STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

Friday, November 5, 2021

Wellfound Behavioral Health Hospital
3402 S 19th Street
Tacoma, WA 98405-2487

Dear Angela Naylor:

This letter contains information regarding the recent investigation at Wellfound Behavioral Health Hospital by the Washington State Department of Health. Your state licensing investigation was completed on Wednesday, September 29, 2021.

During the investigation, deficient practice was found in the areas listed on the attached Statement of Deficiency Report. A written Plan of Correction is required for each deficiency listed on the Statement of Deficiency Report and will be due 14 days after you receive this letter.

Each plan of correction statement must include the following:

- The regulation number;
- How the deficiency will be corrected;
- Who is responsible for making the correction;
- When the correction will be completed
- How you will assure that the deficiency has been successfully corrected. When monitoring activities are planned, objectives must be measurable and quantifiable. Please include information about the monitoring time frame and number of planned observations.

You are not required to write the Plan of Correction on the Statement of Deficiency Report.

Please sign and return the original reports and Plans of Correction to the following address:

Investigator: JAMC03
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874

Enclosures: Statement of Deficiency Report
Plan of Correction Instructions

Statement of Deficiency Report

Department of Health
P.O. Box 47874, Olympia, WA 98504-7874
TEL: 360-236-4732

Wellfound Behavioral Health Hospital
3402 South 19th Street
Tacoma, WA 98405-2487
Agency Name and Address

Angela Naylor
Administrator

Investigation
Inspection Type

Thursday, July 15, 2021
Investigation Start Date

JAMC03
Investigator Number

2020-13318
2020-14805
Case Number

BHA.FS.60925415
License Number

Mental Health
BHA/RTF Agency Services Type

Please note that the deficiencies/violations/observations noted in this report are not all-inclusive, but rather were deficiencies/violations/observations that were observed or discovered during the investigation.

Deficiency Number and Rule Reference	Findings	Plan of Correction
WAC 246-341-0420 Agency policies and procedures. Each agency licensed by the department to provide any behavioral health service must develop, implement, and maintain policies and procedures that address all of the applicable licensing and certification requirements of this chapter including administrative and personnel policies and procedures. Administrative policies and procedures must demonstrate the following, as applicable: (16) Individual rights. A description of how the agency has individual participation	Based on interview, policy and procedure review, and record review, the facility failed to develop and implement policies and procedures consistent with WAC 246-341-0600, including the requirement that policies met the requirements of RCW 71.05 for the services the facility provided. Failure to develop and implement policies and procedures that met the requirements of RCW 71.05 for the services the facility provided can result in poor patient care and failure to discharge patients to appropriate care providers or care services.	

rights and policies consistent with WAC 246-341-0600.

Reference:
WAC 246-341-1060 General requirements for mental health and substance use disorder inpatient and residential service providing services under chapter 71.05 or 71.34 RCW. This section applies to agencies providing secure withdrawal management, evaluation and treatment, involuntary crisis stabilization unit, and involuntary triage services. (1) An agency providing services under chapter 71.05 or 71.34 RCW must (a) Follow the applicable statutory requirements in chapter 71.05 and 71.34 RCW.

RCW 71.05.050(2) Voluntary application for treatment of a behavioral health disorder-Rights-Review of condition and status-Detention-Person refusing voluntary admission, temporary detention. (2) If the professional staff of any public or private agency or hospital regards a person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this

Findings Included:

1. Review of the facility policy and procedure titled "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021, showed that if a patient is determined to be danger, a Designated Crisis Responder (DCR) should be contacted, and "The DCR evaluation may include a request for staff to provide a written affidavit. If this is requested, the facility will provide information to support the petition for on-going detention." Review of the policy "Detainment Referral to Designated Crisis Responder" showed that a Mental Health Professional, defined in the policy as "...a professional clinician who is qualified by education and clinical training / supervision, and who is licensed...Social Workers, Psychiatric ARNPs, Licensed Mental Health Therapists..." should assess to determine if the patient is believed to be a danger to themselves or others. Review of the policy showed that it did not adequately direct staff so as to ensure that 71.05 is consistently followed and patient rights to be promptly released unless certain criteria is clinically present are upheld. For example, this policy did not address staff documentation requirements that included documenting the decision to hold a patient for the evaluation of a DCR, relevant patient observations, patient requests to be discharged, and any change in patient status.

2. Review of the facility policy and procedure titled "Discharge Planning (Transition Planning)", dated 10/2019 and updated 03/2021, showed that it is facility policy to determine the "appropriate post-hospital

chapter, which shall in ordinary circumstances be no later than the next judicial day. RCW 71.05.212(1-3)Evaluation—Consideration of information and records. (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding: (a) Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW; (b) Historical behavior, including history of one or more violent acts; (c) Prior determinations of incompetency or insanity under chapter 10.77 RCW; and (d) Prior commitments under this chapter. (2) Credible witnesses may include family members, landlords, neighbors, or others with significant contact and history of involvement with the person. If the designated crisis responder relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness. (3) Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient behavioral health	discharge destination for a patient", and that it is policy for discharge planning to begin at patient admission and be conducted by a multidisciplinary team. Review of the policy showed that it was incongruent with the facility policy titled "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021.The incongruency included which staff were allowed to determine if a patient was able to be discharged at the request of the patient, without a DCR evaluation. Review of the policy "Discharge Planning (transition Planning)" showed that if a patient requests to leave, it is facility policy for the medical provider to decide if the patient is referred to a DCR for a evaluation. Review of the policy "Detainment Referral to Designated Crisis Responder" showed that a Mental Health Professional , defined in the policy as "...a professional clinician who is qualified by education and clinical training / supervision, and who is licensed...Social workers, Psychiatric ARNPs, Licensed Mental Health Therapists..." should assess to determine if the patient is believed to be a danger to themselves or others. Review of the policy "Discharge Planning (Transition Planning)" showed that a medical provider could decide to discharge the patient without a DCR evaluation, decide to refer the patient for a DCR evaluation before discharge, or could decide to discharge the patient against medical advice. Review of the policy showed that it did not include a reference to the facility policy titled "Detainment Referral to Designated Crisis Responder", the policy that lists procedures staff should follow to contact a Designated Crisis Responder. Review of the policy showed that it did not adequately direct staff so as to ensure that 71.05 is consistently followed and patient rights to be promptly released unless certain criteria is clinically present are upheld. For example, this policy did not address staff	

treatment, when: (a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; (b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and (c) Without treatment, the continued deterioration of the respondent is probable.	documentation requirements that included documenting the decision to hold a patient for the evaluation of a DCR, documenting relevant patient observations, documenting patient requests to be discharged, and any change in patient status. 3. Review of the facility policy titled "Patient Rights", dated 03/2021, showed that the policy referred to the "Patient Handbook" as an attachment. Review of the facility document titled "Attachment A", undated, showed that it contained patient rights and other information that was part of the "Patient Handbook". The rights listed included information from RCW 71.05, "you have the right to immediate release, unless involuntary commitment proceedings are initiated." 4. In an interview on 07/15/21 at 11:00 AM, with Staff A, Director of Clinical Services; Staff B, Interim Quality Director, and staff C, Clinical Supervisor; Staff A stated that the facility had become aware that there was an issue that had been raised by the facility social workers, regarding medical providers requesting that voluntary patients be held at the facility while a Designated Crisis Responder(DCR) was notified of the need for an assessment. Staff A stated that the facility had taken steps to correct this issue, including an email that Staff A had sent out to staff regarding the new procedures for contacting a DCR. Staff A stated that policy and procedure had been updated after that email went out. 5. Review of an email from Staff A to multiple facility staff, dated 10/28/20 at 4:18 AM, showed that staff	

	were directed to document the reason for the DCR referral. 6. In an interview on 08/30/21 at 10:00 AM, Staff A, Clinical Director, acknowledged that the updated policy "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021 did not include the documentation requirements outlined in the email that was sent 10/28/20. Staff A stated, "frankly, the reason for revising the P&P was for the 124 hour [change from 72 to 124 hour initial involuntary hold]. "	
WAC 246-341-0600 Clinical—individual rights. (2) Each agency must develop a statement of individual participant rights applicable to the services the agency is certified to provide, to ensure an individual's rights are protected in compliance with chapters 70.41, 71.05, 71.12, 71.24, and 71.34 RCW, as applicable. To the extent that the rights set out in those chapters do not specifically address the rights in this subsection or are not applicable to all of the agency's services, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:" Reference: RCW 71.05.050(2) Voluntary application for treatment of a behavioral health disorder-Rights-Review of condition and status-Detention-Person refusing voluntary admission, temporary detention. (2) If the professional staff of any public or private agency or hospital regards a	Based on interview, clinical record review, and facility policy and procedure review, the facility failed to protect patients' rights in compliance with chapter 71.05 by failing to immediately release voluntary patients upon request without assessing or documenting the patient's presentation at the time of their request to show that they presented as an imminent likelihood of serious harm or as gravely disabled or failed to document the provision of relevant records to the DCR for 2 of 11 patients reviewed (Patient #2 and #9). Failure to protect patients' rights in compliance with chapter 71.05 by failing to immediately release voluntary patients upon request without assessing or documenting the patient's presentation at the time of their request to show that they presented as an imminent likelihood of serious harm or as gravely disabled; and by failing to document the provision of relevant records to the Designated Crisis Responder can result in a violation of those rights as well as harm and trauma to the patient or community and discourage patients from seeking further needed services.	

person voluntarily admitted who requests discharge as presenting, as a result of a behavioral health disorder, an imminent likelihood of serious harm, or is gravely disabled, they may detain such person for sufficient time to notify the designated crisis responder of such person's condition to enable the designated crisis responder to authorize such person being further held in custody or transported to an evaluation and treatment center, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program pursuant to the provisions of this chapter, which shall in ordinary circumstances be no later than the next judicial day.

RCW 71.05.212(1-3) Evaluation—Consideration of information and records. (1) Whenever a designated crisis responder or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding: (a) Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW; (b) Historical behavior, including history of one or more violent acts; (c) Prior determinations of incompetency or insanity under chapter 10.77 RCW; and (d) Prior commitments under this chapter. (2) Credible witnesses may include family members, landlords, neighbors, or others with significant contact and history of involvement with the person. If the designated

Findings included:

1. Review of Patient #2 records showed that the facility failed to document reasonable grounds to believe that Patient #2 was presenting as an imminent likelihood of serious harm, or was gravely disabled , based on the following:

a. Review of clinical records for Patient #2 showed that Patient #2 asked to be discharged at 11:25 AM on 09/12/21 and was discharged at 10:28 PM on 09/12/21.
b. Review of Patient #2 document, "Master Treatment Plan", dated 09/12/20, showed that date of service was listed as 09/12/20. The section "Patient Voice" showed that the patient stated, "I want to be discharged". The section "Suicide Risk" showed that the patient was at low to moderate risk for suicide or self harm.

b. Review of Patient #2 document, "Ancillary Notes", dated 09/12/20, showed that a facility social worker documented, "Provider requested this writer contact the DCR for a face to face evaluation of pt. [They are] asking to leave AMA b/c they [staff] told [Patient #2] would need someone to sit with [them] while [they] applied [their] makeup. And another staff member told [them that they] needed to wear a sweater over [their] dress b/c the staff member stated the dress was too revealing."

c. Review of Patient #2 document, "Pierce County Designated Crisis Responder Involuntary Treatment Act Evaluation Note", undated, fax date stamped 09/12/20, showed that Patient #2 met with the DCR at 5:33 PM for an evaluation and the outcome of the

crisis responder relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated crisis responder or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness. (3) Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient behavioral health treatment, when: (a) Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; (b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and (c) Without treatment, the continued deterioration of the respondent is probable.

Department of Health Interpretive Statement, Release of Involuntary Individuals from inpatient Behavioral Health Settings: A DCR should not be contacted unless the facility has documented reasonable grounds to believe that the individual may meet the criteria for a limited involuntary detention.

evaluation was noted as "not detained". Per social worker notes, "respondent became upset this morning, threatened to contact [their] attorney and other organizations...expressed frustration that [they] did not feel [their] treatment their [sic] was helpful...Per [Medical Provider] verbalized concern that respondent [Patient #2] left [the facility] in August, did not follow up without patient services, was positive for alcohol and THC upon admit this admission, became agitated this morning, and was aggressive toward [the provider] this morning... respondent appeared able to provide for [their] health and safety...will not be detained for 72 hour Involuntary Treatment". No other reviewed documentation relating to this patient indicated a provider or any other staff conducted an appropriate assessment to establish reasonable grounds to believe that Patient #2 met the statutory criteria at the time they were detained for the DCR referral.

2. Review of Patient #9 records showed that the facility failed to document reasonable grounds to believe that Patient #9 was presenting as an imminent likelihood of serious harm, or was gravely disabled , based on the following:

a. Review of clinical records for Patient #9 showed that Patient #9 asked to be discharged at 3:13 PM on 07/16/21 and was discharged at 7:56 PM on 07/16/21.

b. Review of Patient #9 document "Psychiatric Progress Note", dated 07/16/21 at 11:59 AM, showed that a medical provider assessed the patient as having no suicidal or homicidal ideation and "appears preoccupied, mildly RIS [responding to internal

	stimuli] on the milieu, intense eye contact, responses lack insight, [Patient #9] repeatedly states [they have] no mental issues...unwilling to engage with natural supports or contact payee to gather resources, [Patient #9] appears paranoid on the unit and denies the need for medications although [they] have been medication compliant on the unit." The plan was documented as "DCR referral placed by [social worker] today with acceptance at 1530." No other reviewed documentation relating to this patient indicated a provider or any other staff conducted an appropriate assessment to establish reasonable grounds to believe that Patient #9 met the statutory criteria at the time they were detained for the DCR referral. c. Review of Patient #9 progress note, dated 07/16/21, at 3:13 PM, showed that staff documented that Patient #9 stated "...'I just want my stuff and I want to leave.." A DCR referral was documented on 07/16/21 at 3:30 PM. d. Review of the DCR document titled "Crisis Contact Report", dated 07/16/21 at 5:15 PM, showed that the DCR determined that Patient #9 did not meet the criteria for detainment. The DCR noted that Patient #9 denied current suicidal ideation and homicidal ideation, and "exhibits no current risk..."	
WAC 246-341-1118 Mental health inpatient service – General. (2) An agency providing mental health inpatient services must develop and implement an individualized annual training plan for agency staff members, to include at least: (a) Least restrictive alternative options	Based on interview and facility policy and procedure review, the facility failed to develop and implement an individualized annual training plan that included least restrictive alternative options available in the community and how to access them for 2 of 4 personnel records reviewed (Staff G and Staff I).	

available in the community and how to access them.	Failure to develop and implement an individualized annual training plan that included least restrictive alternative options available in the community and how to access them can result in poor patient care and failure to discharge patients to appropriate care providers or care services. Findings included: 1. Review of the facility policy and procedure titled, "Annual Training Requirements", dated 10/2019, showed that annual training was required on least restrictive alternatives available in the community and how to access them. 2. Review of an email dated 09/29/21, written by Staff A, Clinical Director, showed that Staff G, Social Worker, was employed at the facility in a full time role from 01/20/2020 to 08/18/21. On 08/18/21 Staff G moved into a per diem (on-call) employment status. 3. In an interview on 09/14/21 Staff G, Social Worker, stated that they did not recall attending any specific training on least restrictive alternatives while employed at the facility. 4. Review of personnel records for Staff G, Social Worker, showed that there was no documentation of annual training of least restrictive alternatives available in the community and how to access them. 5. In an interview on 09/10/21 at 10:00 AM, Staff I, Medical Provider, stated that they did not have any	

	training on least restrictive alternatives while employed at the facility. 6. Review of an email written by Staff A, Clinical Director, dated 09/30/21, showed that "[Staff I] started on 09/01/20, [they] would not be eligible to complete annual training until December 2021..." .	

11/22/2021

Plan of Correction Instructions

Introduction

We require that you submit a plan of correction for each deficiency listed on the statement of deficiency form. Your plan of correction must be Submitted to DOH within fourteen calendar days of receipt of the list of deficiencies.

You are required to respond to the statement of deficiencies by submitting a plan of correction (POC). Be sure to refer to the deficiency number. If you include exhibits, identify them and refer to them as such in your POC.

Descriptive Content

Your plan of correction must provide a step-by-step description of the methods to correct each deficient practice to prevent recurrence and provide information that ensures the intent of the regulation is met.

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction.

Simply stating that a deficiency has been "corrected" is not acceptable. If a deficiency has already been corrected, the plan of correction must include the following:

- How the deficiency was corrected,
- The completion date (date the correction was accomplished),
- How the plan of correction will prevent possible recurrence of the deficiency.

Completion Dates

The POC must include a completion date that is realistic and coinciding with the amount of time your facility will need to correct the deficiency. Direct care issues must be corrected immediately and monitored appropriately. Some deficiencies may require a staged plan to accomplish total correction. Deficiencies that require bids, remodeling, replacement of equipment, etc., may need more time to accomplish correction; the target completion date, however, should be within a reasonable and mutually agreeable time-frame.

Continued Monitoring
Each plan of correction must indicate the appropriate person, either by position or title, who will be responsible for monitoring the correction of the deficiency to prevent recurrence.

Checklist:

- Before submitting your plan of correction, please use the checklist below to prevent delays.
- Have you provided a plan of correction for each deficiency listed?
- Does each plan of correction show a completion date of when the deficiency will be corrected?
- Is each plan descriptive as to how the correction will be accomplished?
- Have you indicated what staff position will monitor the correction of each deficiency?
- If you included any attachments, have they been identified with the corresponding deficiency number or identified with the page number to which they are associated?

Your plan of correction will be returned to you for proper completion if not filled out according to these guidelines.

Note: Failure to submit an acceptable plan of correction may result in enforcement action.

Approval of POC
Your submitted POC will be reviewed for adequacy by DOH. If your POC does not adequately address the deficiencies, you will be sent a letter detailing why your POC was not accepted.

Questions?
Please review the cited regulation first. If you need clarification or have questions about deficiencies, you must contact the investigator who conducted the investigation.

Plan of Correction for Wellfound Behavioral Health Hospital
Washington State DOH Hospital Complaint Survey
Complaint Investigation Initiated 07/15/2021

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
ITEM NO.1	Findings Included: 1. Review of the facility policy and procedure titled "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021, showed that if a patient is determined to be danger, a Designated Crisis Responder (DCR) should be contacted, and "The DCR evaluation may include a request for staff to provide a written affidavit. If this is requested, the facility will provide information to support the petition for on-going detention." Review of the policy "Detainment Referral to Designated Crisis Responder" showed that a Mental Health Professional, defined in the policy as "...a professional clinician who is qualified by education and clinical training / supervision, and who is licensed...Social Workers,	The Director of Intake and Community Relations and Chief Medical Officer have created three new internal forms which will address issues surrounding staff documentation inconsistencies as it pertains to voluntary patients at Wellfound Behavioral Health Hospital who ask to leave against medical advice (AMA) when a qualified MHP or Licensed Provider have concerns that they are an imminent danger to self, others and/or gravely disabled. The three forms are as follows: 1) ***Patient Initiated Discharge and AMA Intervention*** which outlines what steps staff should take when a voluntary patient requests to leave AMA. This form ensures that: a) the treating provider be contacted if a patient requests to leave AMA,	The Director of Intake and Community Relations, Director of Inpatient Clinical Services, Director of Quality and Chief Medical Officer. **Policies Corrected as of 11/18/2021** **Forms to be implemented**	• Audit will be completed for 50% of patients discharging AMA to ensure all three forms are completed; target will be 8 weeks' consecutive compliance of ≥ 95% • The Director of Intake and Community Relations has already updated the two pertinent policies referenced including ***"Detainment Referral to Designated Crisis Responder"*** & ***"Discharge Planning (Transition Planning)"*** referencing the three new forms an updating the language that clarifies what constitutes the clinical criteria for initiating an involuntary treatment referral. • All clinical staff will be educated around the change in policy and the three new forms in our electronic healthcare record in EPIC by December 10th, 2021.

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
	Psychiatric ARNPs, Licensed Mental Health Therapists..." should assess to determine if the patient is believed to be a danger to themselves or others. Review of the policy showed that it did not adequately direct staff so as to ensure that 71.05 is consistently followed and patient rights to be promptly released unless certain criteria is clinically present are upheld. For example, this policy did not address staff documentation requirements that included documenting the decision to hold a patient for the evaluation of a DCR, relevant patient observations, patient requests to be discharged, and any change in patient status.	b) that a qualified MHP staff identify if the patient meets clinical criteria for an involuntary commitment referral, c) what specific clinical concerns the qualified MHP or Licensed Provider staff have & d) the clinical outcome, including: if the patient decided to remain a voluntary patient, if they were referred for an involuntary commitment assessment, or if they left AMA *2) DCR Referral for Involuntary Assessment* This new form addresses staff documentation by addressing issues surrounding consistency. In particular, this form ensure that staff list the following" a) The time of the DCR Referral b) Which staff member made the referral c) What the clinical justification/reason for the referral for involuntary commitment d) The time the referral was accepted e) The approximate time to expect the DCR and the evaluation and f) The crisis team staff member who accepted the referral *3) The DCR Evaluation & Summary*	as of 12/10/2021 Training to be completed as of 12/10/2021 Audits to be initiated 12/13/2021	

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
		This form requires staff to complete the following: a) The outcome of the DCR evaluation b) The name and title of the DCR who conducted the assessment c) If the patient was detained, if they elected to stay voluntarily or if they elected to leave Against Medical Advice (AMA). Additionally, the policy ***'Detainment Referral to Designated Crisis Responder'*** has been updated to include the three new aforementioned forms so that staff have a rubric to follow. Additionally, these forms are attached to said policy. Lastly, in Section II of Policy 'Detainment Referral to Designated Crisis Responder' in subsection B. we have added the following language: "The following language defines when a patient is considered to be a danger to self, danger to others and/or if they are assessed to be gravely disabled. *Danger to Self* is defined as a substantial risk that physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself (RCW 71.05)		

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
		Danger to Others is defined as physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or the person has threatened the physical safety of another and has a history of one or more violent acts. (RCW 71.05) *Gravely Disabled* is defined as a means a condition in which a person, as a result of a mental disorder, or as a result of the use of alcohol or other psychoactive chemicals: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety."		

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
	2. Review of the facility policy and procedure titled "Discharge Planning (Transition Planning)", dated 10/2019 and updated 03/2021, showed that it is facility policy to determine the "appropriate post-hospital discharge destination for a patient", and that it is policy for discharge planning to begin at patient admission and be conducted by a multidisciplinary team. Review of the policy showed that it was incongruent with the facility policy titled "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021.The incongruency included which staff were allowed to determine if a patient was able to be discharged at the request of the patient, without a DCR evaluation. Review of the policy "Discharge Planning (transition Planning)" showed that if a patient requests to leave, it is facility policy for the medical provider to decide if the patient is referred to a DCR for a evaluation. Review of the policy "Detainment Referral to Designated Crisis Responder" showed that a Mental Health Professional , defined in the policy as "...a	The Director of Intake and Community Relations has already updated the existing policies, including the ***"Detainment Referral to Designated Crisis Responder' & "Discharge Planning (Transition Planning)"*** to ensure both policies have congruent language. The updated language is stated as *"At the time a patient requests an unplanned release from Wellfound, a provider or qualified Mental Health Professional should assess to determine if the patient is believed to be a danger to themselves or others, or is gravely disabled based on a mental health or substance use disorder."* • **TASK COMPLETED AS OF 11/19/21.**	The Director of Intake and Community Relations has updated the two referenced policies. **TASK COMPLETED AS OF 11/19/21.**	• The Director of Intake and Community Relations has updated the two referenced policies. • **TASK COMPLETED AS OF 11/19/21.**

Tag Number	Identified Deficiency	How the Deficiency Will Be Corrected	Who Responsible Individual(s) & Estimated Date of Correction	What Monitoring procedure; Target for Compliance
	professional clinician who is qualified by education and clinical training / supervision, and who is licensed...Social workers, Psychiatric ARNPs, Licensed Mental Health Therapists..." should assess to determine if the patient is believed to be a danger to themselves or others. Review of the policy "Discharge Planning (Transition Planning)" showed that a medical provider could decide to discharge the patient without a DCR evaluation, decide to refer the patient for a DCR evaluation before discharge, or could decide to discharge the patient against medical advice. Review of the policy showed that it did not include a reference to the facility policy titled "Detainment Referral to Designated Crisis Responder", the policy that lists procedures staff should follow to contact a Designated Crisis Responder. Review of the policy showed that it did not adequately direct staff so as to ensure that 71.05 is consistently followed and patient rights to be promptly released unless certain criteria is clinically present are			

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	upheld. For example, this policy did not address staff documentation requirements that included documenting the decision to hold a patient for the evaluation of a DCR, documenting relevant patient observations, documenting patient requests to be discharged, and any change in patient status.			
	3. Review of the facility policy titled "Patient Rights", dated 03/2021, showed that the policy referred to the "Patient Handbook" as an attachment. Review of the facility document titled "Attachment A", undated, showed that it contained patient rights and other information that was part of the "Patient Handbook". The rights listed included information from RCW 71.05, "you have the right to immediate release, unless involuntary commitment proceedings are initiated."	The Director of Intake and Community Relations reviewed the Patient Handbook and noted that the language referenced was consistent with the patient rights language outlined in RCW.71.05.217.	The Director of Intake and Community Relations. TASK COMPLETED BY 11/19/21.	• The Director of Intake and Community Relations reviewed the Patient Handbook and noted that the language referenced was consistent with the patent rights language outlined in RCW.71.05.217. • TASK COMPLETED BY 11/19/21.

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	4. In an interview on 07/15/21 at 11:00 AM, with Staff A, Director of Clinical Services; Staff B, Interim Quality Director, and staff C, Clinical Supervisor; Staff A stated that the facility had become aware that there was an issue that had been raised by the facility social workers, regarding medical providers requesting that voluntary patients be held at the facility while a Designated Crisis Responder(DCR) was notified of the need for an assessment. Staff A stated that the facility had taken steps to correct this issue, including an email that Staff A had sent out to staff regarding the new procedures for contacting a DCR. Staff A stated that policy and procedure had been updated after that email went out.	See Item 1	See Item 1	See Item 1
	5. Review of an email from Staff A to multiple facility staff, dated 10/28/20 at 4:18 AM, showed that	See Item 1	See Item 1	See Item 1

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	staff were directed to document the reason for the DCR referral. 6. In an interview on 08/30/21 at 10:00 AM, Staff A, Clinical Director, acknowledged that the updated policy "Detainment Referral to Designated Crisis Responder", dated 10/2019 and updated 04/2021 did not include the documentation requirements outlined in the email that was sent 10/28/20. Staff A stated, "frankly, the reason for revising the P&P was for the 124 hour [change from 72 to 124 hour initial involuntary hold]."	The Director of Intake and Community Relations has updated the 'Detainment Referral to Designated Crisis Responder' Policy to add the additional language in Section II Titled Policy section B that clarifies the documentation requirements which would be necessary to constitute an involuntary commitment referral. The amended language is as follows: *"At the time a patient requests an unplanned release from Wellfound, a provider or qualified Mental Health Professional should assess to determine if the patient is believed to be a danger to themselves or others, or is gravely disabled based on a mental health or substance use disorder. The following language defines when a patient is considered to be a danger to self, danger to others and/or if they are assessed to be gravely disabled. A) Danger to Self is defined as a substantial risk that physical harm will be inflicted by a person upon their own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself (RCW 71.05). B) Danger to Others is defined as physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm or which places another*	The Director of Intake and Community Relations has already added this language to the existing policy. **TASK COMPLETED AS OF 11/19/21.**	• The Director of Intake and Community Relations has already updated the existing policies, including the ***"Detainment Referral to Designated Crisis Responder' & "Discharge Planning (Transition Planning)".*** • **TASK COMPLETED AS OF 11/19/21.**

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		person or persons in reasonable fear of sustaining such harm; or physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or the person has threatened the physical safety of another and has a history of one or more violent acts (RCW 71.05). C) Gravely Disabled is defined as a means a condition in which a person, as a result of a mental disorder, or as a result of the use of alcohol or other psychoactive chemicals: (a) Is in danger of serious physical harm resulting from a failure to provide for their essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over their actions and is not receiving such care as is essential for their health or safety." Additionally, the Director of Intake and the Director of Inpatient Clinical Services will send out another email to all clinical staff reiterating the criteria which should be the impetus for an Involuntary Commitment Referral.	The Director of Intake and Community Relations, Director of Inpatient Clinical Services,	• Audit will be completed for 50% of patients discharging AMA to ensure all three forms are completed; target will be 8 weeks' consecutive compliance of ≥ 95% • **TASK TO BE INITIATED THE WEEK OF DECEMBER 13TH 2021.**

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			Director of Quality and Chief Medical Officer. **Audits to be initiated 12/13/2021**	

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ITEM NO.2	Based on interview, clinical record review, and facility policy and procedure review, the facility failed to protect patients' rights in compliance with chapter 71.05 by failing to immediately release voluntary patients upon request without assessing or documenting the patient's presentation at the time of their request to show that they presented as an imminent likelihood of serious harm or as gravely disabled or failed to document the provision of relevant records to the DCR for 2 of 11 patients reviewed (Patient #2 and #9). Failure to protect patients' rights in compliance with chapter 71.05 by failing to immediately release voluntary patients upon request without assessing or documenting the patient's presentation at the time of their request to show that they	See Item 1 Lastly, when a patient is requesting to leave all efforts by a qualified mental health provider will be made to conduct a new and independent assessment of the patient's psychiatric presentation, including specifically if they present with criteria consistent with an involuntary commitment referral identified under RCW.71.05	See Item 1	See Item 1

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	presented as an imminent likelihood of serious harm or as gravely disabled; and by failing to document the provision of relevant records to the Designated Crisis Responder can result in a violation of those rights as well as harm and trauma to the patient or community and discourage patients from seeking further needed services. Findings included: 1. Review of Patient #2 records showed that the facility failed to document reasonable grounds to believe that Patient #2 was presenting as an imminent likelihood of serious harm, or was gravely disabled , based on the following: a. Review of clinical records for Patient #2 showed that Patient #2 asked to be discharged at 11:25 AM on 09/12/21 and was discharged at 10:28 PM on 09/12/21. b. Review of Patient #2 document, "Master Treatment Plan", dated			

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	09/12/20, showed that date of service was listed as 09/12/20. The section "Patient Voice" showed that the patient stated, "I want to be discharged". The section "Suicide Risk" showed that the patient was at low to moderate risk for suicide or self harm. b. Review of Patient #2 document, "Ancillary Notes", dated 09/12/20, showed that a facility social worker documented, "Provider requested this writer contact the DCR for a face to face evaluation of pt. [They are] asking to leave AMA b/c they [staff] told [Patient #2] would need someone to sit with [them] while [they] applied [their] makeup. And another staff member told [them that they] needed to wear a sweater over [their] dress b/c the staff member stated the dress was too revealing." c. Review of Patient #2 document, "Pierce County Designated Crisis			

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	Responder Involuntary Treatment Act Evaluation Note", undated, fax date stamped 09/12/20, showed that Patient #2 met with the DCR at 5:33 PM for an evaluation and the outcome of the evaluation was noted as "not detained". Per social worker notes, "respondent became upset this morning, threatened to contact [their] attorney and other organizations...expressed frustration that [they] did not feel [their] treatment their [sic] was helpful...Per [Medical Provider] verbalized concern that respondent [Patient #2] left [the facility] in August, did not follow up without patient services, was positive for alcohol and THC upon admit this admission, became agitated this morning, and was aggressive toward [the provider] this morning... respondent appeared able to provide for [their] health and safety...will not be detained for 72 hour Involuntary Treatment". No other reviewed documentation			

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	relating to this patient indicated a provider or any other staff conducted an appropriate assessment to establish reasonable grounds to believe that Patient #2 met the statutory criteria at the time they were detained for the DCR referral. 2. Review of Patient #9 records showed that the facility failed to document reasonable grounds to believe that Patient #9 was presenting as an imminent likelihood of serious harm, or was gravely disabled , based on the following: a. Review of clinical records for Patient #9 showed that Patient #9 asked to be discharged at 3:13 PM on 07/16/21 and was discharged at 7:56 PM on 07/16/21. b. Review of Patient #9 document "Psychiatric Progress Note", dated 07/16/21 at 11:59 AM, showed that a medical provider assessed the patient as having no suicidal or homicidal ideation and "appears			

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	preoccupied, mildly RIS [responding to internal stimuli] on the milieu, intense eye contact, responses lack insight, [Patient #9] repeatedly states [they have] no mental issues...unwilling to engage with natural supports or contact payee to gather resources, [Patient #9] appears paranoid on the unit and denies the need for medications although [they] have been medication compliant on the unit." The plan was documented as "DCR referral placed by [social worker] today with acceptance at 1530." No other reviewed documentation relating to this patient indicated a provider or any other staff conducted an appropriate assessment to establish reasonable grounds to believe that Patient #9 met the statutory criteria at the time they were detained for the DCR referral. c. Review of Patient #9 progress note, dated 07/16/21, at 3:13 PM,			

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	showed that staff documented that Patient #9 stated "...'I just want my stuff and I want to leave.." A DCR referral was documented on 07/16/21 at 3:30 PM. d. Review of the DCR document titled "Crisis Contact Report", dated 07/16/21 at 5:15 PM, showed that the DCR determined that Patient #9 did not meet the criteria for detainment. The DCR noted that Patient #9 denied current suicidal ideation and homicidal ideation, and "exhibits no current risk..."			

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ITEM NO.3	Based on interview and facility policy and procedure review, the facility failed to develop and implement an individualized annual training plan that included least restrictive alternative options available in the community and how to access them for 2 of 4 personnel records reviewed (Staff G and Staff I). Failure to develop and implement an individualized annual training plan that included least restrictive alternative options available in the community and how to access them can result in poor patient care and failure to discharge patients to appropriate care providers or care services. Findings included: 1. Review of the facility policy and procedure titled, "Annual Training Requirements", dated 10/2019, showed that annual training was required on least restrictive alternatives available in the	The Director of Intake and Community Relations is in the process of creating a training tool that identifies: a) what least restrictive alternatives are to an involuntary commitment referral, b) what interventions are available to staff and c) what the applicable community based resources are based on the patient's individual needs.	Director of Intake and Community Relations and Director of Inpatient Clinical Services. Training to be completed as of 12/10/2021	The Director of Intake and Community Relations, the Director of Inpatient Clinical Services and the Director of Quality will ensure that all of the clinical staff are educated on these new tools. Current employees will be trained on this tool and have sign off sheets monitored by the Director of Quality in conjunction with the Director of Human Resources. New staff onboarding at Wellfound Behavioral Hospital will have this new tool as part of their onboarding process, which again will be verified by the Director of Quality and the Director of Human Resources. All clinical staff will be educated around the change in policy and the three new forms in our electronic healthcare record in EPIC by December 10th, 2021. An electronic version of the training will be available on our online training tool for all new staff by December 10th, 2021.

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	community and how to access them. 2. Review of an email dated 09/29/21, written by Staff A, Clinical Director, showed that Staff G, Social Worker, was employed at the facility in a full time role from 01/20/2020 to 08/18/21. On 08/18/21 Staff G moved into a per diem (on-call) employment status. 3. In an interview on 09/14/21 Staff G, Social Worker, stated that they did not recall attending any specific training on least restrictive alternatives while employed at the facility. 4. Review of personnel records for Staff G, Social Worker, showed that there was no documentation of annual training of least restrictive alternatives available in the community and how to access them. 5. In an interview on 09/10/21 at 10:00 AM, Staff I, Medical Provider, stated that they did not have any training on least			

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	restrictive alternatives while employed at the facility. 6. Review of an email written by Staff A, Clinical Director, dated 09/30/21, showed that "[Staff I] started on 09/01/20, [they] would not be eligible to complete annual training until December 2021..."			

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

January 6, 2022

Re: Case Number: 2020-13318, 2020-14805
License Number: BHA.FS.60925415

Dear Angela Naylor:

This letter is to inform you that after careful review of the Plan of Correction (POC) you submitted for the investigation recently conducted at your agency, the Department has determined that the POC is acceptable. You stated in your plan that you will implement corrective actions by the specified timeline. By this, the Department is accepting your Plan of Correction as your confirmation of compliance.

Based on the scope and severity of the deficiencies listed in your statement of deficiency report, the Department will conduct an unannounced follow-up compliance visit to verify that all deficiencies have been corrected.

The Department reserves the right to pursue enforcement action for any repeat and/or uncorrected deficiencies based on applicable statute and rules.

Investigator: JAMC03
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874