, the following was discovered: a. Security did not complete Code Gray Case Reports. b. Code Gray data was not collected or analyzed. c. Code Gray Debrief and Huddle sheets were not provided to or reviewed by the Hospital's Safety Committee. 3. At the time of the finding, the Staff #501 consulted with the Security and Environmental Services team and verified the finding. She stated that because the volume of Code Grays called in the hospital, this would not be a feasible policy to	L 340		

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L 340	Continued From page 5 implement.	L 340		
L 355	322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: Based on interview, document review, and review of hospital policy and procedure, the hospital failed to ensure that staff reported patient safety events for 1 of 2 patient safety events reviewed (Patient #502). Failure to report and investigate patient safety incidents limits the hospital's ability to analyze accurate data, implement performance improvement activities, and can result in an unsafe healthcare environment. Findings included: 1 Document review of the hospital's policy and procedure titled, "Critical Event Management and	L 355		

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L 355	Continued From page 6 Disclosure," policy number 7808463, revised 10/19 showed that critical events or occurrences are defined as events causing, or having the potential to cause serious patient harm. If an event is discovered staff will take actions to stabilize the patient, correct the situation and prevent or minimize injury, notify their supervisor as soon as possible, and initiate a paper incident reporting form. The form should be completed within 12 hours of discovering the event. Document review of the hospital's policy and procedure titled, "Incident Reporting Guidelines (for Unusual Occurrence and Critical Events," policy number 7808523, revised 10/19, showed that incident reports are created for any event or occurrence that is unusual or inconsistent with routine care of a patient or routine safety operations of the organization. Reports are completed by the person who discovers, witnesses, or identifies the event and should be completed within 12 hours of discovering the occurrence or event. 2. On 06/03/20 at 3:30 PM, Investigator #5 and the Chief Nursing Officer (Staff #501) reviewed the hospital's incident report log. Surveyor #5 found no evidence that staff completed an incident report for the assault of Patient #502 perpetrated by Patient #501 on 05/14/20. 3. At the time of the finding, Staff #501 verified that staff had not reported or completed an incident report for assaultive event.	L 355		

emailed 7/22/20 Rec on return for validation 7/29/20

approved 7/29/20 and sent to M. Godell KH

Wellfound Behavioral Health Hospital

Complaint Investigation
06/03/20 Case number 100825

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
L000 STATE COMPLAINT INVESTIGATION The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospital, conducted this complaint investigation. Onsite dates: 06/02/20-06/03/20 Case number: 2020-7271 Intake number: 100825 The investigation was conducted by: Investigator #5 Investigator #6 There were violations found pertinent to these complaints.	The complaint itself was unsubstantiated			

L315 322-035.1C POLICIES-TREATMENT WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (c) Providing or arranging for the care and treatment of patients; This Washington Administrative Code is not met as evidenced by: . Based on interview, document review, and review of hospital policy and procedures, the hospital failed to implement policies for assessing and reassessing patients who are victims of physical assault while hospitalized for 1 of 2 assaultive patient incidents reviewed. Failure to assess and reassess patients following a physical assault can lead to patient harm and death. **Findings included:** 1. Document review of the hospital's policy and procedure titled, "Patient Assessment and Reassessment-Inpatient," policy number 7808121, revised 10/19 showed that nursing staff will document a physical and psychiatric assessment every shift and as needed and additional information for an "event" will be documented in the Nursing Note section of the patient medical record. Document review of the hospital's policy and procedure titled, "Record Completion, Retention, Destruction," policy number 7804408, revised 10/19 showed that the purpose of the medical record is to serve as a basis for planning patient care, for continuity of care, and to furnish documentary evidence of the course of the patient's medical evaluation, treatment, and change in condition during the hospital stay. The medical record must include any findings of assessments and reassessments, any diagnosis, or conditions established during the patient's course of care, treatment, and services, and any observations relevant to care, treatment and services.	1. Reviewed policies, Patient Assessment and Reassessment -Inpatient and Record Completion, Retention, Destruction. 2. Education review of policies, Patient Assessment and Reassessment-Inpatient and Record Completion, Retention, Destruction was shared with all clinical staff to include additional scenario to reinforce documentation requirement. -Relias Education	Quality Dir and CNO Quality Dir	7/6/20 7/15/20	7/6/20 8/01/20

2. On 06/02/20 from 9:00 AM until 3:00 PM during interviews with hospital staff, Staff #502, Staff #503, Staff #504, Staff #505, Staff #506, and Staff #507stated that Patient #501 had physically assaulted Patient #502. 3. On 06/03/20 at 4:10 PM, Investigator #5 and the Chief Nursing Officer (Staff #501) reviewed the medical records for Patient #501 and #502. The review showed the following: a. On 05/14/20 at 7:20 AM, a nursing note stated that while trying to move Patient #501 to a seclusion room, Patient #501 "attacked another patient, dragging the patient to the ground." b. On 05/14/20 at 1:13 PM, a provider notes stated that Patient #501 had "attacked another patient, dragging that patient to the ground." c. During review of the medical record for Patient #502, Investigator #5 found no evidence that staff completed or documented an assessment or reassessment of the patient for injury or change in condition after the assault. 4. At the time of the observation, Staff #501 confirmed the finding and stated that staff should have documented an assessment of the patient after the incident.	3. Weekly audits for pt assessment related documentation in connection to patients involved with all event reports 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 Dir	8/01/20	11/01/20

L340 322-035.1H PROCEDURES-BEHAVIOR WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (h) Managing assaultive, self-destructive, or out-of-control behavior, including: (i) Immediate actions and conduct; (ii) Use of seclusion and restraints consistent with WAC 246-322-180 and other applicable state standards; (iii) Documenting in the clinical record; This Washington Administrative Code is not met as evidenced by: Based on interview, document review, and review of hospital policy and procedures showed that the hospital failed to implement its Code Gray Policy. Failure to implement documentation and reporting of the hospital's Code Gray Policy limits the hospitals ability to collect accurate data, identify trends and patterns, and implement process improvement. Findings included: 1. Document review of the hospital's policy titled, "Code Gray Policy," policy number 7808170, revised 10/19 showed the following: -A Debrief/Huddle form will be completed in a timely manner by the Code Gray team and will be submitted to the department supervisor. It will be used weekly during Harm Huddle Discussions, during Safety Committee meetings, and/or for supplemental injury investigations. -The Debrief/Huddle form may be reviewed by regulatory agencies. The team leader will complete an Incident Report. -Security will complete a Security Case Report, which will include the escalation level, the behavior exhibited, and the staff's response to the incident. -If it is a patient offense, the patient's medical record will be documented with the appropriate information related to the incident, by the medical	• Code Gray Policy was updated 7/8/2020 to reflect department tracking of code gray episodes and implementation of electronic event reporting system. • Education review updated code gray policy was rolled out to all clinical staff – Relias Education • Quality department to track Code Grays. Notify quality dept via event reporting, notification, or any other specific event reporting process. • Reports for event types will be pulled from new electronic event reporting system for sharing with various hospital committees such as Safety Committee etc.	Quality Dir Quality Dir Quality Dir Quality Dir	7/10/20 7/15/20 6/15/20 7/10/20	7/10/20 8/01/20 6/15/20 7/10/20

personnel. 2. On 06/03/20 at 3:30 PM, Investigator #5 and the Chief Nursing Officer reviewed the hospital's Incident Report Log. At this time, Surveyor #5 asked to review the Code Gray Debrief for the event involving Patient #501 on 05/14/20. The incident included an assault on another patient. Investigator #5 was not provided with the debrief form for this incident or any others. During the investigation process, the following was discovered: a. Security did not complete Code Gray Case Reports. b. Code Gray data was not collected or analyzed. c. Code Gray Debrief, and Huddle sheets were not provided to or reviewed by the Hospital's Safety Committee. 3. At the time of the finding, the Staff #501 consulted with the Security and Environmental Services team and verified the finding. She stated that because the volume of Code Grays called in the hospital, this would not be a feasible policy to implement.	• Weekly audits for pt assessment related documentation in connection to patients involved with event reports for all events first 90 days or until 95% compliance with complete documentation whichever is longer. Ongoing monitoring will be monthly for 3 months, quarterly thereafter	Quality Dir	7/10/20	10/01/20

L355 322-035.1K POLICIES-STAFF ACTIONS WAC 246-322-035 Policies and Procedures. (1) The licensee shall develop and implement the following written policies and procedures consistent with this chapter and services provided: (k) Staff actions upon: (i) Patient elopement; (ii) A serious change in a patient's condition, and immediately notifying family according to chapters 71.05 and 71.34 RCW; (iii) Accidents or incidents potentially harmful or injurious to patients, and documentation in the clinical record; (iv) Patient death; This Washington Administrative Code is not met as evidenced by: L 355 . Based on interview, document review, and review of hospital policy and procedure, the hospital failed to ensure that staff reported patient safety events for 1 of 2 patient safety events reviewed (Patient #502). Failure to report and investigate patient safety incidents limits the hospital's ability to analyze accurate data, implement performance improvement activities, and can result in an unsafe healthcare environment. Findings included: 1 Document review of the hospital's policy and procedure titled, "Critical Event Management and Disclosure," policy number 7808463, revised 10/19 showed that critical events or occurrences are defined as events causing, or having the potential to cause serious patient harm. If an event is discovered staff will take actions to stabilize the patient, correct the situation and prevent or minimize injury, notify their supervisor as soon as possible, and initiate a paper incident reporting form. The form should be completed within 12 hours of discovering the event. Document review of the hospital's policy and procedure titled, "Incident Reporting Guidelines	• Critical Event Management and Disclosure and Incident Reporting policies were reviewed/revised to include electronic event reporting system tool to improve ability to track and report incident events. • Staff communication regarding the Implementation of electronic event reporting system was completed week of July 6th. Informal hands on demonstration	Quality Dir Quality Dir	7/10/20 7/10/20	7/10/20 7/30/20

(for Unusual Occurrence and Critical Events," policy number 7808523, revised 10/19, showed that incident reports are created for any event or occurrence that is unusual or inconsistent with routine care of a patient or routine safety operations of the organization. Reports are completed by the person who discovers, witnesses, or identifies the event and should be completed within 12 hours of discovering the occurrence or event. 2. On 06/03/20 at 3:30 PM, Investigator #5 and the Chief Nursing Officer (Staff #501) reviewed the hospital's incident report log. Surveyor #5 found no evidence that staff completed an incident report for the assault of Patient #502 perpetrated by Patient #501 on 05/14/20. 3. At the time of the finding, Staff #501 verified that staff had not reported or completed an incident report for assaultive event.	and discussion with staff regarding the tool is also taking place. • Monthly electronic event reporting to be shared with clinical leaders. Event types will be pulled so they can be shared with committee such safety committee and QAPI committees. • Monthly audits for sharing electronic event reporting with leaders and committees starting with August for 3 months or until 95% compliance with sharing monthly event reports whichever is greater.	Quality Dir Quality Dir	7/10/20 8/15/20	8/1/20 9/15/20

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

September 11, 2020

Matt Crockett
Chief Executive Officer
Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, WA 98405

Dear Mr. Crockett,

Surveyors from the Washington State Department of Health conducted a state hospital complaint investigation at Wellfound Behavioral Health Hospital on 06/02/20-06/03/20. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 07/29/20.

Hospital staff members sent a Progress Report dated 09/02/20 that indicates all deficiencies have been corrected. The Department of Health accepts Wellfound Behavioral Health Hospital's attestation to be in compliance with Chapter 246-322 WAC.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Kimberly Metz DNP, RN
Survey Team Leader
Department of Health HSQA
PO Box 47874
Olympia, WA 98504-7874