State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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	INITIAL COMMENTS STATE LICENSING SURVEY The Washington State Department of Health (DOH) in accordance with Washington Administrative Code (WAC), Chapter 246-322 Private Psychiatric and Alcoholism Hospitals conducted this health and safety survey. Onsite dates: 10/01/19 to 10/04/19 Examination number: X2019-869 The survey was conducted by: Surveyor #1 Surveyor #9 The Washington Fire Protection Bureau conducted the fire life safety inspection.	L 000	1. A written PLAN OF CORRECTION is required for each deficiency listed on the Statement of Deficiencies. 2. EACH plan of correction statement must include the following: The regulation number and/or the tag number; HOW the deficiency will be corrected; WHO is responsible for making the correction WHAT will be done to prevent reoccurrence and how you will monitor for continued compliance; and WHEN the correction will be completed. 3. Your PLANS OF CORRECTION must be returned within 10 calendar days from the date you receive the Statement of Deficiencies. Your Plans of Correction must be postmarked by October 21, 2019. 4. Return the ORIGINAL REPORT with the required signatures	
L 455	322-040.8A ADMIN RULES-STAFF WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (a) Organization of the professional staff; This Washington Administrative Code is not met	L 455		

Plan of Correction Rec
10/21/19 eg

Plan of Correction approved
10/25/19 eg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 455	Continued From page 1 as evidenced by: Based on document review and interview, the hospital's governing board failed to review and approve the Medical Staff Bylaws. Failure to maintain oversight and approval for the rules and bylaws of the Medical Staff puts patients at risk of substandard care due to lack of oversight. Findings included: 1. During review of the hospital's medical staff bylaws (No date), Surveyor #1 observed that the medical staff bylaws did not have a signature page indicating Governing Body approval. 2. On 10/02/19 at 1:30 PM, Surveyor #1 interviewed the director of nursing (Staff #103) and director of quality (Staff #104) in regards to the approval of the medical staff bylaws. Surveyor #1 requested documentation indicating the governing body approved the medical staff bylaws. The director of nursing was unable to locate a signed copy of the document and was unable to locate any reference to the approval of the medical staff bylaws in the meeting minutes of the Governing Body.	L 455		
L 495	322-040.8i ADMIN RULES-PERFORM EVALS WAC 246-322-040 Governing Body and Administration. The governing body shall: (8) Require and approve professional staff bylaws and rules concerning, at a minimum: (i) Mechanisms to monitor and evaluate quality of care and clinical	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 495	Continued From page 2 performance; This Washington Administrative Code is not met as evidenced by: . Based on interview, review of the hospital's quality program and review of quality documentation, the hospital failed to ensure that quality data, quarterly reports, the Quality Plan for 2019 and an annual evaluation of the Performance Improvement Plan (2018) had been shared with the Board of Directors (BOD). . Failure to ensure that the BOD oversees the performance of patient care services and quality of care risks provision of inadequate care and poor patient outcomes . Findings included: . 1. Document review of the Board of Trustee Bylaws of Lourdes Hospital, Lourdes Counseling Center (LCC) dba (doing business as) Lourdes Health, Volume 1.3.2014 approved 10/02/19, Section 8.3 titled, "Professional Accountability to the Board," showed that medical staff and other health care professionals staff providing patient care services are accountable to the BOD for activities that contribute to improvement of the quality and efficiency of patient care. This includes mechanisms to monitor and evaluate the quality of patient care; conduct ongoing review, evaluation, and monitoring of patient care practices through a systematic process of overall quality assessment and improvement. . 2. Document review of the Lourdes Health 2019 Quality Improvement Plan shows that the BOD would review a summary of findings of quality improvement activities on a regular basis based on Quality/Patient Safety Council activities and	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 495	Continued From page 3 the Medical Executive Committee (MEC) reports. The Quality/Patient Safety Council meets regularly and disseminates pertinent findings of quality improvement activities to the MEC. MEC meets at least quarterly and makes recommendations to the BOD. Quality measurement and improvement is to be reported to the BOD on a regular basis. Additionally, an annual evaluation Quality Plan and evaluation of quality improvement priorities is conducted by the Quality/Patient Safety Council. This evaluation is to be forwarded to MEC and BOD. . 3. Review of the Board of Director Minutes for 10/18 through 05/19 and 7/19 did not show documentation with specific information about Lourdes Counseling Center (LCC) Inpatient Quarterly Improvement Dashboards or Quality/Patient Safety Council minutes were reported and approved. The Lourdes Health 2019 Quality Improvment Plan for calender year 2019 was presented to Surveyor #9 in draft form, and there was no evidence that the 2019 Plan had been presented to the board. There was no annual evaluation of the organization's quality improvement priorities for 2018 referenced in the BOD minutes. . 4. On 10/3/19 at 1:30 PM, during the quality meeting, the Director of Quality (Staff #902) acknowledged that the BOD minutes did not reflect specific information regarding the Quality Improvement Dashboards or the Quality/Inpatient Safety Council meetings with recommendations for improvements. Additionally, she acknowledged an annual evaluation of the organization's quality improvement plan was not completed in 2018 and there was no evidence that the 2019 Quality Plan was approved by the board	L 495		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 545	322-050.6A ORIENTATION-ORG WAC 246-322-050 Staff. The licensee shall: (6) Provide and document orientation and appropriate training for all staff, including: (a) Organization of the hospital; This Washington Administrative Code is not met as evidenced by: . Based on document review and interview, the hospital failed to ensure that agency staff were oriented to the organization of the hospital for 1 of 2 staff members reviewed (Staff #101). Failure to orient staff to the organization of the hospital places patients at risk for inadequate care. Findings included: 1. Record review of the hospital policy titled, "Human Resources New Orientation," Policy # 5000.11, revised date 2019, showed on page 3 that the human resource department will insure that fire/safety, confidentiality, general orientation (within 60 days), and department specific orientation are completed on each contract associate. 2. Record review of employee personnel and training files showed that 1 of 2 contracted employees, a housekeeper (Staff #101), did not have documentation of new employee orientation regarding the organization of the hospital. 3. On 10/03/19 at 9:00 AM, Surveyor #1 interviewed the human resource manager (staff #102) in regards to orientation for the contracted housekeeper (Staff #101). She provided	L 545		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 545	Continued From page 5 documentation that new employee orientation was assigned in the hospital's training program, "Health Stream" in June 2019 for the contracted housekeeper, but was not completed. The human resource manager indicated that it should have been completed.	L 545		
L 765	322-100.3D INFECT CONTROL-MEETINGS WAC 246-322-100 Infection Control. The licensee shall: (3) Designate an infection control committee, comprised of the individual or individuals assigned to manage the program and multi-disciplinary representatives from the professional staff, nursing staff and administrative staff, to: (d) Meet at regularly scheduled intervals, at least quarterly; This Washington Administrative Code is not met as evidenced by: Based on interview and document review, the hospital failed to maintain an infection control committee that meets on scheduled intervals, at least quarterly as required per Washington State Administrative Code (WAC 246-322). Failure to hold regular meetings prevents the dissemination of information and the opportunity to analyze and share identified infection control issues with hospital staff to prevention of infections. Findings included: 1. Document review of the hospital's "Pharmacy & Therapeutics/ Infection Prevention Meeting	L 765		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 765	Continued From page 6 Minutes," showed that meetings were held on 12/19/18, 02/13/19, and 04/22/19. There were no meeting minutes for the 3rd quarter of 2019. 2. On 10/04/19 at 11:00 AM, Surveyor #1 interviewed the current Infection Control Nurse (ICN) (Staff #105) about the 3rd quarter infection control committee meeting. She stated that the meeting had not been held due to the resignation of the director of pharmacy, who is an integral part of the committee.	L 765		
L 780	322-120.1 SAFE ENVIRONMENT WAC 246-322-120 Physical Environment. The licensee shall: (1) Provide a safe and clean environment for patients, staff and visitors; This Washington Administrative Code is not met as evidenced by: . Based on observation, interview and document review, the psychiatric hospital failed to a secure housekeeping cart in the patient care area to safeguard patients from accessing chemicals. Failure to safeguard equipment in patient areas places patients at risk of accessing chemicals that can cause injury or death.. Findings included: 1. Record review of the hospital policy titled, "Environmental Services Patient Rooms - Daily Clean," Policy #481-4, date reviewed 2019, showed that carts must be locked when staff are not in close proximity. 2. On 10/01/19 at 10:00 AM, Surveyor #1 and the	L 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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 780	Continued From page 7 Facilities Manager (Staff #106) toured the patient common areas. The surveyor observed a housekeeping cart in the common area that was unattended. Surveyor #1 observed that the roll top portion where chemicals were stored was not locked. The housekeeper was observed behind the nurses station not in close proximity of the cart. 3. During the observation, Surveyor #1 interviewed the housekeeper (Staff #101) in regards to securing the housekeeping cart when unattended. The housekeeper stated that she had locked the cart and showed the surveyor that the bottom portion of the cart was locked. The surveyor asked about the roll top portion of the cart where chemicals are also stored. She indicated the roll top portion did not have a lock. Surveyor #1 showed the housekeeper the lock mechanism for the roll top portion of the cart. The housekeeper was able to use her key that locked the bottom portion of the cart to lock the roll top portion of the cart. This was corrected during survey.	L 780		
L1040	322-170.1C TRANSFER PATIENTS WAC 246-322-170 Patient Care Services. (1) The licensee shall: (c) Provide appropriate transfer and acceptance of a patient needing medical care services not provided by the hospital, by: (i) Transferring relevant data with the patient; (ii) Obtaining written or verbal approval by the receiving facility prior to transfer; and (iii) Immediately notifying the patient's family.	L1040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	000101	A. BUILDING: _____ B. WING _____	10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOURDES COUNSELING CENTER	1175 CARONDELET DRIVE RICHLAND, WA 99352

(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
L1040	Continued From page 9 acute care hospital for treatment of urinary retention. . c. Transfer of Patient #903 on 05/15/19 to an acute care hospital for dehydration did not record name of the accepting physician. . 3. At the time of the record review, the Director of Nursing (Staff #901) confirmed that hospital policy had not been followed regarding receiving facility notification with patient transfers. . Item #2 - Patient Transfer Form . 1. Document review of the hospital's policy titled, "COBRA: Transfer of Patients," Policy # C-5d reviewed 2019, showed that the attending physician and nursing staff are to complete a "Patient Transform Form" for transfer of patients for emergent care. . 2. On 10/03/19 at 2:00 PM during closed record review, Surveyor #9 found no Patient Transfer Forms in the records of Patient #904 (transferred 06/28/19) and Patient #905 (transferred 07/01/19) upon transfer to an acute care facility for treatment.	L1040		

updated poc

Lourdes Counseling Center
Plan of Correction for
State Licensing Survey

Tag Number	How the Deficiency Will Be Corrected	Responsible Individual(s)	Estimated Date of Correction	Target for Compliance	Action Level Indicating Need for Change of POC
L1040	322-170.1c WAC 246-322-170 All unit RNs will be re-educated on policy and appropriate documentation by 10/31/19. All transfers will be reviewed and monitored for; • Copy of EMTALA Transfer Record form in patient record, • Transfer Record has documentation of; a. Name of receiving facility and, b. Name of accepting physician.	LCC Director of Nursing/Adult Unit Nurse Manager	11/1/19	100%	All (100%) of EMTALA transfers will be monitored monthly for documentation compliance and reported to Quality Patient Safety Counsel quarterly (see 2nd column for specifics)
L 455	322-040.8A WAC 246-322-040 Hospital board will review and approve the Medical Staff bylaws	Director of Quality	10/23/19	100%	Medical Staff bylaws will be approved by Board of Directors
L 495	322-040.8i WAC 246-322-040 The following will be reviewed, documented, and approved by the Board of Directors: • Quality data • Quality reports • Quality Plan for 2019	Director of Quality	10/23/19 Quality Plan Reviewed and Approved – Annually there after 10/23/19 Quarterly	100%	Board of Directors will review and approve Quality Plan Quality Data / Reports will be presented to Board of Directors

			Reports / Quality Data Reviewed – Quarterly thereafter		quarterly. Presentation of Quality Data / Reports to Board of Directors will be monitored for compliance and reported to Quality Patient Safety Counsel quarterly.
L 545	322-050.6A WAC 246-322-050 Contracted Housekeeping Employee has completed the assigned Health Stream Courses: **2019 Code of Conduct Training & 2019 Information Security Awareness.**	Environmental Services Manager	10/14/19	100%	Lourdes New Hire Orientation was completed in person on 6/20/19. Environmental Services Manager will monitor employee files monthly to ensure all HealthStream training is completed timely. This will be reported to Quality Patient Safety Council quarterly

L 765	322-100.3D WAC 246-322-100 Infection control committee has been designated. Will meet 10/30/19.	Chief Medical Officer / Director of Pharmacy	10/30/19 – Quarterly thereafter	100%	Infection control committee will meet quarterly. Infection Control Nurse will monitor on a regular basis and will report to the CNO when this is not occurring for appropriate action
L 780	322-120.1 WAC 246-322-120 On-call Housekeeper was retrained on the proper securing of Roll Top Portion of cleaning cart. New protocol of bringing cart into nurse station while housekeeper is cleaning has been established.	Environmental Services Manager	Corrected during survey – ongoing thereafter	100%	Staff will ensure rolling cart is locked. Environmental Services Manager will monitor all carts monthly and report to Quality Patient Safety Council quarterly.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

December 30, 2019

Mr. Justin Ratcliffe
Ms. Oliver, Dir. of Nursing
Lourdes Counseling Center
1175 Carondelet Dr.
Richland, WA 99354

Dear Mr. Ratcliffe,

Surveyors from the Washington State Department of Health and the Washington State Patrol Fire Protection Bureau conducted a state licensing survey at Lourdes Counseling Center on 10/01/19 to 10/04/19. Hospital staff members developed a plan of correction to correct deficiencies cited during this survey. This plan of correction was approved on 10/25/19.

Hospital staff members sent a Progress Report dated 12/23/19 that indicates all deficiencies have been corrected. The Department of Health accepts Lourdes Counseling Center attestation to be in compliance with Chapter 246-322 WAC.

The team sincerely appreciates your cooperation and hard work during the survey process and looks forward to working with you again in the future.

Sincerely,

Alex Giel, HSC
Survey Team Leader