Statement of Deficiency Report

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Wellfound Behavioral Health Hospital
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Tacoma, WA 98405-2487
Agency Name and Address

Angela Naylor
Administrator

Investigation	Wednesday, August 18, 2021	JAMC3
Inspection Type	Investigation Start Date	Investigator Number
2021-8539	BHA.FS.60925415	Mental Health
Case Number	License Number	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	Person Responsible and Estimated Date of Correction
WAC 246-341-1060(1)(b)(ii) General requirements for mental health and substance use disorder inpatient and residential services 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:	Based on observation, interview, clinical record review, and facility policy and procedure review, the facility failed to ensure that services were provided in a secure environment with visual monitoring that was appropriate to the individual for 2 of 7 Patients, Patient #2 and #7. Failure to ensure that services were provided in a secure environment with visual monitoring that was appropriate to the individual can result in patient harm and poor patient outcomes.	The staffing matrix to be updated and hiring to take place to ensure appropriate staffing. The staff assignment sheet to be updated to reflect staff being assigned to specific areas of the milieu to ensure visual coverage of the unit for patient safety.	*By AVP-Nursing & Operations (Angie Conklin) By 05/28/2022* *By AVP-Nursing & Operations (Angie Conklin) By 05/28/2022*

(b) Ensure that service are provided in a secure environment. "Secure" means having: (ii) Visual monitoring, in a method appropriate to the individual. Reference: Previous WAC Administrative Code: 246-341-1126(1)(b)	Findings included: Item 1 – Facility Layout and Visual Monitoring 1. On 10/15/21, starting at 9:15 AM, Investigator #1 toured the facility. During the tour, Investigator #1 observed units Beacon, Compass, Galleon, Dock, Flag, and Harbor Units. Units Beacon, Compass, and Galleon did not have patients on the unit. Units Dock, Flag, and Harbor had patients on the unit. Observation of all the facility units showed that patient bedrooms have doors that open to the same hallway. Bedrooms are on both sides of the hallway. The hallway has a curve in it, and angles off slightly to the right or left, depending on the unit. After the curve in the hallway, the hall becomes wider. The wider hallway contains a small fully enclosed room with windows all around it, that appeared to be a nursing station. This nursing station room was not staffed in any of the observed units. Staff refer to this spot where the hallway curves or angles to a different direction as the "dogleg". 2. During the tour of the Harbor Unit, Investigator #1 observed a Mental Health Technician, Staff J, was sitting in a chair at the "dogleg". When asked for clarification on this from the investigator, Staff J stated that they were stationed in that spot specifically to observe the hallway and the	Monitoring for compliance will occur through Supervisor/Management rounding 1x weekly per shift to ensure all staff are in assigned areas on milieu per assignment sheet until we have 8 weeks consecutive compliance of ≥95% Current "Sexually Inappropriate Behavior Between Patients" policy dated 12/2021 states that "The Nurse in Charge and support staff will separate the individuals involved and determine if increased observations are needed." This will be updated to also include that the reason to increase or decrease observations will be documented in the electronic health record The "Routine and Special Precautions" policy is retired. There is no longer a "line of sight" order for patients. There is a "Constant Observer" policy dated 02/2022 for constant observation of patient when determined necessary.	*By AVP-Nursing & Operations (Angie Conklin)* *To Begin By 05/28/2022* *By Dir of Quality (Shikha Gapsch)* *By 04/01/2022* *By Dir of Quality (Shikha Gapsch)* *COMPLETED*

	area of the hall that could not be seen from the area of the milieu near the nurses station, and behind the desk of the nurses station. Staff J stated that they made that decision to stay in that spot because it was the only place to be able to observe the entire hallway. Staff J stated that they had been told to keep an eye on two specific patients, and one of the patients was in a bedroom near the "dogleg" area of the hallway, where Staff J had positioned themselves in a chair. 3. Review of a document titled "Staffing Matrix" showed that unit staffing during the day included 1 residential nurse (RN) on duty for 1-12 patients, and 2 RN's on duty for 12-24 patients per unit. During the day staffing would include 1 Mental Health Technician (MHT) for 8 patients, 2 MHT's for 8-16 patients, and 3 MHTs for 17-24 patients. 4. Review of a document titled "Staffing Matrix" showed that unit staffing during the evening and night "NOC Shift" included 1 residential nurse on duty for 1-12 patients, and 2 RN's on duty for 12-24 patients per unit. During the evening and night staffing would include 1 Mental Health Technician (MHT) for 12 patients, and 2 MHT's for 12-24 patients. 5. During an interview at approximately 12:50 PM on 10/15/21, Staff K, Milieu		

	Manager, stated that when one mental health technician is doing rounding (observing the location of each patient and the activity each patient is involved in), there is no other staff that are told to be monitoring the hallway where the patient rooms are located. Staff K stated that when one mental health technician is doing rounding, the other technician could be doing laundry, getting a drink for a patient, or other tasks. Staff K stated that if an MHT was in a patient room to perform rounding functions, then it would be possible for another patient to see that no staff were watching the hallway and go into another patient's room. During this interview, Staff A, Interim Chief Executive Officer CEO, stated that having more than one Mental Health Technician on duty was based on census, and that there could be one mental health technician on duty if the census was low enough. Item #2 – Staff Monitoring of Patients 1. Review of the facility's policy and procedure titled, "Sexually Inappropriate Behavior Between Patients", dated 10/2020, showed that the facility procedure was to immediately place a patient on line of sight special precautions after the patient had been involved in inappropriate sexual contact with another patient.		

	2. Review of Patient #2's "Nursing Note", dated 02/07/21 at 5:28 AM, showed that Staff N, Certified Nursing Assistant, documented "I was doing my rounds at 2:45 when [Patient #2] began running very fast back and fourth [sic] down the hall. I noticed [they were] not running and no longer in my sight so I went looking for patient and found the patient in the bed in room 33B with [Patient #1]. [Patient #1] sat up and looked very distraught and [they] had tears in [their] eyes [Patient #1] thanked me for coming…" 3. Review of Patient #2's "Nursing Note", dated 02/07/21 at 5:09 AM, showed that Staff O, RN, documented "Patient #2 touched [Patient #1] in the private area after [Patient #2] crawled in bed with [them]. The patient touched the patient on [their] genitals and had to be redirected to the milieu, when I went to get staff to assist with watching [Patient #2, they] tried to climb in a [another patient's] bed [Patient #2] was running as fast as [they] could. [Staff P, ARNP] was notified when I went to get additional staff. The patient was watched by staff and then [Patient #2] was moved to Egret. [Patient #2] had turned down PRN medications…This is a new behavior for [Patient #2] since [their] arrival on our unit."		

	4. Review of Patient #2's nursing note, dated 02/08/21 at 4:58 AM, showed that Patient #2 was given medication to aid in sleeping, and Staff O, RN, documented "[Patient #2] remains line of sight when awake and up out of [their] room…needs to be observed very closely, as can move fast, and slyly… looking all around [them], observing where everyone is situated, staff and pts [patients] alike… 0200 hours, was found in the quiet room sitting next to a male PT [patient] who also has sexually inappropriate behaviors. Requested that they both leave the quiet room, and go to their bedroom and try to sleep more."		
WAC 246-341-0410(4)(a) Agency administration – Administrator key responsibilities. (4) The administrator or their designee must ensure: (a) Administrative, personnel, and clinical policies and procedures are adhered to and compliant with rules in this chapter and other applicable state and federal statutes and regulations. Reference: Previous WAC Administrative Code: 246-341-0410(3)(b) and 246-341-0410(1)(c)	Based on observation, interview, personnel file review, and facility policy and procedure review, the administrator failed to ensure that clinical policies and procedures were adhered to and compliant with state and federal regulations. Failure to ensure that clinical policies and procedures were adhered to and complaint with state and federal regulations can result in poor patient care and patient harm. Findings included: 1. Review of the facility's policy and procedure titled, "Sexually Inappropriate Behavior Between Patients", dated 10/2020, showed that the policy stated, "It	The "Sexually Inappropriate Behavior Between Patients" policy to be updated to ensure all sections are completed. The "Incident Event Reporting and Critical Event Management" policy date 11/2021 to be updated to specifically state to report events to DOH per timeframe guidelines. The "Sexually Inappropriate Behavior Between Patients" policy to be further updated to clarify that all sexual	*By AVP-Nursing & Operations (Angie Conklin)* *By 05/28/2022* *By Dir of Quality (Shikha Gapsch)* *By 04/01/2022* *By AVP-Nursing & Operations (Angie Conklin)* *By 05/28/2022*

	is the policy of [Facility]", there was no other information listed in the policy section of the document. In the procedure section of the document, the procedure addressed how the facility should respond when inappropriate sexual intercourse or sexual contact has occurred between patients. Review of the procedure showed that the procedure referenced to another policy titled "Sexual Intercourse Reporting to Law Enforcement" but did not include any information about reporting to the Department of Health. 2. During an interview at 12:30 PM, with Staff A, Interim CEO; Staff C, Nursing Manager; and Staff D, Quality Manager, this investigator asked about the facility policy titled "Sexually Inappropriate Behavior Between Patients", dated 10/2020, and inquired if there was sexual behavior between patients that was considered appropriate. Staff A stated that there was no sexually appropriate behavior between patients, "we need to fix that policy". 3. Review of the facility's policy and procedure titled "Sexually Inappropriate Behavior Between Patients", dated 10/2020, showed that it was facility policy for a nurse or medical provider to assess the mental , emotional, and physical status of a patient, including written orders for special precautions, after "inappropriate sexual intercourse	behavior between patients is considered inappropriate. Policies to be created for all special precautions that patients can be placed on (Falls, Elopement, Assault, Sexual Behavior) which will also outline what the specific action items exist for each type of precaution. The patient handbook to be updated stating that physical contact is not allowed between patients while at Wellfound Behavioral Health Hospital. The "Routine and Special Precautions" policy is retired. There is no longer a "line of sight" order for patients. There is a "Constant Observer" policy dated 02/2022 for constant observation of patient when determined necessary. The Treatment Plans to be updated to list out the specific precautions rather than the type of precaution, and these will align with the new policies on precautions. The Treatment Team will be	*By AVP-Nursing & Operations (Angie Conklin)* *By 05/28/2022* *By Dir of Intake (Ian Callahan)* *By 05/28/2022* *By Dir of Quality (Shikha Gapsch)* *COMPLETED* *By Dir of Clinical Services (Rhiannon Service)* *By 05/28/2022*

	and / or sexual contact has occurred between patients". 4. Review of Patient #2 clinical records showed that on 02/07/21 at 2:45 AM Patient #2 allegedly had sexual contact with Patient #1. Review of Patient #2 "Nursing Note", dated 02/07/21 at 0528, showed that Staff N, Certified Nursing Assistant, documented "I was doing my rounds at 2:45 [AM] when [Patient #2] began running very fast back and fourth (sic) down the hall. I noticed [they were] not running and no longer in my sight so I went looking for patient and found the patient in the bed in room 33B with [Patient #1]. [Patient #1] sat up and looked very distraught and [they] had tears in [their] eyes [Patient #1] thanked me for coming. 5. Review of a Psychiatric Progress Note, dated 02/07/21 for Patient #2 showed that a medical provider met with Patient #2 for an assessment on 02/07/21 at 10:41 AM, and ordered the precaution of "CIWA", an alcohol withdrawal assessment tool. Review of the "Psychiatric Progress Note" showed that the provider documented "[Patient #2] … entered [Patient #1's] room and apparently touched [Patient #2] (who was sleeping at the time) inappropriately. [Patient #2] was moved to [a different] unit to separate these two patients…Diagnosed with bipolar	able to directly select the precautions there. The "Interdisciplinary Treatment Planning" policy to be updated to reflect this change. RNs and MHTs will be required to review all updated policies and patient handbook. They will be required to sign off on an attestation confirming review of the policy. This will be monitored and confirmed to ensure ≥95% compliance from staff by 06/11/2022. Social Workers will be required to review the updated Treatment Planning policy and required to sign off on an attestation confirming review of the policy. This will be monitored and confirmed to ensure ≥95% compliance from staff by 06/11/2022.	*By AVP-Nursing & Operations (Angie Conklin)* *By 06/01/2022* *By Dir of Clinical Services (Rhiannon Service)* *By 06/01/2022*

	disorder and in the context of inappropriate behavior with disorganization of thought, I will discontinue SSRI [selective serotonin reuptake inhibitors] therapy now and start Latuda." 6. Review of the facility's policy and procedure titled, "Routine and Special Precautions", dated 10/2020, showed that policy did not list precautions related sexually acting out behavior or sexual victimization. Review of the policy showed that it did not address how staff determined the precaution or observation level that a patient would be assigned to, during the treatment episode, from admission through discharge. 7. During an interview starting at 1:00 PM on 01/12/22, Staff D, Quality Manager, stated that they did not see any information in the facility policy and procedures regarding precautions for patients who have been identified to have sexual acting out behaviors. 8. During an interview on 10/15/21 at approximately 11:30 AM, staff I, Registered Nurse, stated that all patients on the unit are observed on the same high level of observation and did not recall a patient being on an observation status that was related to the risk of		

	sexual victimization or sexual acting out behaviors. 9. Review of Patient #2's "Nursing Note", dated 02/07/21 at 5:09 AM, showed that Staff O, RN, documented "[Patient #2] touched [Patient #1] in the private area after [Patient #1] crawled in bed with him. The patient touched the patient on [their] genitals and had to be redirected to the milieu, when I went to get staff to assist with watching [Patient #2, they] tried to climb in a female bed [Patient #2] was running as fast as [they] could. [Staff P, ARNP] was notified when I went to get additional staff. The patient was watched by staff and then [Patient #2] was moved to Egret. [Patient #2] had turned down PRN medications…This is a new behavior for [Patient #2] since [their] arrival on our unit." 10. Review of Patient #2's "Master Treatment Plan", dated 02/07/21, showed that Patient #2 was assigned to the "Special Precautions" of "Sexually Inappropriate Behavior". 11. Review of the facility's form titled, "Observation Form," showed that the form had a list of precautions that could be checked off for each patient. Precaution categories listed were "Suicide, Elopement, Ear Plugs in Use During Hours of Sleep, Visualize Equipment / Cord (CPAP, O2, etc.), Assault / Homicidal, Medically		

	Compromised, No Precautions" and "Fall". The categories of sexual victimization, sexual acting out, or sexually inappropriate behavior were not listed on the form. 12. Review of the observation records for Patient #2 from 01/06/21 to 01/10/21 showed that the precaution of assault, sexual aggression, or sexual acting out was not noted on the observation forms for Patient #2 at any time during their treatment at the facility. Review of Patient #2 observation records showed that the documents did not contain any notes about special observation precautions regarding sexual aggression or sexual acting out behaviors. 13. During observation on the Harbor Unit on 10/15/21 by Investigator #1, it was observed that a Mental Health Technician, Staff J, was sitting in a chair in the hallway. Staff J stated that there was a patient (Patient #4) that had some behaviors that they [the Charge Nurse] wanted to be sure to keep an eye on. Staff J stated that Patient #4 had had some inappropriate outburst and that Staff J was asked to keep an eye out to be sure that patient #4 was appropriate with Patient #5, specifically. Staff J stated that Patient #5 walked around with their hands in their pants, and staff from the previous night shift had noted that Patient #4 had noticed this behavior and was encouraging Patient #5 to		

	fondle themselves. Staff J stated that this information had been relayed from one shift to another during pass down, a meeting where information is passed from one shift team to the next. Staff J said they were verbally told this information by the Charge Nurse on the other shift and could not remember the name of that person. During this discussion, Staff F, Charge Nurse, joined in the conversation. Staff F stated that they were aware that Patient #4 was having issues with inappropriate behavior, but there was no order for extra precautions. 14. Upon conclusion of the facility observations and walk through on 07/15/21, at approximately 12:30 PM, this investigator met in a conference room with Staff A, Interim CEO; Staff C, Nursing Supervisor; and Staff D, Quality Manager. All of these staff reviewed the electronic health record for Patient #4 on their laptops and did not see any notes about inappropriate behavior with another patient in previous nursing notes or other patient record notes. Due to the impromptu nature of this record review, this investigator was reviewing the laptop of Staff D, along with Staff D, as this investigator did not have direct access to the electronic health record. 15. During an interview at approximately 1:00 PM on 10/15/21, investigator #1 asked		

	why there was no documentation regarding Patient #4 and #5's interactions during the night shift that prompted special observation by Staff J. Staff A, Interim CEO, stated that they did not think it was necessary for staff to document the concerns that they had regarding Patient #4 and Patient #5's interactions during the night shift of 10/14/21 to 10/15/21. Staff A stated, "No, I don't identify this as something that is to be charted. I would pass it on for continued monitoring [during pass down meetings], verbal intervention was provided [to Patient #4 and #5 by Staff J during the day shift on 10/15/21]."		
WAC 246-341-0410(4)(g)(iii)(c) Agency administration – Administrator key responsibilities. The administrator or their designee must ensure: (g) A written internal quality management plan, human resources plan or similarly special plan, as appropriate, is developed and maintained that: (iii) continuously improves the quality of care in all of the following: (c) In response to critical incidents and substantiated complaints. Reference: Previous WAC Administrative Code: 246-341-0410(3)(b) and 246-341-0410(3)(c)(iii)(A)	Based on interview, clinical record review, and facility policy and procedure review, the administrator failed to ensure that the facility continuously improved the quality of care in response to critical incidents. Failure to ensure that the facility continuously improved the quality of care in response to critical incidents result in poor patient care and patient harm. Findings included: 1. Review of the facility's policy titled, "Quality Assurance and Performance Improvement Plan (QAPI)", dated 03/2021, showed that the facility had a plan "to ensure the quality assurance and performance improvement (QAPI) activities of staff, medical staff and outside contractors result in continuous	The "Quality Assurance and Performance Improvement Plan (QAPI)" policy is being followed at this time. Incident Reports are reviewed daily by the Quality team and shared in the daily Leadership meeting. All events that meet the adverse reportable event definition are reported to DOH. Root Cause Analyses are conducted on all these events along with the development of action items to address the findings. Follow-up on action items are monitored in the monthly QAPI meetings. This follow-up has been completed	*By Dir of Quality (Shikha Gapsch)* *COMPLETED*

	improvement of patient health outcomes." Review of the policy showed that a root cause analysis review of a critical incident would be conducted and actions that resulted could include "changes to policies, process, and practice as well as reporting to regulatory entities such as Washington State Department of Health." 2. Review of the clinical records for Patient #1 and #2 showed that on 02/07/21, an incident occurred involving an alleged sexual assault of Patient #1 by Patient #2. 3. During an interview starting at 1:00 PM on 01/12/22, Staff D, Quality Manager, stated that they had reviewed the quality assurance documentation and did not see that a root cause analysis was documented for the incident that occurred on 02/07/21. Staff D stated that they were not employed at the facility at the time the incident occurred and did not have direct knowledge of the quality process that occurred for the incident on 02/07/21.		
WAC 246-341-0420(13)(a) 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	Based on interview, clinical record review, and facility policy and procedure review, the agency failed to develop, implement, and maintain policies and procedures that directed staff to report to the department within forty-eight hours a critical incident that occurred involving an individual, and actions taken as a result of the incident.	See above action items	

chapter including administrative and personnel policies and procedures. Administrative polices and procedures must demonstrate the following, if applicable: (13) Reporting critical incidents. A description of how the agency directs staff to report to the department within forty-eight hours any critical incident that occurs involving an individual, and actions taken as a result of the incident. A critical incident is a serious or undesirable outcome that occurs in the agency including: (a) Allegations of abuse, neglect, or exploitation.	Failure to implement policies and procedures that directed staff to report to the department within forty-eight hours a critical incident that occurred involving an individual, and actions taken as a result of the incident, can result in a lack of oversight of the facility and poor patient outcomes. Findings included: 1. Review of the facility's policy titled "Incident Event Reporting and Critical Event Management", dated 04/2021, showed that the policy does not direct staff to report to the department within fourty-eight hours any critical incident that occurs, including allegations of abuse, neglect, or exploitation. Review of the policy showed that "reporting of actual critical events to outside agencies will occur as defined and required by state and federal regulatory agencies…Reportable Event: Defined by DOH and involves events that affect the operation and maintenance of the hospital or facility and affect patient diagnosis, treatment, or care." 2. Review of Patient #1 and #2 clinical records showed that facility staff were aware on 02/07/21 that Patient #1 alleged that they had been sexually assaulted by Patient #2 at the facility on 02/07/21. Review of a nursing note, dated 02/07/21 at 3:30 AM, showed that the writer of the note, Staff M,		

	Registered Nurse, noted "I was informed that a patient was calling the police to report a sexual assault. When I finally received further information, I was told that [Patient 2] had gone into [Patient 1's] room and touched [Patient #1] inappropriately. Review of the nursing note showed that Staff M and Patient #1 discussed what a sexual assault exam would entail, and what an interview with a police detective would entail. 3. Review of clinical records for Patient #1 and #2 and other facility internal investigation documents showed that the facility did not document that the incident that occurred on 02/07/21 met the requirement to be reported to DOH. 4. During an interview on 10/07/21, Staff L, Interim Quality Director as of 10/07/21, stated that they had looked for documentation that the incident involving Patient #1 on 02/07/21 had been reported to the Department of Health (DOH) within the required timeframe of 48 hours. They did not find documentation that the incident had been reported to DOH during that timeframe. Staff L stated that the previous Quality Director may have put the records in a place that was not known to the current staff, and that may be the reason the documentation could not be located.		

	5. Review of the DOH database that contains information about facility reports of incidents showed that a report, dated 07/19/21, was submitted by the facility for the incident involving Patient #1 and Patient #2 on 02/07/21, over 5 months after the incident occurred, and this self-report by the facility referenced a media report of a lawsuit being filed as a consequence of the assault of Patient #1. 6. Review of Patient #6 "Nursing Note", dated 03/11/21, showed that an RN documented that Patient #6 "reported an alleged sexual abuse by another patient stating, "They sexually assaulted me last night…'. MD updated; information reported to Police; police came to [facility] for further interview with patient [Patient #6]…[Patient #6] was then sent to ER at [another hospital] for further assessment. Rn called the hospital and gave pt's [Patient #6's] report to nurse [Individual #3, ER Nurse]." 7. Review of clinical records for Patient #6 and #7 and other facility internal investigation documents showed that the facility did not document that Patients allegations of physical or sexual assault that occurred on 03/11/21 were assessed to determine if they met the requirement to be reported to DOH.		

	8. Review of the DOH database that contains information about facility reports of incidents showed that the database did not contain a report submitted from the facility regarding an alleged sexual assault involving Patient #6 or #7 that occurred on 03/11/21. 9. During an interview starting at 3:30 on 01/20/22, Staff D, Quality Manager, stated that they had reviewed the information regarding the alleged incident involving Patient #6 and #7, and did not see any documentation that DOH was notified of the alleged incident, and stated that it may be because video review determined that there was no contact between the two patients.		
WAC 246-341-0600(2)(e) 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	Based on clinical record review, interview, and facility policy and procedure review, the facility failed to protect patients' rights to be free of sexual harassment for 1 of 7 patients (Patient #1). Failure to protect patients' rights to be free of harassment can result in patient harm and trauma and discourage patients from seeking further needed services. Findings included: 1. Review of the facility's policy titled "Patient Rights", dated 03/2021, showed that patients would be provided with a "Patient rights and Responsibilities	See above action items	

participant rights that incorporates at a minimum the following statements. "You have the right to:"(e) Be free of any sexual harassment. Reference: Previous WAC Administrative Code: 246-341-0600(1)(e)	brochure… This occurs on an annual basis, usually at the time of registration… or more frequently as desired by patient and families." Review of the policy showed that patient rights would be included in the patient handbook, and "patients will sign that they have received this information." Review of the patient handbook showed that it included a list of patient rights, including the right to be free of any sexual harassment. 2. Review of Patient #2's "Nursing Note", dated 02/07/21 at 5:28 AM, showed that Staff N, Certified Nursing Assistant, documented "I was doing my rounds at 2:45 when [Patient #2] began running very fast back and fourth [sic] down the hall. I noticed [they were] not running and no longer in my sight so I went looking for patient and found the patient in the bed in room 33B with [Patient #1]. [Patient #1] sat up and looked very distraught and [they] had tears in [their] eyes [Patient #1] thanked me for coming…" 3. Review of a nursing note, dated 02/07/21 at 3:30 AM, showed that the writer of the note, Staff M, Registered Nurse, noted "I was informed that a patient was calling the police to report a sexual assault. When I finally received further information, I was told that [Patient 2] had gone into [Patient 1's]		

	room and touched [Patient #1] inappropriately. Review of the nursing note showed that Staff M and Patient #1 discussed what a sexual assault exam would entail, and what an interview with a police detective would entail. 4. Review of Patient #1's Psychiatric Progress Note, dated 02/07/21, showed that the provider noted that Patient #1 was "scared and unclear / confused about what happened to [them]…" 5. During an interview at approximately 12:50 PM on 10/15/21, Staff K, Milieu Manager, stated that when one mental health technician is doing rounding (observing the location of each patient and the activity each patient is involved in), there is no other staff that are told to be monitoring the hallway where the patient rooms are located. Staff K stated that when one mental health technician is doing rounding, the other technician could be doing laundry, getting a drink for a patient, or other tasks. Staff K stated that if an MHT was in a patient room to perform rounding functions, then it would be possible for another patient to see that no staff were watching the hallway and go into another patients' room. During this interview, Staff A, Interim CEO, stated that having more than one Mental Health Technician on duty was based on census, and that there could be one mental health technician on duty if the census was low enough.		

	6. Review of a document titled, "Staffing Matrix", undated, showed that unit staffing during the day included 1 residential nurse on duty for 1-12 patients, and 2 RN's on duty for 12-24 patients per unit. During the day staffing would include 1 Mental Health Technician (MHT) for 8 patients, 2 MHT's for 8-16 patients, and 3 MHTs for 17-24 patients.		
WAC 246-341-1050(1)(e) General requirements for mental health and substance use disorder inpatient and residential services: (1) An agency providing substance use disorder services under WAC 246-341-1100 through 246-341-1114 or mental health services under WAC 246-341-1118 through 246-341-1158: (e) Must determine the individual's risk of harm to self, others, or property. Reference: Previous WAC Administrative Code: 246-341-0610(2)(i)	Based on facility policy and procedure review, and record review, facility staff failed to determine individual patient's risk of harm to others for 1 of 7 patients (Patient #7). Failure to determine the individual patient's risk of harm to others can result in poor patient care and patient harm. Findings included: 1. Review of the facility's policy and procedure titled "Routine and Special Precautions", dated 10/2020, showed that it did not address how staff determined the precaution or observation level that a patient would be assigned to, including the risk of assault or danger to others. 2. Review of Patient #7's clinical document titled, "Initial Psychiatric Evaluation", dated 03/10/21 at 9:19 AM, showed that Patient #7's "Chief Complaint" was documented as "my	See above items	

	family got scared of me". Review of the evaluation showed that Patient #7 was admitted to the facility involuntarily and had symptoms of psychiatric illness that included issues with self-care, delusions, internal preoccupation, and non-compliance with prescribed medications. Review of the evaluation showed that the provider documented that review of treatment documents from an emergency room visit showed that Patient #7's sister "verbalized concerns with current regimen…". Review of the Initial Psychiatric Evaluation showed that the "HI [Homicidal Ideation]" section was documented as "no" and "Violence History" was noted as "none reported or elicited" and "Risk Factors" were "Reports family are scared of [Patient #7] but specifics are unknown". The "Risk mitigation for SI / HI" is documented as "Patient's risk in the context of a controlled environment and inpatient milieu appears very low and the following level of observation and risk mitigation has been assessed as appropriate 15 minute checks and elopement." 3. Review of Patient #7's document titled, "ITA Coordination Note", dated 03/10/2112:52 PM showed that a facility social worker noted "Patient was brought into [emergency room] by [their] sister for altered mental status.		

	Per the DCR [Designated Crisis Responder] report, patient [Patient #7] was presenting with increased mental health symptoms to include delusional beliefs, aggressive behavior, responding to internal stimuli and having made verbal threats to the ER [emergency room] staff while not willing to entertain voluntary or less restrictive settings. Patient has a historical diagnosis of schizophrenia. Patient [Patent #7] is reported to have missed taking [their] psychiatric medications the past three days…[sister] attempted to engage with [Patient #7] and [Patient #7] at this point became agitated and threatened to "kick out [sister's] knees." 4. Patient #7's observation forms were requested by this investigator for the dates of 03/10/21 to 03/12/21. Review of the 5 observation forms received by this investigator showed that Patient #7's location and behavior were documented by staff every 15 minutes. Review of the 5 observation forms showed that the forms had a box to check for assault precautions, and the box was unchecked on all the forms. Review of an undated observation form showed Patient #7 was assigned the level of observation of "routing Q15 minute checks" and was assigned "suicide" precaution level from 1930 hours to 0729 (7:30 PM to 7:29 AM), the form is undated at the top date field.		

	The form is signed by an RN at the bottom on 03/11/21 at 1:15 AM. No other completed observation forms showed that Patient #7 was assigned to special precautions. The level of observation is blank on another undated observation form, the form showed that patient location and behavior was documented every 15 minutes. The form is signed at the bottom by a nurse with the date of 03/10/21 at 1030 (10:30 PM). 5. Review of Patient #7's nursing note, dated 03/11/21 at 1251 (12:51 PM), showed "[Patient #7] continued to present with agitation despite PRN [as needed] medications. MD was notified / updated; [Patient #7] was therefore administered with PRN medications per MD order, with effective management." 6. Review of Patient #7's "Psychiatric Progress Note", dated 03/11/21 at 2:49 PM, showed that Patient #7 "was holding a toothbrush and making gestures of stabbing...tried to break the toothbrush…" Review of the progress note showed that "Safety Issues / Precautions" were listed as "hypersexual, DTO [Danger to Others]" with the recommendation to "use PRN". 7. Review of Patient #7's "Treatment Plan", dated 03/12/21, showed that Patient #7 was on routine safety		

	observations every 15 minutes for "interventions for Suicide Risk" and there were no other precautions listed on the treatment plan. Danger to others was not addressed in the treatment plan. 8. Review of Patient #7's "Psychiatric Progress Note", dated 03/12/21 at 2:53 PM showed that a medical provider documented in the "agitation" section: "Yesterday, posturing at staff – hit another patient." 9. Review of the Department of Health Database that tracks the receipt of incident and complaint reports showed that a Social Worker from the emergency department at a hospital notified the Department of Social and Health Services (DSHS) of an alleged assault of Patient #6, and DSHS notified DOH on 03/12/21. Review of the report from DSHS showed "Per reporter, AV [Alleged Victim, Patient #6] entered [emergency room] from [psychiatric hospital] for an alleged sexual assault, and was sent for a SANE evaluation. Upon arrival, AV stated [they were] 'physically assaulted by a staff at [psychiatric hospital].' AVB is a 90 day detain there [involuntarily commitment to facility for 90 days]. AV denied being sexually assaulted and stated, AP [alleged perpetrator, Patient #7] 'hit me in my back, [they] did not sexually		

	assault me.' Per the MD [Medical Doctor] note AV only reported physical and 'verbal assault from a man [they] knew previously, who was now a patient at [the psychiatric hospital].' AV stated AP is an 86 year old [person], and [they] have been attempting to avoid AP at [psychiatric hospital]. AP reportedly 'came up behind' AV while [they were] watching TV two nights ago and hit AV on the right side of [their] upper back, stating AV 'had been acting like [they] didn't know' AP. CT [computerized tomography] was done, which shows 'there are acute to subacute fractures of the lateral right 3rd-7th ribs'. AV was then transported back due to detainment."		
WA 246-341-1118((2)(c) Mental health inpatient services – General. An agency providing mental health inpatient services must develop and implement an individualized annual training plan for agency staff member, to include at least: (c) De-escalation training and management of assaultive and self destructive behaviors, including proper and safe use of seclusion and restraint procedures. Reference: Previous WAC Administrative Code: 246-341-1118(3)(c)	Based on policy and procedure review and personnel record review, the agency failed to implement an individualized annual training plan that included de-escalation training for 2 of 4 personnel records reviewed (Staff I and Staff N). Failure to implement an individualized annual training plan that included de-escalation training can result in a lack of ability to deescalate patient behaviors, which can lead to staff or patient harm and poor patient care. Findings Included: 1. Review of the facility's policy and procedure titled, "Annual Training	Human Resources (HR) is removing staff members from the schedule if they do not complete their mandatory assigned trainings (CPR, MOAB, Food Handlers) by the deadline, including annual trainings. Staff who are outstanding on their annual de-escalation training have a deadline to complete it by March 31st, 2022 and will be pulled from the schedule at that time. Reports will be run monthly to ensure staff members are up-to-date on trainings	*By Sr HR Generalist (Lalonda Hansen)* *By 04/01/2022*

	Requirements", dated 10/2019, showed that the purpose of this policy was to "meet state, federal, Joint Commission and Center for Disease Control recommendations." Review of the policy showed that the human resources staff assigns and monitors completion of annual training requirements. The annual trainings that are required by clinical staff include topics such as least restrictive alternatives available in the community and how to access them, abuse and neglect, de-escalation training, and infection prevention. 2. Review of training records on 01/14/21 for Staff I, RN, showed that they were hired on 10/19/20 and were currently employed at the facility. Staff I had completed a de-escalation training at the time of hire and had not completed an annual refresher training on de-escalation. 3. Review of training records on 01/14/21 for Staff N, CNA, showed that they were hired on 09/21/20 and left employment on 11/09/21. Staff N had completed a de-escalation training at the time of hire and had not completed an annual refresher training on de-escalation.		

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.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

May 31, 2022

Wellfound
3402 19th Street
Tacoma, WA 98405-2487

Re: Case Number: 2021-8539
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.

During review of facility documents submitted to DOH during the Plan of Correction review process, the facility submitted a training document titled “Sexually Safety & Violence Risk Assessment Training”, dated 04/28/22. Review of this document showed that the term “non-consensual sexual aggression” was used. Review of this document and other facility documents submitted to DOH showed that there was no description of how the facility determines patient consent. Your facility treats a diverse patient population, including people on involuntary treatment holds, people with developmental disabilities, and people experiencing acute mental health crises, all of which can affect their ability to consent to sexual activity. It is the responsibility of the facility to ensure staff have the training, tools, and direction to determine consent and capacity to consent. This would include procedures directing staff to consistently respond to events that involve alleged sexual activity in a manner that accurately identify where such activities are assaultive in nature, and meet the legal requirements to report assaults, as well as preserve patient rights and ensure care at your facility is provided in a safe and secure environment.

Review of the facility Policy and Procedure “Constant Observer”, dated 05/2022, showed that the facility has made changes to this procedure as part of the POC. Additional changes may be necessary to meet WAC requirements. This issue will be addressed as part of the revisit process, when the procedure outcome can be fully assessed by reviewing current patient records and other documents, and through conducting interviews.

DOH will conduct a revisit of the facility to review implementation of the POC and facility compliance with other related WAC and RCW.

Investigator: JAMC3
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874