

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013134</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/02/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SMOKEY POINT BEHAVIORAL HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3955 156TH ST NE</b> <b>MARYSVILLE, WA 98271</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 000	<p>INITIAL COMMENTS</p> <p>STATE STATE COMPLAINT INVESTIGATION</p> <p>The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 PRIVATE PSYCHIATRIC AND ALCOHOLISM HOSPITALS conducted this complaint investigation.</p> <p>Onsite dates: 02/02/18 Examination number: 2018 - 144 Intake number: 78510</p> <p>The survey was conducted by: Rosie Tillotson, RN, MSN</p> <p>There were no violations found pertinent to this complaint.</p>	L 000		

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