

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000102</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BHC FAIRFAX HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10200 NE 132ND ST KIRKLAND, WA 98034</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><b>INITIAL COMMENTS</b></p> <p>This off-site State psychiatric hospital complaint investigation was conducted on December 9, 2015 by Mary Wood, MN, BSN, RN, in response to complaint #61166.</p> <p>There were no deficient findings per WAC 246-322 pertinent to this complaint.</p> <p>Shell # 3V7N11</p>	L 000		

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