



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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DIVISION OF LICENSING & CERTIFICATION
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BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7000 1670 0011 3315 1514

August 26, 2015

Carl Hanson, Administrator
Minidoka Memorial Hospital
1224 8th Street
Rupert, ID 83350

RE: Minidoka Memorial Hospital, Provider #131319

Dear Mr. Hanson:

Based on the survey completed at Minidoka Memorial Hospital, on August 6, 2015, by our staff, we have determined Minidoka Memorial Hospital, is out of compliance with the Medicare Hospital Provision of Services (42 CFR 485.635) and Periodic Evaluation & QA Review (42 CFR 485.641). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Minidoka Memorial Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Carl Hanson, Administrator
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- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before September 20, 2015. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 10, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 8, 2015.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626, option 4.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Carroll Wyble, CMS Region X Office

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

PRINTED: 08/26/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131319	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350
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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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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital conducted from 8/03/15 to 8/06/15. The surveyors conducting the Medicare recertification survey were:</p> <p>Gary Guiles, R.N., H.F.S., Team Leader Rebecca Lara, R.N., H.F.S. Teresa Hamblin, R.N., MS, H.F.S Dennis Kelly, R.N., BC, H.F.S</p> <p>Acronyms used in this report include:</p> <p>abd - abdomen AMA - Against Medical Advice APIC - The Association for Professionals in Infection Control and Epidemiology CAH - Critical Access Hospital CDC - The Centers for Disease Control and Prevention CDI - Clostridium Difficile Infection CEO - Chief Executive Officer DNS - Director of Nursing Service ED - Emergency Department EGD - Esophagogastroduodenoscopy ER - Emergency Room DO - Doctor of Osteopathy EMTALA - Emergency Medical Treatment and Active Labor Act H&P - History and Physical Examination IC - Infection Control IDAPA - Idaho Administrative Procedures Act IHA - Idaho Hospital Association pts - patients IV - Intravenous MD - Medical Doctor NIH - National Institute of Health</p>	C 000	<p style="text-align: center;">RECEIVED SEP - 8 2015 FACILITY STANDARDS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Carl Hansen* TITLE *Administrator* (X8) DATE *9-8-15*

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 participation.

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C 000	Continued From page 1 POC - Plan of Care Postop - Postoperative PRN - As needed basis QA - Quality Assurance RT - Respiratory Therapy SNF - Skilled Nursing Facility SSI - Surgical Site Infection URC - Utilization Review Coordinator	C 000	C-0195 Corrective Action: The Administrator has received a revised draft contract with the Idaho Hospital Association (IHA) to provide annual Quality Assurance reviews that includes credentials of the reviewer, specific services to be provided by the contractor, specific areas to be reviewed and findings with recommendations for improvement. The Administrator has been advised that IHA has requested a meeting with the Bureau of Facility Standards to assure that what they are proposing fills the need for an annual CAH hospital review, prior to finalizing the contract. The hospital will report quality monitors to Medicare Beneficiary Quality Improvement Project (MBQIP) data for core inpatient and outpatient measures in October 2015. Process Improvement/Implementation: <ul style="list-style-type: none"> Quality monitors will be reported to Medicare Beneficiary Quality Improvement Project (MBQIP) data for core inpatient and outpatient measures to be able to benchmark with other CAHs beginning October 2015. The hospital has entered into an agreement with the Rural Wisconsin, which is a CMS approved vendor to perform patient satisfaction surveys for inpatient and outpatient services beginning October 2015. Monitoring PoC- <ul style="list-style-type: none"> Quality monitors and patient satisfaction survey summaries will be reported to the Quality Committee, the Medical Staff, and the Board of Trustees at least quarterly. 	9/10/15	
C 195	485.616(b) AGREEMENTS - CREDENTIALING & QA Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least - (1) one hospital that is a member of the network; (2) one QIO or equivalent entity; or (3) one other appropriate and qualified entity identified in the State rural health care plan. This STANDARD is not met as evidenced by: Based on staff interview and review of contracts, letters, and quality assurance documents, it was determined the CAH failed to ensure an agreement with respect to quality assurance, which included the specific services to be provided by the contractor, had been negotiated. This interfered with the CAH's ability to enforce the contract and to seek guidance for its quality assurance program. Findings include: 1. The CAH had an agreement with an outside entity for Quality Assurance reviews, dated 6/05/01. The agreement stated the CAH was required to have an agreement with an appropriate qualified entity identified in the Idaho Rural Health Care Plan and [name of contractor]	C 195			

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C 195	<p>Continued From page 2</p> <p>was such an entity. The agreement stated the CAH would participate in the Maryland Quality Indicator Project. The project is no longer operational.</p> <p>The agreement stated the contractor would conduct "...on-site surveys of Minidoka Memorial Hospital's Quality Assurance activities to insure continued performance." The agreement did not state the qualifications of the surveyors, areas of focus the surveys would include, or how the surveys would be conducted, e.g. interviews, review of medical records, contracts, meeting minutes, etc.</p> <p>A letter from the contractor to the CAH, dated 12/10/14, stated the contractor had conducted a quality review. The letter stated the contractor had reviewed the COP for "Periodic Evaluation and Quality Assurance Review." The letter stated reports were flowing from the "Quality Management Team" to the Medical Staff to the Governing Board as reflected in agendas and meeting minutes. The letter stated "Each department [of the CAH] had many different measures hospital wide and I really feel that your hospital does great things involving data within this program." The letter did not state what items were reviewed and what the specific findings of the review were.</p> <p>In addition, the letter did not state whether the Annual Evaluation had been reviewed and if so, findings of the review. Also, the letter did not contain recommendations to improve the quality assurance program.</p> <p>The Administrative Assistant, who was also the Quality Coordinator, was interviewed on 8/06/15</p>	C 195		

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C 195	Continued From page 3 beginning at 1:30 PM. She confirmed the contract lack specific services to be provided by contractor. She also confirmed the lack of specific feedback provided by the contractor regarding the quality review. She also stated the Maryland Quality Indicator Project was no longer operational. The CAH's agreement with respect to quality assurance was inaccurate and incomplete.	C 195		
C 258	485.631(b)(1)(ii) RESPONSIBILITIES OF MD OR DO [The doctor of medicine or osteopathy--] In conjunction with the physician assistant and/or nurse practitioner member(s), participates in developing, executing, and periodically reviewing the CAH's written policies governing the services it furnishes; This STANDARD is not met as evidenced by: Based on staff interview and policy review, it was determined the CAH failed to ensure an MD/DO participated in the development and review of policies that governed CAH services. This has the potential to interfere with quality and safety of patient care. Findings include: 1. An undated hospital policy, "Policy Creation	C 258	C-0258 Corrective Action: The Policy Creation and Maintenance Policy was revised to include Policy Development Advisory Group. All IDAPA required Emergency Room policies and Defibrillator Checks, Emergency Call Coverage Requirements, IV Conscious Sedation, Triage in ER, Air Medical From Scene, Mental Health Hold Protocols, Code Blue, have been revised by Director or Nursing Service and approved by and with signatures of the Director of Nuring Service, the Emergency Room Medical Director, and a Board of Trustee. Process Improvement: <ul style="list-style-type: none"> A policy and procedure inservice provided by the Bureau of Rural Health & Primary Care was attended by department managers on 8/19/15. A Policy Development Advisory Group has been implemented and will meet at least monthly for policy development. Members will include department managers. Medical Staff, Administration, and Board of Trustees will attend as needed. 	9/10/15

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C 258	<p>Continued From page 4 and Maintenance," included, but was not limited to, the following information: "If any of the affected departments are clinical departments, the physician chairperson assigned to that department, or the Chief of the Medical Staff, must also sign the policy prior to implementation."</p> <p>A second policy "Minidoka Memorial Hospital Emergency Department: IDAPA Rules and Minimum Standard for Hospitals in Idaho," dated 3/19/15, was reviewed. It stated the hospital administration, medical staff, and nursing service shall approve the procedures and the governing body shall approve the (emergency department) policies.</p> <p>The CEO/Administrator was interviewed on 8/05/15 at 8:24 AM. When asked how or where policy review was documented, he stated signatures should appear on the policies.</p> <p>A sample of Emergency Department policies and procedures was reviewed. Policies lacked signature or other evidence of involvement and approval by an MD/DO, including but not limited to, the following policies:</p> <ul style="list-style-type: none"> * "Supporting Procedure for Care of Emergency Equipment," dated 1/31/14 * "Defibrillator Checks," dated 3/17/15 * "Emergency Call Coverage Requirements," not dated. * "IV Conscious Sedation," not dated. * "Procedures that Can/Cannot be Performed in the Emergency Room," dated 1/01/15. 	C 258	<p>C-0258 continued....</p> <p>Implementing Plan of Correction (PoC):</p> <ul style="list-style-type: none"> • Administrator notified department managers of change to the Policy Creation and Management policy. • Director of Nursing will inservice nursing staff to ensure compliance with the revised policies and procedures at the staff meeting on 9/9 and 9/10/15. <p>Monitoring PoC-</p> <ul style="list-style-type: none"> • Emergency Department policies and procedures will be reviewed and report at Quality Committee quarterly to ensure compliance with IDAPA and CMS regulations. 		

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C 258	Continued From page 5 * "Transfer and/or Referral to Another Facility," dated 3/20/15 * "Triage in ER," dated 2/22/12 * "Air Medical From Scene, dated 12/31/14 * "Procurement of Drugs, Equipment, and Supplies," not dated * "Mental Health Hold Protocols," dated 5/05/15 * "Code Blue," dated 1/15/15 * "Alcohol, Drugs or Other Intoxicating Substance, Testing of," dated 2/26/15 The DNS was interviewed on 8/04/15 at 10:23 AM. She confirmed policies did not include evidence of physician approval.	C 258		
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on staff interview, observation, and review of policies, procedures, APIC documentation, the list of contracted services, and the CAH's annual report, it was determined the CAH failed to ensure requirements were met related to patient care policies and contracted services. This impacted multiple hospital departments and programs and had the potential to negatively impact patient care. Findings include: 1. Refer to C-0271 as it relates to the CAH's failure to ensure policies were updated or signed with all appropriate approvals in accordance with	C 270	C-0270 Corrective Action: Refer to C 0271 Refer to C 0272 Refer to C 0273 Refer to C 0274 Refer to C 0278 Refer to C 0291 Refer to C 0292 Refer to C 0298	9/10/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 270	<p>Continued From page 6 hospital policy.</p> <p>2. Refer to C-0272 as it relates to the CAH's failure to ensure policies were reviewed at least annually by a group of professional personnel.</p> <p>3. Refer to C-0273 as it relates to the CAH's failure to have a policy that described the services of the CAH, including services furnished through agreement.</p> <p>4. Refer to C-0274 as it relates to the CAH's failure to ensure policies and procedures for emergency medical services were current with all required approvals.</p> <p>5. Refer to C-0278 as it relates to the CAH's failure to ensure systems to identify and investigate potential post-operative infections had been clearly defined and implemented.</p> <p>6. Refer to C-0291 as it relates to the CAH's failure to ensure the list of contracted services was current and complete.</p> <p>7. Refer to C-0292 as it relates to the CAH's failure to ensure the CEO provided pro-active oversight of contracted services. --</p> <p>8. Refer to C-0298 as it relates to the CAH's failure to ensure nursing care plans were complete and current for each inpatient.</p> <p>The cumulative effect of these negative systemic practices seriously impeded the CAH's ability to provide services of sufficient scope and quality.</p>	C 270	
C 271	485.635(a)(1) PATIENT CARE POLICIES	C 271	

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C 271	<p>Continued From page 7</p> <p>The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and procedures and the annual report, it was determined the CAH failed to ensure policies were updated and/or approved by all required professionals in accordance with hospital policy for 9 of 9 departments (ED, Respiratory Services, Surgical Services, Dietary Services, Housekeeping, Medical Records, Swing Bed Services, Physical Therapy Services and Radiology Services) whose policies were reviewed. This had the potential to result in policies and procedures that did not reflect current standards of practice which could compromise the quality patient care. It also resulted in a lack of direction and resources to staff. Findings include:</p> <p>1. An undated hospital policy, "Policy Creation and Maintenance," included, but was not limited to, the following information:</p> <p>* All policies that affect more than one department must be reviewed and approved by the hospital administrator and the department managers of any affected departments prior to implementation.</p> <p>* If any of the affected departments are clinical departments, the physician chairperson assigned to that department, or the Chief of the Medical Staff, must also sign the policy prior to implementation.</p> <p>* Policies and procedures should be reviewed and updated annually.</p>	C 271	<p>C-0271</p> <p>Corrective Action:</p> <p>The Policy Creation and Maintenance Policy was revised to include Policy Development Advisory Group.</p> <p>All IDAPA required Emergency Room policies and Defibrillator Checks, Emergency Call Coverage Requirements, IV Conscious Sedation, Triage in ER, Air Medical From Scene, Mental Health Hold Protocols, Code Blue, have been revised by Director or Nursing Service and approved by and with signatures of the Director of Nursing Service, the Emergency Room Medical Director, and a Board of Trustees.</p> <p>The EMTALA policy was combined with the Transfer and or Referral to Other Facility Policy into one policy.</p> <p>Respiratory Therapist has revised, updated, and approved the policies and procedures on Medical Gas Safety, Oxygen Rounds, Personal Equipment Use, Aerosol Delivery Devices, Bronchial Hygiene, and Intubation. They were then approved by the Chief of Medicine and Board of Trustees.</p> <p>Dietary policies and procedures were developed and they have been through proper approval.</p> <p>Housekeeping and Laundry policies and procedures were reviewed and have been through the proper approval process.</p> <p>Medical Records policies and procedures were reviewed, revised, and have been through the proper approval including the following: The Release of Patient Information was combined with the Confidentiality of Patient Information. Medical Records Department, Release of Medical Information, Procedure for Finding Charts During Hours When the Department is Closed, Notice to Physicians of Chart Delinquency.</p>

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C 271	Continued From page 8 A second CAH policy "Minidoka Memorial Hospital Emergency Department: IDAPA Rules and Minimum Standard for Hospitals in Idaho," dated 3/19/15 was reviewed. It stated the hospital administration, medical staff, and nursing service shall approve the procedures and the governing body shall approve (emergency department) policies. The CEO/Administrator was interviewed on 8/05/15 at 8:24 AM. When asked how or where review and approval of policies was documented, he stated signatures should appear on the policies. A sample of Emergency Department policies and procedures was reviewed. Policies lacked evidence of appropriate approvals and annual review, as follows: * The policy "Supporting Procedure for Care of Emergency Equipment," dated 1/31/14, was signed by the DNS. There was no documentation of policy approval by the administrator, a physician on the medical staff, or governing body. * The policy, "Defibrillator Checks," dated 3/17/15, was signed by the DNS. There was no documentation of policy approval by the administrator, a physician on the medical staff, or governing body *The policy, "Emergency Call Coverage Requirements," was not signed or dated. There was no documentation of policy approval by the department manager, the administrator, a physician on the medical staff, or governing body.	C 271	C-0271 Continued Surgical Services policies were reviewed, revised, and approved by the Surgical Services Director, Chief of Surgery, and DNS including Regulated Medical Waste Safety, Dress Code, Surgical Attire, Traffic Patterns in the Surgical Suite, Continuing Education, Scheduling Surgery, Care of Patient in PACU, Transporting a Patient to the Surgery Unit, Tissue Specimens Care and Handling, Cardiac Arrest During Surgery, Paracentesis, Arterial Line Insertion, Capillary Glucose Testing, Safety, Safety Equipment, Release of Patient Information. Radiology policies were reviewed, revised, and approved by the Radiology Director, Radiology Medical Director, and the Chief Operations Officer including Operation of Radiology Equipment, Minimizing Exposure to Radiation, Ordering Radiology Tests and Services, MRI Patient Emergency Situation Protocol, IV Contrast Administration, General Safety Precautions, Infection Control, and Scope of Services. The following policies and procedures were achieved: Oxygen Safety Rules, Oxygen E Cylinder, Physician's Order Given to Ancillary Department, Documentation of. The Director of Swing Bed services reviewed and updated the Swing Bed policies and have been through the proper approval. The Physical Therapist has developed policies and procedures and have been through the proper approval.	9/10/15

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C 271	<p>Continued From page 9</p> <p>* The policy, "EMTALA," dated 3/17/15, was not signed. There was no documentation of policy approval by the department manager, the administrator, a physician on the medical staff, or governing body.</p> <p>*The policy, "IV Conscious Sedation," was was not signed or dated. There was no documentation of policy approval by the department manager, the administrator, a physician on the medical staff, or governing body.</p> <p>* The policy, "Procedures that Can/Cannot be Performed in the Emergency Room," dated 1/01/15, was signed by the DNS. There was no documentation of policy approval by the administrator, a physician on the medical staff, or governing body</p> <p>* The policy, "Transfer and/or Referral to Another Facility," dated 3/20/15, was signed by the Administrator. There was no documentation of policy approval by the department manager, a physician on the medical staff, or governing body.</p> <p>* The policy, "Triage in ER," dated 2/22/12, was signed by the DNS. The policy was outdated. There was no documentation of policy approval by the administrator, a physician on the medical staff, or governing body.</p> <p>* The policy, "Air Medical From Scene," dated 12/31/14, was not signed. There was no documentation of policy approval by the department manager, the administrator, a physician on the medical staff, or governing body.</p> <p>* The policy, "Procurement of Drugs, Equipment, and Supplies," was not signed or dated. There</p>	C 271	<p>C-0271 continued...</p> <p>Process Improvement:</p> <ul style="list-style-type: none"> A policy and procedure inservice provided by the Bureau of Rural Health & Primary Care was attended by department managers on 8/19/15. A Policy Development Advisory Group has been implemented and will meet at least monthly for policy development. Members will include department managers. Medical Staff, Administration. Approved policies and procedures will be forwarded to the Board of Trustees for final approval. <p>Implementing Plan of Correction (PoC):</p> <ul style="list-style-type: none"> Administrator notified department managers of change to the Policy Creation and Management policy. Director of Nursing will inservice nursing staff to ensure compliance with the revised policies and procedures at the staff meeting on 9/9 and 9/10/15. Policy and Procedure approval has been added to the Board of Trustee agenda for 9/9/15 and then quarterly. <p>Monitoring PoC-</p> <p>Department policies and procedures will be reviewed and report at Quality Committee quarterly to ensure compliance with IDAPA and CMS regulations.</p> <p>Dietary QA - A Nursing Nutritional Screening tool is being developed to help initiate a Dietitian consult for at risk patients.</p>	

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NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
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C 271	<p>Continued From page 10</p> <p>was no documentation of policy approval by the department manager, the administrator, a physician on the medical staff, or governing body</p> <p>* The policy, "Mental Health Hold Protocols," dated 5/05/15, was signed by the administrator. There was no documentation of policy approval by the department manager, a physician on the medical staff, or governing body</p> <p>* The policy, "Code Blue," dated 1/15/15, was signed by the administrator. There was no documentation of policy approval by the department manager, a physician on the medical staff, or governing body.</p> <p>* The policy, "Alcohol, Drugs or Other Intoxicating Substance, Testing of," dated 2/26/15, was signed by the DNS. There was no documentation of policy approval by the administrator, a physician on the medical staff, or governing body.</p> <p>The DNS was interviewed on 8/04/15 at 10:23 AM. She confirmed the policies did not include all of the required approvals and/or evidence of annual review.</p> <p>2. The bylaws of the Board of Trustees (governing body), was reviewed. Article 4 Responsibilities of the Board, included the following: "The hospital board determines & establishes the policies of the hospital."</p> <p>The "Minidoka Memorial Hospital Annual Report Fiscal Year 2014," dated 10/24/14, was reviewed. A list of policies reviewed and approved by the Board were listed, as follows:</p> <p>* Charity Care Policy</p>	C 271		

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C 271	<p>Continued From page 11</p> <ul style="list-style-type: none"> * Compliance Committee Policies * Conflict of Interest Policy * Credit Policy * Purchasing Policy * Quality Assessment Plan * Risk Management Plan * Utilization Review Plan <p>There was not evidence the Board of Trustees determined or established other hospital policies, as stated in the bylaws.</p> <p>3. A sample of Respiratory Reapartment policies and procedures was reviewed. The policies were lacked evidence of annual review as follows:</p> <ul style="list-style-type: none"> * The policy, "Medical Gas Safety," was dated 2007. * The policy, "Oxygen Rounds," was dated 2007. * The policy, "Personal Equipment Use," was dated 2007. * The policy, "Aerosol Delivery Devices," was dated 2007. * The policy, "Bronchial Hygiene," was dated 2007. * The policy, "Intubation," was dated 2008. 	C 271		

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C 271	<p>Continued From page 12</p> <p>A respiratory therapist was interviewed on 8/06/15 at 9:35 AM. She confirmed the policies were not reviewed annually. She stated the RT department had a new RT Director that was beginning to work on reviewing and revising RT policies.</p> <p>4. Dietary policies and procedures were requested. Hospital-approved dietary policies were not available for review.</p> <p>The registered dietician for the swing beds was interviewed on 8/04/15 at 2:18 PM. The Director of Food Service was also present during the interview. The registered dietician stated she worked for a company which contracted with another company, which in turn, contracted with the hospital. When asked about the dietary policies she used related to swing bed patients, she stated she used "Becky Dormer and Associates" policies and procedures, dated 2013. She provided the policy and procedure manual for review. It included sections for menus and special diets, dining and meal service, food production and safety, sanitation and infection control, cleaning instructions, safety, etc. There was no evidence of hospital approval for the policies for use of "Becky Dormer and Associates" policies and procedures. This was confirmed by the registered dietician and the Director of Food Service during the interview.</p> <p>Another registered dietician was interviewed on 8/05/15 at 11:00 AM. She stated she worked as an employee of the hospital and saw acute patients, upon request, rather than swing beds patient. When asked what dietary policies and procedures she used, she stated she did not operate off of any hospital policies and</p>	C 271			

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C 271	<p>Continued From page 13</p> <p>procedures, but she did have reference material she used, such as the Idaho Dietetic Diet Manual. She stated she was not aware of any hospital dietary policies and procedures.</p> <p>The dietary policies and procedures had not gone through an approval process with the CAH.</p> <p>5. Housekeeping and laundry policies and procedures were requested. During an interview on 8/06/15 at 10:15 AM, the Director of Housekeeping described a collection of resources utilized within the department. The housekeeping and laundry policies did not go through a formal approval process. This was confirmed by the Director of Housekeeping during the interview.</p> <p>6. A sample of Medical Records Service policies and procedures was reviewed. Policies were not reviewed annually and/or lacked appropriate approvals, as follows:</p> <p>* A policy "Hawley Troxell Record Retention & Destruction," was dated 2007. It did not include the hospital's name or signatures to indicate approval. During an interview on 8/06/15 at 8:40 AM, the Administrative Assistant, who also served as the CAH's Quality Coordinator, said the hospital followed the policy. However, during an interview on 8/06/15 at 8:55 AM, the Director of Medical Records said she did not recognize the policy and it was not actually a hospital policy.</p> <p>* A policy "Release of Patient Information, dated 1/15/15, was signed by the CEO/Administrator. There was no documentation to indicate the department manager approved the policy.</p>	C 271		

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C 271	<p>Continued From page 14</p> <p>* A policy, "Medical Record Department," dated 7/23/07, was signed by the Director of Medical Records. It had not been reviewed in 8 years, and was not signed by the Administrator.</p> <p>* A policy, "Release of Medical Information," dated 5/12/15, was signed by the CEO/Administrator. There was no documentation the department manager approved the policy.</p> <p>* A policy, "Procedure for Finding Charts During Hours When the Department is Closed," was not signed or dated.</p> <p>* A policy, "Notice to Physicians of Chart delinquencies, was dated 7/23/07. The policy was not reviewed annually.</p> <p>* A policy, "Scanning policy and Procedure," was dated 07/23/07. The policy was not reviewed annually.</p> <p>* A policy, "Procedure for filing of record, was not dated and not signed.</p> <p>The Director of Medical Records was interviewed on 8/05/15 at beginning at 9:22 AM. She confirmed the policies referenced above were not reviewed annually and/or were missing approvals.</p> <p>7. A sample of Surgical Services policies was reviewed. Though manuals containing written policies related to surgical services were provided, the policies were not reviewed annually and lacked approval by the Board of Trustees.</p> <p>The following sample list of policies related to surgical services were not reviewed annually.</p>	C 271	

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C 271	<p>Continued From page 15</p> <p>They were last signed by the Director of Surgical Services on 10/17/13. The policies were not signed or approved by the Board of Trustees or medical staff.</p> <ul style="list-style-type: none"> * Regulated Medical Waste Safety * Dress Code, Surgical Attire * Traffic Patterns in the Surgical Suite * Continuing Education * Scheduling Surgery * Care of Patient in PACU * Transporting a Patient to the Survey Unit * Tissue Specimens, Care and Handling * Cardiac Arrest During Surgery * Paracentesis * Arterial Line Insertion * Capillary Glucose Testing * Safety * Safety Equipment * Release of Patient Information <p>This was confirmed by the Director of Surgical Services on 8/05/15 at approximately 2:30 PM.</p> <p>Surgical Services policies were not reviewed and</p>	C 271		

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C 271	<p>Continued From page 16 approved consistent with the CAH's policies.</p> <p>8. A sample of policies for Radiology Services was reviewed. The policies had not been routinely reviewed/approved annually, by the Board of Trustees and medical staff. Examples included, but were not limited to, the following:</p> <ul style="list-style-type: none"> * A policy titled, "Hazardous Material, Disposal of" documented the policy was "Review/Approved" last on 4/12/1985 and was signed by a respiratory therapist only. * A policy titled, "Oxygen E Cylinder" documented the policy was "Reviewed/Revised/Approved" on 12/20/1988 and was signed by a respiratory therapist only. * A policy titled, "OXYGEN SAFETY RULES" documented the policy was "Reviewed/Revised/Approved" last on 12/20/1988 and was signed by a respiratory therapist only. * A policy titled, "Physician's Orders Given to Ancillary Departments, Documentation of" documented the policy was "Review/Approved" last on 3/21/1986 and was signed by a respiratory therapist only. <p>This was confirmed by the Director of Radiology on 8/06/04 at 2:00 PM.</p> <p>Radiology Services policies were not reviewed annually and approved by all entitites required by the CAH's policies.</p> <p>9. The Director of Swing Bed Services was interviewed on 8/04/15 beginning at 3:30 PM. She stated the CAH did not have current Swing</p>	C 271		

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C 271	Continued From page 17 Bed policies. She stated she was reviewing and updating them but none of the new policies had been approved by the CEO/Administrator, Board of Trustees, and a medical staff physician. The CAH's Swing Bed Services policies were not reviewed and approved consistent with its policies. 10. A Physical Therapist was interviewed on 8/06/15 beginning at 8:15 AM. She stated she thought the CAH had therapy policies but she said she did not know where to look for them. Physical Therapy policies could not be found for review.	C 271		
C 272	The CAH policies were not reviewed and approved as required by its policies. 485.635(a)(2), (a)(4) PATIENT CARE POLICIES §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least annually by the group of professional personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on staff interview and policy review, the hospital failed to ensure CAH policies were reviewed at least annually by a group of	C 272	C-0272 Corrective Action: Refer to C-0271	9/10/15

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C 272	<p>Continued From page 18</p> <p>professional personnel for 7 of 7 departments which had policies in place (ED, Respiratory Services, Surgical Services, Dietary Services, Housekeeping, Medical Records, Radiology Services) and whose policies were reviewed. This had the potential to result in standards of practice that were not current, which, in turn, could result in negative patient outcomes. Findings include:</p> <p>1. The CEO was interviewed on 8/05/15 at 8:24 AM. When asked if the CAH had a policy development advisory group, he stated "no." The CEO was asked how or when policy review occurred and where review and approval of policies was documented. He explained the review process was somewhat informal, based on responses to deficiencies cited during surveys or the need to update them for other reasons. He stated signatures should be on the policies with the date of review or approval.</p> <p>An undated hospital policy, "Policy Creation and Maintenance," stated the CAH's policies and procedures should be reviewed and updated annually. This was not done, as follows:</p> <p>a. A sample of Emergency Department policies and procedures was reviewed. Policies did not show evidence of annual review, as follows:</p> <p>* The policy "Supporting Procedure for Care of Emergency Equipment," was dated 1/31/14.</p> <p>* The policy "Emergency Call Coverage Requirements," was not dated. It could not be determined it was current.</p> <p>* The policy, "IV Conscious Sedation," was was</p>	C 272		

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C 272	<p>Continued From page 19 not dated. It could not be determined it was current.</p> <p>* The policy, "Triage in ER," was dated 2/22/12.</p> <p>* The policy, "Procurement of Drugs, Equipment, and Supplies," was not dated. It could not be determined it was current.</p> <p>The DNS was interviewed on 8/04/15 at 10:23 AM. She confirmed policies were not reviewed annually.</p> <p>b. A sample of Respiratory department policies and procedures was reviewed. Policies were not reviewed annually by a group of professional personnel as follows:</p> <p>* The policy, "Medical Gas Safety," was dated 2007.</p> <p>* The policy, "Oxygen Rounds," was dated 2007.</p> <p>* The policy, "Personal Equipment Use," was dated 2007.</p> <p>* The policy, "Aerosol Delivery Devices," was dated 2007.</p> <p>* The policy, "Bronchial Hygiene," was dated 2007.</p> <p>* The policy, "Intubation," was dated 2008.</p> <p>A respiratory therapist was interviewed on 8/06/15 at 9:35 AM. She confirmed the policies were outdated based on the expectation for an annual review.</p>	C 272			

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C 272	<p>Continued From page 20</p> <p>c. Dietary policies and procedures were requested. There were no hospital-approved dietary policies available for review.</p> <p>The registered dietician for swing beds patients was interviewed on 8/04/15 at 2:18 PM. The Director of Food Service was also present during the interview. When asked about the dietary policies she used related to swing bed patients, she stated she used "Becky Dormer and Associates" policies and procedures, dated 2013. She provided the policy and procedure manual for review. It included sections for menus and special diets, dining and meal service, food production and safety, sanitation and infection control, cleaning instructions, safety, etc. There was no evidence of hospital review and approval of the policies. This was confirmed by the registered dietician and the Director of Food Service at the time of the interview.</p> <p>The dietary policies and procedures were not reviewed and approved by a group of professional personnel annually.</p> <p>d. Housekeeping and laundry policies and procedures were requested. The Director of Housekeeping described a collection of resources utilized within the department. The housekeeping and laundry policies did not go through formal review process. This was confirmed by the Director of Housekeeping during interview on 8/06/15 at 10:15 AM. Housekeeping and laundry policies were not reviewed and approved annually by a group of professional personnel.</p> <p>e. Medical Records service policies and procedures were reviewed. Policies were not</p>	C 272		

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C 272	<p>Continued From page 21 reviewed annually, as follows:</p> <ul style="list-style-type: none"> * "Hawley Troxell Record Retention & Destruction," dated 2007 * A policy, "Medical Record Department," not dated * A policy, "Procedure for Finding Charts During Hours When the Department is Closed," not dated * A policy, "Notice to Physicians of Chart delinquencies, was dated 7/23/07. * A policy, "Scanning policy and Procedure," was dated 07/23/07 * A policy, "Procedure for filing of record, not dated <p>Medical Records policies were not reviewed annually.</p> <p>f. A sample of Surgical Services policies were reviewed.</p> <p>The following sample list of policies related to surgical services were last signed by the Director of Surgical Services on 10/17/13. The policies were not reviewed annually.</p> <ul style="list-style-type: none"> * Regulated Medical Waste Safety * Dress Code, Surgical Attire * Traffic Patterns in the Surgical Suite * Continuing Education * Scheduling Surgery * Care of Patient in PACU * Transporting a Patient to the Survey Unit 	C 272			

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NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
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C 272	<p>Continued From page 22</p> <ul style="list-style-type: none"> * Tissue Specimens, Care and Handling * Cardiac Arrest During Surgery * Paracentesis * Arterial Line Insertion * Capillary Glucose Testing * Safety * Safety Equipment * Release of Patient Information <p>This was confirmed by the Director of Surgical Services on 8/05/15 at approximately 2:30 PM.</p> <p>Surgical Services policies were not reviewed annually by a group of professional personnel.</p> <p>g. A sample of Radiology Services was reviewed. The policies were not reviewed annually.</p> <ul style="list-style-type: none"> * A policy titled, "Hazardous Material, Disposal of" documented the policy was "Review/Approved" last on 4/12/1985. * A policy titled, "Oxygen E Cylinder" documented the policy was "Reviewed/Revised/Approved" on 12/20/1988. * A policy titled, "OXYGEN SAFETY RULES" documented the policy was "Reviewed/Revised/Approved" last on 12/20/1988. * A policy titled, "Physician's Orders Given to Ancillary Departments, Documentation of" documented the policy was "Review/Approved" last on 3/21/1986. <p>This was confirmed by the Director of Radiology on 8/06/04 at 2:00 PM.</p>	C 272		

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C 272	Continued From page 23 Radiology Services policies were not reviewed annually by a group of professional personnel.	C 272		
C 273	485.635(a)(3)(i) PATIENT CARE POLICIES [The policies include the following:] (i) A description of the services the CAH furnishes, including those furnished through agreement or arrangement. This STANDARD is not met as evidenced by: Based on interview and policy review, it was determined the CAH failed to develop a policy that described the services of the CAH, including services furnished through agreement. This resulted in a lack of organizational clarity. Findings include: The Administrative Assistant, who tracked all administrative policies, was requested to provide a policy that described the services provided by the CAH, including services furnished through contract. During an interview on 8/06/15 at 8:40 AM, she stated the closest thing the CAH had to meet the request was an organizational chart. She confirmed the hospital did not have an established policy that met the description. The hospital's policies did not describe the types of health care services available at the CAH including those furnished by contract.	C 273	C-0273 Corrective Action: A policy has been created that lists the services provided by the CAH, including those provided by contract and through the approval process. The policy will be reviewed at the Policy Development Advisory Group quarterly to ensure it is current.	9/10/15
C 274	485.635(a)(3)(ii) PATIENT CARE POLICIES [The policies include the following:] (ii) Policies and procedures for emergency medical services.	C 274		

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C 274	<p>Continued From page 24</p> <p>This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the CAH failed to ensure policies and procedures for emergency medical services were current with all required approvals for 13 of 13 emergency room policies that were reviewed. This had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>An undated hospital policy, "Policy Creation and Maintenance," included, but was not limited to, the following information:</p> <ul style="list-style-type: none"> * All policies that affect more than one department must be reviewed and approved by the hospital administrator and the department managers of any affected departments prior to implementation. * If any of the affected departments are clinical departments, the physician chairperson assigned to that department, or the Chief of the Medical Staff, must also sign the policy prior to implementation. * Policies and procedures should be reviewed and updated annually. <p>A sample of Emergency Department policies and procedures was reviewed. The following policies lacked evidence of appropriate approvals and annual review:</p> <ul style="list-style-type: none"> * The policy "Supporting Procedure for Care of Emergency Equipment," dated 1/31/14, was signed by the DNS. There was no documentation of policy approval by the administrator, a medical staff physician, and governing body. 	C 274	<p>C-0274 Corrective Action:</p> <p>Refer to C-0258 Refer to C-0271</p>	9/10/15

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C 274	<p>Continued From page 25</p> <p>* The policy "Defibrillator Checks," dated 3/17/15, was signed by the DNS. There was no documentation of policy approval by the administrator, a medical staff physician, and governing body</p> <p>*The policy "Emergency Call Coverage Requirements," was not signed or dated. There was no documentation of policy approval by the department manager, the administrator, a medical staff physician, and governing body.</p> <p>* The policy "EMTALA," dated 3/17/15, was not signed. There was no documentation of policy approval by the department manager, the administrator, a medical staff physician, and governing body.</p> <p>*The policy, "IV Conscious Sedation," was not signed or dated. There was no documentation of policy approval by the department manager, the administrator, a medical staff physician, and governing body.</p> <p>* The policy, "Procedures that Can/Cannot be Performed in the Emergency Room," dated 1/01/15, was signed by the DON. There was no documentation of policy approval by the administrator, a medical staff physician, and governing body</p> <p>* The policy, "Transfer and/or Referral to Another Facility," dated 3/20/15, was signed by the Administrator. There was no documentation of policy approval by the department manager, a medical staff physician, and governing body.</p> <p>* The policy, "Triage in ER," dated 2/22/12, was signed by the DNS. The policy was not reviewed</p>	C 274		
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C 274	<p>Continued From page 26</p> <p>annually. There was no documentation of policy approval by the administrator, a medical staff physician, and governing body.</p> <p>* The policy, "Air Medical From Scene, dated 12/31/14, was not signed. There was no documentation of policy approval by the department manager, the administrator, a medical staff physician, and governing body.</p> <p>* The policy, "Procurement of Drugs, Equipment, and Supplies," was not signed or dated. There was no documentation of policy approval by the department manager, the administrator, a medical staff physician, and governing body</p> <p>* The policy, "Mental Health Hold Protocols," dated 5/05/15, was signed by the administrator. There was no documentation of policy approval by the department manager, a medical staff physician and governing body</p> <p>* The policy, "Code Blue," dated 1/15/15, was signed by the administrator. There was no documentation of policy approval by the department manager, a medical staff physician, and governing body.</p> <p>* The policy, "Alcohol, Drugs or Other Intoxicating Substance, Testing of," dated 2/26/15, was signed by the DNS. There was no documentation of policy approval by the administrator, a medical staff physician and governing body.</p> <p>The DNS was interviewed on 8/04/15 at 10:23 AM. She confirmed the above policies were not reviewed and approved consistent with the CAH's policies.</p>	C 274			

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C 278 C 278	Continued From page 27 485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on staff interview, review of patient records and hospital policies, and review of APIC and NIH documentation, it was determined the CAH failed to ensure systems to identify and investigate communicable infections and potential hospital acquired/post-operative infections had been clearly defined and implemented. This directly impacted 2 of 19 patients whose surgical and inpatient records were reviewed. This lack of direction to staff had the potential to impact all staff and patients in the facility and result in transmission of infections. Findings include: 1. Patient #43 was a 49 year old male who was admitted to the CAH on 8/05/15. He had two outpatient procedures, an EGD (a procedure in which a thin scope with a light and camera is used to observe the upper digestive tract) and a colonoscopy (a procedure in which a thin scope with a light and camera is used to observe the colon.) Patient #43's record included an "Endoscopy Record," dated 8/05/15, and signed by the RN. It stated ringworm (a skin infection due to a fungus) lesions were noted on his back and abdomen when he was positioned in the endoscopy suite. The CAH did not report and/or investigate his identified communicable infection. An article on the National Institute of Health	C 278 C 278	C-0278 Corrective Action: 1. Patient #43's medical record was reviewed by Surgical Services Director who states that the nurse identified ring worm. Surgical Services Director further investigated this and it was stated by the physician that the patient has a history of psoriasis. Surgical Services Director also talked with physician after the patient's follow up visit in the clinic and he again verified that the skin lesions were psoriasis. 2. Infection Control Assessment has been added to the EMR. Continued education with nursing staff about proper documentation of isolation precautions at staff meeting. 3. Refer to C-0271 4. IC surveillance has been extended to include the Rural Health Clinic, Dr. Saunero's Clinic Orthopedic Surgeons, and General Surgeon. Process Improvement. • IC surveillance has been extended to include the Rural Health Clinic, Dr. Saunero's Clinic Orthopedic Surgeons, and General Surgeon and Surgical Services Director.	9/10/15	

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C 278	<p>Continued From page 28</p> <p>website(http://www.nlm.nih.gov/medlineplus/ency/article/001439.htm), last updated on 5/28/11, stated, "...Ringworm can spread easily from one person to another. You can catch ringworm if you touch someone who has the infection, or if you come into contact with items contaminated by the fungus..."</p> <p>The RN who completed Patient #43's "Endoscopy Record" was interviewed on 8/06/15 at 10:25 AM. The RN confirmed an incident report was not completed and the Infection Control Officer was not notified.</p> <p>The RN Director of Surgery was interviewed on 8/06/15 at 10:20 AM. She stated she had not received an incident report related to Patient #43's alleged communicable infection. She confirmed the Infection Control Officer was not notified, and the incident was not included for tracking in the CAH's infection control plan.</p> <p>The CAH did not identify all potential, communicable infection for investigation and tracking in its infection control process.</p> <p>2. Patient #44 was a 79 year old male who was admitted to the CAH on 5/11/15 and was transferred to an acute care hospital on 5/14/15. His H&P, dated 5/14/15 AT 2:29 PM, listed his diagnoses on admission as Clostridium Difficile Colitis, a bacterial infection of the colon, and dehydration.</p> <p>"Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA)" recommended contact</p>	C 278	<p>C-0278 Continued....</p> <p>Implementing PoC.</p> <ul style="list-style-type: none"> IC surveillance form has been developed by the IC nurse. This form has been distributed to the physicians' offices and to the Surgical Services Director. When there is a possible postoperative or post hospital admission infection, the form will be filled out by the provider and forwarded to the IC nurse. The IC nurse will then conduct the investigation for the infection. Surgical Services Director will make follow up phone calls 30 days postoperative and then again at 1 year. IC surveillance for will be filled out and forwarded to IC nurse for any infections complications. IC nurse will then investigate the infection. <p>Monitoring PoC-</p> <ul style="list-style-type: none"> IC surveillance will be discussed at IC meetings. Chart reviews will be conducted to verify compliance with proper isolation technique and documentation. This will be reported at IC meetings and Quality meetings. 	
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C 278	<p>Continued From page 29</p> <p>precautions (isolation) for patients with this highly contagious disease.</p> <p>A POC that directed staff in treating Patient #44's Clostridium Difficile and preventing its spread to other patients, was not documented.</p> <p>The URC was interviewed on 8/11/15 beginning at 3:05 PM. She stated Patient #44 did not have a POC that addressed his Clostridium Difficile infection.</p> <p>The CAH failed to utilize precautions when treating infectious patients.</p> <p>3. Housekeeping and laundry policies and procedures were requested. During an interview on 8/06/15 at 10:15 AM, the departmental policy and procedure manual was requested, at which time the Director of Housekeeping presented a binder with a collection of written resources. He stated he had collected and utilized the resources within the department. The housekeeping and laundry policies did not have CAH reviewed and approved policies and procedures. This was confirmed by the Director of Housekeeping during the interview.</p> <p>4. IC surveillance process:</p> <p>A policy titled, "INFECTION CONTROL COMMITTEE (Serveillance)(sic)" was reviewed. Documented under functions of the committee was "...Establish and implement the surveillance system for evaluating and reporting infections in patients, personnel and discharged patients."</p> <p>A policy titled, "INFECTION CONTROL PLAN" was reviewed. The policy documented</p>	C 278			

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C 278	<p>Continued From page 30</p> <p>"...Surveillance will include nosocomial and hospital acquired infections among patients and personnel..." The policy also stated performance measures included "...1. Comprehensive periodic surveillance (baseline rates established" outcomes;..." The plan did not specify a surveillance process that included surgical patients who had been discharged from the facility.</p> <p>The IC Practitioner (an RN), and the DNS, were interviewed on 8/04/15 beginning at 9:50 AM regarding the hospital's IC plan and related policies. The IC Practitioner stated the hospital follows APIC and CDC infection control guidelines. The IC Practitioner and DNS confirmed the hospital did not have a process to identify/track potential hospital acquired or post operative infections once patients were discharged from the hospital.</p> <p>The CDC's guide, titled "Surgical Site Infection (SSI) Event," last modified in April of 2015 (http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSICurrent.pdf), documented "...SSI monitoring requires active, patient-based, prospective surveillance. Post-discharge and ante-discharge surveillance methods should be used to detect SSIs following inpatient and outpatient operative procedures. These methods include, 1) direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices, 2) review of medical records or surgery clinic patient records, 3) surgeon surveys by mail or telephone, and 4) patient surveys by mail or telephone (though patients may have a difficult time assessing their infections)..."</p> <p>The hospital did not have a comprehensive</p>	C 278			

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C 278	Continued From page 31 surveillance program for identifying and investigating infections.	C 278		
C 291	<p>A comprehensive IC program had not been developed and implemented.</p> <p>485.635(c)(3) SERVICES PROVIDED THRU AGREEMENT/ARRANGEMENT</p> <p>The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of the CAH's list of contracted services, it was determined the CAH failed to ensure the list of contracted services was current and complete. This had the potential to result in a lack of contract oversight and monitoring. Findings include:</p> <p>The hospital's list of contracted services was requested for review. An undated one page list was provided for review. It was titled "MMH Contracts," and included the names of the contracted entity, the services associated with the contracts, contact persons, and the date of expiration, if relevant, or "auto renewal." The list did not indicate whether the services were offered on- or off site or whether there was a limit on the volume or frequency of the services provided, and when the services were available.</p> <p>The following contracted services were not included on the list:</p> <ul style="list-style-type: none"> * Laboratory service * Transcription service 	C 291	<p>C-0291</p> <p>Corrective Action:</p> <p>The hospitals list of contracted services was updated to include Laboratory service, Transcription service, and two respiratory therapists who work on a PRN basis.</p> <p>The list of contracted services will be reviewed quarterly to ensure it is current.</p>	9/10/15

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C 291	Continued From page 32 * Two respiratory therapists who worked on a PRN basis The CEO was interviewed on 8/5/15 at 8:24 AM. He confirmed the list of contracted services was incomplete. The CAH's list of contracted services was not current or complete.	C 291		
C 292	485.635(c)(4) SERVICES PROVIDED THRU AGREEMENT/ARRANGEMENT The person principally responsible for the operation of the CAH under §485.627(b)(2) of this chapter is also responsible for the following: (i) Services furnished in the CAH whether or not they are furnished under arrangements or agreements. (ii) Ensuring that a contractor of services (including one for shared services and joint ventures) furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on staff interview, review of a list of contracted services and hospital policies, it was determined the CAH failed to ensure the CEO provided pro-active oversight of contracted services. This had the potential to interfere with quality and safety of patient care. Findings include: 1. The CEO was interviewed on 8/06/15 at 9:00	C 292	C-0292 Corrective Action: Contracted services will report a patient driven quality monitor to the Quality Committee quarterly to evaluate the services provided. Refer to C-0258 Refer to C-0271 Refer to C-0272 Refer to C-0273	9/10/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131319	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/06/2015
NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
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C 292	<p>Continued From page 33</p> <p>AM. When asked what oversight was provided for contracted services, he stated that if any complaints were received or deficiencies cited, the CAH addressed and corrected the specific concerns or removed the contracted service. He stated that at time of renewal of contracts (most contracts were automatically renewed), administration evaluated the service from a financial perspective and for any complaints. He stated he relied on regulatory surveys and patient satisfaction surveys to determine any actions to take with contracted services. There was no routine or pro-active oversight. This was confirmed by the CEO during the time of the interview.</p> <p>2. Hospital policies for contracted services, as well as policies for services provided directly, were outdated or lacked all appropriate approvals.</p> <p>* Refer to C-0258 as it relates to the CAH's failure to ensure an MD/DO participated in the development of policies that governed CAH services.</p> <p>* Refer to C-0271 as it relates to the CAH's failure to ensure policies were updated or signed with all appropriate approvals in accordance with hospital policy.</p> <p>* Refer to C-0272 as it relates to the CAH's failure to ensure policies were reviewed at least annually by a group of professional personnel.</p> <p>* Refer to C-0273 as it relates to the CAH's failure to ensure a policy was developed that described the services of the CAH, including services furnished through agreement.</p>	C 292			

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C 298	<p>There was insufficient oversight of contracted services.</p> <p>485.635(d)(4) NURSING SERVICES</p> <p>A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on staff interviews and a review of medical records, it was determined the CAH failed to ensure nursing care plans were individualized and complete for every patient based on an assessment of the patient's nursing care needs. This affected the care of 12 of 19 inpatients (#9, #19, #22, #23, #24, #28, #34, #39, #40, #41, #42 and #44), whose records were reviewed, and had the potential to affect all patients. This had the potential to result in a lack of nursing interventions to meet complex patient needs. Findings include:</p> <p>1. Patient #34 was a 67 year old female was admitted to the CAH on 6/27/15. She was transferred to Swing Bed status on 7/01/15.</p> <p>Patient #34's H&P, dated 6/27/15 at 7:43 PM, stated she had diabetes and her blood glucose levels were "well above 500." The CAH's laboratory reports stated normal blood glucose levels were 60-100. The H&P stated Patient #34's husband had "...given her insulin, perhaps as much as 150 units [on the day of admission], without much improvement." The H&P stated she seemed "terribly intoxicated" and said she had a history of polysubstance abuse. The H&P stated Patient #34 was placed on an alcohol detoxification protocol. The H&P stated Patient #34 had black and necrotic areas affecting</p>	C 298	<p>C-0298</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> DNS reviewed the care plans with the nurses involved in the care of the patients reviewed. DNS reviewed the requirement with nursing staff that nursing care plans need to be comprehensive and individualized. <p>Process Improvement.</p> <p>Nurses will provide and document comprehensive, individualized nursing care plans.</p> <p>Implementing PoC.</p> <ul style="list-style-type: none"> Education provided to nursing staff at staff meeting for care plan development and requirements. Nursing EMR super users providing bedside assistance to nursing staff to help with the development of care plans in the EMR. <p>Monitoring PoC-</p> <ul style="list-style-type: none"> Record reviews will be completed to monitor compliance with nursing care plans. Results will be reviewed and reported at Quality meetings. 	9/10/15

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C 298	<p>Continued From page 35</p> <p>several toes. The H&P also stated Patient #34 had acute and chronic renal failure.</p> <p>Patient #34's POC, stated it was initiated on 6/27/15. The POC included "Risk for Falls...Acute Confusion...[and] Risk for Impaired Skin Integrity." The interventions mentioned under "Risk for Impaired Skin Integrity" were "Foot Care, Medication Management, Nutrition Management, Electrolyte Management, Hyperglycemia Management, Vital Signs Monitoring." No specific direction was provided to staff regarding care for Patient #34.</p> <p>The URC was interviewed on 8/04/15 beginning at 3:30 PM. She confirmed Patient #34's POC did not provide specific direction to staff regarding treatment of her diabetes, foot care, and chemical dependency.</p> <p>The CAH did not develop a specific POC to meet Patient #34's needs.</p> <p>2. Patient #44 was a 79 year old male who was admitted to the CAH on 5/11/15 and was transferred to an acute care hospital on 5/14/15.</p> <p>Patient #44's H&P, dated 5/14/15 AT 2:29 PM, listed his diagnoses as Clostridium Difficile Colitis, a bacterial infection of the colon, and dehydration.</p> <p>Patient #44's POC, stated it was initiated on 5/12/15. The POC included "Deficit Fluid Volume." The POC did not address Patient #44's Clostridium Difficile diagnosis. It did not direct staff as to how to care for Patient #44 so as to prevent the spread of infection.</p>	C 298		

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C 298	<p>Continued From page 36</p> <p>The URC was interviewed on 8/11/15 beginning at 3:05 PM. She confirmed Patient #44's POC did not address his Clostridium Difficile or direct staff how to keep the infection from spreading.</p> <p>The CAH did not develop a specific POC to meet Patient #44's needs or to protect other patients.</p> <p>3. Patient #28 was a 93 year old male admitted to the CAH on 5/30/15. He was transferred to Swing Bed status on 6/03/15. He was discharged from Swing Beds on 6/09/15. His H&P, dated 5/30/15 at 11:36 PM, stated he had intractable pain in his left leg and had diabetes. He was started on Insulin for his diabetes when he was admitted to Swing Bed status.</p> <p>Patient #28's POC, dated 7/02/15, did not address his diabetes.</p> <p>This was confirmed by the DNS during interview on 8/05/15 beginning at 9:15 AM.</p> <p>4. Patient #9 was an 81 year old female who was admitted to the hospital on 5/29/15 related to narcotic intoxication after taking pain medication for venous ulcer wound pain. The medical record included information about Patient #9 having been on home health services for wound care prior to admission to the hospital.</p> <p>Nursing notes documented wound care, as follows:</p> <ul style="list-style-type: none"> - Nursing note, dated 5/30/15 at 7:00 PM, documented a "small opened area to her coccyx. Optifoam applied. Will cont to monitor." - Nursing note, dated 5/31/15 at 10:24 PM, documented "Left leg wound weeping through 	C 298	

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C 298	<p>Continued From page 37</p> <p>dressing. Dressing reinforced: heavy drainage pad applied to left leg and then wrapped with Keflex gauze."</p> <p>-Nursing note, dated 6/01/15 at 11:00 PM, documented "pts (sic) dressing changed on pts left leg and [name of individual] here to teach how to change the dressing. old (sic) dressing removed and [name of individual] cleans wounds and graph paper used to draw out the size of the wounds. new (sic) wound covering applied and abd covered and wrapped with head roll. pt (sic) tolerated well. pt (sic) has a total of 7 wounds that were drawn on graph paper and measured and documented, see sizes and information on graph sheets. heel (sic) protector was applied to right hell (sic) and tuba grip size D on both lower extremities. EZ flow graph sheets are in pts chart."</p> <p>Patient #9's nursing plan of care was reviewed. It did not address interventions or goals related to her wounds. This was confirmed by the URC during record review on 8/0515 at 2:00 PM.</p> <p>Patient #9's nursing care plan was incomplete.</p> <p>5. Patient #19 was a 63 year old female admitted to the CAH on 4/17/15. She had a right total knee replacement on 4/17/15 and was transferred to the surgical floor.</p> <p>Patient #19's record included a nursing care plan, dated 4/19/15, two days after her admission and surgical procedure. Her nursing care plan identified 1 nursing problem, acute pain. Interventions for acute pain were implemented on 4/19/15 and documented as resolved on 4/20/15.</p>	C 298			

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C 298	<p>Continued From page 38</p> <p>Patient #19's care plan was not comprehensive to meet her needs. Examples included:</p> <ul style="list-style-type: none"> - A "History and Physical" dated 4/14/15, and signed by her surgeon, included a diagnosis of atrial fibrillation (an irregular heart rhythm), treated with Eliquis (a blood thinner that can cause bleeding). Patient #19's nursing care plan did not include goals or interventions to minimize the risk of complications related to her risk for bleeding. - An "Operative Report" dated 4/17/15, and signed by Patient #19's surgeon, documented a surgical wound to her right knee. A "Physician's Orders" form dated 4/20/15, and signed by her physician, included a dressing change to her surgical wound. Her nursing care plan did not include assessments of her surgical wound, or interventions to minimize her risk of infection. Additionally, her care plan did not include care of her wound including dressing changes. - Patient #19's record included a "Post-Operative Report" dated 4/17/15, and signed by her surgeon. It documented nursing orders that included measurement of fluid intake and urine output, elevation of her leg to maintain circulation, incentive spirometry every hour to expand lungs and decrease risk of respiratory complications, and urinary catheter care. Patient #19's nursing care plan did not include patient assessment or interventions related to intake and output, circulatory, or respiratory status. Additionally, her care plan did not include catheter care. - Patient #19's record included a "Physician's Order" dated 4/18/15, and signed by her physician, to administer Narcan (a medication 	C 298			

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C 298	<p>Continued From page 39</p> <p>that reverses the effect of opioids, including respiratory depression, sedation and hypotension) 0.2 mg intravenous every 2 minutes for 8 doses. The order included assessing Patient #19's responsiveness every 30 minutes and monitoring her for changes in her level of consciousness. However, her care plan was not updated to include nursing assessment of her respiratory status. In addition, Patient #19's nursing care plan was not modified to reflect a potential for increased pain after use of Narcan.</p> <p>- Patient #19's "Post-Operative Orders" dated 4/17/15, and signed by the physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #19's nursing care plan did not include assessments or goals related to the risk of deep vein thrombosis.</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. She reviewed Patient #19's record and confirmed her nursing care plan was initiated on 4/19/15, two days after her admission. The DON also confirmed the nursing care plan included only one patient problem, acute pain. She stated Patient #19's nursing care plan did not include interventions or goals related to surgical wound, circulatory, respiratory or fluid status.</p> <p>Patient #19's nursing care plan was incomplete.</p> <p>6. Patient #22 was a 85 year old female admitted to the CAH on 3/07/15, for repair of a broken left Humerus (long bone in the upper arm).</p>	C 298		

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C 298	<p>Continued From page 40</p> <p>Patient #22's record included a nursing care plan dated 3/07/15 through 3/12/15. Her nursing care plan included one nursing problem, acute pain, which was initiated on 3/07/15.</p> <p>Patient #22's nursing care plan was not comprehensive to meet her needs. Examples included:</p> <ul style="list-style-type: none"> - Patient #22's record included an "ER Report" dated 3/07/15, and signed by her ER physician. It stated she had several falls at home prior to her admission to the CAH and that she complained of being dizzy. A "Progress Notes" form dated 3/11/15, and signed by the physician, stated she remained a fall hazard. The nursing care plan for Patient #22 did not include fall risk as a problem and did not include interventions to minimize the risk of complications related to her ability to ambulate or patient/family teaching related to fall precautions. - Patient #22's record included an "Operative Report" dated 3/09/15, and signed by her surgeon. It documented a surgical wound to her left arm. Her nursing care plan did not include assessment of the wound for signs and symptoms of infection. Additionally, her care plan did not include care of her wound or dressing changes. - Patient #22's "Post-Operative Orders" dated 3/09/15, and signed by her physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #22's 	C 298		

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C 298	<p>Continued From page 41</p> <p>nursing care plan did not include goals and interventions to minimize the risk of complications related to deep vein thrombosis.</p> <p>- Patient #22's record included a "Post-Operative Report" dated 3/09/15, and signed by her surgeon. It documented nursing orders that included measurement of fluid intake and urine output, incentive spirometry every hour to expand lungs and decrease risk of respiratory complications, and urinary catheter care. Patient #19's nursing care plan did not include patient assessment or interventions related to intake and output or respiratory status. Additionally, her care plan did not include catheter care.</p> <p>- An "ER Report" dated 3/07/15, signed by the ER physician and included in Patient #22's medical record, stated she was assisted to the bathroom because she felt she needed to have a bowel movement but was unable to. A "progress notes" form dated 3/08/15, and signed by her physician, stated Patient #22 was "very concerned about constipation." The nursing care plan for Patient #22 did not include interventions to minimize the risk of complications related to constipation.</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. The DON reviewed Patient #22's record and confirmed her nursing care plan included only one patient problem, acute pain. She stated Patient #22's nursing care plan did not include interventions to minimize the risk of complications related to impaired skin integrity, risk for infection, risk for bleeding, risks for blood clots, risk for falls, respiratory status and constipation.</p> <p>Patient # 22's nursing care plan was incomplete.</p>	C 298			

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C 298	<p>Continued From page 42</p> <p>7. Patient #23 was a 75 year old female admitted to the CAH on 12/17/14, for a ruptured tendon repair to her left hip. Her medical record was reviewed.</p> <p>Patient #23's record included a nursing care plan dated 12/17/14 through 12/23/14. Her nursing care plan included one nursing problem, acute pain, which was initiated on 12/17/14.</p> <p>Patient #23's nursing care plan was not comprehensive to meet all her needs. Examples include:</p> <ul style="list-style-type: none"> - Patient #23's record included an "Operative Report" dated 12/17/14, and signed by her surgeon. It documented a surgical wound to her left hip. Her nursing care plan did not include assessment of her wound for signs and symptoms of infection. Additionally, her care plan did not include care of her wound or dressing changes. - Patient #23's "Post-Operative Orders" dated 12/17/14, and signed by her physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #19's nursing care plan did not include goals and interventions to minimize the risk of complications related to deep vein thrombosis. - Patient #23's "Post-Operative Report" dated 12/17/14, and signed by her surgeon, documented nursing orders that included measurement of fluid intake and urine output and 	C 298		

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C 298	<p>Continued From page 43</p> <p>incentive spirometry every hour to expand lungs and decrease risk of respiratory complications. However, Patient #23's nursing care plan did not include patient assessment or interventions related to intake and output or respiratory status.</p> <p>- A "Pre-Admission" form dated 12/17/15, and signed by the pre-op nurse, stated Patient #23's allergies included codeine, penicillin, Percocet and sulfa. Additionally the form documented "polypharmacy" in the medications list. Patient #23's nursing care plan did not include interventions related to risk of complications with multiple allergies and polypharmacy (the use of four or more medications by persons aged 65 years or greater).</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. The DNS reviewed Patient #23's record and confirmed her nursing care plan, initiated on 12/17/14, included only one patient problem, acute pain. She stated Patient #23's nursing care plan did not include interventions to minimize the risk of complications related to impaired skin integrity, risk for infection, risk for bleeding, risks for blood clots, risk for falls, respiratory status and risk of complications related to polypharmacy.</p> <p>The nursing care plan for Patient #23 was incomplete.</p> <p>8. Patient #24 was a 44 year old male admitted to the CAH on 1/19/15, for a right knee arthroplasty (a procedure to restore integrity and function of a joint). His medical record was reviewed.</p> <p>Patient #24's record included a nursing care plan dated 1/09/15 through 1/13/15. His nursing care</p>	C 298			

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C 298	<p>Continued From page 44</p> <p>plan included one nursing problem, acute pain, which was initiated on 1/09/15.</p> <p>Patient #24's nursing care plan was not comprehensive to meet all his needs. Examples include:</p> <ul style="list-style-type: none"> - Patient #24's record included an "Operative Report" dated 1/09/15, and signed by his surgeon, documented a surgical wound to his right knee. His nursing care plan did not include an assessment of his wound for signs and symptoms infection. Additionally, his care plan did not include care of his wound or dressing changes. - Patient #24's "Post-Operative Orders" dated 1/09/15, and signed by his physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #24's nursing care plan did not include goals and interventions to minimize his risk of complications related to deep vein thrombosis. - Patient #24's "Post-Operative Report" dated 1/09/15, and signed by his surgeon, documented nursing orders that included measurement of fluid intake and urine output and incentive spirometry every hour to expand lungs and decrease risk of respiratory complications. Patient #24's nursing care plan did not include patient assessment or interventions related to intake and output or respiratory status. <p>The DNS was interviewed on 8/05/15 at 3:30 PM.</p>	C 298			

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C 298	<p>Continued From page 45</p> <p>The DNS reviewed Patient #24's record and confirmed his nursing care plan, initiated on 1/09/15, included only one patient problem, acute pain. She stated Patient #24's nursing care plan did not include interventions to minimize his risk of complications related to impaired skin integrity, risk for infection, risk for bleeding, risks for blood clots, risk for falls and respiratory status.</p> <p>The nursing care plan for Patient #24 was incomplete.</p> <p>9. Patient #39 was a 57 year old male who was seen in the CAH's ER on 8/03/15 and admitted to the CAH on 8/03/15. He was admitted with the diagnoses of congestion and mental status changes. His medical record was reviewed.</p> <p>Patient #39's record included a nursing care plan dated 8/03/15 through 8/04/15. His nursing care plan included one nursing problem, impaired gas exchange, which was initiated on 8/03/15.</p> <p>Patient #39's nursing care plan was not comprehensive to meet all his needs. Examples include:</p> <ul style="list-style-type: none"> - Patient #39's ER Report, dated 8/03/15, included the patient's complaint of pain related to a history of fibromyalgia. His ER History & Physical dated 8/03/15, signed by his ER physician, included a history of chronic pain for which he was seeing a pain management provider. Patient #39's nursing care plan did not include interventions to minimize the risk of complications related to pain. - Patient #39's ER Report dated 8/03/15, included his complaint of confusion. The report stated he 	C 298		

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C 298	<p>Continued From page 46</p> <p>was sent to the CAH's ER from Twin Fall Psychiatric Services. Patient #39's ER History & Physical dated 8/03/15, signed by the ER physician, stated he was anxious with chronic anxiety. Patient #39's nursing care plan did not include interventions to minimize the risk of complications related to anxiety.</p> <p>- Patient #39's ER History and Physical, dated 8/03/15, stated he currently took Cymbalta, Buspar, Quinapril, Morphine Sulfate, Oxycodone, Flexeril, pain rub medication, Hydrochlorothiazide and Gabapentin. The report also stated Patient #39 had multiple providers that prescribed his medications and that he obtained his medications from multiple pharmacies. Patient #39's nursing care plan did not include interventions to minimize the risk of complications related to complex polypharmacy.</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. The DNS reviewed Patient #39's record and confirmed his nursing care plan, initiated on 8/03/15, included only one patient problem, impaired gas exchange. She stated Patient #39's nursing care plan did not include or interventions to minimize his risk of complications related to his confusion, anxiety or complex polypharmacy.</p> <p>The nursing care plan for Patient #39 was incomplete.</p> <p>10. Patient #40 was a 87 year old female admitted to the CAH on 7/30/15, for a right hip arthroplasty (a procedure to restore integrity and function of a joint). She was discharged to swing bed status in the CAH on 8/03/15. Her medical record was reviewed.</p>	C 298		

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C 298	<p>Continued From page 47</p> <p>Patient #40's record included a nursing care plan dated 7/30/15 through 8/03/15. Her nursing care plan included two nursing problems, acute pain and impaired physical mobility. Interventions for acute pain and impaired physical mobility were initiated on 7/30/15.</p> <p>Patient #40's nursing care plan was not comprehensive to meet all her needs. Examples include:</p> <ul style="list-style-type: none"> - Patient #40's record included an "Operative Report" dated 7/30/15, and signed by her surgeon. It documented a surgical wound to her right hip. Her nursing care plan did not include an assessment of her wound for signs and symptoms of healing or infection. Additionally, her care plan did not include care of her wound or dressing changes. - Patient #40's "Post-Operative Orders" dated 7/30/15, and signed by her physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #40's nursing care plan did not include goals and interventions to minimize her risk of complications related to deep vein thrombosis. - Patient #40's record included a "Post-Operative Report" dated 7/30/15, and signed by her surgeon. It documented nursing orders that included measurement of fluid intake and urine output and incentive spirometry every hour to expand lungs and decrease risk of respiratory complications. Patient #24's nursing care plan 	C 298	

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C 298	<p>Continued From page 48</p> <p>did not include patient assessment or interventions related to intake and output or respiratory status.</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. The DON reviewed Patient #40's record and confirmed her nursing care plan, initiated on 7/30/15, included two patient problems, acute pain and impaired physical mobility. She stated Patient #40's nursing care plan did not include interventions to minimize her risk of complications related to impaired skin integrity, risk for infection, risk for bleeding, risks for blood clots and respiratory status.</p> <p>The nursing care plan for Patient #40 was incomplete.</p> <p>11. Patient #41 was an 80 year old female who was seen in the CAH's ER on 7/31/15 and admitted to the CAH on 7/31/15. She was admitted with the diagnoses of pneumonia, acute renal insufficiency and hypertension. Her medical record was reviewed.</p> <p>Patient #41's record included a nursing care plan dated 7/31/15 through 8/05/15. Her nursing care plan included one nursing problem, risk for falls. Interventions for risk for falls were initiated on 7/31/15.</p> <p>Patient #41's nursing care plan was not comprehensive to meet all her needs. Examples include:</p> <p>- Patient #41's record included an ER Report dated 7/31/15. Her report included her complaint of pain related to 3 falls in the previous week. Her ER History & Physical dated 7/31/15, signed</p>	C 298		

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C 298	<p>Continued From page 49</p> <p>by the ER physician, included a history of residual pain from previous surgical replacements of her right knee and left hip, for which she took narcotics. Patient #41's nursing care plan did not include interventions to minimize the risk of complications related to pain.</p> <p>- Patient #41's ER Report dated 7/31/15, included her complaint of shortness of breath. Patient #41's ER History & Physical dated 7/31/15, signed by her ER physician, stated she was seen by an urgent care center and diagnosed with pneumonia. Patient #41's nursing care plan did not include interventions to minimize the risk of complications related to pneumonia.</p> <p>- Patient #41's ER History and Physical included a medication list. Her medication list stated she currently took Lisinopril, Warfarin, Gabapentin, Sertraline, Trazodone, Brovana, Budesonide, Fluticasone, Moxifloxacin and Hydrocodone. Her report also stated Patient #41 lived alone, was unable to provide information related to her medical regimen and a current medication list was obtained from her pharmacy. Her nursing care plan did not include interventions to minimize her risk of complications related to complex polypharmacy.</p> <p>The DNS was interviewed on 8/05/15 at 3:30 PM. The DNS reviewed Patient #41's record and confirmed her nursing care plan, initiated on 7/31/15, included only one patient problem, risk for falls. She stated Patient #41's nursing care plan did not include interventions to minimize her risk of complications related to her pain, shortness of breath and complex polypharmacy.</p> <p>The nursing care plan for Patient #41 was</p>	C 298		

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C 298	<p>Continued From page 50 incomplete.</p> <p>12. Patient #42 was a 63 year old female admitted to the CAH on 7/31/15, for a left hip arthroplasty (a procedure to restore integrity and function of a joint). Her medical record was reviewed.</p> <p>Patient #42's record included a nursing care plan dated 7/31/15 through 8/05/15. Her nursing care plan included two nursing problems, acute pain and impaired physical mobility. Her care plan stated interventions for acute pain and impaired physical mobility were initiated 7/31/15.</p> <p>Patient #42's nursing care plan was not comprehensive to meet all her needs. Examples include:</p> <ul style="list-style-type: none"> - An "Operative Report" dated 7/31/15, and signed by Patient #42's surgeon, documented a surgical wound to her left hip. The nursing care plan did not include an assessment of her wound for signs and symptoms of infection. Additionally, her care plan did not include care of her wound and dressing changes. - Patient #42's "Post-Operative Orders" dated 7/31/15, and signed by her physician, included Lovenox injections (a medication for the prevention of deep vein thrombosis, a potential post-operative blood clotting complication) and the use of TED and Sequential hose (a preventative measure for reducing risks of blood clot formation after surgery). Patient #42's nursing care plan did not include goals and interventions to minimize the risk of complications related to deep vein thrombosis. 	C 298		

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C 298	Continued From page 51 - A "Post-Operative Report" dated 7/31/15, and signed by her surgeon, documented nursing orders that included measurement of fluid intake and urine output, Incentive spirometry every hour to expand lungs and decrease risk of respiratory complications, and urinary catheter care. Patient #19's nursing care plan did not include patient assessment or interventions related to intake and output or respiratory status. Additionally, her care plan did not include catheter care. The DNS was interviewed on 8/05/15 at 3:30 PM. The DNS reviewed Patient #42's record and confirmed her nursing care plan, initiated on 7/31/15, included two patient problems, acute pain and impaired physical mobility. She stated Patient #42's nursing care plan did not include interventions to minimize her risk of complications related to impaired skin integrity, risk for infection, risk for bleeding, risks for blood clots and respiratory status. The nursing care plan for Patient #42 was incomplete. Nursing care plans were not comprehensive and not updated as required.	C 298		
C 301	485.638(a)(1) RECORDS SYSTEMS The CAH maintains a clinical records system in accordance with written policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and policy review, it was determined the CAH failed to maintain a clinical records system in accordance with current, approved, and enforced written policies and procedures. It also failed to ensure records were	C 301	C-0301 Corrective Action: Refer to C-0271	9/10/15

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C 301	<p>Continued From page 52</p> <p>protected from destruction by water or fire. These practices had the potential to interfere with the operation and access of medical records, which in turn, could negatively impact patient care. Findings include:</p> <p>1. Approval of Policies:</p> <p>An undated hospital policy, "Policy Creation and Maintenance," included, but was not limited to, the following information:</p> <ul style="list-style-type: none"> * All policies that affect more than one department must be reviewed and approved by the hospital administrator and the department managers of any affected departments prior to implementation. * Policies and procedures should be reviewed and updated annually. <p>A sample of Medical Records service policies and procedures was reviewed. Policies were not reviewed annually or lacked appropriate approvals, as follows:</p> <ul style="list-style-type: none"> * A policy "Hawley Troxell Record Retention & Destruction," was dated 2007 and did not include the hospital's name on the policy or any signatures to indicate approval. During an interview on 8/06/15 at 8:40 AM, the Administrative Assistant who tracked the CAH's policies said the hospital followed this policy. In contrast, during an interview on 8/06/15 at 8:55 AM, the Director of Medical Record said she did not recognize the policy and it was not actually a hospital policy. * A policy "Release of Patient Information, dated 	C 301		

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C 301	<p>Continued From page 53</p> <p>1/15/15, was signed by the administrator. There was no documentation to indicate the department manager had approved the policy.</p> <p>* A policy, "Medical Record Department," dated 7/23/07, was signed by the Director of Medical Records. The policy had not been reviewed in 8 years, and had not been signed by the administrator.</p> <p>* A policy, "Release of Medical Information, dated 5/12/15, was signed by an administrator. There was no documentation to indicate the department manager had approved the policy.</p> <p>* A policy, "Procedure for Finding Charts During Hours When the Department is Closed," was not signed or dated.</p> <p>* A policy, "Notice to Physicians of Chart delinquencies, was dated 7/23/07. It had not been reviewed in 8 years.</p> <p>* A policy, "Scanning policy and Procedure," was dated 07/23/07. It had not been reviewed in 8 years.</p> <p>* A policy, "Procedure for filing of record, was not dated and not signed.</p> <p>The Director of Medical Records was interviewed beginning on 8/05/15 at 9:22 AM. She confirmed the referenced policies were outdated and/or were missing approvals.</p> <p>2. Enforcement of Policies:</p> <p>The Director of Medical Record Service was interviewed on 8/05/15 beginning at 9:22 AM.</p>	C 301		

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C 301	Continued From page 54 When asked about physician chart delinquencies and how they were handled, she provided a list of delinquencies, dated 3/17/15 that included 78 delinquent records. She also provided a sample letter that was distributed to physicians when physician did not respond to requests by the medical record service personnel and the administration to complete late records. The sample letter to physicians stated "According to Medical Staff Regulations in the Bylaws it states: 'A penalty of \$10.00 per day per chart shall be assessed beginning on the 21st day after the record is available for completion and shall continue daily until completed.' It also stated: 'In no case shall a physician take longer than 30 days, excluding extensions as granted above to complete the medical record. If the medical record is not completed within 30 days, the physician shall be referred to Medical Executive Committee for possible disciplinary action up to and including suspension as provided in the bylaws." The Director of Medical Record Services stated the CAH never enforced penalties as stated in the letter and the Medical Staff Bylaws.	C 301		
C 308	3. Also refer to C-0308 as it relates to the failure of the CAH to ensure medical records were protected from fire and water damage. 485.638(b)(1) PROTECTION OF RECORD INFORMATION The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.	C 308		

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C 308	Continued From page 55 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the CAH failed to ensure record information was safeguarded against destruction by fire and water. This impacted 2 of 2 medical record storage areas that were observed. This has the potential to result in inaccessible medical records. Findings include: 1. The Director of Medical Records provided a tour of the record storage room on 8/05/15 at 9:20 AM. Paper records were observed to be stored on open shelving that did not enclose the records. The storage room was sprinklered. In the event the sprinklers went off, the paper records would not be protected from water. If the sprinklers malfunctioned the records could be destroyed by fire. The Director of Medical Records did not comment in response to pointing out the records would not be protected from water in the event of sprinkler use. Medical records were not protected from fire or water. 2. The storage of radiography films was discussed during an interview with the Director of Radiology 8/06/04 at 2:00 PM. The Director of Radiology stated pediatric films and mammography films were stored in a locked building outside of the hospital on open, metal shelves, without doors, in an area of the building that did not possess a sprinkler system for fire safety. Radiography films were not protected from fire or water.	C 308			

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C 308	Continued From page 56	C 308	C-0308			
C 330	The CAH did not store medical records and films in a protected environment. 485.641 PERIODIC EVALUATION & QA REVIEW Periodic Evaluation and Quality Assurance Review This CONDITION is not met as evidenced by: Based on staff interview and review of hospital policies and quality documents, it was determined the hospital failed to ensure a comprehensive periodic evaluation and quality assurance program had been developed and implemented. This resulted in the inability of the hospital to thoroughly assess its total program, identify areas that required improvement, and implement steps to improve and monitor quality of patient services. Findings include: 1. Refer to C-0333 as it relates to the failure of the hospital to ensure a periodic evaluation of its total program, including a sample of both active and closed clinical records, was completed annually. 2. Refer to C-0334 as it relates to the failure of the hospital to ensure a periodic evaluation of its total program, including comprehensive review of the hospital's health care policies, was completed annually. 3. Refer to C-0335 as it relates to the failure of the hospital to ensure an evaluation had been conducted to determine whether utilization of services was appropriate, policies were followed	C 330	Corrective Action: Medical Records stored in the records storage room had metal filing cabinets with drawers installed on 8/31/15 to house the medical records and protect them from fire and water. Radiology Films that are stored in a building outside of the hospital will be evaluated and those that exceed the time required for records retentions will be purged by 9/20/15. The remainder of the stored films will be digitized and stored in hospital's PACS system by 12/31/15.	8/31/15	9/20/15	12/31/15

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C 330	<p>Continued From page 57 and necessary changes were implemented.</p> <p>4. Refer to C-0337 as it relates to the failure of the hospital to ensure the QA program included an evaluation of all patient care services.</p> <p>These negative systemic practices interferred with the ability of the hospital to evaluate the care and services it provided.</p> <p>C 333 485.641(a)(1)(ii) PERIODIC EVALUATION</p> <p>[The evaluation is done at least once a year and includes review of--]</p> <p>a representative sample of both active and closed clinical records.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of QA documents, it was determined the hospital failed to conduct a review of its total program annually, including a sample review of both active and closed clinical records. This resulted in the potential for unsafe and/or ineffective patient care practices to continue without identification, correction and re-evaluation. Findings include:</p> <p>The hospital's "Annual Report" for 2014 was reviewed. Evidence of a sample review of both active and closed clinical records was not found. The Administrative Assistant, who also functioned as the Quality Coordinator, was interviewed on 8/06/15 at approximately 1:00 PM. She confirmed an annual review of open and closed clinical records did not occur.</p>	C 330	<p>C-0330</p> <p>Corrective Action:</p> <p>Refer to C-0333</p> <p>Refer to C-0334</p> <p>Refer to C-0335</p>	9/10/15

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C 333	Continued From page 58 The hospital did not review a sample of both open and closed medical records as part of its annual review.	C 333			
C 334	485.641(a)(1)(iii) PERIODIC EVALUATION [The evaluation is done at least once a year and includes review of--] the CAH's health care policies. This STANDARD is not met as evidenced by: Based on review of the hospital's annual report and hospital policies, and staff interview, it was determined the CAH failed to ensure the CAH's health care policies were reviewed annually. This had the potential to result in continued implementation of policies that did not reflect current standards of practice. Findings include: 1. The "Minidoka Memorial Hospital Annual Report Fiscal Year 2014, dated 10/24/14, was reviewed. It included a list of policies that were reviewed and approved by the Board. They were limited to the following policies and plans: * Charity Care Policy * Compliance Committee Policies * Conflict of Interest Policy * Credit Policy * Purchasing Policy	C 334	C-0333 Corrective Action: The Administrator will prepare the hospital's "Annual Report" after the end of the hospital's fiscal year ending 9/30/15 to include summary of the review of both active and closed clinical records. The summary of the monthly review of both active and closed clinical records will be reported quarterly to the Quality Committee, then included in the hospital's "Annual Review" report annually.	9/10/15	

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C 334	Continued From page 59 * Quality Assessment Plan * Risk Management Plan * Utilization Review Plan This was confirmed by the Administrative Assistant, who also functioned as the Quality Coordinator, during interview on 8/04/15 at 11:00 AM.	C 334	C-0334 Corrective Action: Refer to C-0271	9/10/15	
C 335	485.641(a)(2) PERIODIC EVALUATION The purpose of the evaluation is to determine whether the utilization of services was appropriate, the established policies were followed, and any changes are needed. This STANDARD is not met as evidenced by: Based on staff interview and review of the CAH's "Annual Report," and QA documents, it was determined the CAH failed to ensure an evaluation was conducted to determine whether the utilization of services was appropriate, policies were followed, and if changes were needed. This interfered with the ability of the hospital to effectively evaluate its services and had the potential to negatively impact the quality of patient care provided in the facility. Findings include:	C 335	C 335 Corrective Action: The Administrator will prepare the hospital's "Annual Report" after the end of the hospital's fiscal year ending 9/30/15 to include more inclusive details of utilization of each service provided and summary of policy review.	9/10/15	

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C 335	Continued From page 60 The "Annual Report" and "QUALITY MONITORING AND IMPROVEMENT PLAN" were reviewed during the survey. Neither included evidence of utilization review. During an interview on 8/06/15, beginning at 9:00 AM, the Administrator confirmed neither report specified the CAH would conduct a comprehensive annual evaluation of services that determined whether policies were followed and/or changes were made based on results. A comprehensive evaluation of the CAH's services and policy compliance, that allowed for changes and improvement in quality of patient care, was not completed.	C 335		
C 336	485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on staff interview, review of the "QUALITY MONITORING AND IMPROVEMENT PLAN" and review of policies and QA documents, it was determined the CAH failed to ensure its quality program included all patient care services provided in the hospital and that those services were evaluated for appropriateness, quality, and patient outcomes. This impacted 2 of 2 ED patients who left AMA or without being seen (#13 and #15) and whose ED records were reviewed. It also impacted 9 of 9 ED patients listed on the	C 336		

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C 336	<p>Continued From page 61</p> <p>ED log between 7/07/15 and 7/31/15, and left AMA. This prevented the CAH from identifying potentially negative processes/practices, which could be improved upon through corrective action and on-going monitoring. Findings include:</p> <p>1. The policy "Incident/Accident/Sentinel Event Reporting," dated 1/15/15, was reviewed. The policy included the expectation that an incident report would be completed for patients who left AMA.</p> <p>The undated policy "Against Medical Advice, Elective Discharge," instructed staff to complete an incident report when patients left against medical advice. In the following examples of ED patients who left AMA or without being seen, there were no incident reports completed.</p> <p>a. Patient #13 was 30 year old female who arrived at the emergency room on 6/07/15 after a tailbone injury. The ED record documented she left when she heard there was no specific treatment for tailbone injury except ice. The MD and x-ray tech were notified.</p> <p>b. Patient #15 was a 22 year old male who arrived in the ED on 6/15/15 at 7:17 PM. A note on Patient #15's face sheet indicated the "ER was full at this time pt in every room except cardiac." The note stated Patient #15 left without being seen.</p> <p>c. The ED log was reviewed for documentation of patients who left AMA or without being seen. The ED log included nine patients who left the ED AMA or without being seen between 7/07/15 and 7/31/15.</p>	C 336	<p>C 336</p> <p>Corrective Action:</p> <p>1-2.</p> <ul style="list-style-type: none"> • Nursing staff were in-serviced on incident reporting on 08-12-15 and 08-13-15. • ER clerks were in-serviced on incident reporting for AMA/LWOT at the 08-19-15 staff meeting. • Department managers were in-serviced on 08-28-15 on the importance of filling out, following up, and reporting of incident reports as indicated in the policy. • DNS discussed with pharmacy and nursing the importance of filling out medication error incident reports. <p>3.</p> <ul style="list-style-type: none"> • Oversight of Quality Program has been designated to the DNS. • Dr. Wynn accepted appointment to the Quality Committee. <p>4. Contract services (patient care) have been added to the quarterly reporting schedule in the Quality Committee.</p> <p>5. ECF and Hospital services have been further separated for quality assurance reporting.</p> <p>Process Improvement.</p> <ul style="list-style-type: none"> • Quality Committee reporting structure has been changed to include all patient care services. • Quality reporting will include incident reports per department including any follow up or trends. • Pharmacy along with Nursing will monitor trends in med error reporting. 	9/10/15	

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C 336	<p>Continued From page 62</p> <p>During the interview on 8/04/15 at 10:18 AM, The DNS confirmed incident reports had not been completed for patients who left AMA or without being seen, as far as she knew, in the 3 months since she started employment with the CAH.</p> <p>2. The policy "Incident/Accident/Sentinel Event Reporting," dated 1/15/15, defined an incident as "any happening which is consistent (sic) with the routine operation of the hospital or the routine care of a patient." The policy included, but was not limited to the following as reasons incident reports should be initiated: "...To improve practice or outcomes of care...To provide a base from which hospital staff can further investigate, and determine deviations from standards of care, and determine corrective actions..., and...To develop and monitor trends regarding hospital incident/accident experiences through the QA Committee."</p> <p>This policy was not followed. Examples include:</p> <p>a. The Director of Housekeeping was interviewed on 8/06/15 beginning at 10:15 AM. When asked if the housekeeping staff ever had incidents of finding biohazard trash or needles in general trash or whether carts with hazardous chemicals had been left unattended in patient care areas, he stated the incidents did occasionally occur. He stated when the incidents occurred, he gave corrective feedback to involved staff but he did not record or track the incidents. He explained that the only incidents that was documented on incident reports, were needle sticks.</p> <p>Incidents involving deviations in standards of care were not completed.</p>	C 336	<p>C-0336 Continued....</p> <p>Implementing PoC.</p> <ul style="list-style-type: none"> Incident reports will be filled out and followed up for appropriate circumstances as defined in the policy. Education on incident reporting, follow up, and trends will continue through Quality Committee. <p>Monitoring PoC-</p> <p>Reporting per patient care department and contracted patient care services at Quality Committee.</p>		

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C 336	<p>Continued From page 63</p> <p>b. The Director of Surgical Services was interviewed on 8/05/15 at approximately 2:30 PM. When asked to explain the hospital's incident/occurrence reporting system and how she participated, she stated she reported anything that was out of the ordinary. For example, she said she completed incident reports for accidental, improper positioning of a patient when on the surgical table, which could have resulted in injury to a patient. She said she documented files observed in the OR and she completed an incident report when a urinary catheter was accidentally pulled out of a patient with the balloon inflated. The Director of Surgical Services further explained she filed the incident reports in her office and placed copies in employee files when an incident required employee counseling. She then said she destroyed the incident reports when they were no longer required. The Director of Surgical Services said she did not forward copies of the incident reports to anyone else. She was unaware of a process for tracking incidents through the QA program.</p> <p>Incident reports were completed but not kept for inclusion in the hospital's quality program.</p> <p>c. The Administrative Assistant, who served as the Quality Coordinator, was interviewed on 8/04/15 at approximately 9:30 AM. The hospital's incident/occurrence reporting system was discussed. The Quality Coordinator stated all incident reports were forwarded to her, and she compiled the data for the QA monitoring process. When asked what type of incidents/occurrences she expected to be reported, she said she only received reports of medication errors and patient slips and falls. The following documents were</p>	C 336		

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C 336	<p>Continued From page 64 reviewed related to incident/occurrence reporting:</p> <ul style="list-style-type: none"> * Nine documents titled, "MEDICATION ERROR REPORTS" * Two documents related to patient slips/falls titled, "INCIDENT/OCCURRENCE REPORT" * A document titled, "INCIDENT REPORT LOG-2015" that included 5 entries for 2015, all relating to patient slips and falls. * Documents titled, "MEDICATION ERROR LOG 1ST Q AND 2ND Q 2015," that tracked medication errors by medication name and dosage, date, time and type of error, such as "Med Missed/Not Given, Wrong Med Given, Wrong Route of Admin., Wrong Patient, Pharmacy Dispensed Wrong med/dose and Pharmacy No Med In Cart." <p>Falls and medication errors only were reported through the incident/occurrence reporting system and forwarded to the Quality Coordinator for quality monitoring. The CAH had not developed or implemented a process for capturing and reporting all adverse patient events for quality monitoring.</p> <p>3. The "QUALITY MONITORING AND IMPROVEMENT PLAN" was approved and signed, on 4/13/15, by a physician who was the Chair of the QA Committee, a member of the Board of Trustees, and the Administrator of the CAH. The QA plan named these individuals, along with the Quality Coordinator, as the "Quality Monitoring and Improvement Committee."</p> <p>The Administrative Assistant, who also served as</p>	C 336			

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C 336	<p>Continued From page 65</p> <p>the Quality Coordinator, was interviewed on 8/04/15 at approximately 9:30 AM. She said the physician, who held the position of Chair of the QA Committee, had recently left the organization. The Quality Coordinator said the position remained vacant. When she was asked who was responsible for oversight of the quality program, she stated the responsibility was hers.</p> <p>The CAH's Administrator was interviewed during the entrance conference, on 8/03/15, beginning at 1:00 PM, and again on 8/06/15, beginning at 9:00 AM. During the entrance conference, he indicated the Quality Coordinator was the contact person for the QA program. The Administrator subsequently reported, during the interview on 8/06/15, that there was not an individual who was providing oversight for the QA program.</p> <p>The hospital did not have a designated responsible party who oversaw its QA program.</p> <p>4. The following quality related documents were reviewed during the survey for evidence of inclusion of contracted services in the quality program:</p> <ul style="list-style-type: none"> * "QUALITY MONITORING AND IMPROVEMENT PLAN," signed and dated by the Quality Committee on 4/13/15 * "...QUALITY ASSURANCE..." meeting minutes for 2014 and 2015 * "QUALITY IMPROVEMENT COMMITTEE QUARTERLY REPORTING" for 2015 * "QUALITY IMPROVEMENT REPORTING FORMS" for 2015 	C 336		

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C 336	Continued From page 66 The CAH's Administrator was interviewed on 8/06/15, beginning at 9:00 AM. The Administrator stated services the CAH provided under agreement were "not routinely" monitored or reviewed for quality. He said review or discussion would be "complaint or deficiency driven." He explained contracted services would only be discussed on an "as needed" basis, perhaps if a complaint was submitted about a contracted entity, or if a deficiency is cited during a survey. Contracted services were not proactively evaluated through the QA program. 5. The "QUALITY IMPROVEMENT COMMITTEE QUARTERLY REPORTING" for 2015 and the "QUALITY IMPROVEMENT REPORTING FORMS" for 2015 contained quality data and studies for the CAH and the SNF, located within the same physical structure and overseen by the same parent company as the CAH. For example, the "QUALITY MANAGEMENT REPORTING FORM..." for the Department of PT, dated "March, April, May 2015," included quality data for "...adherence to the Plan Of Care." The form did not include information that clearly indicated whether the data was related to the CAH or the SNF. The Physical Therapist was interviewed on 8/06/15 beginning at 8:15 AM. She stated she gathered quality indicator data for the attached SNF. She stated therapy services did not participate in the CAH's QA program. The hospital did not clearly define and/or separate quality studies and data between the	C 336			

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C 336	Continued From page 67 CAH and the SNF.	C 336			
C 337	The CAH did not have an effective or comprehensive QA program that evaluated the appropriateness of all patient care services provided by the facility. 485.641(b)(1) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that- all patient care services and other services affecting patient health and safety are evaluated. This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure an effective QA program to evaluate the quality and appropriateness of treatment furnished in the CAH, including services provided under agreement, and all other services affecting patient health and safety, were evaluated. This prevented the CAH from assessing its services in order to identify potential areas of concern and take corrective action. Findings include: 1. A CAH policy titled, "Annual Evaluation of Services" was reviewed. The policy included the CAH will "...evaluate its services and programs annually..." The policy also said "...The purpose of the evaluation will be to insure that suitable services are being delivered to the community..."	C 337			

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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	
C 337	Continued From page 68 The "QUALITY IMPROVEMENT COMMITTEE QUARTERLY REPORTING" for 2015 was reviewed. The following departments did not include quality indicator data that assessed patient care services and how those services were evaluated for appropriateness. - Discharge Planning - The Department of Discharge Planning was using a document titled, "Patient Satisfaction Survey" to monitor the quality of its services. There was no evidence that the information gleaned from the surveys was used to identify and improve/correct negative practices. - Social Services - Information derived from "...Grievances/Complaints" was being tracked for the SNF, but there was no quality indicator data for the CAH being monitored by the department of Social Services. - Surgical Services - Information was being gathered from "Orthopedic Postop Patient Satisfaction Surveys." There was no evidence that the information gleaned from these surveys was used to identify and improve/correct negative practices. - Nursing Services - Nursing care plans were incomplete during the survey. This issue had not been identified and addressed through the QA program (refer to C-0298). - Therapy Services - Physical Therapy's quality indicator was identified as "Review of adherence to Plan of Care," but was collected only for the SNF. There was no evidence of a PT, quality indicator identified for the CAH.	C 337	C 337 Corrective Action: <ul style="list-style-type: none">• Discharge Planning: Patient Satisfaction Surveys will be conducted by a 3rd party CMS approved vendor starting Oct. 1, 2015.• Social Services: Grievances for Swing Bed patients was reported at Quality Committee 09-01-15 and will continue to be reported.• Surgical Services: Patient Satisfaction Surveys will be conducted by a 3rd party CMS approved vendor starting Oct. 1, 2015.• Nursing Services: Care plans were discussed and staff educated at staff meeting for better compliance with comprehensive, individualized care plans. Quality measures still being developed and will be reported at next Quality Committee meeting.• Physical Therapy: Developing a quality indicator for acute care and report at the Quality Committee meeting on 09-01-15.• Radiology Services: Changed quality indicator to include informed consent prior to any procedure and the tracking of proper signatures on those forms. This was reported to Quality Committee on 09-01-15.• IC Services: Refer to C278	9/10/15	

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C 337	Continued From page 69 - Radiology Services - The department of Radiology Services was monitoring quality indicator data related to "Missed/Incorrect Charges." A quality indicator that assessed patient care related services was not identified by Radiology Services. - Infection Control Services - The Department of Infection Control identified "Nosocomial (Hospital Acquired) Infection Rates" as a quality indicator. However, the surveillance process for tracking potential post-operative/hospital acquired infections, was found to be incomplete (refer to C-0278.) The CAH's Administrator was interviewed on 8/06/15, beginning at 9:00 AM. The Administrator confirmed the CAH's quality indicator data did not represent all departments of the CAH and did not consistently assess patient care services and how those services were evaluated.	C 337	C-0337 Continued... Process Improvement. Patient care services will provide a Patient driven Quality Indicator to the Quality Committee. Implementing PoC. Education to Patient Care Services to change quality indicators to patient driven at Department Head Meeting 08-28-15. Monitoring PoC-. Reporting through Quality Committee quarterly per department.		
C 338	485.641(b)(2) QUALITY ASSURANCE [The program requires that--] nosocomial infections and medication therapy are evaluated; This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies and patient records, it was determined the CAH failed to implement a QA program that included a process to effectively identify and evaluate nosocomial infections and monitor/evaluate medication therapy in the CAH. Findings include:	C 338			

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C 338	<p>Continued From page 70</p> <p>1. IC surveillance process:</p> <p>A policy titled, "INFECTION CONTROL PLAN" was reviewed. The policy documented "...Surveillance will include nosocomial and hospital acquired infections among patients and personnel..." The policy also stated performance measures included "...1. Comprehensive periodic surveillance (baseline rates established outcomes;..." The plan did not specify a surveillance process that included surgical patients who had been discharged from the facility.</p> <p>The RN IC Practitioner and DNS were interviewed together on 8/04/15 beginning at 9:50 AM regarding the CAH's IC plan and related policies. The IC Practitioner stated the hospital followed APIC and CDC infection control guidelines. When discussing surveillance and identification of hospital acquired and/or post operative infections, the IC Practitioner and DNS confirmed the hospital did not have a process to identify/track potential hospital acquired or post operative infections once patients were discharged from the hospital.</p> <p>The CDC's guide, titled "Surgical Site Infection (SSI) Event," last modified in April of 2015, (http://www.cdc.gov/nhsn/PDFs/pscManual/9pscSSICurrent.pdf), documented "...SSI monitoring requires active, patient-based, prospective surveillance. Post-discharge and ante-discharge surveillance methods should be used to detect SSIs following inpatient and outpatient operative procedures. These methods include, 1) direct examination of patients' wounds during follow-up visits to either surgery clinics or physicians' offices, 2) review of medical records or surgery</p>	C 338		

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C 338	Continued From page 71 clinic patient records, 3) surgeon surveys by mail or telephone, and 4) patient surveys by mail or telephone (though patients may have a difficult time assessing their infections)..." The hospital did not have a comprehensive surveillance program for identifying and investigating hospital acquired infections. 2. Medication errors potentially related to the EMR: The Pharmacy Director was interviewed on 8/04/15 beginning at 9:25 AM. He stated the CAH had experienced an increase in medication errors since an Electronic Medical Record system had been implemented in the spring of 2015. He stated he did not have data or know how much the error rate had increased. He stated quality indicators had not been developed to measure the impact of the Electronic Medical Record on medication errors. The CAH had not developed or implemented an effective process for capturing and reporting medication errors. The CAH's QA program did not identify effective processes to adequately monitor occurrences of nosocomial infections. The program also did not effectively analyze and address the increase in medication errors since the implementation of the EMR.	C 338	C 338 Corrective Action: 1. Refer to C 278 2. Revised medication error reporting form to include barcode scanning or EMR as a possible contributor to the error. Process Improvement. Decrease medication errors related to EMR and barcode scanning. Implementing PoC. • Education to nursing staff on barcode scanning 07/08 & 07/09/2015 • Report to staff the individual barcode scanning compliance 07/08 & 07/09/2015 Monitoring PoC-. • Monitor medication scanning compliance through BCMA reports. • Report at nursing staff meetings, respiratory staff, P&T committee, and Quality	9/10/15
C 385	485.645(d)(4) PATIENT ACTIVITIES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:]	C 385		

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C 385	<p>Continued From page 72</p> <p>Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy.</p> <p>Quality of Life - activities (§483.15(f))</p> <p>"(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>(2) The activities program must be directed by a qualified professional who-</p> <p>(i) Is a qualified therapeutic recreation specialist or an activities professional who-</p> <p>(A) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or</p>	C 385	<p>C 385</p> <p>Corrective Action:</p> <p>Activities policy was revised.</p> <p>Education provided to staff.</p> <p>Process Improvement.</p> <p>Activity program will be initiated on every Swing Bed Patient</p> <p>Implementing PoC.</p> <p>Education to involved staff on activity program requirements for Swing Bed Patients.</p> <p>Revision of EMR charting to include Activity Plan of Care.</p> <p>Monitoring PoC-</p> <p>Charts will be reviewed and quality indicators will be reported at Quality Meeting.</p>	9/10/15

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C 385	<p>Continued From page 73</p> <p>(iii) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(iv) Has completed a training course approved by the State."</p> <p>This STANDARD Is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure an activities program was provided to 2 of 5 Swing Bed patients (#28 and #34), whose records were reviewed. This interfered with the CAH's ability to meet the needs of Swing Bed patients. Findings include:</p> <p>1. Patient #28 was a 93 year old male admitted to the CAH on 5/30/15. He was transferred to Swing Bed status on 6/03/15. He was discharged from Swing Beds on 6/09/15. His H&P, dated 5/30/15 at 11:36 PM, stated he had intractable pain in his left leg and had diabetes.</p> <p>Neither an activities assessment nor an activities plan were documented for Patient #28. An activities program was not documented.</p> <p>The URC, who was also responsible for the Swing Bed program, was interviewed on 8/04/15 beginning at 3:30 PM. She stated Patient #28 did not have a documented activities assessment or an activities plan. She confirmed an activities program was not documented.</p> <p>The CAH did not provide an ongoing activities program to Patient #28.</p> <p>2. Patient #34 was a 67 year old female admitted</p>	C 385			

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C 385	Continued From page 74 to the CAH on 6/27/15. She was transferred to Swing Bed status on 7/01/15. She was currently a patient as of 8/04/15. Her H&P, dated 6/27/15 at 7:43 PM, stated she had poorly controlled diabetes, confusion, polysubstance abuse, weakness, and necrotic areas on her feet. An activities assessment for Patient #34 was documented on 7/03/15 at 10:20 AM. However, an activities plan or program related to the assessment was not documented. The URC was interviewed on 8/04/15 beginning at 3:30 PM. She stated Patient #34 did not have a documented activities plan or an activities program. She stated the Activities Director from the attached SNF had invited Patient #34 to participate in activities on at the SNF but the patient refused. She stated no other activities plan was documented. The CAH did not provide an ongoing activities program to Patient #34.	C 385			
C 395	485.645(d)(6) COMPREHENSIVE CARE PLANS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).]	C 395	C 395 Corrective Action: Care Plan policy was revised. Education provided to staff. Process Improvement. Comprehensive Care Plans will be initiated on every Swing Bed Patient Implementing PoC. Education to involved staff on Comprehensive Care Plan requirements for Swing Bed Patients. Revision of EMR charting to include Comprehensive Care Plan. Monitoring PoC- Charts will be reviewed and quality indicators will be reported at Quality Meeting.	9/10/15	

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C 395	<p>Continued From page 75 Comprehensive care plans (§483.20(k)(1))</p> <p>"The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following-</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and</p> <p>(ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4)."</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure a comprehensive care plan was developed for 2 of 5 Swing Bed patients (#28 and #34), whose records were reviewed. This resulted in a lack of direction to staff caring for Swing Bed patients. Findings include:</p> <p>1. Patient #34 was a 67 year old female admitted to the CAH on 6/27/15. She was transferred to Swing Bed status on 7/01/15. She was currently a patient as of 8/05/15. Her H&P, dated 6/27/15 at 7:43 PM, stated she had poorly controlled diabetes, confusion, polysubstance abuse, weakness, and necrotic areas on her feet. During her stay, Patient #34's blood glucose</p>	C 395		

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C 395	<p>Continued From page 76</p> <p>levels varied widely, from a low of 36 on 7/06/15 at 2:47 PM to 382 on 7/19/15 at 7:19 AM. (The CAH's laboratory reports stated normal blood glucose levels were 60-100.)</p> <p>Patient #34's POC, dated 7/02/15, did not address her diabetes, the sores on her feet, or her substance abuse.</p> <p>This was confirmed by the DNS during interview on 8/05/15 beginning at 9:15 AM.</p> <p>2. Patient #28 was a 93 year old male admitted to the CAH on 5/30/15. He was transferred to Swing Bed status on 6/03/15. He was discharged from Swing Beds on 6/09/15. His H&P, dated 5/30/15 at 11:36 PM, stated he had intractable pain in his left leg and had diabetes. He was started on Insulin for his diabetes when he was admitted to Swing Bed status.</p> <p>Patient #28's POC, dated 7/02/15, did not address his diabetes.</p> <p>This was confirmed by the DNS during interview on 8/05/15 beginning at 9:15 AM.</p>	C 395			

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BB149	<p>16.03.14.250.06 Review of Policies and Procedures</p> <p>06. Review of Policies and Procedures. The medical staff shall review and approve all policies and procedures directly related to medical care. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on staff interview and policy review, the CAH failed to ensure the medical staff reviewed and approved all policies and procedures directly related to medical care. This had the potential to interfere with quality and safety of patient care. Findings include:</p> <p>Refer to C-0258</p>	BB149	<p>BB 149 Refer to C 0258</p> <p style="text-align: center;"><i>RECEIVED</i> SEP - 8 2015 <i>FACILITY STANDARDS</i></p>	9/10/15
BB175	<p>16.03.14.310.03 Patient Care Plans</p> <p>03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)</p> <p>a. Nursing care treatments required by the patient; and (10-14-88)</p> <p>b. Medical treatment ordered for the patient; and (10-14-88)</p> <p>c. A plan devised to include both short-term and long-term goals; and (10-14-88)</p> <p>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)</p> <p>e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)</p>	BB175	<p>BB 175 Refer to C 0298</p>	9/10/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Carl Harmon

TITLE

administrator

(X6) DATE

9-8-15

Bureau of Facility Standards

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BB175	Continued From page 1 This Rule is not met as evidenced by: Based on record review and staff interview, the CAH failed to ensure patient care plans were individualized and kept current for 11 of 19 inpatients (#9, #19, #22, #23, #24, #34, #39, #40, #41, #42 and #44) whose records were reviewed. This had the potential to interfere with coordination of patient care. Findings include: Refer to C-0298	BB175		
BB209	16.03.14.320.08 Dietary Policies and Procedures 08. Dietary Policies and Procedures. Written policies and procedures shall be developed for all areas of the dietary Department. They shall be reviewed at least once a year, revised if necessary, and dated at time of review. (10-14-88) a. Policies and procedures which involve another department shall be developed in cooperation with that department's personnel. Copies shall be available in each department involved. These policies and procedures shall include, but are not limited to: (10-14-88) i. Serving of trays; and (10-14-88) ii. Serving of nourishments; and (10-14-88) iii. Procedures for hold or late trays; and (10-14-88) iv. Exchange of information when patient isn't eating or isn't accepting a diet. (10-14-88) This Rule is not met as evidenced by: Based on review of dietary policies and	BB209	BB 209 Refer to C 0271	9/10/15

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BB209	Continued From page 2 procedures and staff interview, it was determined the CAH failed to ensure written dietary policies and procedures were developed and reviewed annually. This had the potential to negatively impact the quality of dietary services. Findings include: Refer to C-0271.	BB209		
BB273	16.03.14.360.02 Policies and Procedures 02. Policies and Procedures. There shall be written policies and procedures for the operation of the medical records service. (10-14-88) This Rule is not met as evidenced by: Based on review of medical records policies and procedures and staff interview, it was determined the CAH failed to ensure written policies and procedures for the operation of the medical record service were current and appropriately approved. Refer to C-0271.	BB273	BB 273 Refer to C 0271	9/10/15
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be	BB297	BB 297 Refer to C 0274	9/10/15

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDXLW0	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2015
NAME OF PROVIDER OR SUPPLIER MINIDOKA MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 8TH STREET RUPERT, ID 83350		
(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
BB297	Continued From page 3 approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to, the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs,	BB297		

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BB297	<p>Continued From page 4 equipment, and supplies; and (10-14-88)</p> <p>i. Policy and supporting procedures involving toxicology; and (10-14-88)</p> <p>j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88)</p> <p>k. Policy involving instructions relative to disclosure of patient information; and (10-14-88)</p> <p>l. A policy for integration of the emergency room into a disaster plan. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on policy review and staff interview, it was determined the CAH failed to ensure emergency room policies and procedures were approved by all required individuals. This had the potential to interfere with quality and safety of patient care. Findings include: Refer to C- 274.</p>	BB297	<p>BB 302</p> <p>Corrective Action: Diagnosis was added to the Emergency Room Register</p> <p>Process Improvement. Diagnosis will be documented in Emergency Room Register on all ER patients.</p> <p>Implementing PoC.</p>	9/10/15
BB302	<p>16.03.14.370.06 Emergency Room Register</p> <p>06. Emergency Room Register. There shall be an emergency room register containing name of patient, age, physician, and diagnosis. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on review of the emergency room register and staff interview, it was determined the emergency room register was incomplete. This resulted in patients' diagnosis not being included on the register. Findings include: The Emergency Room Register was reviewed. It</p>	BB302	<ul style="list-style-type: none"> • ER Clerks were educated on requirement at staff meeting 08-19-15 • ER Medical Director was informed of requirement 8-6-15 and discussed the requirement with ER medical staff to ensure compliance. • Nursing Staff was educated on requirement on 8-6-15. <p>Monitoring PoC-</p> <ul style="list-style-type: none"> • Log will be monitored for compliance by UR. • Any deficiencies will be tracked and reported to DNS for follow up. 	

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BB302	Continued From page 5 did not include patient diagnoses. This was confirmed by the DNS on 8/04/15 at 10:35 AM. The Emergency Room Register was incomplete.	BB302		