

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Western Division of Survey and Certification  
Seattle Regional Office  
701 Fifth Avenue, Suite 1600  
Seattle, WA 98104



**IMPORTANT NOTICE – PLEASE READ CAREFULLY**

**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42 CFR §488.  
NO HARD COPY TO FOLLOW.**

July 22, 2015

Judd Wright, Administrator  
Southwest Idaho Advanced Care Hospital  
6651 West Franklin Road  
Boise, ID 83709

CMS Certification Number: 13-2003

**Re: Notice of Enforcement Action  
Complaint survey completed on July 15, 2015  
Condition of Participation Not Met  
90-day termination track  
Removed Deemed Status**

Dear Mr. Wright:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Southwest Idaho Advanced Care Hospital no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. The hospital is now placed on a **90-day termination track** based on the completion date of the survey. This letter serves as notification that effective **October 13, 2015**, the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Southwest Idaho Advanced Care Hospital. Also, your deemed status with the Joint Commission (JC) is removed and you are placed under the State's jurisdiction. Your deemed status will be restored when you get back in substantial compliance with Medicare regulatory requirements.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a hospital is found to be out of compliance with the Medicare Condition of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a hospital's Medicare provider agreement if the hospital no longer meets the regulatory requirements for a hospital. 42 CFR § 489.53 authorizes the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider no longer meets the Condition of Participation.

On July 15, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility. The survey found that the following Medicare Condition of Participation (CoP) was not met:

42 CFR § 482.57      Respiratory Services

This deficiency limits the capacity of Southwest Idaho Advanced Care Hospital to furnish services of an adequate level and quality. The details of the above deficiency are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS 2567).

II.      PUBLIC NOTICE OF TERMINATION AND OPPORTUNITY TO CORRECT

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper 15 days before the termination date.

Southwest Idaho Advanced Care Hospital can avoid the 90-day termination action by correcting the deficiencies prior to the effective date of the termination. CMS must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the deficiencies have been corrected. **Complete your plan of correction in the space provided on the CMS-2567 within the next 10 calendar days.** An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

- Plan of Correction for each specific deficiency cited.
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited.
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.
- Address process improvement and demonstrate how the hospital has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited.
- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

CMS strongly encourages Southwest Idaho Advanced Care Hospital to have its plan of correction fully implemented by no later than **August 6, 2015**. Please send your plan of correction to the State survey agency and to CMS:

**CMS – Division of Survey and Certification**  
**Attention: Aileen Renolayan (Mail Stop 400)**  
**701 Fifth Avenue, Suite 1600**  
**Seattle, WA 98104**

Or by email at [aileen.renolayan@cms.hhs.gov](mailto:aileen.renolayan@cms.hhs.gov)

III. APPEAL RIGHTS

If you disagree with the Centers for Medicare and Medicaid Services' determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board (DAB).

The regulations governing this process are set out in 42 CFR § 498.40 et seq. You will find the DAB's e-filing procedures on the internet at the following URL:

<http://www.hhs.gov/dab/divisions/civil/procedures/filing-and-service.html>

A request for a hearing should identify the specific issues, and the findings of fact, and conclusions of law with which you disagree. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense. **A hearing request must be filed not later than 60 days after the date you receive this letter.**

If you have no internet access and would prefer to file your appeal in writing, please contact the DAB office below:

<b>Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201</b>	<b>Please also send a copy to:</b>	<b>Chief Counsel, DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 M/S RX-10 Seattle, WA 98121-2500</b>
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If you have any questions, please contact Aileen Renolayan of my staff at (206) 615-2041 or by email at [aileen.renolayan@cms.hhs.gov](mailto:aileen.renolayan@cms.hhs.gov).

Sincerely,



Patrick Thrift, Branch Manager  
Division of Survey and Certification, Seattle

Enclosure: CMS 2567 Summary of Deficiencies

cc: Idaho Bureau of Facility Standards  
Office of General Counsel, DHHS  
The Joint Commission

From:

08/13/2015 10:01

#004 P.001/115

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Fax server

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  132003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/15/2015
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, ID 83709
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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) COMPLETION DATE
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A000

INITIAL COMMENTS

A000

The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were

Teresa Hamblin, RN, MS, Health Facility Surveyor, Team Leader  
Dennis Kelly, RN-BC, CHPN, Health Facility Surveyor

The following acronyms were used in this report:

AARC- American Association for Respiratory Care  
CEO - Chief Executive Officer  
DNO- Director of Nursing Service  
DNR - Do not resuscitate  
MEC - Med Executive Committee  
RT- Respiratory therapy

A1151

482.57 RESPIRATORY CARE SERVICES

A1151

The hospital must meet the needs of the patients in accordance with acceptable standards of practice. The following requirements apply if the hospital provides respiratory care services.

This CONDITION is not met as evidenced by. Based on review of organizational documents, policies, procedures, protocols, medical records, and staff interview, it was determined the hospital failed to meet respiratory care services requirements as it related to organization of the department, a physician director, and delivery of services within approved and current medical staff directives and policies. This had the potential to negatively impact patient care. Findings include.

The Governing Body Of Southwest Idaho Advanced Care Hospital is responsible for ensuring the corrective actions for deficiencies related to the provision of Respiratory Care Services are implemented and sustained by the Administrator, Medical Staff and Senior Leadership as indicated.

➤ The Governing Body will approve the plan of correction

➤ The actions described in this plan of correction will drive improvement in compliance with the CMS Conditions of Participation for Respiratory Care Services and improve the delivery of patient care. The appointment of a director of respiratory care services; revision of the organizational structure

8/6/15

8/5/15

8/6/15

RECEIVED  
AUG 13 2015  
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Carrie Johnson*

Interim CEO

8/13/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, ID 83709	
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A1151	Continued From page 1 1. Refer to A-1152 as it relates to the failure of the hospital to ensure the organization of respiratory care services was appropriate to the scope and complexity of the services offered. 2. Refer to A-1153 as it relates to the failure of the hospital to ensure a physician director was appointed to the respiratory care services department 3. Refer to A-1160 as it relates to the failure of the hospital to ensure services were consistently delivered in accordance with medical staff directives. 4. Refer to A-1161 as it relates to the failure of the respiratory services was consistently provided in accordance with hospital policy and within RT job description and competencies.  The cumulative effects of these negative systemic practices impeded the ability of the hospital to ensure respiratory service requirements were met.	A1151	defining the oversight of Respiratory Care Services department and staff to the director of respiratory care services; defined policies for the delivery of respiratory care services; periodic review and revision of policies and protocols by the director of respiratory care services, Medical Executive Committee (MEC) and Governing Body; staff education; and monitoring will improve on the organization structure and delivery of respiratory care services.  The Governing Body will review all documentation of monitoring and measured results of actions taken to assure improvement has occurred and is sustained by the actions taken.	8/6/15
A1152	482.57(a) ORGANIZATION OF RESPIRATORY CARE SERVICES  The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered.  This STANDARD is not met as evidenced by: Based on staff interview and review of the hospital's organizational chart, policies, procedures, protocols and references used in the respiratory therapy department, and MEC documents, it was determined the organization of the respiratory care services was not appropriate	A1152	The Administrator is responsible for ensuring the hospital has a structure appropriate to the scope and complexity of the respiratory services offered. Procedure/Process: ➤ A Doctor of Medicine with the education, experience and specialized training to supervise and administer the respiratory care services appointed as the director of respiratory care services ➤ Organizational chart revised to define the fixed line of authority of the respiratory care services to the director	8/6/15  7/30/15  7/30/15

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, ID 83709	

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A1152	Continued From page 2 to the scope and complexity of the services offered. This was evidenced by a lack of qualified leadership, a failure to define in writing the scope of respiratory services provided by the hospital, outdated policies, and use of unapproved resources. It had the potential to interfere with delivery of patient care. Findings include:  The hospital's public website ( <a href="http://siach.ernesthealth.com">http://siach.ernesthealth.com</a> ) was reviewed. It introduced the hospital's broad scope of services. It stated 'We treat any patient requiring extended acute care, including those requiring intensive care, medically complex care, modified rehabilitation, ventilator/pulmonary care and wound care.  1. The hospital's organizational chart was reviewed. It placed the RT Manager under the supervision of the DNO, who in turn reported to the hospital's CEO. There was no organizational relationship between the RT Manager and physician oversight. This was confirmed by the RT Manager during an interview on 7/13/15 at approximately 10:29 AM.  The Respiratory Therapy Manager's job description, last revised 3/15, was consistent with the above referenced interview. It stated the Respiratory Therapy Manager reported directly to the CEO or DNO. No physician director was referenced. The Respiratory Therapy Manager confirmed the reporting schedule during an interview on 7/13/15 at approximately 10:29 AM  The Manager of Respiratory Therapy services was interviewed on 7/13/15 at approximately 2:30 PM. She was asked who she contacted with questions or concerns related to respiratory	A1152	of respiratory care services. Policy PC 010 "Clinical Standards of Practice" was reviewed and revised to include updated resources for the respiratory care services. Policy update approved by director of respiratory care services, MEC, and Governing Body. The respiratory care services' policies were revised to clearly define the scope of care and delivery of respiratory care services. Policies and guidelines reviewed and approved by the director of respiratory services, MEC, and Governing Body. Policy and guideline updates communicated to staff by the the Respiratory Therapy Manager and Director of Nursing via hospital email and department staff meeting. Communicated the new organizational structure with Dr. Kumar as the Physician Director of Respiratory Care Services, applicable policy revisions, discontinued protocols at this time, and wound care/stoma care is a nursing responsibility. Monitoring or Tracking: The Administrator or designee will verify the appointment of the doctor of medicine as the director of respiratory care services and the revision of the organizational chart. The director of respiratory care services or designee will verify the respiratory care staff provide services within the defined scope of services.	8/5/15 8/5/15 8/6/15 8/3/15 8/6/15

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A1152	<p>Continued From page 3</p> <p>therapy. She stated she used a variety of resources. She would generally contact the RN leader at corporate or other RT respiratory therapy managers at other hospitals within the health care system. If the staff pulmonologist was available she might ask him questions (he worked 2 weeks on and 2 weeks off). When asked if she consulted the general medical director, she stated she did not because he was the wound care director.</p> <p>The Respiratory Manager was asked who attended respiratory department meetings. She stated "only respiratory therapists." There was no physician presence. There was no senior management presence, such as the DNO or CEO who the organizational chart indicated was responsible for respiratory therapy.</p> <p>The organization of the respiratory department did not include immediate physician oversight. Senior leadership was not involved in respiratory care meetings.</p> <p>2. The references and resources for the respiratory department were not clear. During an interview on 7/13/15 at approximately 2:30PM, the Manager of Respiratory Therapy explained that she collected resources for respiratory staff and included the resources in the policy and procedure manual for staff reference. She stated she primarily used Egan's Fundamentals of Respiratory Care, Eighth edition, dated 2003, as a resource as well as online information from the American Association for Respiratory Care.</p> <p>The hospital's policy "Clinical Standards of Practice," (PC 010) was reviewed. It listed the approved resources for various departments.</p>	A1152	<p>➤ The Administrator or designee will verify the annual review and revision of policies, guidelines, protocols, standing orders, and order sets.</p> <p>Measure:</p> <p>➤ The Administrator or designee will report compliance with changes to Quality Council, MEC, and Governing Body quarterly.</p>	8/6/15  8/6/15

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A1152	<p>Continued From page 4</p> <p>The respiratory resource was listed as "Lippincott Nursing Procedures (Sixth Edition 2012). Egan's Fundamentals of Respiratory Care, Eighth edition, dated 2003, was not included in the approved references.</p> <p>3. The respiratory department's policy and procedure manual included undated protocols and procedures that did not document any medical staff approvals or include any reference. Example Include: -Tracheostomy Care (Cleaning inner cannula, stoma site, and trach ties) -Tracheostomy Care (Speaking Valve) -Tracheostomy Care (Button Insertion) - Postural Drainage Therapy</p> <p>Some respiratory policies and procedures and or protocols did not have evidence of appropriate medical staff approval.</p> <p>3. The respiratory therapy department's policies and procedures were reviewed. They were included in a binder titled "Policies and Procedures" and presented to surveyors for review by the Manager of Respiratory Therapy.</p> <p>The Respiratory department policies and procedure manual included policies that had been initially approved in 2007 and 2008. There was no evidence the policies had been reviewed or revised since the dates listed on the policies. Examples include, but were not limited to, the following policies and procedures</p> <ul style="list-style-type: none"> <li>- Respiratory care, dated 10/07</li> <li>-Code Blue, dated 10/07</li> <li>- DNR, dated 10/07</li> <li>- Invasive ventilation, dated 10/07</li> </ul>	A1152	
(X5) COMPLETION DATE			

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A1152	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>- Withholding/withdrawing Life Sustaining Treatment, dated 10/07</li> <li>- Medications brought from home, dated 10/07</li> <li>- Oxygen Therapy Protocol, dated 12/08</li> <li>- Critical response values, dated 10/07</li> <li>- Respiratory care equipment, dated 10/07</li> <li>- Rental equipment, dated 10/07</li> <li>- Electrical cords and adapters, dated 10/07</li> <li>- Equipment failure and replacement, dated 10/07</li> <li>- Private owned equipment, date 10/07</li> <li>- Medical equipment management plan, dated 01/08</li> </ul> <p>The dates of the policies were confirmed by the Respiratory Manager during interview on 7/13/15 at at approximately 11:49 AM. She stated she was not aware of any additional review or revisions.</p> <p>A policy was requested related to how often policies were expected to be reviewed. The Corporate Director of Quality and Risk Management was interviewed on 7/14/15 at approximately 9 00 AM. She stated there was no specific hospital policy that stated the required frequency for policy review, however it was the practice of the hospital to review policies annually. It was a part of the MEC annual schedule.</p> <p>The Corporate Director of Quality and Risk Management provided a generic schedule of MEC tasks according to quarter of each year for surveyor review. The third quarter topic agenda included policy and procedure review. It stated "A summary (written or oral) of a review of all policies. A listing (index or table of contents) should be provided. Policies changed over the year would be presented."</p>	A1152		

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A1152	<p>Continued From page 6</p> <p>Documentation was requested to verify the annual review of policies occurred as referenced on the sample topic agenda. The Corporate Director of Quality and Risk Management stated, during an interview on 7/14/15 at approximately 4:30 PM, she had not been able to locate documentation in the MEC meeting minutes of the annual review of policies.</p> <p>The hospital's overall Medical Director was interviewed on 7/14/15 at 4:00PM. He stated that when he started working as the general medical director about 14 months prior, he was given a stack of papers to sign off on. He stated he looked them over, "not every page," and could not remember if he signed off on them.</p> <p>Respiratory policies were not current. The hospital did not have a reliable process to ensure respiratory policies were reviewed on a regular basis.</p> <p>4. The scope of respiratory services was not clearly defined in writing.</p> <p>a. The hospital's policies and procedures. They did not describe in writing the scope of the diagnostic and/or therapeutic respiratory care services offered by the hospital. This was confirmed by the Manager of Respiratory Services during an interview on 7/13/15 at approximately 10:30 AM. She stated the respiratory department's scope of services were reflected in the hospital's RT job descriptions and in the AARC position statement (not a hospital document). She stated she was not aware of any specific written description of services.</p>	A1152		

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A1152	Continued From page 7  b. The Corporate Director of Quality & Risk Management provided a document for review, "Plan for the Provision of Patient Care," (HP.020), dated 10/07. She stated it defined the scope of respiratory care services. The document stated "J. SCOPE OF SERVICE- The hospital has defined the scope of service for the inpatient department of the hospital. The scope of care/service includes the types and ages of patients served, hours of operations, procedures, and processes of each department and/or services provided (See attached Addendums 1a and 1b)." The referenced addendums were reviewed.  Addendum A referenced "SCOPE OF SERVICE." It stated "Procedures include medical management, rehabilitation therapy (physical therapy, speech therapy, and occupational therapy), respiratory therapy, dietary service, and pharmacy. The documents did not specifically define the scope of diagnostic and therapeutic respiratory services offered by the hospital. Addendum B did not reference scope of services.  There was insufficient organization and physician oversight of the respiratory services department.	A1152		
A1153	482.57(a)(1) DIRECTOR OF RESPIRATORY SERVICES  There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis.	A1153	The Administrator is responsible for ensuring the hospital has a structure appropriate to the scope and complexity of the respiratory services offered.	8/6/15

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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, ID 83709	

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A1153	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of administrative documents, it was determined the hospital did not have a physician director of respiratory care services, either on a full-time or part-time basis. This resulted in a lack of direction for the respiratory services department. It had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>Upon arrival for a complaint investigation on 7/13/15, an individual was introduced as the Director of Respiratory Therapy. The sign outside her door said "Director." When asked for a position description, a job description was provided for the "Manager of Respiratory Therapy." On the second day of the survey, 7/14/15, the Director clarified she was the Manager, although she had thought she was serving in the role of manager and director. She stated she had been in the respiratory management role for "about a year" and the individual she replaced had been an RT. During an interview on 7/14/15 at 9:22AM, she stated she has not seen a physician in the director position since the hospital opened.</p> <p>The DNO was interviewed on 7/13/15 at 12:03 PM. He initially identified a hospital pulmonologist as the Director of critical care, including respiratory services. After review of the physician's credentialing file, he stated he had been mistaken, that the pulmonologist was a staff physician rather than a director.</p> <p>The hospital's pulmonologist was interviewed on 7/14/15 at 11:15 AM. He stated he tried to be helpful and answer respiratory questions when he was available. He explained he worked a</p>	A1153	<p>Procedure/Process:                      &gt; A Doctor of Medicine with the education, experience and specialized training to supervise and administer the respiratory care services appointed as the director of respiratory care services</p> <p>Monitoring or Tracking:                      &gt; The Administrator or designee will verify the appointment of the doctor of medicine as the director of respiratory care services and the revision of the organizational chart.</p> <p>Measure:                      &gt; The Administrator or designee will report compliance with changes to Quality Council, MEC, and Governing Body quarterly.</p>	<p>7/30/15</p> <p>7/30/15</p> <p>8/6/15</p>

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  132003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  8. WING _____	(X3) DATE SURVEY COMPLETED  C 07/15/2015	
NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 6851 WEST FRANKLIN ROAD BOISE, ID 83709		
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A1153	<p>Continued From page 9</p> <p>schedule of 2 weeks on and 2 weeks off. He stated he did not direct the respiratory department and did not have any administrative responsibilities, such as attending respiratory meetings or other oversight. He stated the hospital had been looking for another pulmonologist for a couple of years since the prior one left but had not been successful in locating one. When asked how the respiratory needs of patients with complex respiratory needs were met when he was not available, he stated the hospital did their best to assign hospitalists with comfort in respiratory issues to cover the hospital in his absence, and if necessary, patients would be transferred out to an acute care hospital.</p> <p>During a phone interview on 7/13/15 at approximately 1:30 PM, the Corporate Director of Quality and Risk Management identified the hospital's general Medical Director as having oversight of the entire hospital, including the respiratory therapy department.</p> <p>The general Medical Director was interviewed on 7/14/15 at 4:00 PM. When asked if he was the Director of Respiratory Services, he stated he was not the Director of Respiratory Services. He stated he had been the general Medical Director for about 14 months and had been the Director of Wound Services for years since the hospital opened. He stated he spent about 2 hours per week in the general Medical Director role, mostly handling physician to physician issues. He stated he directed the wound service during the rest of his time with the hospital. He explained that the individual who had been the general Medical Director before he took the position had been a pulmonologist and had provided direction to the respiratory department. He stated the hospital</p>	A1153		

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  132003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED  C 07/15/2015
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, ID 83709
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A1153	<p>Continued From page 10</p> <p>had been trying to recruit a pulmonologist for some time without success.</p> <p>Portions of the medical staff bylaws, dated 6/19/13, were reviewed. The bylaws included, but were not limited to, the following information</p> <p>-ARTICLE 2 DEFINITIONS- 2.18 "A Medical Staff physician member employed by or under a contractual agreement or otherwise servicing the hospital to provide medical direction in a specific clinical unit or function of the hospital. Responsibilities may include both administrative and clinical duties.</p> <p>- ARTICLE 9 CLINICAL ORGANIZATIONAL OF THE MEDICAL STAFF-</p> <p>9.3 MEDICAL DIRECTORS</p> <p>A. SELECTION. Medical Directors will be Board Certified, or have affirmatively established comparable competence through the credentialing process.</p> <p>B. RESPONSIBILITIES: Each Medical Director shall:</p> <ol style="list-style-type: none"> <li>1. Determine and manage the clinically related and administrative activities within his/her program.</li> <li>2. Where Program Rules and Regulations are desired, shall be accountable for the development and implementation of those Rules and Regulations, ensuring that they support the overall Performance Improvement Plan of the Hospital, directly pertaining to professional medical care within their Program. Shall submit such Program Rules and Regulations to the</li> </ol>	A1153		

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A1153	Continued From page 11 Medical Executive Committee.  3. Develop and implement programs for orientation of new members, credentials review and privileges, delineation for initial appointment and reappointment, continuing medical education utilization review, concurrent evaluation of practice, and retrospective evaluation of practice,  4. Continuously assess and improve the quality of care, treatment and services, and maintain quality improvement programs as appropriate.  5. Transmit to the appropriate authorities as required in these Bylaws, the Programs recommendations concerning appointment, reappointment, delineation of clinical privileges, and disciplinary action;  6. Recommend the criteria for clinical privileges that are relevant to the care provided in the Program;  7. Assess and recommend to the relevant Hospital authority space issues, resource needs, and off-site sources for needed safe patient care, treatment, and services not provided by the Program or the organization;  8. Recommend a sufficient number of qualified and competent persons to provide care, treatment, and services;  9. Determine the qualifications and competence of personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;  10. Maintain continuing surveillance of the	A1153		

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A1153	Continued From page 12 professional performance of all members with clinical privileges with the program with appropriate documentation thereof,  11. Assist in developing and enforcing hospital policies and procedures that guide and support the provision of care, treatment and services; the Medical Staff Bylaws, Rules and Regulations; and the requirements and Rules and Regulations (if any) of the Program;  12. Integrate the Program into the primary functions of the organization,  13. Coordinate and integrate interdepartmental and intradepartmental services:  14. Implement within the Program actions take by the Medical Executive Committee;  15. Perform such other duties commensurate with his/her office as may from time to time be assigned by the President of the Medical Staff, the Medical Executive Committee or the Governing Body;  16. Report to the Medical Staff on all professional and administrative activities within their program; and  17. Establish such committees, task forces, or other mechanisms are necessary and desirable to perform properly the functions assigned to it.  The hospital did not have a qualified director appointed to or fulfilling the roles and functions of a medical director for the respiratory service.	A1153			
A1160	482.57(b) RESPIRATORY CARE SERVICES	A1160	The Administrator is responsible for ensuring the hospital has a structure appropriate to the scope and complexity of the respiratory services offered.		8/6/15

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A1160	<p>Continued From page 13</p> <p><b>POLICIES</b></p> <p>Services must be delivered in accordance with medical staff directives.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and procedures, was determined the hosp at failed to ensure services were consistently delivered in accordance with medical staff directives. This had the potential to interfere with quality and safety of patient care. Findings include</p> <p>1. Policies and procedures for the delivery of respiratory care services were reviewed in coordination with the Manager of Respiratory Therapy.</p> <p>The respiratory department's policy and procedure manual included undated protocols and procedures that did not document any medical staff approvals or include any reference. Example include:</p> <ul style="list-style-type: none"> <li>- Tracheostomy Care (Cleaning inner cannula, stoma site, and trach ties)</li> <li>- Tracheostomy Care (Speaking Valve)</li> <li>- Tracheostomy Care (Button Insertion)</li> <li>- Postural Drainage Therapy</li> </ul> <p>2. The hospital's policy "Clinical Standards of Practice," (PC 010) was reviewed. It listed the approved resources for various departments. The respiratory resource was listed as "Lippincott Nursing Procedures (Sixth Edition 2012).</p> <p>The Manager of Respiratory Therapy was interviewed on 7/13/15 at approximately 2:30 PM. She stated the respiratory department primarily</p>	A1160	<p><b>Procedure/Process:</b></p> <ul style="list-style-type: none"> <li>➤ Policy PC 010 "Clinical Standards of Practice" was reviewed and revised to include updated resources for the respiratory care services. Policy update approved by the director of respiratory care services, MEC, and Governing Body. 8/5/15</li> <li>➤ The respiratory care services policies were revised to clearly define the scope of care and delivery of respiratory care services. Policy and guideline review and approval by the director of respiratory services, MEC, and Governing Body. 8/5/15</li> <li>➤ Policy and guideline updates communicated to staff by the Respiratory Therapy Manager and Director of Nursing via hospital email and department staff meeting. Communicated the new organizational structure with Dr. Kumar as the Physician Director of Respiratory Care Services, applicable policy revisions, discontinued protocols at this time, and wound care/stoma care is a nursing responsibility. 8/6/15</li> </ul> <p><b>Monitoring or Tracking:</b></p> <ul style="list-style-type: none"> <li>➤ The director of respiratory care services or designee will verify the respiratory care staff provides services within the defined scope of services. 8/6/15</li> <li>➤ The Administrator or designee will verify the annual review and revision of policies, procedures, guidelines, order sets, standing orders, and protocols. 8/6/15</li> </ul>	8/5/15 8/5/15 8/6/15 8/6/15 8/6/15
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NAME OF PROVIDER OR SUPPLIER  SOUTHWEST IDAHO ADVANCED CARE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 6651 WEST FRANKLIN ROAD BOISE, 10 83709		
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A1160	Continued From page 14 used Egan's Fundamentals of Respiratory Care, Eighth edition, dated 2003.  Egan's Fundamentals of Respiratory Care, Eighth edition, dated 2003, was not included in the approved references.  Some respiratory policies, procedures, protocols, and references were not based on medical staff directives.		Measure: A1160 ➤ The Administrator or designee will report compliance with changes to Quality Council, MEC, and Governing Body quarterly.	8/6/15	
A1161	482.57(b)(1) RESPIRATORY CARE PERSONNEL POLICIES  Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.  This STANDARD is not met as evidenced by: Based on staff interview and review of policies and procedures, medical records, job descriptions and personnel competency requirements, it was determined the hospital failed to ensure respiratory services were provided in accordance with hospital policy, RT job description, and personnel competencies for 1 of 5 patients (#2) receiving respiratory services whose records were reviewed. This resulted in delivery of care without documented competencies. It had the potential to interfere with quality and safety of patient care. Findings include:  The "Respiratory Care" policy (PC 205), dated 10/07, was reviewed. The policy included, but was not limited to, the following information:  -The purpose of the policy is to outline the	A1161	The Director of Nursing Operations (DNO) is responsible for ensuring the delivery of care is provided by qualified staff. Procedure/Process: ➤ Stoma and wound care is provided by nurses who have demonstrated competency; respiratory therapist will not provide wound care per compliance with scope of service and job description. ➤ Communicated to respiratory therapy staff and wound care physician. Monitoring or Tracking: ➤ The director of respiratory care services or designee will verify the respiratory care staff provided services within the defined scope of services. Measure: ➤ The Administrator or designee will report compliance with changes to Quality Council, MEC, and Governing Body quarterly	8/6/15  7/30/15  8/6/15  8/6/15	

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A1161	<p>Continued From page 15 respiratory care services provided to patients.</p> <p>-ONLY those procedures approved within the job description, competency assessments, and policy may be provided.</p> <p>- Respiratory care procedures will be performed as directed by the clinical practice manual/resource approved by the medical staff.</p> <p>- Respiratory care will be provided in a manner that meets hospital policy.</p> <p>This policy was not followed related to Patient #2, as outlined below:</p> <p>Patient #2 was a 70 year old female who was admitted to the hospital on 6/21/15 for care after being transferred from another hospital for complications in weaning her off a ventilator. The medical records indicated Patient #2 had a tracheostomy which decannulated and subsequently exhibited signs of a non-healing stoma.</p> <p>A physician's order, dated 7/08/15 at 10 20 AM, stated "Microclense (sic) wet to dry 2 x 2 packed in superficial opening of tracheostomy and then cover with Allevyn Foam dressing- RT to change daily."</p> <p>The Manager of Respiratory Services was interviewed on 7/13/15 at 9:45AM. When asked if there was respiratory standard of practice for stoma care, as ordered for Patient #2, she stated that there was not a respiratory standard of care because the procedure was typically done by nursing, RTs did not typically do wound care once a trach is removed and it was not typical to pack</p>	A1161		

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A1161	<p>Continued From page 16</p> <p>a stoma. She stated the circumstance was unique and the care was provided based on a physician's order, not based on a respiratory standard of practice..</p> <p>The RT job description, "Respiratory Therapist," last revised 10/06/05, was reviewed. Post trach wound care was not addressed as a respiratory care procedure. This was confirmed by the Manager of Respiratory services during an interview on 7/13/15 that began on 9:45AM.</p> <p>A generic "Initial Clinical Competency" checklist for respiratory therapists was reviewed. The list of respiratory procedures verified for competency did not include post-trach wound care. This was confirmed by the Manager of Respiratory Therapy during an interview on 7/13/15 that began on 9:45 AM.</p> <p>An RT note in Patient #2's record, dated 7/08/15 at 2:30 PM, documented "Foam placed on pt trach as written per MD. Family concerned - explained RT will do stoma care per orders." The RT was interviewed by telephone on 7/14/15 at 10:45 AM. When asked if she had been familiar with this wound procedure or had received any training in the procedure, she stated she had never seen a stoma packed before and typically wound care was done by nursing. She stated she had not been trained in this particular type of stoma care and it was not a respiratory standard of practice.</p> <p>A second RT documented doing the wound care procedure on 7/09/15 at 3:30 PM and 7/10/15 at 9:05AM. The RT was interviewed on 7/13/15 at approximately 11:50 AM. He stated a physician did the procedure with him two times and showed</p>	A1161		

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A1161	<p>Continued From page 17</p> <p>him how to do the procedure.</p> <p>The RT Manager was asked if any other RTs in the department were trained in the procedure. she replied "No, only the one" on 7/15/15 at 11.15 AM.</p> <p>A procedure was assigned to RT personnel for Patient #2 that was not consistent with a respiratory care standard of practice, the RT job description, or required competencies in accordance with the requirements specified in hospital policy.</p>	A1161		



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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TAMARA PRISOCK—ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
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August 10, 2015

Connie Johnson, Administrator  
Southwest Idaho Advanced Care Hospital  
6651 West Franklin Road  
Boise, ID 83709

Provider #132003

Dear Ms. Johnson:

An unannounced on-site complaint investigation was conducted from July 13, 2015 to July 15, 2015 at Southwest Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00007097**

**Allegation #1:** Physician orders related to wound care for patients with tracheostomys, whose tubes had been removed, posed a danger to patients, with a particular increased risk for aspiration.

**Findings #1:** During the investigation, four medical records were reviewed. Patients, family members, and staff, were observed and interviewed.

One medical record documented a 70 year old female admitted to this hospital 6/20/15. She was admitted for complications in weaning her off of a ventilator. Her medical record included documentation of the patient's tracheostomy, from which tube had been removed. She subsequently exhibited signs of a non-healing wound where the tube was removed.

The hospital medical director, a wound care specialist, in collaboration with the attending physician, developed a plan for wound care to the patient's wound. The patient and her spouse were consulted by the physicians and treatments were initiated to the patient's wound.

A staff physician was interviewed 6 days after the wound care was initiated. He stated the patient was never at any risk of aspirating due to the wound care orders and her wound showed signs of healing. He stated the procedure made good clinical sense and the outcomes have been positive as evidenced by signs of healing not previously observed.

In an interview with the patient and spouse, they stated they were pleased with the care and pleased with the outcome.

Unsafe procedures were not noted in the other three medical records reviewed.

It could not be verified that the procedure ordered by the physician posed an imminent risk to the patient.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Respiratory therapists are required to perform tracheostomy care that is not within their standard of practice and for which they are not trained.

**Findings #2:** During the investigation four patients' records, policies, job descriptions, and competency assessments, were reviewed. Staff were interviewed.

Three of the four patients' records reviewed, noted respiratory services were provided consistent with the standards of practice for respiratory therapy. Services provided to one patient, were not.

The "Respiratory Care" policy (PC 205), dated 10/07, was reviewed. The policy included, but was not limited to, the following information:

- The purpose of the policy is to outline the respiratory care services provided to patients.
- ONLY those procedures approved within the job description, competency assessments, and policy may be provided.
- Respiratory care procedures will be performed as directed by the clinical practice manual/resource approved by the medical staff.
- Respiratory care will be provided in a manner that meets hospital policy.

Connie Johnson, Administrator  
August 10, 2015  
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This policy was not followed related to one patient, as outlined below:

One patient was a 70 year old female who was admitted to the hospital on 6/21/15, for care after being transferred from another hospital for complications in weaning her off a ventilator. The medical records indicated the patient had a tracheostomy, which decannulated (planned or accidental removal of a tracheostomy tube) and subsequently exhibited signs of a non-healing stoma.

A physician's order, dated 7/08/15 at 10:20 AM, stated "Microclense (sic) wet to dry 2 x 2 packed in superficial opening of tracheostomy and then cover with Allevyn Foam dressing - RT to change daily."

The Manager of Respiratory Services was interviewed on 7/13/15 at 9:45 AM. When asked if there was respiratory standard of practice for stoma care, as ordered for the patient, she stated that there was not a respiratory standard of care because the procedure was typically done by nursing, respiratory therapists (RTs) did not typically do wound care once a trach is removed and it was not typical to pack a stoma. She stated the circumstance was unique and the care was provided based on a physician's order, not based on a respiratory standard of practice.

The RT job description, "Respiratory Therapist," last revised 10/06/05, was reviewed. Post-tracheostomy wound care was not addressed as a respiratory care procedure. This was confirmed by the Manager of Respiratory services during an interview on 7/13/15, that began on 9:45 AM.

A generic "Initial Clinical Competency" checklist for RTs was reviewed. The list of respiratory procedures verified for competency did not include post-tracheostomy wound care. This was confirmed by the Manager of Respiratory Therapy during an interview on 7/13/15 that began on 9:45 AM.

An RT note in the patient's record, dated 7/08/15 at 2:30 PM, documented "Foam placed on pt trach as written per MD. Family concerned - explained RT will do stoma care per orders." The RT was interviewed by telephone on 7/14/15 at 10:45 AM. When asked if she had been familiar with this wound procedure or had received any training in the procedure, she stated she had never seen a stoma packed before and typically wound care was done by nursing. She stated she had not been trained in this particular type of stoma care and it was not a respiratory standard of practice.

A second RT documented doing the wound care procedure on 7/09/15 at 3:30 PM and 7/10/15 at 9:05 AM. The RT was interviewed on 7/13/15 at approximately 11:50 AM. He stated a physician did the procedure with him two times and showed him how to do the procedure.

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The RT Manager was asked if any other RTs in the department were trained in the procedure, she replied "No, only the one" on 7/15/15 at 11:15 AM.

A procedure was assigned to respiratory therapy personnel that was not consistent with a respiratory care standard of practice, the RT job description, or required competencies in accordance with the requirements specified in hospital policy.

A deficiency was cited at 42 CFR §482.57(b)(1) as it relates to the failure of the facility to ensure procedures performed by RT staff, and the amount of supervision needed for each, were outlined in writing.

Related deficiencies were also cited at 42 CFR §482.57-Condition of Participation of Respiratory Services; 42 CFR §482.57(a) related to the failure of the facility to ensure the organization of the respiratory care services was appropriate to the scope and complexity of the services offered; 42 CFR §482.57(a)(1) as it relates to the failure of the hospital to ensure a qualified physician served as the Director of Respiratory Services; 42 CFR §482.57(b) as it relates to the failure of the hospital to ensure services were consistently delivered in accordance with medical staff directives.

**Conclusion #2:** Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626, option 4. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

*Heidi Kelly for Teresa Hamblin*

TERESA HAMBLIN  
Health Facility Surveyor  
Non-Long Term Care

*Sylvia Creswell*

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

TH/pmt