Statement of Deficiency Report

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

Wellfound Behavioral Health Agency Name and Address		Angela Naylor Administrator
Investigation Inspection Type	Tuesday, November 23, 2021 Investigation Start Date	#33894 Investigator Number
2021-13713 Case Number	BHA.FS.60925415 License Number	Adult E&T 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
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 the rules in this chapter and other applicable state and federal statutes and regulations;	Based on interview, policy and procedure review, and clinical record review, the facility failed to ensure that personnel and clinical policies and procedures that addressed staff suicide risk assessment training and assessing patient suicide risk levels were adhered to. Failure to ensure that personnel and clinical policies and procedures that address staff suicide risk assessment training and assessing patient suicide risk levels are adhered to can result in inconsistent and poor patient care and poor patient outcomes, including death.	

	Item #1 – Not Adhering to Policy Addressing Training Findings included: 1. Review of the facility's policy titled, "Suicide Assessment and Intervention," Policy #8676227 revised 10/2020, showed the following: a. The purpose of the policy and procedure is for identifying patient suicidal ideation (SI) and behaviors, determining levels of risk, and making clinical decisions about safety precautions and clinical care. b. Patients are assessed at pre-admission, admission, and at regular intervals throughout their stay using the Columbia-Suicide Severity Rating Scale (C-SSRS) to classify and determine risk levels. c. All staff assessing suicide risk using the C-SSRS tool are trained and determined to be competent annually. 2. Review of the facility's policy titled, "Annual Training Requirements," Policy #7804235 dated 10/2019, showed that annual training is done through a combination of classroom and online training. The requirements listed did not include suicide risk assessment training. 3. Review of the facility's policy titled, "New Employee Orientation & Staff Training," Policy #9078865 dated 04/2021, showed that the goal of orientation is to address and instruct new staff	

	regarding program-specific policies and procedures, benefits, competency testing, as well as individual responsibilities and relationships to other staff. The review showed that orientation may include suicide risk/prevention training. 4. Interviews with facility staff members showed that staff at the facility did not receive suicide risk assessment training and competencies for 3 of 3 staff reviewed (Staff M, O and Q) based on the following: a. During an interview on 12/16/21 at 9:45 AM, Staff M, Registered Nurse (RN), when asked what suicide risk assessment training or competencies they had received as a staff member at the facility, Staff M stated, “None recently. Probably in the beginning yes, but not recently.” b. During an interview on 12/16/21 at 11:30 AM, Staff O, Social Worker, when asked what suicide risk assessment training or competencies they had received as a staff member at the facility, Staff O stated that their training was from other social workers and only on how to fill out the forms. Staff O stated that they were unclear about how to answer the assessment questions for patients who are not suicidal. Staff O stated that their electronic record system automatically generates scores for SAFE-T risk assessments, and they feel that “the number is so arbitrary that it’s taken on no meaning to [them].” c. During an interview on 12/16/21 at 3:30 PM, Staff Q, Director of Clinical Services, when asked about suicide assessment training and competencies, stated	

	that they had not been trained, that there is no official training, but that there may be a PowerPoint that can be reviewed. d. During an interview on 12/16/21 at 3:15 PM, Staff P, Clinical Educator, stated that suicide risk assessment training and competencies are not part of the onboarding system. 5. Review of personnel records showed that staff at the facility did not receive suicide risk assessment training and competencies for 3 of 3 staff reviewed (Staff M, N and O) based on the following: a. Review of the personnel record for Staff M, RN, showed that they received annual training in January 2019 and December 2021, but did not show that they received suicide risk assessment training or competencies as part of the annual training. Staff M's training transcript titled, "Relias," showed a class on 02/05/19 titled, "Suicide Risk Assessment Using C-SSRS." However, the document showed "0.0" hours and a final exam score of "N/A". Review of Staff M's document titled, "[Facility] Position Specific Orientation Checklist, Inpatient Department, RN," dated 09/2019, showed that on 10/04/19 Staff M was checked off for reviewing policies on suicide assessment, prevention, and mitigation, and for verbally reviewing the skills. However, the document did not indicate any training was provided. b. Review of the personnel record for Staff N, Physician's Assistant Certified (PA-C), showed that they were oriented on 10/07/19, but does not show that suicide	

	risk assessment training or competencies were included in the orientation. c. Review of the personnel record for Staff O, Social Worker, showed that they received orientation on 01/27/21. Review of Staff O's "[Facility] Position Specific Orientation Checklist, Social Work," dated 08/2019, showed that on 01/27/21 Staff O was checked off for the following: reviewing policies on suicide assessment and reassessment; understanding the C-SSRS; administering SAFE-T; documenting clinical formulation of risk; assessing for access to lethal means; and for verbally reviewing the skills and being observed performing the skills. However, the document did not indicate any training was provided. Item #2 – Not Adhering to Policy Addressing Suicide Risk Levels 1. Review of facility policies and procedures showed criteria for determining suicide risk levels based on the following: a. Review of facility policy titled, "Suicide Assessment and Intervention," Policy #8676227 revised 10/2020, showed the following: (1) The purpose of the policy and procedure is for identifying patient suicidal ideation and behaviors, determining levels of risk, and making clinical decisions about safety precautions and clinical care. (2) All patients are assessed at pre-admission, admission, and at regular intervals throughout their	

	stay using the Columbia-Suicide Severity Rating Scale (C-SSRS) to classify and determine risk levels. The risk levels included: (i) Level 1, very low risk of harming self, is when the patient responds no to suicide behavior question #6 within the past 90 days and yes or no to suicide ideation questions #1 and #2 within the past 30 days or with an ideation intensity score of 8 or less. (ii) Level 2, low to moderate risk of harming self, is when the patient responds yes to question #3 for active suicidal ideation without plan within the past 30 days and no for active suicidal ideation/behavior questions #4, #5 and #6 within the past 30 days. (iii) Level 3, heightened risk of harming self, is when the patient responds yes for active suicidal ideation with intent questions #4 or #5 within the past 30 days or yes for suicide behaviors question #6 in the past 90 days. (iv) Level 4, imminent risk of harming self, is when the patient meets the description of Level 3 plus any of the following: has attempted suicide in the past week by a particularly lethal method (e.g., hanging, guns, self-mutilation, carbon monoxide), has had any suicide behaviors in question #6 during the hospitalization, currently exhibits gestures of self-harm behaviors, verbalizes clear intent of self-harm with viable means available, is unwilling or unable to follow safety plan, currently experiencing command hallucinations or delusions to self-harm with intent to	

	follow through, or exhibits other imminent risk factors identified by the care team and provider. b. Review of the facility's document titled, "Attachment A: Clinical Guidelines Using the Columbia-Suicide Severity Risk Screening," no date, showed the following suicide risk levels based on the assessment: (1) Level 1, very low risk of harming self, is when patients respond yes to questions #1 and #2, suicide ideation, and score 8 or less for intensity of ideation, within the past 30 days. (2) Level 2, low to moderate risk of harming self, is when the patient responds yes to question #3 for active suicidal ideation without plan, and no to questions #4, #5 and #6 for active suicidal ideation/behavior within the past 30 days. (3) Level 3, heightened risk of harming self, is when the patient responds yes to questions #4 or #5 for active suicidal ideation with intent within the past 30 days, or yes to question #6, suicide behaviors in the past 90 days. (4) Level 4, imminent risk of harming self, is when the patient meets the description of Level 3 plus any of the following: attempted suicide in the past week by a particularly lethal method, had any suicide behaviors in question #6 during the hospitalization, currently exhibits gestures of self-harm behaviors, verbalized clear intent of self-harm with viable means available, unwilling or unable to follow safety plan,	

	currently experiencing command hallucinations or delusions to self-harm with intent to follow through, or exhibits other imminent risk factors identified by the care team and provider. c. Review of the facility's document titled, "Attachment B: Safe-T," no date, showed the following: (1) SAFE-T stands for Suicide Assessment Five-step Evaluation and Triage. The five steps included: (i) Identifying risk factors. (ii) Identifying protective factors. (iii) Conducting suicide inquiry. (iv) Determining risk level and intervention. (v) Documentation. (2) Low risk level included modifiable risk factors, strong protective factors, and thoughts of death with no plan, intent or behavior. (3) Moderate risk level included multiple risk factors, few protective factors, and suicidal ideation with plan but no intent or behavior. (4) High risk level included psychiatric disorders with severe symptoms or acute precipitating event, protective factors not relevant, and potentially lethal	

	suicide attempt or persistent ideation with strong intent or suicide rehearsal. 2. Review of patient clinical records showed that staff failed to use criteria for determining suicide risk levels based on suicide risk assessments per facility policies and procedures for 3 of 7 patients reviewed (Patient #1, #3 and #5) based on the following: a. Review of Patient #1's clinical record showed that the patient was 19 years old and admitted voluntarily to the facility for suicidal ideation twice within one month, on 08/31/21 for 3 days, and on 09/29/21 for 2 days. The review showed that the patient requested discharge on 10/01/21, was discharged Against Medical Advice (AMA), and died by suicide the same day after discharging to home. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Review of Patient #1's "Initial Psychiatric Evaluation," dated 09/30/21, signed by Staff N, PA-C, showed that the patient's chief complaint was "I am depressed, I feel worthless…I wanted to kill myself. I was going to drown myself or take pills." The evaluation showed that the patient admitted voluntarily due to suicidal ideation/gestures which had been worsening for 18 months and stated that the patient started "researching ways and making plans six months ago." (2) Review of Patient #1's "Psychiatric Discharge Summary," dated 09/03/21 by Staff AA, Medical Doctor	

	(MD), showed that the patient's reason for admission was "a suicide attempt." (3) Review of Patient #1's "Admission Assessment," dated 08/31/21, showed that at 12:18 PM, Staff S, RN, conducted a C-SSRS suicide risk assessment resulting in criteria that placed the patient at suicide risk level 3, heightened risk of harming self, based on the patient's response of "yes" to questions #1-#6. The patient's intensity of ideation for the past month was rated level 5 "most severe" with a score of 22 due to reasons that included greater than 8 hours daily of persistent suicidal thoughts that they were unable to control. The assessment showed that the patient was placed at suicide risk level 1, "Very Low Risk of Harming Self." (4) Review of Patient #1's "Admission Assessment," dated 09/29/21, showed that on their second visit to the facility at 4:48 PM, Staff S, RN, conducted a C-SSRS suicide risk assessment resulting in criteria that placed the patient at suicide risk level 3, heightened risk of harming self, based on the patient's response of "yes" to questions #1-#6. The assessment did not contain a suicide risk level placement. (5) Review of Patient #1's "Initial Psychiatric Evaluation," dated 09/30/21 at 6:42 AM by Staff N, PA-C, showed that the patient answered "yes" to questions #1-#6 on the C-SSRS suicide risk assessment, placing the patient at suicide risk level 3, heightened risk of harming self. The assessment showed that the patient was placed at suicide risk level 2, "Low to Moderate."	

	b. Review of the clinical records for Patient #3 showed that the patient was 29 years-old and admitted voluntarily on 11/15/21 for "seeing things, confused, and paranoia" with a history of schizophrenia and substance use disorder (SUD), and discharged AMA on 11/24/21. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Patient #3's clinical record review showed that throughout the patient's stay they denied suicidal ideation. (2) Review of Patient #3's documents titled, "Flowsheets" dated 11/17/21 – 11/24/21, showed that the patient consistently answered "no" to questions #1, #2 and #6 on the C-SSRS assessments placing them at suicide risk level of 1, very low risk of harming self. The flowsheets showed that the patient's "Suicide Risk Level" was consistently documented as "Very Low Risk of Harming Self." However, the "Risk Stratification and Triage" section on the flowsheets consistently documented the patient to be suicide risk level 2, "Moderate Suicide Risk." (3) Review of Patient #3's documents titled, "Master Treatment Plan Update," dated 11/17/21 and 11/23/21, showed the box for "Suicide Risk: Level 2 Low to Moderate Risk" was checked.	

	c. Review of the clinical records for Patient #5 showed that the patient was 34 years-old and admitted voluntarily on 10/30/21 for suicidal ideation and depression and discharged AMA on 11/05/21. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Patient #5's clinical record review showed that throughout the patient's stay they denied suicidal ideation. (2) Review of Patient #3's documents titled, "Flowsheets" dated 10/31/21 at 8:15 PM – 11/05/21, showed that the patient consistently answered "no" to questions #1, #2 and #6 on the C-SSRS assessments placing them at suicide risk level of 1, very low risk of harming self. The flowsheets showed that the patient's "Suicide Risk Level" was consistently documented as "Very Low Risk of Harming Self." (3) Review of Patient #5's document titled, "Master Treatment Plan Update," dated 11/01/21, showed the box for "Suicide Risk: Level 2 Low to Moderate Risk" was checked.	
WAC 246-341-0640(1)(f) Clinical record content. Each agency is responsible for the components and documentation in an individual's clinical record content unless specified otherwise in specific service certification requirements. (1) The clinical record must include: (f) Progress and group notes including the date, time, duration, participant's name, response to interventions or clinically significant behaviors during the group	Based on interview and clinical record review, the facility failed to ensure that clinical records included progress notes for all individual sessions for 1 of 7 patients reviewed (Patient #1). Failure to ensure that clinical records include progress notes for all individual sessions can result in undocumented treatment which can result in poor patient care and outcomes.	

session, and a brief summary of the individual or group session and the name and credential of the staff member who provided it.	Findings included: 1. During an interview on 12/16/21 at 11:30 AM, Staff O, Social Worker, stated that they conducted an intervention with Patient #1 that was over one hour on 09/30/21 that was not documented. When asked why they didn't go back and do a late entry, Staff O stated because they were "slammed", and they weren't sure how to do it in the electronic medical record. 2. Review of the clinical record for Patient #1 showed that the record did not contain a progress note for the one-hour intervention by Staff O on 09/30/21.	

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.

Wellfound Behavioral Health Hospital (WBHH)
Plan of Correction
(Case #2021-13713)

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Monitoring procedure; Target for Compliance
246-341-0410(4)(a)	1-All staff assessing suicide risk (Providers, RNs, Social Workers) will complete the Columbia Lighthouse Project online training during New Employee Orientation (NEO) and annually. This training addresses identifying suicide risk and utilizing the Columbia Protocol. 2-Staff (RNs, Providers, Social Workers, Care Coordinators) will complete a training along with knowledge assessment on the changes to the "Suicide Assessment and Intervention Policy."	1 & 2-Senior Human Resources (HR) Generalist Lalonda Hansen and Dir. Of Quality Shikha Gapsch	1 & 2-Completed by 02/11/22	1 & 2-Greater than or equal to 95% of required staff complete training by 02/11/2022. HR will run reports on completion of NEO trainings and annual trainings as trainings are due. Individual supervisors to follow-up to ensure timely completion.
	3-Staff (RNs, Providers, Social Workers) will complete an in-person training with Clinical Leadership to review the policy and the interdisciplinary work and documentation that needs to occur for suicide risk assessments. This training will also be available to new staff in NEO.	3-CMO Dr. Neal, Dir. Clinical Services Rhiannon Service, Dir. Of Nursing Pam Barrington/CEO and CNO Angie Naylor, Dir. Quality Shikha Gapsch	3-Completed by 03/18/22	3-Greater than or equal to 95% of required staff complete training by 03/18/2022. HR will run reports on completion of training. Individual supervisors to follow-up to ensure timely completion.
WAC 246-341-0640(1)(f)	1-Staff (Social Workers) to receive written communication regarding documentation expectations for individual sessions and care provided to patients. Staff (Social Workers) to receive in-person training regarding documentation requirements, processes to complete documentation in the electronic health record, and timelines to complete documentation.	1-Dir. Clinical Services Rhiannon Service	1-02/18/22	1-Weekly Tracer to be completed on 10 Charts that involves reviewing Social Work Progress Notes. Compliance target is equal to or greater than 95% for 8 consecutive weeks.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

Thursday, January 27, 2022

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

Dear Ms. Naylor:

This letter contains information regarding the recent investigation at Wellfound Behavioral Health by the Washington State Department of Health. Your state licensing investigation was completed on Friday, January 7, 2022.

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.

You may receive notice of the Department's intent to take enforcement action against your license under RCW 71.24.037 and WAC 246-341-0335 based on any deficiency listed on the enclosed report. Your submission of a Plan of Correction or any other action you take in response to this Statement of Deficiency Report may be taken into consideration in an enforcement action but does not prevent the Department from proceeding with enforcement action.

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

Investigator: *#33894*
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 Agency Name and Address		Angela Naylor Administrator
Investigation Inspection Type	Tuesday, November 23, 2021 Investigation Start Date	#33894 Investigator Number
2021-13713 Case Number	BHA.FS.60925415 License Number	Adult E&T BHA/RTF Agency Services Type

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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 the rules in this chapter and other applicable state and federal statutes and regulations;	Based on interview, policy and procedure review, and clinical record review, the facility failed to ensure that personnel and clinical policies and procedures that addressed staff suicide risk assessment training and assessing patient suicide risk levels were adhered to. Failure to ensure that personnel and clinical policies and procedures that address staff suicide risk assessment training and assessing patient suicide risk levels are adhered to can result in inconsistent and poor patient care and poor patient outcomes, including death.	

Angie Naur 2/9/2022

	Item #1 – Not Adhering to Policy Addressing Training Findings included: 1. Review of the facility's policy titled, "Suicide Assessment and Intervention," Policy #8676227 revised 10/2020, showed the following: a. The purpose of the policy and procedure is for identifying patient suicidal ideation (SI) and behaviors, determining levels of risk, and making clinical decisions about safety precautions and clinical care. b. Patients are assessed at pre-admission, admission, and at regular intervals throughout their stay using the Columbia-Suicide Severity Rating Scale (C-SSRS) to classify and determine risk levels. c. All staff assessing suicide risk using the C-SSRS tool are trained and determined to be competent annually. 2. Review of the facility's policy titled, "Annual Training Requirements," Policy #7804235 dated 10/2019, showed that annual training is done through a combination of classroom and online training. The requirements listed did not include suicide risk assessment training. 3. Review of the facility's policy titled, "New Employee Orientation & Staff Training," Policy	

	#9078865 dated 04/2021, showed that the goal of orientation is to address and instruct new staff regarding program-specific policies and procedures, benefits, competency testing, as well as individual responsibilities and relationships to other staff. The review showed that orientation may include suicide risk/prevention training. 4. Interviews with facility staff members showed that staff at the facility did not receive suicide risk assessment training and competencies for 3 of 3 staff reviewed (Staff M, O and Q) based on the following: a. During an interview on 12/16/21 at 9:45 AM, Staff M, Registered Nurse (RN), when asked what suicide risk assessment training or competencies they had received as a staff member at the facility, Staff M stated, "None recently. Probably in the beginning yes, but not recently." b. During an interview on 12/16/21 at 11:30 AM, Staff O, Social Worker, when asked what suicide risk assessment training or competencies they had received as a staff member at the facility, Staff O stated that their training was from other social workers and only on how to fill out the forms. Staff O stated that they were unclear about how to answer the assessment questions for patients who are not suicidal. Staff O stated that their electronic record system automatically generates scores for SAFE-T risk assessments, and they feel that "the number is so arbitrary that it's taken on no meaning to [them]."	

	c. During an interview on 12/16/21 at 3:30 PM, Staff Q, Director of Clinical Services, when asked about suicide assessment training and competencies, stated that they had not been trained, that there is no official training, but that there may be a PowerPoint that can be reviewed. d. During an interview on 12/16/21 at 3:15 PM, Staff P, Clinical Educator, stated that suicide risk assessment training and competencies are not part of the onboarding system. 5. Review of personnel records showed that staff at the facility did not receive suicide risk assessment training and competencies for 3 of 3 staff reviewed (Staff M, N and O) based on the following: a. Review of the personnel record for Staff M, RN, showed that they received annual training in January 2019 and December 2021, but did not show that they received suicide risk assessment training or competencies as part of the annual training. Staff M's training transcript titled, "Relias," showed a class on 02/05/19 titled, "Suicide Risk Assessment Using C-SSRS." However, the document showed "0.0" hours and a final exam score of "N/A". Review of Staff M's document titled, "[Facility] Position Specific Orientation Checklist, Inpatient Department, RN," dated 09/2019, showed that on 10/04/19 Staff M was checked off for reviewing policies on suicide assessment, prevention, and mitigation, and for verbally reviewing the skills. However, the document did not indicate any training was provided.	

	b. Review of the personnel record for Staff N, Physician's Assistant Certified (PA-C), showed that they were oriented on 10/07/19, but does not show that suicide risk assessment training or competencies were included in the orientation. c. Review of the personnel record for Staff O, Social Worker, showed that they received orientation on 01/27/21. Review of Staff O's "[Facility] Position Specific Orientation Checklist, Social Work," dated 08/2019, showed that on 01/27/21 Staff O was checked off for the following: reviewing policies on suicide assessment and reassessment; understanding the C-SSRS; administering SAFE-T; documenting clinical formulation of risk; assessing for access to lethal means; and for verbally reviewing the skills and being observed performing the skills. However, the document did not indicate any training was provided. Item #2 – Not Adhering to Policy Addressing Suicide Risk Levels 1. Review of facility policies and procedures showed criteria for determining suicide risk levels based on the following: a. Review of facility policy titled, "Suicide Assessment and Intervention," Policy #8676227 revised 10/2020, showed the following: (1) The purpose of the policy and procedure is for identifying patient suicidal ideation and behaviors,	

	determining levels of risk, and making clinical decisions about safety precautions and clinical care. (2) All patients are assessed at pre-admission, admission, and at regular intervals throughout their stay using the Columbia-Suicide Severity Rating Scale (C-SSRS) to classify and determine risk levels. The risk levels included: (i) Level 1, very low risk of harming self, is when the patient responds no to suicide behavior question #6 within the past 90 days and yes or no to suicide ideation questions #1 and #2 within the past 30 days or with an ideation intensity score of 8 or less. (ii) Level 2, low to moderate risk of harming self, is when the patient responds yes to question #3 for active suicidal ideation without plan within the past 30 days and no for active suicidal ideation/behavior questions #4, #5 and #6 within the past 30 days. (iii) Level 3, heightened risk of harming self, is when the patient responds yes for active suicidal ideation with intent questions #4 or #5 within the past 30 days or yes for suicide behaviors question #6 in the past 90 days. (iv) Level 4, imminent risk of harming self, is when the patient meets the description of Level 3 plus any of the following: has attempted suicide in the past week by a particularly lethal method (e.g., hanging, guns, self-mutilation, carbon monoxide), has had any suicide behaviors in question #6 during the	

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	the following: attempted suicide in the past week by a particularly lethal method, had any suicide behaviors in question #6 during the hospitalization, currently exhibits gestures of self-harm behaviors, verbalized clear intent of self-harm with viable means available, unwilling or unable to follow safety plan, currently experiencing command hallucinations or delusions to self-harm with intent to follow through, or exhibits other imminent risk factors identified by the care team and provider. c. Review of the facility's document titled, "Attachment B: Safe-T," no date, showed the following: (1) SAFE-T stands for Suicide Assessment Five-step Evaluation and Triage. The five steps included: (i) Identifying risk factors. (ii) Identifying protective factors. (iii) Conducting suicide inquiry. (iv) Determining risk level and intervention. (v) Documentation. (2) Low risk level included modifiable risk factors, strong protective factors, and thoughts of death with no plan, intent or behavior.	

	(3) Moderate risk level included multiple risk factors, few protective factors, and suicidal ideation with plan but no intent or behavior. (4) High risk level included psychiatric disorders with severe symptoms or acute precipitating event, protective factors not relevant, and potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal. 2. Review of patient clinical records showed that staff failed to use criteria for determining suicide risk levels based on suicide risk assessments per facility policies and procedures for 3 of 7 patients reviewed (Patient #1, #3 and #5) based on the following: a. Review of Patient #1's clinical record showed that the patient was 19 years old and admitted voluntarily to the facility for suicidal ideation twice within one month, on 08/31/21 for 3 days, and on 09/29/21 for 2 days. The review showed that the patient requested discharge on 10/01/21, was discharged Against Medical Advice (AMA), and died by suicide the same day after discharging to home. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Review of Patient #1's "Initial Psychiatric Evaluation," dated 09/30/21, signed by Staff N, PA-C, showed that the patient's chief complaint was "I am depressed, I feel worthless...I wanted to kill myself. I was going to drown myself or take pills." The evaluation showed that the	

	patient admitted voluntarily due to suicidal ideation/gestures which had been worsening for 18 months and stated that the patient started "researching ways and making plans six months ago." (2) Review of Patient #1's "Psychiatric Discharge Summary," dated 09/03/21 by Staff AA, Medical Doctor (MD), showed that the patient's reason for admission was "a suicide attempt." (3) Review of Patient #1's "Admission Assessment," dated 08/31/21, showed that at 12:18 PM, Staff S, RN, conducted a C-SSRS suicide risk assessment resulting in criteria that placed the patient at suicide risk level 3, heightened risk of harming self, based on the patient's response of "yes" to questions #1-#6. The patient's intensity of ideation for the past month was rated level 5 "most severe" with a score of 22 due to reasons that included greater than 8 hours daily of persistent suicidal thoughts that they were unable to control. The assessment showed that the patient was placed at suicide risk level 1, "Very Low Risk of Harming Self." (4) Review of Patient #1's "Admission Assessment," dated 09/29/21, showed that on their second visit to the facility at 4:48 PM, Staff S, RN, conducted a C-SSRS suicide risk assessment resulting in criteria that placed the patient at suicide risk level 3, heightened risk of harming self, based on the patient's response of "yes" to questions #1-#6. The assessment did not contain a suicide risk level placement.	

	(5) Review of Patient #1's "Initial Psychiatric Evaluation," dated 09/30/21 at 6:42 AM by Staff N, PA-C, showed that the patient answered "yes" to questions #1-#6 on the C-SSRS suicide risk assessment, placing the patient at suicide risk level 3, heightened risk of harming self. The assessment showed that the patient was placed at suicide risk level 2, "Low to Moderate." b. Review of the clinical records for Patient #3 showed that the patient was 29 years-old and admitted voluntarily on 11/15/21 for "seeing things, confused, and paranoia" with a history of schizophrenia and substance use disorder (SUD), and discharged AMA on 11/24/21. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Patient #3's clinical record review showed that throughout the patient's stay they denied suicidal ideation. (2) Review of Patient #3's documents titled, "Flowsheets" dated 11/17/21 – 11/24/21, showed that the patient consistently answered "no" to questions #1, #2 and #6 on the C-SSRS assessments placing them at suicide risk level of 1, very low risk of harming self. The flowsheets showed that the patient's "Suicide Risk Level" was consistently documented as "Very Low Risk of Harming Self." However, the "Risk Stratification and Triage" section on the flowsheets consistently documented the	

	patient to be suicide risk level 2, "Moderate Suicide Risk." (3) Review of Patient #3's documents titled, "Master Treatment Plan Update," dated 11/17/21 and 11/23/21, showed the box for "Suicide Risk: Level 2 Low to Moderate Risk" was checked. c. Review of the clinical records for Patient #5 showed that the patient was 34 years-old and admitted voluntarily on 10/30/21 for suicidal ideation and depression and discharged AMA on 11/05/21. The review showed the patient was placed on suicide risk levels that were not based on their suicide risk assessments as evidenced by: (1) Patient #5's clinical record review showed that throughout the patient's stay they denied suicidal ideation. (2) Review of Patient #3's documents titled, "Flowsheets" dated 10/31/21 at 8:15 PM – 11/05/21, showed that the patient consistently answered "no" to questions #1, #2 and #6 on the C-SSRS assessments placing them at suicide risk level of 1, very low risk of harming self. The flowsheets showed that the patient's "Suicide Risk Level" was consistently documented as "Very Low Risk of Harming Self." (3) Review of Patient #5's document titled, "Master Treatment Plan Update," dated 11/01/21, showed the box for "Suicide Risk: Level 2 Low to Moderate Risk" was checked.	

WAC 246-341-0640(1)(f) Clinical record content. Each agency is responsible for the components and documentation in an individual's clinical record content unless specified otherwise in specific service certification requirements. (1) The clinical record must include: (f) Progress and group notes including the date, time, duration, participant's name, response to interventions or clinically significant behaviors during the group session, and a brief summary of the individual or group session and the name and credential of the staff member who provided it.	Based on interview and clinical record review, the facility failed to ensure that clinical records included progress notes for all individual sessions for 1 of 7 patients reviewed (Patient #1). Failure to ensure that clinical records include progress notes for all individual sessions can result in undocumented treatment which can result in poor patient care and outcomes. Findings included: 1. During an interview on 12/16/21 at 11:30 AM, Staff O, Social Worker, stated that they conducted an intervention with Patient #1 that was over one hour on 09/30/21 that was not documented. When asked why they didn't go back and do a late entry, Staff O stated because they were "slammed", and they weren't sure how to do it in the electronic medical record. 2. Review of the clinical record for Patient #1 showed that the record did not contain a progress note for the one-hour intervention by Staff O on 09/30/21.	

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

February 28, 2022

Wellfound Behavioral Hospital

Re: Case Number: 2021-13713
License Number: BHA.FS.60925415
Acceptable Plan of Correction

Dear Ms. 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 facility, 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 not 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: 33894
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874