STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47874 • Olympia, Washington 98504-7874

December 1, 2020

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

Dear Ms. Shotts:

This letter contains information regarding the recent investigation at Wellfound Behavioral Health Hospital by the Washington State Department of Health. Your state licensing investigation was completed on October 29, 2020.

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. In light of the current challenges related to COVID-19, please feel free to request an extension of the normal due date outlined in the attached report for submission of your written plan of correction.

Each plan of correction statement must include the following:

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

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

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

Investigator: 30471
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874

Enclosures: DOH Statement of Deficiencies
Plan of Correction Brochure

Statement of Deficiency Report

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

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

Agency Name and Address

Pamela Shotts
Administrator

Investigation	08/14/20 – 10/29/20	30471
Inspection Type	Investigation Dates	Investigator Number
2020-9465	BHA.FS.60925415	BHA Mental Health Inpatient and Outpatient Services
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	Observation Findings	Plan of Correction
246-341-0600(1)(e) Clinical—Individual rights. (1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for...In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:" (e) Be free of any sexual harassment.	Based on interview and document review, the facility failed to protect an individual's right to be free of sexual harassment. Failure to protect an individual's right to be free of sexual harassment may result in patient harm and trauma. Findings included:	

	1. Review of the facility's policy "Patient Rights Responsibilities and Notice of Privacy Practices", PolicyStat ID 7830406, effective 11/2019, showed it gives patients the right to be free from sexual harassment in accordance with WAC 246-341-0600. The policy also states patients have a right to receive care in a safe setting, free from all forms of abuse and harassment. 2. Review of a spreadsheet of patient assault/aggression events from February 2020 through July 2020 received from the facility on 08/24/20 found the following: a. 40 events were documented on the spreadsheet. The spreadsheet showed that six of the 40 events (15%) were potentially sexual in nature. b. An event from 07/19/20 described a "consensual act" between a male (Patient #1) and female (Patient #3) patient found together undressed in the male patient's room. 3. Review of the clinical record for Patient #1 showed the following: a. The patient was admitted on 07/11/20 on an initial 72-hour involuntary hold that was converted to a 14-day involuntary hold for grave disability. b. The "Initial Psychiatric Evaluation" dated 07/11/20 described the hospital admission as "involuntary due to agitation, psychosis". The evaluation says the patient has a criminal history of stalking. The document also said the patient had "Impulsive or aggressive	

	tendencies" and "Recent violent behavior". Based on the evaluation, the initial treatment plan placed the patient on line of sight monitoring. c. A 07/13/20 registered nurse (RN) "Clinical Notes" described the patient as "verbally aggressive and threatening" and said some other unidentified patients reported being "fearful" of the patient. d. The "Involuntary Treatment Note Evaluation for 14day petition" completed on 07/13/20 stated that right before the evaluation, the patient was in another patient's room after opening the door and threatening the female patient inside. e. A 07/18/20 RN "Clinical Notes" written at 11:59 PM stated the patient "continues to be hostile towards staff and peers" and that the patient is "delusional that others are from other planets". f. A 07/19/20 RN "Clinical Notes" written at 5:11 PM stated the patient was found with a female patient [Patient #3] in their room. The note said the patients were "undressed from the waist down" in a bed "having penile-vaginal sex". The note described Patient #1 as "delusional, labile, with paranoia and psychosis noted". 4. Review of the clinical record for Patient #3 on 10/06/20 found the following: a. The patient was admitted on 07/16/20 on an initial 72-hour involuntary hold that was converted to a 14-day involuntary hold for grave disability.	

	b. The 07/16/20 "ED to Hosp-Admission (Discharged) in Wellfound Behavioral Health Egret" stated the patient had "psychotic symptoms and grave disability" with "delusions, disorganized behavior and disorganized speech". c. A 07/17/20 "Group Therapy Note" stated the patient "entered the room and grabbed the upper arm of a male patient". Patient #3 then said, "why don't you come back and sit with me". Patient #3 was overheard talking about meeting up with the male patient after discharge. She then asked another male patient to show her his room. d. A 07/17/20 "Involuntary Treatment Coordination Note" documented interviews with the patient that were done during the initial psychiatric provider assessment. One interview said the patient told the provider she was paralyzed from the neck down, even as she walked to her bed. The patient also said she "was going to have sex with "2 Pac'" after she was found naked. e. A 07/18/20 "Psychiatric Progress Note" documented that, during the evaluation, the patient talked about being "raped by a spiritual force...It didn't feel human". The patient was offered a SANE [sexual assault nurse examiner] exam and responded by saying, "No, I don't think it was human". The note also described the patient as "agitated and hostile", as "responding to internal stimuli not observed or reported", and with thought content that was "paranoid and persecutory" with "Delusions Bizarre". The patient was described as having poor insight, judgment, and impulse control.	

f. A 07/18/20 "Nursing Notes" stated the patient reported someone entering her room at night and raping her. Staff documented that cameras were reviewed, and no other person entered the room. The patient was also described as being "hypersexual in her talk with staff all night."

g. A 07/19/20 "Nursing Notes" described the patient as "manic, hyperverbal, delusional, not redirectable, demanding, loud, yelling". The note read in part, "Pt with paranoid delusions, delusions of grandeur, becoming escalated and a risk of harm to self/others". The patient was medicated with Klonopin and Zyprexa around 1:25 PM. The same note indicated that, at 3:40 PM, Patient #3 was found in a male patient's room [Patient #1]. Both patients were "undressed from the waist down and in bed together having vaginal sex".

h. A 07/19/20 "Clinical Notes" written at 5:40 PM stated Patient #3 was in their room with a male patient "having intercourse". Patient #3 was described as "irritable". They were offered a SANE exam and declined "3 different times".

5. Review of the clinical record for Patient #5 found a 06/29/20 "Clinical Notes" that read in part, "Pt reports that she feels scared after a male peer [Patient #4] walked into her room and propositioned sex...says the male peer attempted to touch her privates but she did everything she could to protect herself...". The note was started 15 minutes after the patient was documented as being admitted to the unit. A follow up note the same day said Patient #5 described the male patient as

	physically aggressive and touching her even when she asked him to stop. A staff member doing rounds found the two together and intervened. 6. Review of the clinical record for Patient #4 on 10/12/20 found a 06/29/20 "Clinical Notes" documented at 2:21 AM that said, "Patient presents with sexually inappropriate behavior towards female peer and makes delusional statements that female peer is his creation and just wanted to reconnect". A follow up note at 9:00 PM the same day said Patient #4 was put on line of site monitoring "after touching a peer on the arm". 7. During an interview on 10/12/20 beginning at 12:00 PM, Staff #2, advanced registered nurse practitioner (ARNP) stated that their main role involves medical assessment, but they consult with the psychiatrist anytime they are aware of issues with monitoring or sexually inappropriate behaviors. Staff #2 stated they remember speaking with Patient #3 after the sexual encounter with Patient #1 and Patient #3 told them Patient #1 was a high school sweetheart. Staff #2 said they couldn't determine if the statement was true or part of a delusion. 8. During an interview on 10/15/20 beginning at 8:00 AM, Staff #3, registered nurse (RN) said they worked with Patient #1 and remembered them as "delusional", calling themselves a baby and stating they were God. When asked how consent for a sexual act is determined, Staff #3 stated they "mostly assume [patients are] not in a position to give consent".	

	9. During an interview on 10/15/20 beginning at 2:15 PM, Staff #1, Director of Quality, was asked how patient consent for sexual behavior at the facility was determined and what type of event would be reported to the police and/or the Department of Health (DOH). Staff #1 stated that all patients are offered a SANE exam after a sexual encounter and may request police notification. Staff #1 said they would report any non-consensual intercourse to the DOH. In the case of Patient #1 and #3, Staff #1 said both patients were angry about being separated and made active moves to be together again. Staff #1 said the provider [Staff #4] made the final determination about consent based on their assessment. 10. During an interview on 10/20/20 beginning at 2:00 PM, Staff #4, psychiatrist, said, in determining sexual consent, they try to determine capacity in the moment as capacity can change over time. Staff #4 said they work with administration in determining if a sexual event is reportable. Staff #4 says a full capacity evaluation is not done, but symptoms and presentation of the patient at the time are reviewed. In the case of Patient #1 and #3, Staff #4 said they "probably knew" what they were doing but consent sometimes changes if insight changes. Staff #4 said they had a hard time determining consent is this case. Patient #3 was their patient and Staff #4 stated that they did not appear distressed at the time and wanted to see Patient #1 again. Staff #4 said, around the time Patient #3 was getting ready to be discharged, they said, "Maybe [I] shouldn't have done that" in referring to sex with Patient #1.	

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 onsite investigation, or you may contact the supervisor.

Statement of Deficiency Report

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

Wellfound Behavioral Health Hospital
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Agency Name and Address

Pamela Shotts
Administrator

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Chris Rabbitts 12/4/2020

	1. Review of the facility's policy "Patient Rights Responsibilities and Notice of Privacy Practices", PolicyStat ID 7830406, effective 11/2019, showed it gives patients the right to be free from sexual harassment in accordance with WAC 246-341-0600. The policy also states patients have a right to receive care in a safe setting, free from all forms of abuse and harassment. 2. Review of a spreadsheet of patient assault/aggression events from February 2020 through July 2020 received from the facility on 08/24/20 found the following: a. 40 events were documented on the spreadsheet. The spreadsheet showed that six of the 40 events (15%) were potentially sexual in nature. b. An event from 07/19/20 described a "consensual act" between a male (Patient #1) and female (Patient #3) patient found together undressed in the male patient's room. 3. Review of the clinical record for Patient #1 showed the following: a. The patient was admitted on 07/11/20 on an initial 72-hour involuntary hold that was converted to a 14-day involuntary hold for grave disability. b. The "Initial Psychiatric Evaluation" dated 07/11/20 described the hospital admission as "involuntary due to agitation, psychosis". The evaluation says the patient has a criminal history of stalking. The document also said the patient had "Impulsive or aggressive	

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Wellfound Behavioral Health Hospital
Progress Report for
State Psychiatric Hospital Complaint Investigation Case 2020-9465

Tag Number Washington State Reference	How Corrected	Responsible	Date Occurred	Monitoring procedure, Target for Completion
246-341-0600(1)(e) Clinical—Individual rights. (1) Each agency licensed by the department to provide any behavioral health service must develop a statement of individual participant rights applicable to the service categories the agency is licensed for...In addition, the agency must develop a general statement of individual participant rights that incorporates at a minimum the following statements. "You have the right to:" (e) Be free of any sexual harassment.				
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	Discussions with care team. Nursing and providers regarding communicating observations and patient statements and process of offering SANE examples regardless of if felt anything occurred vs delusional	CNO	7/2020	7/2020
2. Review of a spreadsheet of patient assault/aggression events from February 2020 through July 2020 received from the facility on 08/24/20 found the following: a. 40 events were documented on the spreadsheet. The spreadsheet showed that six of the 40 events (15%) were potentially sexual in nature. b. An event from 07/19/20 described a "consensual act" between a male (Patient #1) and female (Patient #3) patient found together undressed in the male patient's room. 3. Review of the clinical record for Patient #1 showed the following:	Milieu management and constant observer policy shared in Safety Alert education shared with all staff.	Chief Medical Officer	10/13/20	10/13/20

Thomas Rathmes 12/11/2020

a. The patient was admitted on 07/11/20 on an initial 72-hour involuntary hold that was converted to a 14-day involuntary hold for grave disability. b. The "Initial Psychiatric Evaluation" dated 07/11/20 described the hospital admission as "involuntary due to agitation, psychosis". The evaluation says the patient has a criminal history of stalking. The document also said the patient had "Impulsive or aggressive tendencies" and "Recent violent behavior". Based on the evaluation, the initial treatment plan placed the patient online of sight monitoring. c. A 07/13/20 registered nurse (RN) "Clinical Notes" described the patient as "verbally aggressive and threatening" and said some other unidentified patients reported being "fearful" of the patient. d. The "Involuntary Treatment Note Evaluation for 14day petition" completed on 07/13/20 stated that right before the evaluation, the patient was in another patient's room after opening the door and threatening the female patient inside. e. 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The note also described the patient as "agitated and hostile", as "responding to internal stimuli not observed or reported", and with thought content that was "paranoid and persecutory" with Delusions Bizarre". The patient was described as having poor insight, judgment, and impulse control. f. A 07/18/20 "Nursing Notes" stated the patient reported someone entering her room at night and raping her. Staff documented that cameras were reviewed, and no other person entered the room. The patient was also described as being "hypersexual in her talk with staff all night." g. A 07/19/20 "Nursing Notes" described the patient as "manic, hyperverbal, delusional, not redirectable, demanding, loud, yelling". The note read in part, "Pt with paranoid delusions, delusions of grandeur, becoming escalated and a risk of harm to self/others". The patient was medicated with Klonopin and Zyprexa around 1:25 PM. The same note indicated that, at 3:40 PM, Patient #3 was found in a male patient's room [Patient #1]. Both patients were "undressed from the waist down and in bed together having vaginal sex".	Pt Right and Constant Observer policies referenced Implemented new process of utilizing Lead MHT positions and establishing charge nurses based on specific criteria with standardized processes to improve milieu management along with lead MHT. Build on MOAB training and combine with team building to improve patient care, milieu management, and overall team communication. July started entering incident reports in an electronic system by category allow tracking and reporting. Specific communication and face to face education was completed with frontline staff on use of incident reporting tool. Monthly incident category with highlight are shared with all staff posted on the unit. RCA was completed to involve all parties involved with care of the patients where determined consensual sex occurred. Staffing grid was higher than normal that day. • Patients were split up and male pt was moved to a different unit. • Throughout both patient's hospital stays they were on various observation levels as felt warranted by the attending provider in consultation with care team.	CNO Quality Dir Quality Dir Quality Dir	8/7/2020 7/2020 July 2020 8/15/2020 7/24/20	9/23/20 8/7/2020 9/8/2020 8/15/20 8/15/20

h. A 07/19/20 "Clinical Notes" written at 5:40 PM stated Patient #3 was in their room with a male patient "having intercourse". Patient #3 was described as "irritable". They were offered a SANE exam and declined "3 different times". 5. Review of the clinical record for Patient #5 found a 06/29/20 "Clinical Notes" that read in part, "Pt reports that she feels scared after a male peer [Patient #4] walked into her room and propositioned sex...says the male peer attempted to touch her privates but she did everything she could to protect herself...". The note was started 15 minutes after the patient was documented as being admitted to the unit. A follow up note the same day said Patient #5 described the male patient as physically aggressive and touching her even when she asked him to stop. A staff member doing rounds found the two together and intervened. 6. Review of the clinical record for Patient #4 on 10/12/20 found a 06/29/20 "Clinical Notes" documented at 2:21 AM that said, "Patient presents with sexually inappropriate behavior towards female peer and makes delusional statements that female peer is his creation and just wanted to reconnect". A follow up note at 9:00 PM the same day said Patient #4 was put online of site monitoring "after touching a peer on the arm". During an interview on 10/12/20 beginning at 12:00 PM, Staff #2, advanced registered nurse practitioner (ARNP) stated that their main role involves medical assessment, but they consult with the psychiatrist anytime they are aware of issues with monitoring or sexually inappropriate behaviors. Staff #2 stated they remember speaking with Patient #3 after the sexual encounter with Patient #1 and Patient #3 told them Patient #1 was a high school sweetheart. Staff #2 said they couldn't determine if the statement was true or part of a delusion. 8. During an interview on 10/15/20 beginning at 8:00 AM, Staff #3, registered nurse (RN) said they worked with Patient #1 and remembered them as "delusional", calling themselves a baby and stating they were God. When asked how consent for a sexual act is determined, Staff #3 stated they "mostly assume [patients are] not in a position to give consent 9. During an interview on 10/15/20 beginning at 2:15 PM, Staff #1, Director of Quality, was asked how patient consent for sexual behavior at the facility was determined and what type of event would be reported to the police and/or the Department of Health (DOH). Staff #1 stated that all patients are offered a SANE exam after a sexual encounter and may request police notification. Staff #1 said they would report any non-consensual intercourse to the DOH. In the case of Patient #1 and #3, Staff #1 said both patients were angry about being separated and made active moves to be together again. Staff #1 said the provider [Staff #4] made the final determination about consent based on their assessment. 10. During an interview on 10/20/20 beginning at 2:00 PM, Staff #4, psychiatrist, said, in determining sexual consent, they try to determine capacity in the moment as capacity can change over time. Staff #4 said they work with administration in determining if a sexual event is reportable. Staff #4 says a full capacity evaluation is not done, but symptoms and presentation of the patient at the time are reviewed. In the case of Patient #1 and #3, Staff #4 said they "probably knew" what they were doing but consent sometimes changes if insight changes. Staff #4 said they had a hard time determining consent is this case. Patient #3 was their patient and Staff #4 stated that they did not appear distressed at the time and wanted to see Patient #1 again. Staff #4 said, around the time Patient #3 was getting ready to be discharged, they said, "Maybe [I] shouldn't have done that" in referring to sex with Patient #1.	• Both patients were offered medical assessments, counseling, SANE example on multiple occasions, and post DC care. • Video review was shared with staff involved so they could visually see their actions and state of the unit vs perceptions. • Scenarios as relates to observation tracking added to MOAB training and lead MHT discussions Second scenario, patients were separated found with clothing still on and intake during Q15 min observation. Female was moved to different unit. Both patients were offered SANE exams and next day female was transported for a SANE exam when she decided to have one. stating she did not have sexual intercourse, but her breasts were touched and then she was DC as planned the following day. Individual discussions were completed with each staff working that shift. Providers and nursing staff talked with both patients separately and the female patient ultimately requested a SANE exam. Male pt. refused SANE exam stating "we did not go all the way"			

	Shared education regarding care of patients who are focused on sexuality and hypersexual behaviors	Dir Clinical Services/Dir Quality	12/14/20	12/14/20
	Weekly audits for pt assessment related documentation in connection to patients with hypersexual behavioral/comments for first 90 days or until 95% compliance with complete documentation. Ongoing monitoring will be monthly for 3 months, quarterly thereafter. Includes: • Weekly unit rounding discussions with charge nurse and lead MHT for patients at risk. • Identification or discussion regarding such patients during daily leadership huddle for awareness and discussions regarding how being managed • Incident sharing at committee agendas	Quality Dir	12/7/20	3/1/21

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

January 7, 2021

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

Re: Case Number: 2020-9465
License Number: BHA.FS.60925415
Acceptable Plan of Correction
Date(s) of Investigation: 08/14/20-10/29/20

Dear Ms. Shotts:

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: 30471
Department of Health
HSQA/Office of Health Systems Oversight
PO Box 47874
Olympia, Washington 98504-7874