IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK—ADMINISTRATOR
DIVISION OF LICENSING & CERTIFICATION
DEBBY RANSOM, R.N., R.H.I.T. – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

CERTIFIED MAIL: 7012 3050 0001 2125 5648

September 18, 2015

Timothy Powers, Administrator
North Canyon Medical Center
267 North Canyon Dr
Gooding, ID 83330

RE: North Canyon Medical Center, Provider #131302

Dear Mr. Powers:

Based on the survey completed at North Canyon Medical Center, on September 3, 2015, by our staff, we have determined North Canyon Medical Center, is out of compliance with the Medicare Hospital Condition of Participation of **Organizational Structure (42 CFR 485.627)**. 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 this conditions to be unmet, substantially limit the capacity of North Canyon Medical Center, 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.

<u>An acceptable Plan of Correction contains the following elements</u>:

- 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;
- 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 October 18, 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 October 8, 2015.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 1, 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
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Aileen Renolayan CMS Region X Office

NORTH CANYON
MEDICAL CENTER

RECEIVED
OCT - 9 2015
FACILITY STANDARDS

October 9, 2015

Sylvia Creswell
Idaho Department of Health & Welfare
3232 Elder Street
Boise, ID 83720

Re: North Canyon Medical Center, Provider #131302 - Credible Allegation of Compliance/Plan of Correction

Dear Ms. Creswell,

The original statement of deficiencies Plan of Correction from the survey completed at North Canyon Medical Center on September 3, 2015 was submitted for review on October 1, 2015. Additional changes discussed in a conference call on October 7, 2015 can be located on pages 2 of 16 and 4 of 16 in the report. A signed CMS-2567 form is also enclosed with administrator signature and completion dates.

The deficiency statements have been addressed with appropriate departments and noted in the report.

If you have any questions, please contact me at 208-934-4433x1109.

Sincerely,

Sara Otto

Sara Otto
Chief Compliance Officer

Enclosures:
ED-201 *"Emergency Department Medical Director"*
MS-103 *"Physician Oversight of Mid-Level Providers"*
Pages two (2) and four (4) of correction plan.
CMS-2567 with administrator signature on page one (1) and implementation dates listed in right hand column.

cc: Tim Powers, Chief Executive Officer

Phone 208-934-4433 • Fax 208-934-9389
267 North Canyon Dr. • Gooding, ID 83330 • www.ncm-c.org

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

PRINTED: 09/18/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	131302		09/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CANYON MEDICAL CENTER	267 NORTH CANYON DR GOODING, ID 83330

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C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital conducted from 8/31/15 to 9/03/15. The surveyors conducting the Medicare recertification survey were: Gary Gulles, R.N., H.F.S., Team Leader Rebecca Lara, R.N., BA, H.F.S. Laura Thompson, R.N., BSN, H.F.S Dennis Kelly, R.N., BC, H.F.S Nancy Bax, R.N., BSN, H.F.S. Acronyms used in this report include: ACLS - Advanced Cardiac Life Support CAH - Critical Access Hospital CEO - Chief Executive Officer COO - Chief Operating Officer CHF - Congestive Heart Failure CNO - Chief Nursing Officer CPR - Cardiopulmonary Resuscitation DM - Diabetes Mellitus DO - Doctor of Osteopathy ED - Emergency Department EKG - electrocardiogram H&P - History and Physical Examination IDAPA - Idaho Administrative Procedures Act IV - Intravenous NP - Nurse Practitioner MD - Medical Doctor mg - milligram PA - Physician Assistant PI - Performance Improvement QA - Quality Assurance RN - Registered Nurse	C 000	RECEIVED OCT - 9 2015 FACILITY STANDARDS	
C 240	485.627 ORGANIZATIONAL STRUCTURE	C 240		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 10-1-15

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

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C 240	Continued From page 1 Organizational Structure This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws, Medical Staff Policies, Governing Board and Medical Staff meeting minutes, and call schedules, it was determined the CAH failed to ensure its organizational structure was sufficient to direct patient care. This impeded the ability of the CAH to provide safe and effective care. Findings include: Refer to C241 as it relates to the failure of the Governing Body to assume responsibility for determining and implementing Medical Staff policies. These systemic negative practices seriously impeded the ability of the CAH to direct and oversee the Medical Staff.	C 240	*C240 Response:* Policies MS-103 *"Physician Oversight of Mid-Level Providers"* and MS-104 *"Mid-Level Provider Physician Consultation"* were developed and will be reviewed at the Medical Staff meeting on October 21, 2015. Meeting minutes will provide evidence of education of policy. These policies outline the supervision of all allied health providers and ensure patients are under the care of a licensed physician. MS-103: Supervising physicians shall oversee and direct care provided by mid-level providers in accordance with NCMC Medical Staff Bylaws, State of Idaho law, and applicable rules and regulations. Mid-level providers practicing at NCMC will maintain strict adherence to the local standards of patient care when providing medical services within the hospital.	10/01/15
C 241	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws, Medical Staff Policies, Governing Board and Medical Executive	C 241	A. Patients who are admitted to the Med/Surg floor will be under the care of a physician per NCMC Medical Staff Bylaws RULE 2, §2.2 "Admission Requirements." B. The mid-level provider must obtain consultation and medical direction for the following: i. Patients whose physical condition changes and/or deteriorates. ii. Patients whose condition may require specialty care that is unavailable at this facility or whose condition requires a higher level of care, the mid-level provider will consult directly with appropriate physician specialist to ensure the highest quality of care.	

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C 241	Continued From page 2 meeting minutes, and call schedules, it was determined the CAH's Governing Body failed to assume responsibility for determining and implementing Medical Staff policies. This directly affected the care of 2 of 15 inpatients (#12 and #13) and 1 of 10 ED patients (#6), whose records were reviewed. The Governing Body failed to oversee the medical care provided to both inpatients and emergency patients. This resulted in the CAH's inability to ensure quality healthcare was provided. Findings include: 1. Patient #13 was a 78 year old male who presented to the ED on 8/27/15. A report by the PA, dated 8/27/15 at 4:46 PM, stated Patient #13 complained of pain in his mouth and throat as well as nausea and vomiting. The report stated he had history of chronic obstructive pulmonary disease requiring 4 liters of oxygen continuously. The report also stated Patient #13 had fallen 2 weeks prior, injuring his ribs. The PA diagnosed Patient #13 with a collapsed lung and possible pneumonia. An inpatient bed was not available so Patient #13 elected to return home with an appointment to see another PA in the CAH's clinic the following day. Patient #13's medical record contained an H&P by a PA, dated 8/28/15 but not timed. It stated Patient #13 complained of increased shortness of breath and had a low oxygen saturation level at 85%. The H&P stated he was not in acute distress but he was admitted to the CAH on 8/28/15, as an inpatient. A PA report, dated 8/29/15 at 11:40 AM, stated he was in no acute distress. A PA report, dated 8/29/15 at 5:13 PM, stated Patient #13's breath sounds had worsened at 4:00 PM so the PA	C 241	*C240 cont.* C. Mid-level provider will consult with Physician within twenty-four (24) hours of admission and document in patient chart. D. Supervising Physician will assess patient during inpatient stay; not to exceed forty-eight (48) hours after initial consult. E. Physicians will review no less than ten percent (10%) of mid-level provider's medical records per *HI-403 Peer Review Policy*. MS-104: Mid-level providers practicing at NCMC will maintain strict adherence to the local standards of patient care when providing medical services within the hospital. Supervising physicians shall oversee and direct care provided by mid-level providers in accordance with NCMC Medical Staff Bylaws, State of Idaho law, and applicable rules and regulations. A. The mid-level provider must obtain consultation and medical direction for the following: i. Patients whose physical condition changes unfavorably and/or deteriorates. ii. Patients whose condition may require specialty care that is unavailable at this facility or whose condition requires a higher level of care, the mid-level provider will consult directly with appropriate physician specialist to ensure the highest quality of care.	

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C 241	Continued From page 3 came in and examined him. The report stated she examined Patient #13, then called a physician at an acute care hospital. The PA report stated the physician advised the PA to intubate Patient #13 and transfer him to the acute care hospital. Patient #13 was taken to the CAH's ED. A PA report, dated 8/29/15 at 5:44 PM, stated Patient #13 developed respiratory failure in the CAH. The report stated Patient #13 was intubated and placed on a ventilator by the PA. The report stated a helicopter was on site and transferred him to an acute care hospital. All care for Patient #13 was provided by PAs. No documentation was present that Patient #13 was examined or treated by a physician. Patient #13's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the events of Patient #13's hospital stay. He stated PAs had provided all of the medical care for this critically ill patient. The Chief of Staff, a physician, was interviewed on 9/02/15 beginning at 8:00 AM. He stated the CAH did not have policies that outlined physicians' responsibilities to examine patients or to supervise/monitor the care provided by Allied Health Professionals. He stated physicians were supposed to see all inpatients within 24 hours of admission. He stated the physicians were a little slack about that. He stated a physician should have examined Patient #13 during his stay. He stated Patient #13's case did not meet the criteria for automatic peer review and his care would not necessarily be reviewed by a physician.	C 241	*C240 cont.* A. Mid-level provider will consult with Physician within twenty-four (24) hours of admission and document in patient chart. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer. *C241 Response:* Policies MS-103 *"Physician Oversight of Mid-Level Providers"* and MS-104 *"Mid-Level Provider Physician Consultation"* (discussed in C240 above) were developed and approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015. Policy HI-403 *"Peer Review Policy"* has been reviewed and revised on September 30, 2015. Policies communicated to medical staff via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Meeting agendas and minutes from medical staff, quarterly ER Provider review, and peer review meetings will evidence ongoing compliance with this Condition of Participation.	

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C 241	Continued From page 4 Patient #13's care was not provided or supervised by a physician. 2. Patient #12 was a 39 year old female who presented to the ED on 7/25/15 at 8:43 AM. A report by the PA, dated 7/25/15 at 1:36 PM, stated Patient #12 was admitted to a nearby alcohol treatment center on 7/19/15. The report stated Patient #12 had a history of a blood clot on her spleen. The report stated Patient #12 complained of worsening abdominal pain and distention for the past 2 days. The report stated while in the ED, Patient #12 received a "massive amount" of IV Fentanyl, a powerful narcotic, "...which induced drowsiness, sedation, dramatic improvement, but [did] not get resolution of her pain. It actually brought down her blood pressure so I am now giving 750 cc normal saline bolus...The patient is requesting hospitalization at our facility. I will now confer with [a PA], her primary care physician. Final disposition and care will be at primary care provider's discretion." A corresponding note by the PA, dated 7/26/15 at 12:27 AM, stated a central IV line was placed in the ED. Patient #12 was then admitted to the CAH as an inpatient. A "Final Report" by another PA, dated 7/25/15 at 7:48 PM, documented vital signs were within normal limits at 5:28 PM. The report stated Patient #12 was in no acute distress and her lungs were clear. The report stated Patient #12's diagnoses were alcoholic cirrhosis and acute pancreatitis. The report stated an order to transfer Patient #12 to an acute care hospital to the care of a physician was written at 8:00 PM on 7/25/15. An admission H&P was not documented. A reason for the transfer was not	C 241	*C241 cont.* H1-403: NCMC will assess the performance of individuals with clinical privileges at NCMC, through its Peer Review Committee, for the purpose of bettering the system of delivery of health care, reducing patient morbidity and mortality and improving the quality of patient care. Circumstances eligible for review by the Peer Review Committee include: A. Peer review activities identified in NCMC and medical staff organizational documents, policies and agreements. B. Peer review activities required by standards, laws and regulations imposed by state, federal or private licensing or accrediting body. C. Sentinel events or "near miss' incidents identified by any person or entity. D. Unusual individual cases or clinical pattern of care identified by any person or entity. E. Surgery on wrong body part F. Unplanned surgical care readmission within 30 days for same or related tissue G. Mortality within 30 days of surgery (Notification by surgery) H. Cases involving excessive blood loss, re-operation, post-surgical infection, mortality, unexpected complication. I. Hypoglycemic events J. Codes K. Medication errors - Level C and above	

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C 241	Continued From page 5 documented. Examination by a physician and consultation with a physician were not documented. Patient #12's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the documentation and stated he did not know why Patient #12 was transferred. He confirmed Patient #12's record did not include documentation to show a physician had been involved in or had been consulted about her care. Patient #12's care was not provided or supervised by a physician. 3. The CAH had 11 active PAs and NPs who cared for patients. The ED was staffed exclusively by these Allied Health Professionals. Patients were routinely admitted as inpatients and were discharged from the CAH by Allied Health Professionals. Physicians did round at times but the bulk of care at the CAH was provided by Allied Health Professionals. This was confirmed by interview with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. Medical Staff Bylaws, dated 1/28/14, stated the Allied Health Professional Staff could admit patients consistent with approved clinical privileges. The bylaws stated the Allied Health Professional Staff could exercise privileges "...Provided that a physician member of the Medical Staff will have the ultimate responsibility for patient care." Medical Staff Bylaws and Rules and Regulations did not state what care should be provided by	C 241	*C241 cont.* L. Unplanned return to OR M. Post op complication N. Referrals from parties such as clinical staff or administration. O. Work performed by practitioners granted privileges at NCMC. These policies will outline the supervision of all allied health providers, ensure patients are under the care of a licensed physician and provide criteria for chart review. Monitoring and tracking procedures to ensure the policies and procedures are effective will include a review of 100% of admitted patient charts over the next 12 months for compliance monitoring. After 12 months, the frequency of monitoring will be re-evaluated and a decision made as to 100% or less monitoring. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer.	

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C 241	Continued From page 6 physicians. Neither the Bylaws nor the Medical Staff Rules and Regulations outlined how the Medical Staff would supervise and monitor care provided by the Allied Health Professional Staff. Progress notes were co-signed by physicians but no documentation was present to show physicians supervised care provided by the Allied Health Professional Staff. A formal process to oversee the work of the Allied Health Professional Staff had not been developed. The Chief of Staff was interviewed on 9/02/15 beginning at 8:00 AM. He stated the CAH did not have policies that outlined physicians' responsibilities to examine patients or to supervise/monitor the care provided by Allied Health Professionals. The Medical Staff Coordinator was interviewed on 9/02/15 beginning at 9:10 AM. She reviewed the Medical Staff Bylaws and policies. She stated a policy that outlined the responsibilities of physicians to provide care and to supervise the care provided by Allied Health Professionals had not been developed. The Governing Body failed to ensure the duties of physicians, in relation to providing care and the oversight of care provided by Allied Health Professionals, were defined. 4. The Medical Staff Rules and Regulations, dated 1/28/14, stated "It is the responsibility of the scheduled on-call provider [physician] to respond to calls from the Emergency Department in accordance with Hospital policies and procedures.	C 241		

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C 241	Continued From page 7 ED schedules from April 2015 to September 2015 were reviewed. The schedules listed the PAs that were scheduled to work in the ED. No physicians were scheduled to staff the ED during this time. No physician on-call list was maintained for the CAH or the ED during this time. During an interview on 9/02/15 at 11:30 AM, the PA on duty stated he owned the PA group which staffed the ED. He stated PAs provided all medical care to patients in the ED. He stated the PA group had an independent contract with a local physician. The PA stated, as part of the contract, the physician reviewed a random 10% of their records. He stated he did not call physicians for consultation when he was treating emergent patients. The PA stated he was unable to recall a situation when he had called a physician to come in to the facility to evaluate a patient or to discuss an emergent situation. The PA did not admit inpatients to the CAH. The PA stated he called 1 of 2 physicians groups' offices when required to discuss patients' potential admission. One of the physician groups worked for the CAH. The other was independent. The Supervising Physician for the PAs who staffed the ED was interviewed on 9/02/15 beginning at 1:05 PM. He stated he reviewed 10% of ED records for the medical care provided. He stated he met with the PAs every 1 to 3 months to talk about the reviews. He stated he did this per his contract with the PA group that staffed the ED. He stated he did not review cases for the CAH and said the CAH did not have a record of his reviews. He stated he did not supervise the PAs for the CAH. He stated PAs could contact a physician by phone if they were uncomfortable about how to treat a patient.	C 241		

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C 241	Continued From page 8 The Governing Body failed to ensure a system had been developed for oversight of care provided by Allied Health Professionals in the ED. 5. Medical Executive meeting minutes, dated between 8/01/14 and 9/01/15, were reviewed. Meeting minutes did not include documentation of discussion of the provision of care by Allied Health Professionals. Additionally, the meeting minutes did not include documentation of discussion of the supervision and monitoring of the Allied Health Professional Staff. Partners in Healthcare Board meeting minutes, dated between 8/01/14 and 9/01/15, were reviewed. No meeting minutes discussed the provision of care by Allied Health Professionals. No meeting minutes discussed the supervision and monitoring of the Allied Health Professional Staff. The CEO was interviewed on 9/10/15 beginning at 1:50 PM. He stated the Partners in Healthcare Board was the CAH's Governing Body. He stated the board minutes probably did not address medical care and the supervision of Allied Healthcare Professionals because it was not perceived as a problem. The Governing Body did not document oversight of the Medical Staff. 6. Patient #6 was a 29 year old female brought in to the ED by private auto on 5/30/15. She was found by her parents unconscious and unresponsive in the backseat of their car. Patient #6's medical history included developmental disability, atrial fibrillation, CHF, sleep apnea, and	C 241		

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C 241	Continued From page 9 long term anticoagulant use. The Emergency Documentation note, signed by the ED Supervisor, an RN, documented Patient #6 was with her family on a recreational drive when her parents realized she stopped talking to them. Her parents stated Patient #6 was in the back seat of their car, was not breathing, and was blue in color. The note documented the parents of Patient #6 started CPR and drove her to the CAH's ED. According to the Emergency Documentation note, Patient #6 arrived in the ED at 6:46 PM. She was immediately removed from the vehicle by ED staff and taken to a room. Patient #6 was placed on a cardiac monitor and her heart rhythm was in ventricular fibrillation, a life threatening arrhythmia. CPR was continued and Patient #6 was assisted with breathing using a bag valve mask. ED staff started an IV in Patient #6's right forearm and placed an intraosseous needle (a large bore needle placed in a large bone for administration of medications and fluid) in her right lower leg. The Medscape website, accessed 9/10/15, stated "Acute Ventricular Fibrillation (VF) is treated according to Advanced Cardiac Life Support (ACLS) protocols. The ACLS algorithm for ventricular fibrillation stated: - Initiate CPR and attach a cardiac monitor/defibrillator - Defibrillate the patient - Continue CPR for 5 cycles or 2 minutes and establish IV access - If ventricular fibrillation continues, defibrillate the patient	C 241		

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C 241	Continued From page 10 - Continue CPR for 5 cycles or 2 minutes, give Epinephrine 1 mg every 3 to 5 minutes, consider an advanced airway (Endotracheal tube) - If ventricular fibrillation continues, defibrillate the patient- Continue CPR for 5 cycles or 2 minutes, give Amiodarone 300 mg for the first dose; then 150 mg for a second dose - If ventricular fibrillation continues repeat the cycle, search for reversible causes of the heart rhythm The Emergency Documentation note and IV Medication Administration form documented the following: - 6:52 PM 1 ampule of Epinephrine was administered via IV - 6:53 PM Patient #6 was intubated with an ET (endotracheal) tube - 6:56 PM 1 ampule of Epinephrine was administered via IV - 7:00 PM 1 ampule of Epinephrine was administered via IV - 7:04 PM 1 ampule of Epinephrine was administered via IV - 7:07 PM 1 ampule of Epinephrine was administered via IV - 7:10 PM 1 ampule of Epinephrine was administered via IV - 7:08 PM 2 grams of Magnesium Sulfate was administered via IV - 7:09 PM 300 mg of Amiodarone (an antiarrhythmic medication) was administered via IV - 7:12 PM 150 mg of Amiodarone was administered via IV Additionally, Patient #6 was defibrillated 8 times during the ACLS code. The recorded EKG strips	C 241		

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C 241	Continued From page 11 documented the first defibrillation occurred at 6:49 PM and the last defibrillation was at 7:14 PM. The ACLS algorithm for people presenting with ventricular fibrillation was not followed. The Epinephrine dosage was documented as 1 ampule. However, it did not specify the actual dosage of Epinephrine administered. Per the ACLS algorithm, after the first dose of Epinephrine, the next medication to be given was Amiodarone. However, 5 additional doses of Epinephrine and 1 dose of Magnesium Sulfate were administered prior to giving Patient #6 Amiodarone. At 7:11 PM, the Emergency Documentation note stated Patient #6's family was counseled by the PA and the family requested to stop resuscitation efforts by the ED staff. Patient #6 was pronounced dead at 7:15 PM by the PA. During an interview on 9/02/15 at 11:20 AM, the ED Supervisor reviewed the record and confirmed ACLS protocols and algorithms were not followed for Patient #6. She stated the PA was running the code. During an interview on 9/02/15 at 11:30 AM, the PA in charge of the resuscitation reviewed the record and confirmed ACLS protocols and algorithms were not followed for Patient #6. He stated the CAH did not review cases where CPR was performed in order to determine whether hospital protocols were followed. He stated Patient #6's case was not reviewed. The Supervising Physician for the PAs who	C 241		

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C 241	Continued From page 12 staffed the ED was interviewed on 9/02/15 beginning at 1:05 PM. He stated he reviewed 10% of ED records for the medical care provided. He stated the records were chosen at random. He stated the reviews were not documented. The Revenue Cycle Compliance Officer was interviewed on 9/10/15 beginning at 2:40 PM. She stated Patient #6's case was scheduled for external peer review but the record had not yet been sent for review, 3 months and 10 days after the event. The Governing Body did not ensure a system was in place to review care provided to critically ill patients by Allied Health Professionals.	C 241		
C 257	485.631(b)(1)(i) RESPONSIBILITIES OF MD OR DO The doctor of medicine or osteopathy-- Provides medical direction for the CAH's health care activities and consultation for, and medical supervision of, the health care staff; This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, Medical Staff Bylaws, policies, Governing Board and Medical Staff meeting minutes and medical provider call schedules, it was determined the CAH failed to ensure physicians (MDs and DOs) provided medical direction and supervision of PAs and NPs, who provided care for inpatients, outpatients and patients treated in the ED. This lack of supervision negatively impacted the care of 2 of	C 257	*C257 Response*: Policies ED-201 "*Emergency Department Medical Director*" and MS-103 "*Physician Oversight of Mid-Level Providers*" were developed, approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015 and will be reviewed at the Medical Staff meeting on October 21, 2015. Meeting minutes will provide evidence of education of policy. Meeting agendas and minutes from medical staff, quarterly ER Provider review, and peer review meetings will evidence ongoing compliance with this Condition of Participation. ED-201 "*Emergency Department Medical Director*" policy will outline the physician supervision of all allied health providers in the Emergency Department.	

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C 257	Continued From page 13 15 inpatients (#12 and #13) and 1 of 10 ED patients (#6), whose records were reviewed. Additionally, this deficient practice had the potential to directly impact the care of all patients receiving treatment in the CAH and interfered with the CAH's ability to provide quality care to its patients. Findings include: 1. Patient #13's medical record described a 78 year old male who presented to the ED on 8/27/15. A report by the PA, dated 8/27/15 at 4:46 PM, stated Patient #13 complained of pain in his mouth and throat as well as nausea and vomiting. The report stated he had history of chronic obstructive pulmonary disease requiring 4 liters of oxygen continuously. The report also stated Patient #13 had fallen 2 weeks prior, injuring his ribs. The PA diagnosed Patient #13 with a collapsed lung and possible pneumonia. An inpatient bed was not available so Patient #13 was sent home with an appointment to see another PA in the CAH's clinic the following day. An H&P by a PA, dated 8/28/15 but not timed, stated Patient #13 complained of increasing shortness of breath and his oxygen saturation level was low at 85%. The H&P stated he was not in acute distress but he was admitted to the CAH as an inpatient. A PA report, dated 8/29/15 at 11:40 AM, stated he was in no acute distress. A PA report, dated 8/29/15 at 5:13 PM, stated Patient #13's breath sounds were worse at 4:00 PM so the PA came in and examined him. The report stated she examined Patient #13 and then called a physician at an acute care hospital. The PA report stated the physician advised the PA to intubate Patient #13 and transfer him to the acute care hospital.	C 257	*C257 cont.* The supervising physician for the Emergency Department shall serve as ED Medical Director and be responsible for the overall care provided to patients by mid-level providers. Responsibilities of the supervising physician will include, but are not limited to: A. Medical direction and supervision for the mid-level providers. B. Assist in development of policy and procedures affecting patient care in the emergency department. C. Provide chart review and critique medical records in compliance with the provisions provided by the Idaho State Board of Medicine. D. Meet with emergency department mid-level providers on a quarterly basis (or sooner as needed) to discuss all patient deaths in the emergency department for quality assurance. E. NCMC will maintain a supervision agreement with of the Emergency Department Medical Director. MS-103 "*Physician Oversight of Mid-Level Providers*" as discussed in C240 above ensures all patients are under the care of a licensed physician. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer.	10/01/15

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C 257	Continued From page 14 Patient #13 was taken to the CAH's ED. A PA report, dated 8/29/15 at 5:44 PM, stated Patient #13 developed respiratory failure in the CAH. The report stated Patient #13 was intubated and placed on a ventilator by the PA and a helicopter was on site to transfer him to an acute care hospital. All care for Patient #13 was provided by PAs. No documentation was present that Patient #13 was examined or treated by a physician. No documentation was present to show Patient #13's medical care was supervised by a physician or his care was reviewed by a physician. Patient #13's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the events of Patient #13's hospital stay. He stated PAs had provided all of the medical care for this critically ill patient. He confirmed there was no documentation by a physician in his medical record. The Chief of Staff, an MD, was interviewed on 9/02/15 beginning at 8:00 AM. He stated the CAH did not have policies that outlined physicians' responsibilities to examine patients or to supervise/monitor the care provided by PAs and NPs. He stated physicians, MDs and DOs, were supposed to see all inpatients within 24 hours of admission. He stated the physicians were "a little slack about that." He stated a physician should have examined Patient #13 during his stay. A physician did not provide care supervision for Patient #13.	C 257		

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C 257	Continued From page 15 2. Patient #12's medical record described a 39 year old female who presented to the ED on 7/25/15 at 8:43 AM. A report by a PA, dated 7/25/15 at 1:36 PM, stated Patient #12 was admitted to an alcohol treatment center on 7/19/15 at a nearby facility. The report stated Patient #12 had a history of a blood clot on her spleen. The report stated Patient #12 complained of worsening abdominal pain and distention for the past 2 days. The report stated Patient #12 received a "massive amount" of IV Fentanyl, a narcotic, "...which induced drowsiness, sedation, dramatic improvement, but [did] not get resolution of her pain. It actually brought down her blood pressure so I am now giving 750 cc normal saline bolus... The patient is requesting hospitalization at our facility. I will now confer with [a PA], her primary care physician. Final disposition and care will be at primary care provider's discretion." A corresponding note by the PA, dated 7/26/15 at 12:27 AM, stated a central IV line was placed while the patient was in the ED. Patient #12 was then admitted to the CAH as an inpatient. A "Final Report" by another PA, dated 7/25/15 at 7:48 PM, documented vital signs were within normal limits at 5:28 PM. The report stated Patient #12 was in no acute distress and her lungs were clear. The report stated Patient #12's diagnoses were alcoholic cirrhosis and acute pancreatitis. Finally, the report stated an order to transfer Patient #12 to an acute care hospital was written at 8:00 PM on 7/25/15. An admission H&P was not documented. A reason for the transfer was not documented. Examination by a physician, or consultation with a physician, was not documented. No documentation was present	C 257		

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C 257	Continued From page 16 to show Patient #13's medical care was supervised by a physician or her care was reviewed by a physician. Patient #12's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the documentation and stated he did not know why Patient #12 was transferred. He confirmed Patient #12's record did not include documentation to show a physician was involved in, was consulted about her care, or supervised her care. A physician did not provide care supervision for Patient #12. 3. Patient #6 was a 29 year old female brought in to the ED by private auto on 5/30/15. She was found by her parents unconscious and unresponsive in the backseat of their car. Patient #6's medical history included developmental disability, atrial fibrillation, CHF, sleep apnea, and long term anticoagulant use. The Emergency Documentation note, signed by the ED Supervisor, an RN,documented Patient #6 was with her family on a recreational drive when her parents realized she stopped talking to them. Her parents stated Patient #6 was in the back seat of their car, was not breathing, and was blue in color. The note documented the parents of Patient #6 started CPR and drove her to the CAH's ED. According to the Emergency Documentation note, Patient #6 arrived in the ED at 6:46 PM. She was immediately removed from the vehicle by ED staff and taken to a room. Patient #6 was placed on a	C 257		

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C 257	Continued From page 17 cardiac monitor and her heart rhythm was in ventricular fibrillation, a life threatening arrhythmia. CPR was continued and Patient #6 was assisted with breathing using a bag valve mask. ED staff started an IV in Patient #6's right forearm and placed an intraosseous needle (a large bore needle placed in a large bone for administration of medications and fluid) in her right lower leg. The Medscape website, accessed 9/10/15, stated "Acute Ventricular Fibrillation is treated according to Advanced Cardiac Life Support (ACLS) protocols. The ACLS algorithm for ventricular fibrillation stated: - Initiate CPR and attach a cardiac monitor/defibrillator - Defibrillate the patient - Continue CPR for 5 cycles or 2 minutes and establish IV access - If ventricular fibrillation continues, defibrillate the patient - Continue CPR for 5 cycles or 2 minutes, give Epinephrine 1 mg every 3 to 5 minutes, consider an advanced airway (Endotracheal tube) - If ventricular fibrillation continues, defibrillate the patient- Continue CPR for 5 cycles or 2 minutes, give Amiodarone 300 mg for the first dose; then 150 mg for a second dose - If ventricular fibrillation continues repeat the cycle, search for reversible causes of the heart rhythm The Emergency Documentation note and IV Medication Administration form documented the following: - 6:52 PM 1 ampule of Epinephrine was	C 257		

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C 257	Continued From page 18 administered via IV - 6:53 PM Patient #6 was intubated with an ET (endotracheal) tube - 6:56 PM 1 ampule of Epinephrine was administered via IV - 7:00 PM 1 ampule of Epinephrine was administered via IV - 7:04 PM 1 ampule of Epinephrine was administered via IV - 7:07 PM 1 ampule of Epinephrine was administered via IV - 7:10 PM 1 ampule of Epinephrine was administered via IV - 7:08 PM 2 grams of Magnesium Sulfate was administered via IV - 7:09 PM 300 mg of Amiodarone (an antiarrhythmic medication) was administered via IV - 7:12 PM 150 mg of Amiodarone was administered via IV Additionally, Patient #6 was defibrillated 8 times during the ACLS code. The recorded EKG strips documented the first defibrillation occurred at 6:49 PM and the last defibrillation was at 7:14 PM. The ACLS algorithm for people presenting with ventricular fibrillation was not followed. The Epinephrine dosage was documented as 1 ampule. However, it did not specify the actual dosage of Epinephrine administered. Per the ACLS algorithm, after the first dose of Epinephrine, the next medication to be given was Amiodarone. However, 5 additional doses of Epinephrine and 1 dose of Magnesium Sulfate were administered prior to giving Patient #6 Amiodarone.	C 257		

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C 257	Continued From page 19 The Emergency Documentation note documented at 7:11 PM, Patient #6's family was counseled by the PA and the family requested to stop resuscitation efforts by the ED staff. Patient #6 was pronounced dead at 7:15 PM by the PA. During an interview on 9/02/15 at 11:20 AM, the ED Supervisor reviewed the record and confirmed ACLS protocols and algorithms were not followed for Patient #6. She stated the PA was running the code. During an interview on 9/02/15 at 11:30 AM, the PA reviewed the record and confirmed ACLS protocols and algorithms were not followed for Patient #6. He stated the CAH did not review cases where CPR was performed in order to determine whether hospital protocols were followed. He stated Patient #6's case was not reviewed. A physician did not provide care supervision for Patient #6. 4. The CAH had 11 active Allied Health Professionals (NPs and PAs) who cared for patients. The ED was staffed exclusively by PAs. Patients were routinely admitted as inpatients and were discharged from the CAH by PAs and NPs. Medical Staff Bylaws and Rules and Regulations, dated 1/28/14, did not define how physicians would supervise and monitor care provided by the Allied Health Professional Staff. According to the Chief of Staff, during an interview on 9/02/15, beginning at 8:00 AM, physicians "made rounds," but the majority of	C 257		

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C 257	Continued From page 20 patient care at the CAH was provided by Allied Health Professionals. He stated there were no policies defining how physicians would supervise and monitor care provided by PAs and NPs. The CAH did not direct physicians to supervise PAs and NPs.	C 257		
C 261	485.631(b)(2) RESPONSIBILITIES OF MD OR DO A doctor of medicine or osteopathy is present for sufficient periods of time to provide medical direction, consultation, and supervision for the services provided in the CAH, and is available through direct radio or telephone communication or electronic communication for consultation, assistance with medical emergencies, or patient referral. This STANDARD is not met as evidenced by: Based on staff interview and review of policies and call schedules, it was determined the CAH failed to ensure a physician was available for consultation, assistance with medical emergencies, or patient referral. This resulted in the potential for delays in patient care. Findings include: Physician call schedules between 4/01/15 and 9/30/15 were not present in the CAH. Policies that outlined physicians' responsibilities in relation to assistance with medical emergencies, and patient referral were not present. The Chief of Staff, was interviewed on 9/02/15 beginning at 8:00 AM. He stated the CAH did not have policies that outlined physicians'	C 261	*C261 Response*: MS-102 "*Physician Back Up Call Schedule*" policy that provides 24/7 access to physician coverage was developed on September 25, 2015; approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015. Policy was communicated to medical staff, Emergency department and Med/Surg departments via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Formal procedure for the physician on-call schedule will be as follows: A. Chief of Staff will create and maintain a physician backup call schedule in agreement with participating providers. B. Monthly physician call schedule will be delivered to the Emergency and Med/Surg departments one week before the first calendar day of the month.	10/01/15

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C 261	Continued From page 21 responsibilities in relation to assistance with medical emergencies, and patient referral. He stated individual physician groups had a physician on call but he acknowledged the CAH did not maintain a formal call schedule. Without formal policies and call schedules, the CAH could not guarantee physicians were available for consultation, assistance with medical emergencies, and patient referral.	C 261	*C261 cont.* A. Monthly physician call schedule will be posted in the Emergency and Med/Surg departments and contain appropriate physician contact information. B. Physicians will be available to report to NCMC within thirty (30) minutes of call during schedule on call shifts. C. Any changes to back up call schedule shall be approved by Chief of Staff and reported to Emergency and Med/Surg departments at least twenty-four (24) hours prior to on-call shift. The formal call schedule for physicians will provide additional oversight for mid-level provider patient care and assures physicians assess patients if there is an adverse change in their condition. This policy also fulfills requirements for BB298 - *IDAPA 16.03.14.370.02* on Staffing. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer. ***C271 Response***: Physician oversight policy created to match NCMC Medical Staff Bylaws and comply with: ***IDAPA 16.03.14.200.01(h)***: "The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine." Policy #MS-103 "*Physician Oversight of Mid-Level Providers*"	10/01/15
C 271	485.635(a)(1) PATIENT CARE POLICIES 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 medical records, the CAH's bylaws, and policies, it was determined the CAH failed to ensure health care services were furnished in accordance with appropriate written policies that were consistent with applicable State law. This directly affected the care provided to 2 of 15 inpatients (#12 and #13), whose records were reviewed and had the potential to affect all emergency patients. This resulted in the failure of the CAH to provide services in accordance with state standards of practice. Findings include: 1. Idaho Administrative Code found at IDAPA 16.03.14200.01(h) requires the "Governing Body to adopt bylaws in accordance with Idaho Code...which specify at least the following: h. The bylaws shall specify that every patient be under the care of a physician." The CAH's Governing Body bylaws did not specify this. The lack of bylaws led to situations where patients were not under the care of a physician. For	C 271		

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C 271	Continued From page 22 example: a. Patient #13 was a 78 year old male who presented to the ED on 8/27/15. A report by the PA, dated 8/27/15 at 4:46 PM, stated Patient #13 complained of pain in his mouth and throat as well as nausea and vomiting. The report stated he had history of chronic obstructive pulmonary disease requiring 4 liters of oxygen continuously. The report also stated Patient #13 had fallen 2 weeks prior, injuring his ribs. The PA diagnosed Patient #13 with a collapsed lung and possible pneumonia. An inpatient bed was not available so Patient #13 elected to return home with an appointment to see another PA in the CAH's clinic the following day. Patient #13's medical record contained an H&P by another PA, dated 8/28/15 but not timed. It stated Patient #13 complained of increasing shortness of breath and had a low oxygen saturation level at 85%. The H&P stated he was not in acute distress but he was admitted to the CAH on 8/28/15, as an inpatient. A PA report, dated 8/29/15 at 11:40 AM, stated he was in no acute distress. A PA report, dated 8/29/15 at 5:13 PM, stated Patient #13's breath sounds had worsened at 4:00 PM so the PA came in and examined him. The report stated she examined Patient #13 and then called a physician at another hospital. The PA report stated the physician advised the PA to intubate Patient #13 and transfer him to the acute care hospital. Patient #13 was taken to the CAH's ED. A PA report, dated 8/29/15 at 5:44 PM, stated Patient #13 developed respiratory failure in the CAH.	C 271	***C271 cont.*** (discussed in C240 above) outlines that all patient care will be under the direction of a MD or DO Policy developed on September 29, 2015; approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015. Policy was communicated to medical staff, Emergency department and Med/Surg departments via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. MS-102 "*Physician Back Up Call Schedule*" policy that provides 24/7 access to physician coverage and complies with ***IDAPA 16.03.14.370.02***: "There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: 1. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed." Policy approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015. Policy communicated to medical staff via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer.	

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C 271	Continued From page 23 The report stated Patient #13 was intubated and placed on a ventilator by the PA. The report stated a helicopter was on site and transferred him to an acute care hospital. All care for Patient #13 was provided by PAs. No documentation was present that Patient #13 was examined or treated by a physician. Patient #13's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the events of Patient #13's stay at the CAH. He stated PAs provided all of the medical care for this critically ill patient. The Chief of Staff, a physician, was interviewed on 9/02/15 beginning at 8:00 AM. He stated the hospital did not have policies that outlined physicians' responsibilities to examine patients or to supervise/monitor the care provided by non-physician practitioners. He stated a physician should have examined Patient #13 during his stay. b. Patient #12 was a 39 year old female who presented to the ED on 7/25/15 at 8:43 AM. A report by the PA, dated 7/25/15 at 1:36 PM, stated Patient #12 was admitted to a nearby alcohol treatment center on 7/19/15. The report stated Patient #12 had a history of a blood clot on her spleen. The report stated Patient #12 complained of worsening abdominal pain and distention for the past 2 days. The report stated while in the ED, Patient #12 received a "massive amount" of IV Fentanyl, a powerful narcotic, "...which induced drowsiness, sedation, dramatic improvement, but [did] not get resolution of her pain. It actually brought down her blood pressure	C 271		

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C 271	Continued From page 24 so I am now giving 750 cc normal saline bolus...The patient is requesting hospitalization at our facility. I will now confer with [a PA], her primary care physician. Final disposition and care will be at primary care provider's discretion." A corresponding note by the PA, dated 7/26/15 at 12:27 AM, stated a central IV line was placed in the ED. Patient #12 was then admitted to the CAH as an inpatient. A "Final Report" by another PA, dated 7/25/15 at 7:48 PM, documented vital signs were within normal limits at 5:28 PM. The report stated Patient #12 was in no acute distress and her lungs were clear. The report stated Patient #12's diagnoses were alcoholic cirrhosis and acute pancreatitis. The report stated an order to transfer Patient #12 to an acute care hospital to the care of a physician was written at 8:00 PM on 7/25/15. An admission H&P was not documented. A reason for the transfer was not documented. Examination by a physician and consultation with a physician were not documented. Patient #12's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the documentation and stated he did not know why Patient #12 was transferred. He confirmed Patient #12's record did not include documentation to show a physician had been involved in or had been consulted about her care. CAH policies were not developed in accordance with state laws related to patients being under the care of a physician. 2. Idaho Administrative Code found at IDAPA	C 271		

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C 271	Continued From page 25 16.03.143700.02(a) states "There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed." CAH policies did not require a physician to be on call 24 hours per day or require a physician to be available to see emergency patients. ED schedules from April 2015 to September 2015 were reviewed. The schedules listed the PAs that were scheduled to work in the ED. No physicians were scheduled to staff the ED during this time. No physician on-call list was maintained for the hospital or the ED during this time. During an interview on 9/02/15 at 11:30 AM, the PA on duty stated he owned the PA group which staffed the ED. He stated PAs provided all medical care to patients in the ED. He stated he did not call physicians for consultation when he was treating emergent patients. The PA stated he was unable to recall a situation when he had called a physician to come in to the facility to evaluate a patient or to discuss an emergent situation. The Supervising Physician for the PA group that staffed the ED was interviewed on 9/02/15 beginning at 1:05 PM. He stated physicians were not on call to come to the ED. CAH policies were not developed in accordance with state laws related to emergency services.	C 271		

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C 275	485.635(a)(3)(iii) PATIENT CARE POLICIES [The policies include the following:] Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, it was determined the CAH failed to ensure guidelines for the medical management of health problems that included the conditions requiring medical consultation and/or patient referral, had been developed. This resulted in a lack of guidance to providers. Findings include: The CAH had 11 active PAs and NPs who cared for patients. The ED was staffed exclusively by these Allied Health Professionals. Patients were routinely admitted as inpatients and were discharged from the CAH by Allied Health Professionals. A policy that addressed guidelines for the medical management of health problems including the conditions requiring medical consultation with physicians and/or patient referral was not present. The Medical Staff Coordinator was interviewed on 9/02/15 beginning at 9:10 AM. She stated a policy that addressed the conditions requiring medical consultation and/or patient referral had not been developed. The CAH did not develop a policy to address medical consultation.	C 275	*C271 Response*: Consultation policy #MS-104 "*Mid-Level Provider Physician Consultation*" (discussed in C240 above) was created and outlines requirements for when a mid-level provider must consult with a physician or on-call physician after hours. Policy developed on September 30, 2015; approved by Chief of Staff, Chief Executive Officer and governing body Board Chair October 1, 2015. Policy was communicated to Medical Staff, Emergency Department and Med/Surg Department via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Chief of Staff will be responsible for implementing this correction with oversight from Chief Executive Officer.	10/01/15

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C 278	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 policy review, observation, and staff interview it was determined the CAH failed to ensure the implementation of procedures to avoid potential transmission of infections and communicable diseases. This had the potential to impact all staff and patients in the CAH. Failure to follow policies and standard precautions had the potential to allow for transmission of infections. Findings include: The CAH had a policy titled, "INFECTION PREVENTION, FACILITY-WIDE." The policy was dated and signed by the the Infection Control RN and CEO on 7/17/15. Within the section of the policy titled "Personal Hygiene," the policy stated hand hygiene is indicated "...Any time soiling occurs (requires soap and water)." A policy titled, "INFECTION CONTROL IN THE KITCHEN," unsigned, but last revised on 8/05/15 included "...Hair restraints shall be used." The policies were not followed. Examples include: 1. A tour of the CAH's kitchen was conducted on 9/02/15, beginning at approximately 11:00 AM. Kitchen staff was observed preparing food, assembling patient trays, and serving lunch to facility staff. During observation of the kitchen staff, an	C 278	*C278 Response*: Food Service Policy # FS-505 "*Vendors & Visitors*" developed September 29, 2015 for visitors, addresses appropriate sign in, hygiene and delivery of food supplies. All vendors & visitors entering the Food Service Department must enter through the back door and sign in. They must wash their hands thoroughly in the hand wash station prior to entering the Food Service Department. All vendors & visitors must wear a vendor or visitor identification badge and put on a hair net and/or beard cover if the visitor has a long beard. **PROCEDURE:** 1. Sign in on the sign-in sheet. 2. Wear Vendor Badge while in kitchen. 3. Put on hairnet and/or beard cover. 4. Wash hands thoroughly in the hand wash station. 5. Deliver goods through the back door. 6. A department Manager, Lead Cook, Purchase ordering assistant will check-in the delivery and signed the invoice. Sign-in will be at the back food service entrance. Vendors will be required to sign in with their name, date and the company they are delivering for. A vendor badge will be picked up at the sign in sheet and worn in a prominent area during their delivery time. The vendor badge will identify their position and company. They will deposit the badge at the sign-in log when they depart the facility.	10/01/15

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C 278	Continued From page 28 unknown delivery person entered the kitchen through a back door that was accessible from the outside of the hospital. He was carrying a box of bananas and walked to the table where staff was preparing patient trays. He then placed the box on the floor and waited for a member of the kitchen staff to sign a form indicating delivery of the food. After the staff signed the form, the delivery person opened the walk-in refrigerator, picked up the box of bananas and placed them in the refrigerator. The delivery person's hands were visibly soiled. He failed to wash his hands or don a head cover prior to entering the kitchen. An interview with the Food Services Manager was conducted on 9/02/15, beginning at 11:25 AM. He confirmed it was the practice of the facility that all personnel should perform hand hygiene and don a clean head cover prior to entering the kitchen. 2. During observation of kitchen staff on 9/03/15 at approximately 9:55 AM, a dairy company delivery person was noted to exit the kitchen's walk-in refrigerator, carrying a tray containing dairy products. He set the tray on the kitchen floor. The delivery person's hands were visibly soiled. He was wearing a baseball cap that was also visibly soiled. Upon questioning, the delivery person stated he delivered dairy products to the CAH, and removed expired dairy products from the CAH's refrigerator. He stated he had not received instruction from the CAH regarding appropriate hygiene practices prior to entering the kitchen, such as hand washing and donning head cover. An interview with the Food Services Manager was	C 278	*C278 cont.* This will eliminate the ability of visitors and/or vendors to approach the food prep area without signing in, being identified, washing their hands and wearing the appropriate protective gear to ensure a safe and hygienic food prep environment. The sign-in sheet has been developed and placed right next to the delivery door. In addition, all of our vendors have been notified of our new process for delivery of food supplies. Weekly review of sign in sheet and if a vendor violates the procedures, they will be counseled. If the vendor violates the procedure again, they will be refused and we will notify their supervisor. Nutrition Services Supervisor will be responsible for implementing this correction with oversight from Chief Operating Officer.	

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C 278	Continued From page 29 conducted on 9/03/15, beginning at 10:05 AM. He confirmed people who delivered food products to the CAH were allowed to enter the kitchen. Additionally, he confirmed the delivery people were not instructed regarding hygiene practices prior to entering the kitchen. The CAH did not implement a process to ensure patients and staff were protected from possible transmission of infections and communicable diseases.	C 278		
C 279	485.635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following:] Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving posthospital SNF care. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview it was determined the CAH failed to ensure the implementation of procedures to ensure the nutritional needs of patients were met, in accordance with recognized dietary practices. This had the potential to impact all patients in the facility. Failure to follow recognized dietary practices had the potential to affect the quality of foods served in the CAH. Findings include: 1. The CAH's policy FS-262R1, titled, "INFECTION CONTROL IN THE KITCHEN," unsigned, but last revised on 8/05/15, stated "No food will be kept or used beyond its	C 279	*C279 Response*: Food Service Policy # FS-504 "*Food Purchasing & Inventory*" was developed September 29, 2015 for purchasing and inventory of food supplies. This policy addresses the weekly audit of food/supplies/products for expiration and appropriate shelf life for each food item or product to eliminate the possibility of consumption. A. A review of stock will be completed on a weekly basis. 1. During this review and expired food products will be removed from inventory and disposed according to any specific manufacture directions. B. A physical Inventory will be completed on the fourth Friday of each month. 1. During this inventory, expired food products will be removed from inventory and disposed according to any specific manufacture directions. C. Inventory price extensions need to be updated quarterly. D. Inventory hard copies will be retained in the unit. E. The grand total monthly inventory dollar amount needs to be reported to Accounting. F. First In, First Out (FIFO) is required to ensure oldest inventory is used first.	10/01/15

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C 279	Continued From page 30 recommended shelf life." Additionally, it stated "All equipment, utensils, and working surfaces will be cleaned and sanitized after use." A tour of the CAH's kitchen and food storage areas was conducted by the Food Services Manager on 9/02/15 beginning at 11:10 AM. Recognized dietary practices were not followed. Examples include: a. Stored food items past the manufacturer's printed expiration date included: - Cream of Rice, expired 6/16/15 - Couscous, expired 8/15/15 - Brown sugar, expired March, 2015 - Special K cereal, individual boxes, expired 5/12/15 - Individual servings of honey, expired 6/09/15 - Individual servings of jelly, expired 1/25/15 - Rotini pasta, expired 3/19/15 b. Stored food items without a manufacturer's printed expiration date included: - Long grain rice - Mexican rice - Pancake mix - Sweet and sour sauce - Ketchup - Individual servings of peanut butter - Individual servings of tartar sauce - Bag of walnuts c. A working surface was noted to contain a puddle of fluid, and a wet, visibly soiled wiping cloth. The Food Services Manager stated he did not know how long the puddle and wiping cloth had been there. During an interview on 9/02/15 at 11:25 AM, the	C 279	*C279 cont.* This will be monitored and tracked as part of our quality assurance program which is reviewed quarterly to ensure patient safety and quality. This information will then be reported to the Performance Improvement Committee of the Governing Body quarterly. Nutrition Services Supervisor will be responsible for implementing this correction with oversight from Chief Operating Officer.	

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C 279	Continued From page 31 Food Services Manager stated an inventory of stored foods was completed weekly, and all expired foods were discarded. He stated he was not aware of the expired foods in the storage room, or of the foods that did not include an expiration date. He was unable to explain the reason some foods did not include an expiration date. He stated all food items past the manufacturers' printed expiration date, and all food items without a manufacturers' printed expiration date would be discarded by the end of the day. d. A second visit was made to the food storage area on 9/03/15 at 9:30 AM. Food items without a manufacturers' printed expiration date were noted to have a new label affixed. Each label included the date the item was received by the CAH. Additionally, the labels included a date 6 months after the date of receipt, which was labeled as the expiration date. The Food Services Manager stated he was unable to determine the manufacturers' expiration dates, therefore, items would be discarded 6 months after delivery to the CAH. However, he confirmed he was unable to determine if an item's manufacturer's expiration date was prior to the expiration date on the label. When asked how the delivery date was determined, the Food Services Manager stated each item included a sticker with the date of delivery. However, the sticker included only the month and day, not the year. A box of graham cracker crumbs included a sticker with the delivery date of 5/7. It did not include the year. The item included a handwritten notation, "Open 5/8/14, Exp [expired] 11/8/14," indicating it was received by the CAH more than a year prior.	C 279		

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C 279	Continued From page 32 e. Additional items that were expired or did not contain a manufacturers' expiration date remained in the food storage area on 9/03/15, included: - Rotini, expired 3/19/15 - Individual servings of jelly, expired 7/09/15 - Individual servings of syrup, no expiration date During an interview on 9/03/15 at 10:05 AM, the Food Services Manager confirmed the food storage area included items without a manufacturer's printed expiration date. Additionally, he confirmed the sticker that indicated the date items were received did not include the year, and it was possible items were more than a year old. The CAH's kitchen and food storage areas were not maintained in accordance with the CAH's policies which reflected recognized dietary practices. 2. A policy titled, "INFECTION CONTROL IN THE KITCHEN," unsigned, but last revised on 8/05/15, included "...Unauthorized personnel are kept out of the food service area." The policy was not followed. Examples include: a. A tour of the CAH's kitchen was conducted on 9/02/15, beginning at approximately 11:00 AM. Kitchen staff was observed preparing food, assembling patient trays, and serving lunch to facility staff. During observation of the kitchen staff, an unknown delivery person entered the kitchen through a back door that was accessible from the	C 279		

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C 279	Continued From page 33 outside of the hospital. He was carrying a box of bananas and walked to the table where staff was preparing patient trays. He then placed the box on the floor and waited for a member of the kitchen staff to sign a form verifying delivery of the food. After the staff signed the form, the delivery person opened the walk-in refrigerator, picked up the box of bananas and placed them in the refrigerator. The delivery person did not obtain permission prior to entering the food preparation area of the kitchen. An interview with the Food Services Manager was conducted on 9/02/15, beginning at 11:25 AM. He confirmed the delivery person would not have been considered authorized personnel and should not have been in the food preparation area of the kitchen. b. During observation of kitchen staff on 9/03/15 at approximately 9:55 AM, a dairy company delivery person was noted to exit the kitchen's walk-in refrigerator, carrying a tray containing dairy products. He set the tray on the kitchen floor. When questioned, he stated he delivered dairy products to the CAH, and removed expired dairy products from the CAH's refrigerator. An interview with the Food Services Manager was conducted on 9/03/15, beginning at 10:05 AM. He confirmed people who delivered food products to the CAH were allowed to enter the kitchen. The CAH did not implement a process to prevent unauthorized individuals from entering the food preparation area of the kitchen.	C 279		
C 385	485.645(d)(4) PATIENT ACTIVITIES	C 385		

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C 385	Continued From page 34 [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] 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. Quality of Life - activities (§483.15(f)) "(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. (2) The activities program must be directed by a qualified professional who- (i) Is a qualified therapeutic recreation specialist or an activities professional who- (A) Is licensed or registered, if applicable, by the State in which practicing; and (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 (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of	C 385	***C385 Response:*** SB-101 "*Activities Assessment*" Policy has been reviewed and revised on September 30, 2015. Nursing staff will work under the direction of NCMC's contracted Occupational Therapist, Connie VanKleek. The Swing Bed Coordinator and the Social Worker will review charts and discuss at the weekly Inter-Disciplinary Team Meeting. Patients who are admitted to the NCMC Swing Bed Program shall have activities available to them each day. The facility provides for daily activities but mostly on an individual basis given the short stay of the program. The Activities Program shall have oversight by the Occupational Therapist who may then delegate daily activities to supportive staff as needed. The Occupational Therapist shall meet regularly with supportive staff to review activities and patient participation. Activities will be designed to meet, in accordance with the comprehensive assessment, interests and physical, mental, and psychosocial well-being of each patient. **PROCEDURE:** 1. The Occupational Therapist and/or Social Services will assess the patient's activity preferences during the discharge assessment. 2. An activity assessment and plan will be completed and shared with the patient. 3. An activity calendar will be created for each patient and posted in the patient's room.	10/01/15

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C 385	Continued From page 35 which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State." This STANDARD is not met as evidenced by: Based on policy review, record review, patient interview and staff interview, it was determined the CAH failed to provide an ongoing program of activities, directed by a qualified professional, to Swing Bed patients. This directly affected 4 of 6 (#19, #20, #21 and #27) Swing Bed patients whose records were reviewed, and had the potential to result in unmet needs for all Swing Bed patients. Findings include: 1. The CAH's policy SB-101R3, "ACTIVITIES ASSESSMENT," revised, and signed by the Transitions RN and the CNO on 11/24/14, stated "The Transition RN is designated as the activity director responsible to see that patient's [sic] needs are met." The Transition RN was interviewed on 9/01/15 at 11:35 AM. She stated she was responsible for the Swing Bed activity program. She confirmed she was not licensed or certified as a therapeutic recreation specialist, activities professional or occupational therapist and did not have prior experience in a recreational program. Additionally, she stated she did not work in consultation with a qualified recreation professional.	C 385	*C385 cont.* 4. All disciplines will incorporate activities into the patient's daily activities. 5. All disciplines will document activities on the activity form as to what was offered, refused, or participated, including interactions with family, friends, and volunteers. 6. An activity room is available and will be offered to each patient at hours convenient to the patient, i.e., morning, afternoon, early evenings, on a daily basis and including weekends with supervision. Items included in the activity room are: a. Reading material of different kinds to meet the local resident's liking (magazines and books) b. Activity booklets (Word Find, Crossword, Sudoku) c. Cards, Puzzles, Board games d. Movies 7. Other activities may also include ambulating with the patient, inside the hospital and/or outdoor area; 1:1 socializing with the patient; reminiscing; reading to them; listening to music; TV, based on what the patient prefers, etc. Extra attention will be given to patients who have little to no visitors or are in isolation. 8. The patient has the right to refuse participation in activities, but attempts will be made to motivate him/her to do so especially for those in a program greater than 2 weeks.	

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C 385	Continued From page 36 The CAH did not have a qualified activities director. 2. The CAH's policy SB-101R3, "ACTIVITIES ASSESSMENT" also stated "An activity room is available and will be offered to each patient at hours convenient to the patient...on a daily basis and including weekends with supervision." The policy was not followed. Examples include: Swing Bed patient records included a "SWING BED ACTIVITY FORM." The form included areas to document activities, and indicate if the patient participated in, or refused activities offered on each day of their Swing Bed stay. a. Patient #19 was a 94 year old female admitted to Swing Bed services on 6/04/15, with diagnoses of pneumonia and debility. She was discharged on 6/08/15. Patient #19's activity calendar stated she was to be offered activities of choice on a daily basis, to include visit with family, visit with staff, look at pictures, read book, and weekend activities. However, her activity form stated her only activity on 6/04/15, and 6/05/15, was visiting with family/friends. The form did not state additional activities were offered and refused. b. Patient #20 was an 82 year old male admitted to Swing Bed services on 6/16/15, with a diagnosis of pneumonia. He was discharged on 6/26/15. Patient #20's activity calendar stated he was to be offered activities of choice on a daily basis, to include visit with family, visit with staff, watch	C 385	*C385 cont.* QA indicator that will monitor the number of Swing Bed patients with activity log developed. Threshold will be 100%. The Swing Bed Coordinator and the Social Worker will review charts to ensure activity plan has been created for each patient and is being utilized and updated and provider quarterly stats. This information will then be reported to the Performance Improvement Committee of the Governing Body quarterly. Swing Bed Coordinator will be responsible for this correction with oversight from Director of Nursing Services.	

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C 385	Continued From page 37 television and use box of activities and toys from home. However, his activity form was blank on 6/18/15, 6/19/15, 6/22/15, 6/23/15, and 6/24/15, indicating he did not participate in, or refuse activities. c. Patient #21 was a 74 year old male admitted to Swing Bed services on 4/27/15, with a diagnoses of septic knee joint and DM. He was discharged on 5/03/15. Patient #21's activity calendar stated he was to be offered activities of choice on a daily basis, to include visit with family, visit with staff, watch television and read. However, his activity form stated his only activity on 4/27/15, and 4/30/15, was visiting with family, and his only activities on 5/01/15 were visiting with family and visiting with staff. The form did not state additional activities were offered and refused. d. Patient #27 was an 80 year old female admitted to Swing Bed services on 8/18/15, with a diagnosis of left patellar fracture with an infected joint. She was a current patient as of 9/03/15. Patient #27 was interviewed on 9/01/15 beginning at 10:25 AM. She was alert and oriented. She stated she had been hospitalized since 8/14/15 and was on Swing Bed services since 8/18/15. She stated she had to stay another month to receive IV antibiotics. She stated she was not aware if she had an activities plan or not. She stated she had been invited to go to lunch in the cafeteria with a staff person but she declined. She stated no other activities had been offered. A half finished puzzle was on a table in her room. She stated her husband had completed most of it.	C 385		

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C 385	Continued From page 38 During an interview on 9/01/15 at 9:05 AM, the Transition RN, who acted as the activity director for Swing Bed patients, stated the Swing Bed activity program did not include group activities or planned activities in the activity room. She confirmed most patient activities were limited to visiting with family and staff, watching television and reading. The CAH did not provide a program of activities to meet the needs of Swing Bed patients.	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)).] Comprehensive care plans (§483.20(k)(1)) "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- (i) The services that are to be furnished to attain	C 395	*C395 Response*: Policy SB-107 "*Assessment for Swing Bed* Patients" has been reviewed and revised. Patient specific care plans have been created to address: high risk for skin integrity impairment, feeding tubes, communication, anticoagulant, and patient/caregiver education. These are currently being developed in the Electronic Medical Record (EMR). Nurses are being educated on care plans available and what a comprehensive care plan entails specific to diagnosis. Additional one-on-one education will be provided as needed. Care plans have been created internally and will be available in the EMR 11/01/15.	10/01/15

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C 395	Continued From page 39 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (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)." This STANDARD is not met as evidenced by: Based on policy review, medical record review, and staff interview, it was determined the CAH failed to ensure a comprehensive care plan was developed for 4 of 6 Swing Bed patients (#18, #19, #20, and #21), whose records were reviewed. This resulted in a lack of direction to staff caring for Swing Bed patients. Findings include: The CAH's policy SB-105R4, "NURSING CARE PLAN: ACUTE CARE/SWING BED," revised, and signed by the Nursing Supervisor and the CNO on 10/13/14, stated "All patients admitted to NCMC will have a comprehensive nursing care plan within 24 hours of admission related to admitting diagnosis." This policy was not followed. Examples include: 1. Patient #18 was a 90 year old female admitted to Swing Bed services on 4/23/15, with admitting diagnoses of profound weakness and urinary tract infection. Patient #18's diagnoses included urinary tract infection. However, her care plan did not include assessment, interventions or patient education related to her urinary tract infection.	C 395	*C395 cont.* Each patient will be monitored to ensure a diagnosis-specific, comprehensive care plan is in place. This will be documented within the patient's plan of care in the medical record. Swing Bed Coordinator will be responsible for implementing this correction with oversight from Director of Nursing Services.	

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C 395	Continued From page 40 During an interview on 9/01/15, beginning at 9:05 AM, the Transitional Care RN, who was responsible for the Swing Bed program, reviewed Patient #18's record and confirmed her care plan should have addressed her urinary tract infection. 2. Patient #19 was a 95 year old female admitted to Swing Bed services on 6/04/15, with admitting diagnoses of pneumonia, debility, and atrial fibrillation. Patient #19 was on continuous oxygen therapy, and took an anticoagulant (blood thinner) to treat her atrial fibrillation. However, her care plan did not include assessment, interventions or patient education related to oxygen therapy or anticoagulant therapy. During an interview on 9/01/15, beginning at 9:05 AM, the Transitional Care RN reviewed Patient #19's record and confirmed her care plan should have addressed oxygen therapy and anticoagulant therapy. 3. Patient #20 was an 82 year old male admitted to Swing Bed services on 6/16/15, with admitting diagnosis of pneumonia. Patient #20's record included a Braden Scale score. The Braden Scale predicts a patient's risk of developing pressure ulcers, based on the patient's sensory perception, skin moisture, activity, mobility, nutrition and assistance needed to move. A Braden Scale score of 18 or less indicates a risk of developing pressure ulcers. Patient #20's Braden Scale score was 17. However, his care plan did not include assessment, interventions or patient education	C 395		

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C 395	Continued From page 41 related to prevention of pressure ulcers. During an interview on 9/01/15, beginning at 9:05 AM, the Transitional Care RN reviewed Patient #20's record and confirmed his care plan should have addressed his risk of developing pressure ulcers. 4. Patient #21 was a 74 year old male admitted to Swing Bed services with admitting diagnoses of infected knee wound, DM and CHF. Patient #21 was on oxygen therapy, and was placed on insulin to treat his DM. However, his care plan did not include assessment, interventions or patient education related to oxygen therapy or diabetes, including insulin administration. During an interview on 9/01/15, beginning at 9:05 AM, the Transitional Care RN reviewed Patient #21's record and confirmed his care plan should have addressed oxygen therapy and diabetes. The CAH failed to develop comprehensive care plans for Swing Bed patients.	C 395		
C 404	485.645(d)(8) DENTAL SERVICES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Dental services (§483.55 of this chapter): "The facility must assist residents in obtaining routine and 24-hour emergency dental care."	C 404	*C404 Response*: Memorandum of Agreement developed between Governing Body and local dentist to outline services they will provide for Swing Bed patients. This agreement will be referenced in policy #SB-109 "*Dental Services.*" This policy identifies the availability and contact information of an emergent dental provider for Swing Bed patients.	10/01/15

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C 404	Continued From page 42 This STANDARD is not met as evidenced by: Based on policy review and staff interview, it was determined the CAH failed to ensure dental services were available to Swing Bed patients. This resulted in the potential for patients' dental needs to go unmet. Findings include: The CAH's policy SB-109 "DENTAL SERVICES," revised, and signed by the Transition RN and the CNO on 11/26/14, stated "For more urgent situations...the program staff will call the dentist of the patient's choice or use a dentist identified by the hospital as willing to meet the patient's needs in such situation." During an interview on 9/01/15 at 4:05 PM, the Transition RN, who was responsible for the Swing Bed program, stated the CAH did not have a contract or agreement with a dentist to provide dental services to Swing Bed patients. The CAH failed to ensure a dentist was available to meet the needs of Swing Bed patients.	C 404	*C404 cont.* 1. Patient, patient's family member, significant and/or concerned other, Nurse or care team member(s) or attending physician, may identify dental care needs. 2. Discuss issues with teeth with primary physician to determine the urgency of the need for a dentist. If primary physician is not available, refer to ED physician to determine urgency of situation. 3. If the need is not urgent, but should be addressed, this will be discussed with patient and/or family. Assistance to schedule an appointment with a dentist of their choice for post-discharge will be offered. 4. For more urgent situations as described above, the program staff will call the dentist of the patient's choice or use a dentist identified by the hospital as willing to meet the patient's needs in such situation. 5. Emergent care dental provider will be: John McLaughlin, DDS, 126 5th Ave W Gooding, ID 83330 6. The staff will assist in arranging transportation (as may be required) per patient/family request. 7. Patients with lost or damaged dentures that may cause interference with eating will be promptly referred to a dentist for evaluation and treatment. Swing Bed Coordinator will be responsible for implementing this correction with oversight from Director of Nursing Services.	

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the Idaho state licensure survey of your Critical Access Hospital conducted from 8/31/15 to 9/03/15. The surveyors conducting the Medicare recertification survey were: Gary Guiles, R.N., H.F.S., Team Leader Rebecca Lara, R.N., BA, H.F.S. Laura Thompson, R.N., BSN, H.F.S Dennis Kelly, R.N., BC, H.F.S Nancy Bax, R.N., BSN, H.F.S. Acronyms used in this report include: CEO - Chief Executive Officer CNO - Chief Nursing Officer ED - Emergency Department H&P - History and Physical Examination IV - Intravenous PA - Physician Assistant	B 000	RECEIVED OCT - 9 2015 FACILITY STANDARDS	
BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91)	BB115	*BB115 Response*: NCMC Medical Staff Bylaw currently in place: RULE 2, §2.2 "Admission Requirements": A patient may only be admitted by an order of a Medical Staff member who is granted admitting privileges and shall be attended by a Physician Staff Member. Physician oversight policy created that references NCMC Medical Staff Bylaws. Policy #MS-103 "*Physician Oversight of Mid-Level Providers*" outlines that all patient care will be under the direction of a MD or DO. Policy developed on September 29, 2015; approved by Chief of Staff, Chief Executive Officer and governing	10/01/15

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: CEO (X6) DATE: 10-1-15

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BB115	Continued From page 1 i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician	BB115	***BB115 cont.*** body Board Chair September 30, 2015. Policy was communicated to medical staff, Emergency Department and Med/Surg Department via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Chief of Staff will be responsible for this correction with oversight from Chief Executive Officer.	

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	ID9C0B		09/03/2015

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BB115	Continued From page 2 practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88)	BB115		

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BB115	Continued From page 3 h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of Governing Body Bylaws and medical records, it was determined the hospital failed to ensure the bylaws specified that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. This directly affected the care of 2 of 15 inpatients (#12 and #13) whose records were reviewed. This prevented the hospital from identifying clear roles for physician. Findings include: 1. Governing Body Bylaws, dated 1/28/14, did	BB115		

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BB115	Continued From page 4 not include a requirement that every patient must be under the care of a physician. The Medical Staff Coordinator was interviewed on 9/11/15 beginning at 11:15 AM. She stated the Governing Body Bylaws did not include a statement that all patients would be under the care of a physician. The Governing Body Bylaws did not specify all patients would be under the care of a physician. 2. Patient #13 was a 78 year old male who presented to the ED on 8/27/15. A report by the PA, dated 8/27/15 at 4:46 PM, stated Patient #13 complained of pain in his mouth and throat as well as nausea and vomiting. The report stated he had history of chronic obstructive pulmonary disease requiring 4 liters of oxygen continuously. The report also stated Patient #13 had fallen 2 weeks prior, injuring his ribs. The PA diagnosed Patient #13 with a collapsed lung and possible pneumonia. An inpatient bed was not available so Patient #13 elected to return home with an appointment to see another PA in the CAH's clinic the following day. Patient #13's medical record contained an H&P by another PA, dated 8/28/15 but not timed. It stated Patient #13 complained of increasing shortness of breath and had a low oxygen saturation level at 85%. The H&P stated he was not in acute distress but he was admitted to the hospital on 8/28/15, as an inpatient. A PA report, dated 8/29/15 at 11:40 AM, stated he was in no acute distress. A PA report, dated 8/29/15 at 5:13 PM, stated Patient #13's breath sounds had worsened at 4:00 PM so the PA came in and examined him. The report stated	BB115		

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BB115	Continued From page 5 she examined Patient #13 and then called a physician at another hospital. The PA report stated the physician advised the PA to intubate Patient #13 and transfer him to the acute care hospital. Patient #13 was taken to the hospital's ED. A PA report, dated 8/29/15 at 5:44 PM, stated Patient #13 developed respiratory failure in the hospital. The report stated Patient #13 was intubated and placed on a ventilator by the PA. The report stated a helicopter was on site and transferred him to an acute care hospital. All care for Patient #13 was provided by PAs. No documentation was present that Patient #13 was examined or treated by a physician. Patient #13's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the events of Patient #13's hospital stay. He stated PAs provided all of the medical care for this critically ill patient. The Chief of Staff, a physician, was interviewed on 9/02/15 beginning at 8:00 AM. He stated the hospital did not have policies that outlined physicians' responsibilities to examine patients or to supervise/monitor the care provided by non-physician practitioners. He stated a physician should have examined Patient #13 during his stay. Patient #13 was not under the care of a physician. 2. Patient #12 was a 39 year old female who presented to the ED on 7/25/15 at 8:43 AM. A report by the PA, dated 7/25/15 at 1:36 PM,	BB115		

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BB115	Continued From page 6 stated Patient #12 was admitted to a nearby alcohol treatment center on 7/19/15. The report stated Patient #12 had a history of a blood clot on her spleen. The report stated Patient #12 complained of worsening abdominal pain and distention for the past 2 days. The report stated while in the ED, Patient #12 received a "massive amount" of IV Fentanyl, a powerful narcotic, "...which induced drowsiness, sedation, dramatic improvement, but [did] not get resolution of her pain. It actually brought down her blood pressure so I am now giving 750 cc normal saline bolus...The patient is requesting hospitalization at our facility. I will now confer with [a PA], her primary care physician. Final disposition and care will be at primary care provider's discretion." A corresponding note by the PA, dated 7/26/15 at 12:27 AM, stated a central IV line was placed in the ED. Patient #12 was then admitted to the hospital as an inpatient. A "Final Report" by another PA, dated 7/25/15 at 7:48 PM, documented vital signs were within normal limits at 5:28 PM. The report stated Patient #12 was in no acute distress and her lungs were clear. The report stated Patient #12's diagnoses were alcoholic cirrhosis and acute pancreatitis. The report stated an order to transfer Patient #12 to an acute care hospital to the care of a physician was written at 8:00 PM on 7/25/15. An admission H&P was not documented. A reason for the transfer was not documented. Examination by a physician and consultation with a physician were not documented. Patient #12's medical record was reviewed with the Performance and Quality Improvement Nurse on 8/31/15 beginning at 2:50 PM. He confirmed the documentation and stated he did not know	BB115		

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BB115	Continued From page 7 why Patient #12 was transferred. He confirmed Patient #12's record did not include documentation to show a physician had been involved in or had been consulted about her care. Patient #12 was not under the care of a physician.	BB115		
BB173	16.03.14.310.01 Director of Nursing Services 310. NURSING SERVICE. There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use which delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. (10-14-88) 01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: (10-14-88) a. To organize, coordinate, and evaluate nursing service functions and staff; and (10-14-88) b. To be responsible for development and implementation of policies and procedures as they relate to care of patients; and (10-14-88) c. To select, promote, and terminate nursing staff; and (10-14-88)	BB173	***BB173 Response***: A Director of Nursing candidate was awarded the position on September 16, 2015 by Chief Executive Officer and made effective immediately. All nursing care will be organized and evaluated by this position. This will provide clear direction on the org chart and to nursing staff. A description was developed and candidate was interviewed. Position was awarded on September 16, 2015 and took effect immediately. Email communication was sent to all staff on September 16, 2015 by Chief Executive Officer. Chief Executive Officer will be responsible for this correction.	09/16/15

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BB173	Continued From page 8 d. To establish a procedure to insure staff licenses are valid and current. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of organization charts, it was determined the hospital failed to ensure the nursing service shall be under the overall direction of a qualified registered nurse. This prevented the hospital from identifying clear lines of authority. Findings include: The hospital's organizational chart, dated 5/06/15, showed 3 separate persons in charge of the nursing service. The Nurse Supervisor of the Medical Surgical Unit was interviewed on 9/01/15 beginning at 9:00 AM. She stated when the last CEO resigned the hospital decided to share the CNO duties between 3 nurses. She stated no 1 person had been designated to be responsible for the management and oversight of the nursing service. The hospital failed to designate a person to be responsible for the overall direction of the nursing service.	BB173		
BB208	16.03.14.320.07 Food Preparation and Service 07. Food Preparation and Service. (10-14-88) a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. (10-14-88)	BB208	***BB208 Response:*** **Per IDAPA Code 16.03.14.320.07:** a. "The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value." This regulation is now satisfied per FS-504 "*Food Purchasing & Inventory*" that governs purchasing and inventory of food supplies. This policy addresses the weekly audit of food/supplies/products for expiration and appropriate shelf life for each food item or product to eliminate the possibility of consumption. Discussed above in C279.	10/01/15

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BB208	Continued From page 9 b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value. (10-14-88) This Rule is not met as evidenced by: Refer to C279 as it relates to food storage practices which failed to ensure the retention of their nutritive value.	BB208		
BB298	16.03.14.370.02 Staffing 02. Staffing. There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: (10-14-88) a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed. (10-14-88) b. A qualified registered nurse shall be on duty in the facility and available to the emergency room at all times. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of Medical Staff Rules and Regulations and call schedules, it was determined the hospital failed to ensure a physician was on call 24 hours a day and available to see emergency patients as needed. This resulted in the inability of the hospital to provide care by qualified personnel as needed. Findings include: The Medical Staff Rules and Regulations, dated 1/28/14, stated "It is the responsibility of the scheduled on-call provider [physician] to respond to calls from the Emergency Department in	BB298	*BB298 Response:* **Per** *IDAPA 16.03.14.370.02*: "There shall be adequate medical and nursing personnel to care for patients arriving at the emergency room. Minimum personnel and qualifications of such personnel shall be as follows: a. A physician in the hospital or on call twenty-four (24) hours a day and available to see emergency patients as needed." This regulation is now satisfied per MS-102 "*Physician Back Up Call Schedule*" policy that provides 24/7 access to physician coverage was developed on September 25, 2015; approved by Chief of Staff, Chief Executive Officer and governing body Board Chair September 30, 2015. Policy was communicated to medical staff, Emergency department and Med/Surg departments via email on October 1, 2015. In addition, it will be reviewed at the Medical Staff meeting on October 21, 2015. Discussed above in C261.	10/01/15

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BB298	Continued From page 10 accordance with Hospital policies and procedures. ED schedules from April 2015 to September 2015 were reviewed. The schedules listed the PAs that were scheduled to work in the ED. No physicians were scheduled to staff the ED during this time. No physician on-call list was maintained for the hospital or the ED during this time. During an interview on 9/02/15 at 11:30 AM, the PA on duty stated he owned the PA group which staffed the ED. He stated PAs provided all medical care to patients in the ED. He stated he did not call physicians for consultation when he was treating emergent patients. The PA stated he was unable to recall a situation when he had called a physician to come in to the facility to evaluate a patient or to discuss an emergent situation. The PA did not admit inpatients to the hospital. The PA stated he called 1 of the physician groups' offices when required to discuss patients' potential admission. The Supervising Physician for the PA group that staffed the ED was interviewed on 9/02/15 beginning at 1:05 PM. He stated physicians were not on call to come to the ED. The hospital failed to arrange for physicians to be on call and to be available to come to the ED as needed.	BB298		