



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](mailto:fsb@dhw.idaho.gov)

April 1, 2016

Curtis Maier, Administrator  
St. Luke's Jerome  
709 North Lincoln Avenue  
Jerome, Idaho 83338

RE: St. Luke's Jerome, CCN: 13-1310

Dear Mr. Maier:

Based on the survey completed at St. Luke's Jerome on March 18, 2016, by our staff, we have determined, St. Luke's Jerome is out of compliance with the Medicare Critical Access Hospital Condition of Participation of **Organization 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 these conditions to be unmet, substantially limit the capacity of St. Luke's Jerome, 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 correct the deficiencies which led to the finding of non-compliance with the Conditions of Participation referenced above, by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- 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 May 2, 2016. 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 April 20, 2016.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 11, 2016**.

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,

A handwritten signature in black ink that reads "Dennis Kelly for". The signature is written in a cursive, flowing style.

DENNIS KELLY, R.N.  
Co-Supervisor  
Non-Long Term Care

DK/sc

ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief  
Linda Harris, R.N., CMS Region X Office  
Aileen Renolayan, R.N., CMS Region X Office



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April 11, 2016

Curtis Maier, Administrator  
St Luke's Jerome  
709 North Lincoln Ave  
Jerome, Idaho 83338

RE: St. Luke's Jerome, CCN: 13-1310

Dear Mr. Maier:

Based on a review of the Statement of Deficiencies/Plan of Correction (CMS-2567) of the recertification survey completed at St. Luke's Jerome on March 18, 2016, an amendment has been made to the IDAPA rule cited. The corrected IDAPA reference, in support of the deficiencies stated previously, is included in the enclosed Statement of Deficiencies/Plan of Correction.

As stated in the letter dated April 1, 2016, you have an opportunity to correct the deficiencies which led to the finding of non-compliance with the Conditions of Participation by submitting a written Credible Allegation of Compliance/Plan of Correction.

The date for submission of your Allegation of Compliance/Plans of Correction to this office has been extended to April 14, 2016.

If you have questions, please do not hesitate to contact this office.

Sincerely,

DENNIS KELLY, RN-BC, CHPN, CHPCA, NE-BC  
Co-Supervisor  
Non-Long Term Care

DK/pmt

cc: Debby Ransom, R.N., R.H.I.T., Bureau Chief  
Linda Harris, R.N., CMS Region X Office  
Aileen Renolayan, R.N., CMS Region X Office  
Jordan Heller, St. Luke's Health System  
Chelsea Kidney -- CO 10<sup>th</sup>



Date: April 11, 2016

To: Dennis Kelly, RN

Number: 208-364-1888

From: Jon Scallan, Regional Director of Accreditation

Attached: Corrective Action Plan Report

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  ID7D5E	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  03/18/2016
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NAME OF PROVIDER OR SUPPLIER  ST LUKE'S JEROME	STREET ADDRESS, CITY, STATE, ZIP CODE 709 NORTH LINCOLN AVENUE JEROME, ID 83338
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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B 000	16.03.14 Initial Comments  The following deficiencies were cited during the Idaho state licensure survey of your Hospital, conducted from 3/14/16 to 3/18/16. The surveyors conducting the licensure survey were:  Laura Thompson, RN, BSN, HFS - Team Leader Susan Costa, RN, HFS Gary Guiles, RN, HFS	B 000	<p>Please see Corrective Action Plan Report Attached</p> <p><b>RECEIVED</b></p> <p>APR 11 2016</p> <p><b>FACILITY STANDARDS</b></p>	
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)  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	BB115		

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

*Curtis Miller*

TITLE  
ADMINISTRATOR

(X6) DATE  
4/11/16

Bureau of Facility Standards

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BB115	<p>Continued From page 1</p> <p>attendance requirement. (10-14-88)</p> <p>iii. Minutes of all governing body meetings shall be maintained. (10-14-88)</p> <p>c. Committees, (12-31-91)</p> <p>i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88)</p> <p>ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88)</p> <p>d. Medical Staff Appointments and Reappointments; (12-31-91)</p> <p>i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88)</p> <p>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 practitioners who are granted clinical privileges. (10-14-88)</p> <p>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)</p> <p>iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants,</p>	BB115		

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BB115	<p>Continued From page 2</p> <p>appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88)</p> <p>v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88)</p> <p>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)</p> <p>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)</p> <p>f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88)</p> <p>g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88)</p> <p>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)</p> <p>i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88)</p> <p>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)</p>	BB115		

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NAME OF PROVIDER OR SUPPLIER  <b>ST LUKE'S JEROME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>709 NORTH LINCOLN AVENUE JEROME, ID 83338</b>
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BB115	<p>Continued From page 3</p> <p>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)</p> <p>l. Bylaws shall be dated and signed by the current governing body. (10-14-88)</p> <p>m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C241 as it relates to the failure of the Governing Body to assume responsibility for ensuring hospital services were available on a consistent basis.</p>	BB115		
BB144	<p>16.03.14.250.01 Medical Staff Qualifications and Privileges</p> <p>250. MEDICAL STAFF. The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88)</p> <p>01. Medical Staff Qualifications and Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88)</p> <p>a. Privileges shall be granted only on the basis of individual training, competence, and experience.</p>	BB144		

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BB144	Continued From page 4 (10-14-88)  b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88)  c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88)  This Rule is not met as evidenced by: Refer to C257 as it relates to the failure of the Medical Staff to ensure providers were responsible for the quality of all medical care provided the patients.	BB144		
BB180	16.03.14.310.08 Staffing  08. Staffing. The following rules apply to the nursing staff: (12-31-91)  a. There shall be adequate nursing personnel to plan, administer, and evaluate individual bedside nursing care; and (10-14-88)  b. A registered nurse shall be on duty on the premises twenty-four (24) hours a day. (10-14-88)  This Rule is not met as evidenced by: Refer to C253 as it relates to the failure of the hospital to ensure there was sufficient numbers of nursing personnel to ensure the quality of patient care.	BB180		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital conducted from 3/14/16 to 3/18/16. The surveyors conducting the Medicare recertification survey were:</p> <p>Laura Thompson, RN, BSN, HFS - Team Leader Susan Costa, RN, HFS Gary Gulles, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>ACLS - Advanced Cardiac Life Support CAH - Critical Access Hospital CEO - Chief Executive Officer CNO - Chief Nursing Officer CNM - Certified Nurse Midwife COO - Chief Operating Officer CPD - Cephalo Pelvic Disproportion CPR - Cardiopulmonary Resuscitation CRNA - Certified Registered Nurse Anesthetist DM - Diabetes Mellitus DO - Doctor of Osteopathy ED - Emergency Department EKG - electrocardiogram EMS - Emergency Medical Services F/U - Follow Up H&amp;P - History and Physical Examination IDAPA - Idaho Administrative Procedures Act IM - Intramuscular IV - Intravenous L&amp;D - Labor and Delivery LOC - Level of Consciousness MAR - Medication Administration Record MD - Medical Doctor mg - milligram MRSA - Methicillin Resistant Staphylococcus</p>	C 000	<p>Please see Corrective Action Plan Report Attached</p> <p><b>RECEIVED</b></p> <p>APR 11 2016</p> <p><b>FACILITY STANDARDS</b></p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Curtis Mator TITLE: ADMINISTRATOR (X6) DATE: 4/11/16

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 180 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 000	Continued From page 1 aureus NP - Nurse Practitioner OB - Obstetrical Unit OR - Operating Room PA - Physician Assistant PI - Performance Improvement PO - by mouth PQRC - Peer Review Quality Committee QA - Quality Assurance RN - Registered Nurse SME - Subject Matter Expert SpO2 - An estimate of the amount of oxygen in the blood SQ - Subcutaneous SWOT - Strengths, Weaknesses, Opportunities, and Threats TORB - Telephone Order Read Back VORB - Verbal Order Read Back VRE - Vancomycin Resistant Enterococci	C 000		
C 152	485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS  All patient care services are furnished in accordance with applicable State and local laws and regulations.  This STANDARD is not met as evidenced by: Based on record review, credentialing review, and staff interview, it was determined the CAH failed to furnish services in accordance with applicable state laws and regulations. This resulted in the CNM directing and managing the care of patients which were outside of her privileges for the facility, and not within her scope of practice. This had the potential to result in the inappropriate care of patients and negative outcomes. Findings include:	C 152		

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C 152	Continued From page 2  The Idaho Board of Nursing, IDAPA 23.01.01.400.01(c) states "The decision-making model is the process by which a licensed nurse evaluates whether a particular act is within the legal scope of that nurse's practice and determines whether to delegate the performance of a particular nursing task in a given setting. This model applies to all licensure categories permitting active practice, regardless of the practice setting." Additionally, it states "Determining Scope of Practice. To evaluate whether a specific act is within the legal scope of nursing practice, a licensed nurse shall determine whether: (c.) The act does not exceed any existing policies and procedure's established by the nurse's employer".  A facility policy "Maternal Transfer to Higher Level Acuity Facility," revised 12/09/15, stated "The following obstetrical populations would necessitate mandatory transfer to a tertiary care facility: Pre-term labor under 35 weeks gestation requiring ongoing labor suppression." Additionally, the policy stated "Mothers who are suspected or known as high risk must immediately be assessed by a provider/physician."  1. A CNM managed the care of patients which was outside of her privileges and scope of practice.  a. Patient #6 was a 19 year old female admitted on 8/18/15 at 2:00 AM. She was 23 and 5/7 weeks pregnant and experiencing contractions every 3 to 5 minutes.  Patient #6 arrived to L&D at 1:45 AM,	C 152		

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C 152	<p>Continued From page 3</p> <p>complaining of contractions every 3 to 5 minutes which started at 9:00 PM on 8/17/15. She was also complaining of low back pain which was 9 out of 10, on a 1 to 10 scale with 10 being the worst pain.</p> <p>The RN documented the CNM was notified by phone of Patient #6's arrival and her status at 2:08 AM. The RN documented she received verbal orders from the CNM at that time. At 2:50 AM, the RN documented she contacted the CNM again by phone and updated her on Patient #6's status. Patient #6 was continuing to have contractions 3 to 5 minutes apart and experiencing continued back pain.</p> <p>Patient #6's record documented the CNM was called at 3:37 AM and updated on her status. She was continuing to have contractions with increased pain. Patient #6 stated she was having vaginal discharge. The RN documented "This nurse suggest to call Dr. [doctor] on call and asked CNM [proper name] to come in and examine pt [patient]. CNM [proper name] replied if you are going to call [proper name] on call Dr. then I will not be in." The RN documented at 3:38 AM she contacted the on call physician, and he was on his way to the CAH.</p> <p>Patient #6's record included 3 telephone orders for medication, signed by the RN, and received from the CNM. The orders, dated 8/18/15, were for Terbutaline 0.25 mg IM at 2:08 AM, 2:51 AM, and 3:37 AM, prior to physical evaluation and examination.</p> <p>A document titled "8.27.15. Jerome Visit Premature Birth Debrief--Action items and notes" stated Is there a standard of practice regarding</p>	C 152		

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C 152	<p>Continued From page 4</p> <p>the management of a patient in the ER? Standard of care is for a patient to physically be seen within (30 min - need to confirm). Impression: There was a delay between the time that she was seen by a provider and the time she arrived in the ER. Question: What is Jerome's...standard of practice for triage and phone triage versus in person triage?"</p> <p>A form titled "Certified Nurse-Midwife Privileges," with an appointment date of 5/28/15, documented core privileges which were requested by the CNM and granted by the medical staff. The privileges included management of low risk, singleton pregnancies.</p> <p>The privileges included "Delivery Management Care," which was requested by the CNM and granted by the medical staff. The delivery management section stated the CNM may "Perform and manage uncomplicated spontaneous vaginal deliveries in patients of 37-42 weeks." However, Patient #6's record did not include documentation the supervising physician was contacted for consultation by the CNM. The on-call physician was contacted by the RN at 3:38 AM, almost 2 hours after her arrival to the facility.</p> <p>During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #6's record and confirmed she spoke with the RN by phone the early morning of 8/18/15. The CNM confirmed she gave telephone orders for Terbutaline for Patient #6's contractions on 3 occasions. The CNM stated when the RN contacted her the third time, she asked the RN to contact the physician on call. The CNM confirmed that managing preterm laboring patients was not in her scope of</p>	C 152		

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C 152	<p>Continued From page 5 practice, nor was she privileged to manage preterm laboring patients.</p> <p>The Chief of Staff was interviewed on 3/17/16 beginning at 9:10 AM. When asked about the case of the premature birth and the delay in examination by a provider, he stated he did not remember if the case was reviewed by the Medical Staff. He stated he did not remember if the Medical Staff had any recommendations or if any action had been taken as a result of reviewing the case.</p> <p>The Chief of Staff stated he did not remember any concerns from the case that warranted a discussion by the Medical Executive Committee. "My expectation is that any patient in premature labor would be evaluated. Recognizing preterm labor [versus contractions] requires a physical evaluation to determine." He stated if a patient was in preterm labor the CNM cannot treat and would need to call the physician. The Chief of Staff was unable to recall the PRQC (Peer Review Quality Committee) reviewing this case.</p> <p>b. Patient #5 was a 24 year old female admitted to L&amp;D on 12/01/15 in active labor. Complications included a stillborn delivery, and chorioamnionitis. The CNM managed her care during her hospitalization. Patient #5 did not have recent prenatal care and it could not be determined if her pregnancy was a high risk pregnancy. Additionally, the record included an H&amp;P which stated "She reports that she thinks she might have felt the baby move a couple of days ago."</p> <p>A form titled "Certified Nurse-Midwife Privileges," with an appointment date of 5/28/15, documented</p>	C 152		

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C 152	Continued From page 6 core privileges which were requested by the CNM and granted by the medical staff. The privileges included management of low risk, singleton pregnancies.  The privileges included "Indication for CNM Collaboration," which was requested by the CNM and granted by the medical staff. The collaboration section stated the supervising physician would be consulted for complications such as elevated temperature, induction or arrest of labor, and for fetal demise. However, Patient #5's record did not include documentation the supervising physician was contacted for consultation by the CNM.  During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #5's record and confirmed she performed the delivery of Patient #5's stillborn infant. The CNM confirmed there was no documentation of physician consultation prior to the delivery of the infant. Additionally, the CNM confirmed that she was contacted rather than the physician on call for the delivery.	C 152		
C 240	485.627 ORGANIZATIONAL STRUCTURE  Organizational Structure  This CONDITION is not met as evidenced by: Based on staff interview and review of meeting minutes, hospital logs, and administrative documents, it was determined the CAH failed to ensure its organizational structure was sufficient to direct patient care. This impeded the ability of	C 240		

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C 240	Continued From page 7 the CAH to provide effective care. Findings include:  Refer to C241 as it relates to the failure of the Governing Body to assume responsibility for determining and implementing policies to provide uninterrupted services to the community it served.  These systemic negative practices seriously impeded the ability of the CAH to provide services to patients.	C 240			
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 meeting minutes, hospital logs, and administrative documents, it was determined the CAH's Governing Body failed to assume responsibility for determining and implementing policies to provide uninterrupted services to the community it served. This resulted in the inability of the CAH to provide consistent health care to patients. Findings include:  Diversion is a temporary status for a health care facility, in which it informs local EMS, and surrounding hospitals, that its beds are full and it	C 241			

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C 241	<p>Continued From page 8 cannot take new patients.</p> <p>The CAH repeatedly invoked the diversion status in 2013 through March 2016, including diversion for OB, medical/surgical, and surgical services.</p> <p>The Clinical Director, interviewed on 3/17/16 beginning at 2:00 PM, stated the diversion episodes had resulted in postponement of induction of labor for some patients.</p> <p>A document titled "Float Pool for St. Lukes Jerome," dated January 2015, stated the CAH had "at least 28 incidents of going on divert - majority of which were related to staffing" for calendar year 2013. The document also stated "at least 37 incidents of going on divert" for calendar year 2014.</p> <p>A request was made on 3/16/16, for documentation regarding diversion status of the CAH for 2015 and 2016. On 3/17/16, 2 reports were received which included documentation of the date of the diversion status, the time diversion was implemented, the time diversion was discontinued, the reason for diversion, and the type of diversion (e.g., lack of staff, no patient beds, no OR staff). The diversion reports documented the CAH was closed to admission of patients, for the amount of time that follows:</p> <p>For the year 2015:</p> <ul style="list-style-type: none"> <li>- 1/2015 4 days</li> <li>- 2/2015 7 days</li> <li>- 3/2015 1.5 days</li> <li>- 4/2015 1 day</li> <li>- 5/2015 16 hours</li> <li>- 7/2015 14 days</li> </ul>	C 241		
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C 241	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>- 8/2015 9 days</li> <li>- 10/2015 15 days</li> <li>- 11/2015 3 days</li> </ul> <p>The diversion report documented a total of 55 days the CAH was on diversion. Of the 55 days documented for 2015, 48 of those days were due to lack of available staff.</p> <p>For the year 2016:</p> <ul style="list-style-type: none"> <li>- 2/2016 9 days</li> <li>- 3/2016 10 days</li> </ul> <p>The diversion report documented a total of 19 days the CAH was on diversion. Of the 19 days documented for 2016, 18 of those days were due to lack of available staff.</p> <p>The CAH annual evaluation stated 158 babies were born from October 2014 through September 2015. There was no mention of number of days the OB service was on diversion. This was confirmed by the Performance Improvement Coordinator on 3/17/16 at 12:40 PM.</p> <p>A document titled "Women's Service Line-January 2014, Topic Site Visit with Jerome SWOT analysis," not otherwise dated, stated "Weaknesses...the facility goes on divert due to RN staffing and provider c-section coverage. Difficult to staff the hospital due to nursing multi-skill set requirements. The nursing staff cares for both medical and obstetrical patients."</p> <p>All "ST LUKES EAST BOARD OF DIRECTORS" meeting minutes, dated between 4/28/15 to 2/23/16, were reviewed. The 4/28/15 minutes stated the swing bed project at the CAH had</p>	C 241		

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C 241	<p>Continued From page 10</p> <p>positively impacted readmissions. No other minutes included mention of specific services provided at the CAH. None of the minutes included mention of the CAH being on diversion status or specifically addressed ways to decrease the number of diversion episodes. None of the minutes addressed the impact of the numerous diversion episodes.</p> <p>The CAH was licensed for 25 inpatient beds. The Clinical Director, interviewed on 3/17/16 beginning at 2:00 PM, stated the CAH utilized 11 beds plus 3 labor and delivery beds. She stated the CAH was under pressure to save beds for the obstetrical, emergency, and surgical departments. She stated a lack of available beds was the cause for some episodes of diversion.</p> <p>No Governing Body meeting minutes, dated between 4/28/15 to 2/23/16, mentioned the lack of available beds or the discrepancy between the number of licensed beds or the actual utilization of beds.</p> <p>The Administrator was interviewed on 3/17/16 beginning at 10:05 AM, he stated the main reason the CAH went on diversion was the lack of OB nurses. He stated other reasons included the lack of nursing staff available for surgical services, the lack of physicians with privileges to perform Caesarean Section surgeries, and the lack of bed availability. He stated the CAH had increased the number of swing bed admissions in order to stabilize the overall census but this increase in swing bed admissions led to a shortage of acute care beds at times.</p> <p>The Administrator was again interviewed on 3/17/16 beginning at 2:10 PM. He stated there</p>	C 241		

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C 241	Continued From page 11 was no documentation that the Governing Body had assessed services that were diverted at the CAH. He stated there was no documentation specific action was taken by the Governing Body related to the inability to provide OB, medical, and surgical services at specific times.  The Governing Body failed to address the ongoing reliance on the use of diversion and to take action to ensure services were not interrupted.	C 241			
C 253	485.631(a)(3) STAFFING  The staff is sufficient to provide the services essential to the operation of the CAH.  This STANDARD is not met as evidenced by: Based on review of administrative records and staff interview, it was determined the CAH failed to ensure staffing was sufficient to provide services offered. This resulted in closure of the CAH to services for the community for several days a month over the last 15 months. This placed patients at risk of not receiving medical care for their condition in a timely manner. Findings include:  A request was made on 3/16/16, for documentation regarding diversion status of the CAH for 2015 and 2016. On 3/17/16, 2 reports were received which included documentation of the date of the diversion status, the time diversion was implemented, the time diversion was discontinued, the reason for diversion, and the type of diversion (e.g., lack of staff, no available patient beds, no OR staff, no OB staff). The diversion reports documented the CAH was closed to admission of patients, for the amount of	C 253			

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C 253	<p>Continued From page 12 time that follows:</p> <p>For the year 2015:</p> <ul style="list-style-type: none"> <li>- 1/2015 4 days</li> <li>- 2/2015 7 days</li> <li>- 3/2015 1.5 days</li> <li>- 4/2015 1 day</li> <li>- 5/2015 16 hours</li> <li>- 7/2015 14 days</li> <li>- 8/2015 9 days</li> <li>- 10/2015 15 days</li> <li>- 11/2015 3 days</li> </ul> <p>The 2015 report documented a total of 55 days the CAH was on diversion. Of the 55 days documented for diversion status, 48 of those days were due to lack of available staff. Additionally, 17.5 days were due to staffing difficulties for the OB unit.</p> <p>For the year 2016:</p> <ul style="list-style-type: none"> <li>- 2/2016 9 days</li> <li>- 3/2016 10 days</li> </ul> <p>The 2016 report documented a total of 19 days the CAH was on diversion. Of the 19 days documented for diversion status, 18 of those days were due to lack of available staff. Additionally, 18 days were due to staffing difficulties for the Medical Surgical unit.</p> <p>A request was made to review The Medical Executive Committee meeting minutes for the previous 12 months. The Medical Executive Committee meeting minutes were reviewed from 4/07/15 to 3/01/16.</p>	C 253			

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C 253	<p>Continued From page 13</p> <p>The Medical Executive Committee meeting minutes, dated 7/07/15, included documentation of the CNO update which included issues regarding staffing. The update stated a float pool was under way and was going to be available in September of 2015. The meeting minutes documented the conclusions were "informational" and no actions were initiated by the committee.</p> <p>The Medical Executive Committee meeting minutes, dated 9/01/15, documented the CNO update included training of OB staff and filling open positions with travelling nurses. The meeting minutes documented the conclusions were "informational" and no actions were initiated by the committee.</p> <p>During an interview on 3/17/16 at 9:10 AM, the Chief of Staff confirmed the CAH was on diversion for OB services. He stated diversion times were for 12 hours or less. The Chief of Staff stated he was aware the administration was attempting to hire more nurses and also reviewing patient census. He stated the CAH was limiting admission of Swing Bed patients to 9 beds. The Chief of Staff stated the CAH was hiring another OB physician, but he would not begin working until the summer of 2016, upon completion of his fellowship.</p> <p>During an interview on 3/17/16 at 10:00 AM, the Administrator confirmed the CAH was on diversion for staffing problems and also due to census. He confirmed staffing of the CAH was the primary reason for not accepting new patients. The Administrator stated the CAH was working on staffing problems over the last year by training staff to work in different units and hiring new staff.</p>	C 253		

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C 253	Continued From page 14  During an interview on 3/17/16 at 11:35 AM, the CNO reviewed the diversion report and Medical Executive Committee meeting minutes and confirmed the main reason for diversion at the CAH was staffing problems. She stated diverting patients was "a last resort only." The CNO stated the CAH was having difficulty filling open RN positions because nurses must be willing to float around the hospital as needed, due to patient census and needs. She stated many nurses wanted to specialize within a unit and not float to where they are needed. The CNO confirmed a float pool of nurses was implemented in September of 2015, with the hospital in Magic Valley. She stated, at the time of survey, only Medical/Surgical nurses were available through the float pool. The CNO stated the CAH was cross training RNs to work in OB and OR, but this required a significant amount of time.	C 253			
C 257	The CAH failed to ensure adequate staffing to provide the services offered.  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, provider privileges, and Medical Staff meeting minutes, it was determined the CAH	C 257			

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C 257	<p>Continued From page 15</p> <p>failed to ensure the Medical Staff provided medical direction for obstetrical services. This affected the care of 1 of 3 obstetrical patients (#6) cared for by a nurse midwife and had the potential to affect all obstetrical patients. This resulted in a lack of oversight of the medical care provided to obstetrical patients. Findings include:</p> <p>Patient #6 was a 19 year old female admitted on 8/18/15 at 2:00 AM. She was 23 and 5/7 weeks pregnant. She was having severe low back pain and contractions every 3 to 5 minutes.</p> <p>Patient #6 arrived at the L&amp;D at 1:45 AM, complaining of contractions every 3 to 5 minutes which started at 9:00 PM on 8/17/15. She was also complaining of low back pain which was 9 out of 10, on a 1 to 10 scale with 10 being the worst pain.</p> <p>The RN documented the CNM was notified, by phone, of Patient #6's arrival and her status at 2:08 AM. The RN documented she received telephone orders from the CNM at that time. At 2:50 AM, the RN documented she contacted the CNM by phone again and updated her on Patient #6's status. Patient #6 was continuing to have contractions 3 to 5 minutes apart and experiencing continued back pain.</p> <p>Patient #6's record documented the CNM was called at 3:37 AM and updated on her status. She was continuing to have contractions with increased pain. Patient #6 stated she was having vaginal discharge. The RN documented "This nurse suggest to call Dr. [doctor] on call and asked CNM [proper name] to come in and examine pt [patient]. CNM [proper name] replied if you are going to call [proper name] on call Dr.</p>	C 257		

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C 257	<p>Continued From page 16 then I will not be in." The RN documented at 3:38 AM she contacted the on call physician, and he was on his way to the CAH.</p> <p>Patient #6's record included 3 telephone orders for medication, signed by the RN, and received from the CNM. The orders, dated 8/18/15, were for Terbutaline 0.25 mg IM at 2:08 AM, 2:51 AM, and 3:37 AM, prior to physical evaluation and examination.</p> <p>Nursing progress notes documented the pre-term baby was delivered at 7:33 AM on 8/18/15. The baby required stabilization and was transferred by air to an acute care hospital with a neonatal intensive care unit on 8/18/15 at 10:05 AM, 2 hours and 32 minutes after birth. A discharge planning note by the RN Case Manager, dated 8/21/15 at 9:17 AM, stated the baby was transferred "...in critical condition."</p> <p>A form titled "Certified Nurse-Midwife Privileges," with an appointment date of 5/28/15, documented core privileges which were requested by the CNM and granted by the medical staff. The privileges included management of low risk, singleton pregnancies.</p> <p>The privileges included "Delivery Management Care," which was requested by the CNM and granted by the medical staff. The delivery management section stated the CNM may "Perform and manage uncomplicated spontaneous vaginal deliveries in patients of 37-42 weeks." However, Patient #6's record did not include documentation the supervising physician was contacted for consultation by the CNM. The on-call physician was contacted by the RN at 3:38 AM, almost 2 hours after her</p>	C 257		

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C 257	<p>Continued From page 17 arrival to the facility.</p> <p>During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #6's record and confirmed she spoke with the RN by phone the early morning of 8/18/15. The CNM confirmed she gave telephone orders for Terbutaline for Patient #6's contractions on 3 occasions. The CNM stated when the RN contacted her the third time, she asked the RN to contact the physician on call. The CNM confirmed that managing preterm laboring patients was not in her scope of practice, nor was she privileged to manage preterm laboring patients.</p> <p>The Medical Executive Committee meeting minutes were reviewed from 4/07/15 to 3/01/16. The Medical Executive Committee meeting minutes, dated 9/01/15, documented the CNO update included a debrief on a 22 week old neonate. The minutes did not include documentation of NP and PA responsibilities regarding management of preterm labor. Additionally, there was no documentation in the meeting minutes regarding standard of practice, privileges, or need for consultation by a physician for NPs or PAs regarding management of preterm labor.</p> <p>A document attached to the Medical Executive Committee meeting minutes, dated 9/01/15, was titled "8.27.15. Jerome Visit Premature Birth Debrief--Action items and notes" stated, "Is there a standard of practice regarding the management of a patient in the ER? Standard of care is for a patient to physically be seen within (30 min - need to confirm). Impression: There was a delay between the time that she was seen by a provider and the time she arrived in the ER. Question:</p>	C 257			

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C 257	<p>Continued From page 18</p> <p>What is Jerome's...standard of practice for triage and phone triage versus In person triage?"</p> <p>During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #6's record and confirmed she spoke with the RN by phone the early morning of 8/18/15. The CNM confirmed she gave telephone orders for Terbutaline for Patient #6's contractions on 3 occasions. The CNM stated when the RN contacted her the third time, she asked the RN to contact the physician on call. The CNM confirmed that managing preterm laboring patients was not in her scope of practice, nor was she privileged to manage preterm laboring patients.</p> <p>The Chief of Staff was interviewed on 3/17/16 beginning at 9:10 AM. When asked about the case of the premature birth and the delay in examination by a provider, he stated he did not remember if the case was reviewed by the Medical Staff. He stated he did not remember any concerns from the case that warranted a discussion by the Medical Executive Committee. He stated "My expectation is that any patient in premature labor would be evaluated. Recognizing preterm labor requires a physical evaluation to determine." He stated if a patient was in preterm labor the CNM could not treat her and would need to call the physician. He stated did not recall the Peer Review Quality Committee reviewing the case. He stated he did not remember if the Medical Staff had any recommendations or if any action had been taken as a result reviewing the case.</p> <p>The Medical Executive Committee did not examine Patient #6's care and address care deficiencies that were identified. The Medical</p>	C 257			

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C 257	Continued From page 19 Executive Committee did not take action to ensure standards of care were met including the enforcement of staff privileges.	C 257			
C 265	485.631(c)(2)(i) PA, NP & CLINICAL NURSE SPEC RESPONSIBILITIES  §485.631(c)(2) The physician assistant, nurse practitioner, or clinical nurse specialist performs the following functions to the extent they are not being performed by a doctor of medicine or osteopathy:  (i) Provides services in accordance with the CAH's policies.  This STANDARD is not met as evidenced by: Based on record review, policy review, provider privileges review, and staff interview, it was determined the CAH failed to ensure the CNM provided services in accordance with facility policies for 2 of 3 patients (Patient #5 and #6) who received care from a CNM. This resulted in inappropriate care of OB patients and had the potential to result in negative outcomes for patients. Findings include:  A facility policy "Maternal Transfer to Higher Level Acuity Facility," revised 12/09/15, stated "The following obstetrical populations would necessitate mandatory transfer to a tertiary care facility: Pre-term labor under 35 weeks gestation requiring ongoing labor suppression." Additionally, the policy stated "Mothers who are suspected or known as high risk must	C 265			

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C 265	<p>Continued From page 20 immediately be assessed by a provider/physician."</p> <p>A form titled "Certified Nurse-Midwife Privileges," with an appointment date of 5/28/15, documented core privileges which were requested by the CNM and granted by the medical staff. The privileges included management of low risk, singleton pregnancies.</p> <p>The privileges included "Delivery Management Care," which was requested by the CNM and granted by the medical staff. The delivery management section stated the CNM may "Perform and manage uncomplicated spontaneous vaginal deliveries in patients of 37-42 weeks." However, Patient #6's record did not include documentation the supervising physician was contacted for consultation by the CNM. The on-call physician was contacted by the RN at 3:38 AM, almost 2 hours after her arrival to the facility.</p> <p>1. Patient #6 was a 19 year old female admitted on 8/18/15 at 2:00 AM. She was 23 and 5/7 weeks pregnant. She was having severe low back pain and contractions every 3 to 5 minutes.</p> <p>Patient #6 arrived at the L&amp;D at 1:45 AM, complaining of contractions every 3 to 5 minutes which started at 9:00 PM on 8/17/15. She was also complaining of low back pain which was 9 out of 10, on a 1 to 10 scale with 10 being the worst pain.</p> <p>The RN documented the CNM was notified of Patient #6's arrival and her status at 2:08 AM. The RN documented she received orders from the CNM at that time. At 2:50 AM, the RN</p>	C 265			

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C 265	<p>Continued From page 21</p> <p>documented she contacted the CNM again and updated her on Patient #6's status. Patient #6 was continuing to have contractions 3 to 5 minutes apart and experiencing continued back pain.</p> <p>Patient #6's record documented the CNM was called at 3:37 AM and updated on her status. She was continuing to have contractions with increased pain. Patient #6 stated she was having vaginal discharge. The RN documented "This nurse suggest to call Dr. [doctor] on call and asked CNM [proper name] to come in and examine pt [patient]. CNM [proper name] replied if you are going to call [proper name] on call Dr. then I will not be in." The RN documented at 3:38 AM she contacted the on call physician, and he was on his way to the CAH.</p> <p>Patient #6's record included 3 telephone orders for medication, signed by the RN, and received from the CNM. The orders, dated 8/18/15, were for Terbutaline 0.25 mg IM at 2:08 AM, 2:51 AM, and 3:37 AM, prior to physical evaluation and examination.</p> <p>A document titled "8.27.15. Jerome Visit Premature Birth Debrief--Action items and notes" stated, "Is there a standard of practice regarding the management of a patient in the ER? Standard of care is for a patient to physically be seen within (30 min - need to confirm). Impression: There was a delay between the time that she was seen by a provider and the time she arrived in the ER. Question: What is Jerome's...standard of practice for triage and phone triage versus in person triage?"</p> <p>The Chief of Staff did not remember any</p>	C 265			

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C 265	<p>Continued From page 22</p> <p>concerns from the case that warranted a discussion by the Medical Executive Committee. "My expectation is that any patient in premature labor would be evaluated. Recognizing preterm labor [versus contractions] requires a physical evaluation to determine." He stated if a patient was in preterm labor the CNM cannot treat and would need to call the physician.</p> <p>During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #6's record and confirmed she spoke with the RN by phone the early morning of 8/18/15. The CNM confirmed she gave telephone orders for Terbutaline for Patient #6's contractions on 3 occasions. The CNM stated when the RN contacted her the third time, she asked the RN to contact the physician on call. The CNM confirmed that managing preterm laboring patients was not in her scope of practice, nor was she privileged to manage preterm laboring patients.</p> <p>The CNM failed to follow CAH policies.</p> <p>2. Patient #5 was a 24 year old female admitted to L&amp;D on 12/01/15 in active labor. Complications included a stillborn delivery, and chorioamnionitis. The CNM managed her care during her hospitalization.</p> <p>Patient #5 did not have recent prenatal care and it could not be determined if her pregnancy was a high risk pregnancy.</p> <p>Patient #5's record included an H&amp;P, dated 12/01/15, which stated Patient #5 reported she had a couple of prenatal visits early in her pregnancy with a CNM. The H&amp;P stated "She reports that she thinks she might have felt the</p>	C 265		

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C 265	Continued From page 23 baby move a couple of days ago." The H&P further stated when the CNM palpated the neonate's head it felt swollen and the neonate was probably nonviable (not able to grow or survive).  The neonate was delivered at 2:37 AM on 12/01/15, and was stillborn at delivery. There was no documentation in Patient #5's record a physician was consulted by the CNM.  During an interview on 3/17/16 beginning at 7:00 AM, the CNM reviewed Patient #5's record and confirmed she performed the delivery of Patient #5's stillborn infant. The CNM confirmed there was no documentation of physician consultation prior to the delivery of the infant. Additionally, the CNM confirmed that she was contacted rather than the physician on call for the delivery.	C 265		
C 275	The CNM failed to follow CAH policies. 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	C 275		

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C 275	Continued From page 24 guidance to providers. Findings include:  A policy that specified the conditions requiring medical consultation and/or patient referral was not present at the CAH.  The Chief of Staff was interviewed on 3/17/16 beginning at 9:10 AM. He stated he was not aware of a policy that discussed the conditions requiring medical consultation and/or patient referral.	C 275		
C 296	485.635(d)(2) NURSING SERVICES  A registered nurse or, where permitted by State law, a physician assistant, must supervise and evaluate the nursing care for each patient, including patients at a SNF level of care in a swing-bed CAH. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure an RN evaluated the care for each patient upon admission and, when appropriate, on an ongoing basis. This directly impacted the care of 2 of 7 obstetrical patients (Patients #19 and #5) whose records were reviewed. This resulted in incomplete assessments and orders not followed. Findings include:  1. Patient #19 was a 19 year old female who was admitted to L&D on 3/10/16, for induction of labor. Patient #19 delivered a baby girl on 3/11/16. Complications included chorioamnionitis, and Patient #19 and her newborn were treated with	C 296		

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C 296	<p>Continued From page 25 antibiotics.</p> <p>Patient #19's medical record was reviewed and the following was noted:</p> <p>a. Her record included a "screen shot" of an undated computer image that was titled "View Critical Care Indicators." The form stated "Does Pt [patient] have a Hx [history] of MRSA/VRE or Other Resistant Organism?" The box included a "Y" to indicate yes. However, Patient #19's record did not include further information related to an MRSA, VRE, or other antibiotic resistant infection.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #19's record and stated the form was printed by the admissions department when Patient #19 was admitted to the facility. She stated the information triggered the RN to look up laboratory results or do a swab to determine if the patient had an active infection. The SME was unable to find documentation that it was done.</p> <p>b. Patient #19's record documented a CRNA placed an epidural catheter for pain management. Her record included an order sheet titled "Epidural-Intrathecal Standing Orders-CRNA," dated 3/11/16 at 4:40 AM, and signed by the CRNA. The form included specific orders for documentation by the RN, which stated "Monitor and record vital signs, including respiratory rate, level of sedation, for duration of infusion every 5 minutes times 30 minutes, then every 1/2 hour." Additionally, the orders stated "Monitor and record sensory level every 5 minutes times 30 minutes, then every 1/2 hour for duration of infusion."</p>	C 296		

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C 296	Continued From page 26  The RN providing care for Patient #19 documented at 4:26 AM, "epidural in, lying down, and back on monitors, B/P [blood pressure] set for every 5 minutes." However, the monitoring and documentation as ordered by the CRNA did not occur. Vital signs were documented at 4:20 AM, 4:56 AM, 5:20 AM, 6:20 AM, 6:58 AM, and 7:50 AM. They did not follow the frequency of every 5 minutes for 30 minutes, and every 1/2 hour as ordered by the CRNA. Additionally, the Patient #19's record did not include documentation of a sensory level after the epidural was performed.  Patient #19's record did not include vital signs as ordered during the epidural process.  During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #19's record and confirmed vital signs and other documentation were not performed as ordered, and as the policy directed. She provided a packet of papers, identified as the fetal heart tracing. The fetal heart tracing included documentation of the blood pressure cuff readings automatically printed on the strips, at a frequency of every 5 minutes after the epidural was placed. The SME confirmed the orders for documentation of all components of the orders were not performed.  Patient #19 was not monitored during labor as per facility policy and orders specified.  2. Patient #5 was a 24 year old female admitted to L&D on 12/01/15 in active labor. Complications included a stillborn delivery, and chorioamnionitis. Patient #5 did not have recent prenatal care. A CNM managed her care during	C 296		

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C 296	Continued From page 27 her hospitalization.	C 296			
C 297	<p>Patient #5's record included an order for an A1c (a blood test to determine a 3 month average of blood sugar, a test routinely performed on individuals with diabetes). Patient #5's record did not include evidence the test was performed as ordered.</p> <p>This was confirmed during an interview with the SME on 3/16/16 beginning at 3:30 PM.</p> <p>485.635(d)(3) NURSING SERVICES</p> <p>All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure medications were correctly ordered, administered, and documented for 5 of 11 obstetrical and neonatal patients (#1, #6, #18, #19, and #20), whose records were reviewed. This resulted in medications administered at the wrong rate and by the wrong route, administered without orders, administered with orders written incorrectly, and had the potential to result in patient harm and/or death to obstetrical and neonate patients. Findings include:</p> <p>A policy titled "Medications-Ordering, Dispensing, Administration, and Monitoring," revised 12/01/15, included the required medication order elements:</p>	C 297			

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C 297	<p>Continued From page 28</p> <ul style="list-style-type: none"> <li>- Date and Time</li> <li>- Patient Name</li> <li>- Drug Name</li> <li>- Dosage</li> <li>- Route</li> <li>- Frequency</li> <li>- Rate (e.g. IV fluids)</li> <li>- Indications for use (with the order or within the medical record.)</li> </ul> <p>The CAH policy stated, for verbal and telephone orders, the orders were to be authenticated, dated, and timed by the prescriber within 48 hours. Additionally, the policy stated Pediatric orders should be written on a weight basis. However, the policy was not followed.</p> <p>1. Patient #6 was a 19 year old female that was admitted to L&amp;D on 8/18/15, for preterm labor and delivery of a 23 5/7 week male. Medications were ordered by her CNM which were not consistent with the facility medication policy:</p> <p>a. Patient #6's record included 3 telephone orders for medication, signed by the RN, and received from the CNM. The orders, dated 8/18/15, were for Terbutaline 0.25 mg IM at 2:08 AM, 2:51 AM, and 3:37 AM. A portion of the medication orders were written over with a different pen. The parts which were written over was the route of administration for the medication. It was rewritten as SQ, rather than IM. According to the Nursing 2015 Drug Handbook, Terbutaline for preterm labor is to be administered SQ, not IM. The Drug Handbook includes a Black Box Warning which states "Don't use injectable form in pregnant women for prevention or prolonged treatment (beyond 48 to</p>	C 297		

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C 297	<p>Continued From page 29</p> <p>72 hours) of preterm labor in either the hospital or outpatient setting because of the potential for serious maternal heart problems and death."</p> <p>b. Patient #6's record included documentation Terbutaline 0.25 mg was administered IM in the left deltoid at 2:20 AM. Additional doses were administered at 2:55 AM via IM in her right deltoid, and 3:40 AM via IM in her left deltoid. The portion of the record which documented the route of administration was written over in a different pen, and documented the medications was given SQ rather than IM.</p> <p>c. The RN documented, in the narrative portion of the nursing note, Terbutaline 0.25 mg was administered at 2:20 AM and 2:55 AM. The original documentation by the RN stated the medication was given IM both times. The IM portion of the narrative note was written over in a different pen and written as SQ.</p> <p>d. Patient #6's record included a physician order for 4 grams of Magnesium Sulfate (MgSO4) as a bolus (a large dose of a medication used to accelerate a response by the body), then 2 grams an hour after the bolus was infused. However, the physician did not include the route of administration.</p> <p>e. Patient #6's MAR included documentation the administration of the MgSO4 bolus was started at 5:47 AM on 8/18/15. The continuous infusion of MgSO4 was started at 5:50 AM, which indicated the 4 gram bolus infused over 3 minutes. According to the Nursing 2015 Drug Handbook, the rate of a MgSO4 bolus should be no greater than 150 mg/minute, or 30 minutes, to avoid cardiac or respiratory arrest.</p>	C 297		

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C 297	<p>Continued From page 30</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME, who was also an RN, reviewed Patient #6's record and confirmed the telephone orders from the CNM received by the RN included documentation of an "over write." She was unable to determine if the medication was ordered and administered as IM or SQ, and she confirmed the "over write" was not initialed to indicate who did that. Additionally, the SME confirmed the order for MgSO4 did not include a route to be delivered, and confirmed the documentation of bolus and continuous infusion was 3 minutes apart, which would indicate an unsafe rapid delivery of the bolus.</p> <p>Patient #6 received medications that were not administered in a safe and correct manner.</p> <p>2. Patient #20 was a full term newborn female, born on 3/11/16 at 1:56 PM. Her mother showed signs of chorioamnionitis (Inflammation of the fetal membranes due to a bacterial infection which is most often associated with prolonged labor, and can lead to infections in the mother and baby).</p> <p>Patient #20's physician ordered antibiotics shortly after her birth at 2:18 PM on 3/11/16. The physician order Ampicillin 100 mg/kg IV and Gentamicin 4 mg/kg IV. The medication orders did not include Patient #20's weight for calculating the appropriate dose of medication.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #20's record and confirmed the orders written by her physician did not follow the CAH policy.</p>	C 297		

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C 297	<p>Continued From page 31</p> <p>Patient #20's medication orders did not include her weight according to the CAH's policy.</p> <p>3. Patient #18 was a 37 week gestational age neonate who was born on 12/20/15 at 8:55 PM. He immediately presented with signs of respiratory distress and was ultimately transferred to a higher level of care facility.</p> <p>The CNM wrote orders for medications, however the medication orders were incorrect as follows:</p> <p>a. An order was written for IV fluid 10 ml/kg. The order did not specify the type of IV fluid for administration. Additionally, the time noted by the CNM was 8:10 PM, 45 minutes before Patient #18 was born.</p> <p>b. At 11:00 PM on 12/20/15, the CNM ordered Gentamicin 4 mg/kg IV. However, the medication order did not include Patient #18's weight for calculating the appropriate dose of medication.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #18's record and confirmed the orders written by the CNM were not in accordance with the policy.</p> <p>Patient #18's medication orders did not include his weight or the type of IV fluid for administration, according to the CAH's policy.</p> <p>4. Patient #1 was a 19 year old pregnant female that was admitted to the hospital at 1:27 PM on 1/24/16, in active labor.</p> <p>The facility policy titled "Fentanyl Use in L&amp;D," revised 11/08/13, stated "Monitoring shall include patient mental status, pulse, blood pressure,</p>	C 297			

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C 297	<p>Continued From page 32</p> <p>SpO2, and respiratory rate every 15 minutes X4 and as needed." The policy further stated a sterile vaginal exam shall be performed within 30 minutes of the Fentanyl administration. The monitoring and exam were not performed as the policy dictated.</p> <p>Patient #1's record included a pre-printed order set titled "Intrapartum Orders" which were not signed by the physician. The order set included a section titled "Medications." However, the boxes next to the orders were un-marked. The bottom of the page included a section for Cesarean Section Orders which was signed by Patient #1's physician and dated 1/24/16. However, the order was not timed by the physician, as required by the CAH's policies.</p> <p>Patient #1's record included documentation she received 50 mcg of Fentanyl at 2:13 PM. Patient #1's record did not include an order from her physician for Fentanyl.</p> <p>Patient #1's record documented on 1/24/16 at 2:13 PM, vital signs were obtained, and Fentanyl 50 mcg was administered. Vital signs were documented again at 2:30 PM, her heart rate and respiratory rate were documented at 2:51 PM and 2:58 PM. Her record documented she received an epidural at 2:58 PM. The next vital signs were documented at 3:05 PM, and 3:10 PM, a vaginal exam was performed at that time. Vital signs were assessed 4 times over the course of 35 minutes. Patient #1's post Fentanyl assessments were not completed 4 times at 15 minute intervals (one hour) in accordance with the policy.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #1's record and</p>	C 297		

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C 297	<p>Continued From page 33</p> <p>confirmed Fentanyl was administered without an order from a provider. She confirmed the policy for medication administration was not followed.</p> <p>Patient #1 received a narcotic without a physician order.</p> <p>5. Patient #19 was a 19 year old female who was admitted to L&amp;D on 3/10/16, for induction of labor. Patient #19 delivered a baby girl on 3/11/16. Complications included chorioamnionitis, and Patient #19 and her newborn were treated with antibiotics.</p> <p>Patient #19's record documented at 2:21 AM, a vaginal exam was performed, vital signs were obtained, and Fentanyl 50 mcg was administered. Vital signs were documented again at 2:40 AM, and at 2:56 AM. Her record documented she received an epidural at 4:20 AM, and vital signs were obtained. The next vital signs were documented at 4:56 AM, and a vaginal exam was performed at that time. Vital signs were assessed 4 times over the course of 2 hours and 35 minutes. Patient #19's post Fentanyl assessments were not completed 4 times at 15 minute intervals (one hour) in accordance with the policy.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #19's record and confirmed vital signs and other documentation was not performed as ordered, and as the policy directed.</p> <p>Patient #19 was not monitored after medication administration per facility policy.</p> <p>The facility failed to ensure all components of</p>	C 297			

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C 298	safe medication delivery were followed. 485.635(d)(4) NURSING SERVICES  A nursing care plan must be developed and kept current for each Inpatient. This STANDARD is not met as evidenced by: Based on staff interviews and review of medical records, it was determined the CAH failed to ensure nursing care plans were individualized and complete for 1 of 7 obstetrical patients (Patient #5) whose records were reviewed. This resulted in a lack of care planning to address the unique needs of a mother whose baby was stillborn. Findings include:  Patient #5 was a 24 year old female admitted to L&D on 12/01/15 in active labor. Complications included a stillborn delivery, and chorloamnionitis. Patient #5 did not have recent prenatal care. A CNM managed her care during her hospitalization.  Patient #5's record did not include a care plan which was individualized and specific to newborn loss, grieving, or interventions to relieve engorged breasts due to milk production and no infant to feed.  During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #5's record and confirmed there was no nursing care plan which addressed her unique needs after delivery of a stillborn infant.	C 298			
C 304	Patient #5's care plan was incomplete. 485.638(a)(4)(i) RECORDS SYSTEMS  For each patient receiving health care services,	C 304			

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C 304	<p>Continued From page 35</p> <p>the CAH maintains a record that includes, as applicable--</p> <p>identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the facility failed to ensure the patient medical records included documentation of properly executed admission and surgical consents for 10 of 11 obstetrical and newborn patients (#1, #2, #3, #4, #5, #7, #18, #19, #20 and #21) whose records were reviewed. This resulted in outpatient consents signed for inpatient admissions, and missing components of a properly executed surgical consent. Findings include:</p> <p>1. Patients were admitted to the facility as inpatients, however, their record did not include the appropriate consent, as follows:</p> <p>A facility policy titled "Consent Process," revised 9/20/14, stated "For inpatient admission to the hospital and/or for routine tests and procedures, a Hospital Admission Consent is obtained from the patient." Inpatient records did not include a Hospital Admission Consent.</p> <p>a. Patient #1 was a 19 year old female who was admitted to L&amp;D on 1/24/16, in active labor. She was discharged on 1/27/16.</p>	C 304			

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C 304	<p>Continued From page 36</p> <p>Patient #1's record included a consent signed and dated 1/24/16 at 11:16 AM. The consent was titled "Outpatient Services Consent." The consent was two pages, the first of which was numbered 1-10. The second page included sections numbered 12-16, and was signed by Patient #1 on 1/24/16 at 1:40 PM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #1's record and confirmed her record did not include an Inpatient Admissions Consent.</p> <p>Patient #1's record did not include an Inpatient Admissions Consent.</p> <p>b. Patient #21 was a 25 year old female admitted to L&amp;D on 12/20/15 in active labor.</p> <p>Patient #21's record included a consent signed and dated 12/20/15 at 2:25 PM. The consent was titled "Outpatient Services Consent." The consent was two pages, the first of which was numbered 1-10. The second page included sections numbered 12-16, and was signed by Patient #21 on 12/20/15 at 3:22 PM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #21's record and confirmed her record did not include an Inpatient Admissions Consent.</p> <p>Patient #21's record did not include an Inpatient Admissions Consent.</p> <p>c. Patient #20 was a newborn female, born on 3/11/16. Her record did not include an Inpatient Admissions Consent. This was confirmed by the</p>	C 304		

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C 304	<p>Continued From page 37</p> <p>SME during an interview on 3/16/16 beginning at 9:00 AM.</p> <p>The CAH did not ensure Patient #20's record included an Inpatient Admissions Consent signed by his parent(s).</p> <p>d. Patient #5 was a 24 year old female admitted to L&amp;D on 12/01/15, in active labor.</p> <p>Patient #5's record included a consent titled "Outpatient Services Consent." The consent was two pages, the first of which was numbered 1-10. The second page included sections numbered 12-16, and was signed and dated by Patient #5 on 12/01/15 at 2:37 AM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #5's record and confirmed her record did not include an Inpatient Admissions Consent.</p> <p>The CAH did not ensure Patient #5's record included an Inpatient Admissions Consent.</p> <p>e. Patient #7 was a newborn male, born on 8/18/15. His record documented he was transferred to a higher level of care at approximately 4 hours of age. Patient #7's record did not include an Inpatient Admissions Consent.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #7's record and confirmed his record did not include an Inpatient Admissions Consent signed by his parent(s).</p> <p>The CAH did not ensure Patient #7's record included an Inpatient Admissions Consent.</p>	C 304			

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C 304	<p>Continued From page 38</p> <p>f. Patient #18 was a newborn male, born on 12/20/15. His record documented he was transferred to a higher level of care at approximately 4 hours of age. Patient #18's record did not include an Inpatient Admissions Consent. His record included what appeared to be page "2" of the consent. It was signed by Patient #18's father on 12/20/15 at 9:22 PM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #18's record and confirmed his record did not include a form titled "Inpatient Admissions Consent". She stated the page "2" was the second page of the consent, and confirmed the first page was not included in his record.</p> <p>The CAH did not ensure Patient #18's record included an Inpatient Admissions Consent.</p> <p>g. Patient #4 was a newborn male, born on 1/29/16. Patient #4's record did not include an Inpatient Admissions Consent. His record included what appeared to be page "2" of the consent. It was signed by Patient #4's mother on 1/29/16 at 6:22 PM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #4's record and confirmed his record did not include a form titled "Inpatient Admissions Consent". She stated the page "2" was the second page of the consent, and confirmed the first page was not included in his record.</p> <p>The CAH did not ensure Patient #4's record included an Inpatient Admissions Consent.</p> <p>h. Patient #2 was a newborn female, born on</p>	C 304		

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C 304	<p>Continued From page 39</p> <p>1/24/16. Patient #2's record did not include an Inpatient Admissions Consent. Her record included what appeared to be page "2" of the consent, signed by Patient #2's father on 1/24/16 at 7:02 PM.</p> <p>During an interview on 3/16/16 beginning at 9:00 AM, the SME reviewed Patient #2's record and confirmed her record did not include a form titled "Inpatient Admissions Consent". She stated the page "2" was the second page of the consent, and confirmed the first page was not included in his record.</p> <p>The CAH did not ensure Patient #2's record included an Inpatient Admissions Consent.</p> <p>2. The policy "Consent Process," included a section titled "Informed Consent Inpatient, Outpatient." It stated "For certain surgical and non-routine medical procedures or treatment involving more than a slight risk, which will be performed in the hospital. Informed Consent must be documented through an appropriate Informed Consent form which is signed by the patient or when appropriate, the patient's representative."</p> <p>Consent forms did not include signatures, date, and/or time when signed or witnessed. Examples include:</p> <p>a. Patient #3 was a 24 year old female who was admitted to L&amp;D on 1/29/16, for induction of labor for post dates. Patient #3 delivered a baby boy on 1/29/16. Complications included failure of labor to progress, and a Cesarean Section was performed.</p>	C 304			

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NAME OF PROVIDER OR SUPPLIER  ST LUKE'S JEROME			STREET ADDRESS, CITY, STATE, ZIP CODE 709 NORTH LINCOLN AVENUE JEROME, ID 83338		
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C 304	<p>Continued From page 40</p> <p>Patient #3's record included a form titled "Informed Consent."</p> <p>i. The Informed Consent included the name of the procedure for induction of labor, however, the section where the physician's name was to be listed remained empty. The physician signed the form, however, he did not date or time when he signed the consent.</p> <p>ii. The Informed Consent was signed by Patient #3, however, there was no date or time as to when it was signed.</p> <p>iii. The Informed Consent included a section for the individual to sign as a witness to Patient #3's signature, however, the signature line, date, and time were blank.</p> <p>During an interview on 3/16/16 beginning at 3:30 PM, the SME reviewed Patient #3's record and confirmed the consent form was incomplete.</p> <p>Consents for Patient #3 were incomplete.</p> <p>b. Patient #19 was a 19 year old female who was admitted to L&amp;D on 3/10/16, for induction of labor. Patient #19 delivered a baby girl on 3/11/16. Complications included chorioamnionitis, and Patient #19 and her newborn were treated with antibiotics.</p> <p>i. The Informed Consent included the name of the procedure for induction of labor, however, the section where the physician was to sign the form indicating the procedure was explained along with the risks, benefits, and alternatives, was not signed by the physician or dated.</p>	C 304			

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C 304	Continued From page 41 ii. The Informed Consent for induction of labor was signed, dated and timed by Patient #19, however, the section for the witness did not include a date or time.  iii. The Consent for Anesthesia Services was signed by Patient #19. The consent included 6 different modes of anesthesia, however, none of modes were selected as the one(s) to be used by the CRNA. Additionally, Patient #19's signature on the form did not include a time or date.  During an interview on 3/16/16 beginning at 10:50 AM, the CRNA reviewed Patient #19's record and confirmed the "Consent For Anesthesia Services," signed by he and Patient #19, did not include a time or date as to when she signed the form. The CRNA stated Patient #19 signed the consent just before he signed as a witness. Additionally, the CRNA confirmed the Informed Consent did not specify that he would be performing an epidural anesthesia for Patient #19's labor pain.	C 304			
C 307	Consent forms for Patient #19 were incomplete. 485.638(a)(4)(iv) RECORDS SYSTEMS  [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-]  dated signatures of the doctor of medicine or osteopathy or other health care professional.  This STANDARD is not met as evidenced by: Based on review of policies, medical records,	C 307			

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C 307	<p>Continued From page 42</p> <p>and staff interview, it was determined the facility failed to ensure telephone, verbal, and written orders included the appropriate components for 8 of 11 obstetrical and newborn patients (#1, #3, #4, #5, #6, #18, #19, and #21) whose records were reviewed. This had the potential to result in incomplete authentication of orders and missed times and/or dates when the order was authenticated. Findings include:</p> <p>In a CAH policy titled "Medical Records," undated, stated "All orders must be written clearly, legibly and completely." Additionally, for verbal orders, the policy stated "The Individual receiving the order must immediately reduce the verbal order to writing on the order sheet of the practitioner who originated the order and immediately sign, date and time the entry. All verbal orders must be read back to the practitioner immediately after they have been written on the order sheet to ensure accuracy."</p> <p>For Authentication of Orders, the policy stated "Verbal orders must be authenticated by the practitioner who originated the order in a timely manner as prescribed by law." The CAH staff did not follow the policy as follows:</p> <p>1. Patient #1 was a 19 year old female who was admitted to the CAH on 1/24/16, for induction of labor.</p> <p>a. Patient #1's record included pre-printed "OB Outpatient/Observation Orders." They were signed on 1/24/16 by her physician, however they did not include a time when they were written by the physician. Additionally, the orders were not noted by the RN.</p>	C 307		

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C 307	<p>Continued From page 43</p> <p>b. Patient #1's record included pre-printed "Intrapartum Provider Orders," that were not signed by her physician, The bottom of the form included a section titled "Cesarean Section Orders," signed by her physician, and dated, however they did not include a time as to when they were written. Additionally, the orders were not noted by the RN.</p> <p>c. Patient #1's record included pre-printed "Postpartum Provider Orders," signed by her physician on 1/24/16, but not timed. The order sheet included a written "add on" dated 1/26/16. The "Add on" was written in a different handwriting than the physician who signed the orders. It read "Lactation rounds: recommend pt has electric breast pump prior to discharge." The "Postpartum Provider Orders" were not noted by the RN.</p> <p>d. Patient #1's record included an order clarification dated 1/25/16, however it was not timed. The "Order clarification" was noted as a T.O.R.B., however the RN included her name followed by her name. The physician name was not written by the RN. The order was authenticated by the physician, however, it did not include a time or date when it was authenticated.</p> <p>e. The physician wrote an order on 1/25/16 at 8:20 AM, for Rhogam. The order was noted by the RN, however she did not include the date or time when the order was noted. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.</p> <p>2. Patient #18 was a newborn male who was born at the CAH on 12/20/15.</p>	C 307		

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C 307	<p>Continued From page 44</p> <p>a. The CNM wrote orders for Patient #18 to be transferred to a higher level of care on 12/20/15 at 8:00 PM. The orders were not noted by the RN.</p> <p>b. The CNM wrote an order for Patient #18 to receive an IV at 8:10 PM on 12/20/15. The order was not noted by the RN.</p> <p>c. Pre-printed orders titled "Newborn Nursery Provider Orders," dated 12/20/15 at 10:00 PM. The pre-printed orders were not noted by an RN. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.</p> <p>3. Patient #21 was a 25 year old female who was admitted to the CAH on 12/20/15, in active labor.</p> <p>a. Patient #21's record included admission orders, documented as T.O.R.B, from the CNM. However, the RN who wrote the order did not document a date or a time when the telephone order was received, and the order was not noted by an RN. The order was authenticated by the CNM on 12/26/15 at 9:00 PM.</p> <p>b. Patient #21's record included pre-printed "Intrapartum Provider Orders." The first section of the order sheet was documented as T.O.R.B the midwife/RN name. However, the telephone order was dated 12/20/15, and no time was documented as to when she received the order. Additionally, the order did not include evidence it was noted by the RN.</p> <p>c. Patient #21's record included pre-printed "Postpartum Provider Orders." They were signed and dated, however the CNM did not include a time when she wrote the orders.</p>	C 307			

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C 307	Continued From page 45  d. Patient #21's record included orders written on 12/21/15 at 8:45 AM, by the CNM. The orders stated "Discharge home, F/U 6 weeks." However the orders were not noted by an RN. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  4. Patient #5 was a 24 year old female who was admitted to the CAH on 12/01/15, in active labor.  a. Order written 12/01/15 at 3:15 PM, "Discharge home, F/U [follow up] 2 weeks." The order was signed by the CNM, however it was not noted by an RN.  b. Order dated 12/01/15, but not timed "Do A1C before discharge. T.O.R.B. [CNM name/RN name]." The order was authenticated on 12/07/15 by the CNM at 8:30 AM. The order was not noted by the RN, and the result was not in Patient #5's record. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  5. Patient #6 was a 19 year old female who was admitted to the CAH on 8/18/15, in active labor, which was premature labor. She delivered a preterm male infant that was transferred to a higher level of care.  Patient #6's physician wrote orders on 8/18/15 at 5:30 AM, however they were not noted by the RN. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  6. Patient #19 was a 19 year old female who was admitted to the CAH on 3/10/16, for induction of labor.	C 307			

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C 307	Continued From page 46  The CRNA completed a pre-printed "Epidural Standing Orders," on 3/10/16 at 4:00 AM. However, the orders were not noted by an RN. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  7. Patient #3 was a 24 year old female who was admitted to the CAH on 1/29/16, for induction of labor.  Her record included orders dated 1/29/16 at 7:30 AM. The order was "Admit to Inpt [inpatient] status for induction of labor. V.O.R.B. [physician name/RN name]. The order included a signature indicating it was authenticated, however, it did not include a time or date when the physician authenticated it. Additionally, the order was not noted by the RN. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  8. Patient #4 was a newborn male who was born at the CAH on 1/29/16.  Pre-printed orders titled "Newborn Nursery Provider Orders," were signed as T.O.R.B. on 1/29/16 at 7:58 PM. The orders were authenticated, however, the physician did not include a time or date when he authenticated the orders. This was confirmed during an interview with the SME on 3/16/16 beginning at 9:00 AM.  The CAH did not ensure orders were written and received accurately and completely.	C 307			
C 322	485.639(b) ANESTHETIC RISK & EVALUATION  (1) A qualified practitioner, as specified in	C 322			

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C 322	<p>Continued From page 47</p> <p>paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.</p> <p>(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.</p> <p>(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the CAH failed to ensure a post-anesthesia evaluation was completed by an individual qualified to administer anesthesia. This directly impacted 1 of 7 obstetrical patients (Patient #3) whose records were reviewed. This had the potential to result in negative patient outcomes. Findings include:</p> <p>Patient #3 was a 24 year old female who was admitted to L&amp;D on 1/29/16, for induction of labor. Patient #3 delivered a baby boy on 1/29/16. Complications included failure of labor to progress, and a Cesarean Section was performed.</p> <p>Patient #3 received a spinal anesthetic for the Cesarean Section. The spinal was administered by a CNRA. A form titled "Anesthesia Evaluation," was found in Patient #3's record. The form included a section titled "Postanesthesia Note". This section was to document cardiopulmonary status, LOC, follow up care or observations. The section also included 2 boxes to check, if applicable, for "No</p>	C 322			

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C 322	<p>Continued From page 48</p> <p>apparent anesthesia complications at this time" and "See progress notes." The section included a signature line with date and time. This section of the form was blank. The form was not signed or dated.</p> <p>During an interview on 3/16/16 beginning at 3:30 PM, the SME reviewed Patient #3's record and confirmed the section of the form to be completed by the CRNA was blank. She confirmed a post-anesthesia evaluation was not documented by the CRNA.</p> <p>Patient #3 did not receive a post-anesthesia evaluation by the CNRA.</p>	C 322			

St. Luke's Jerome Corrective Action Plan for Idaho Health and Welfare 2567 Report received 4/1/2016

**CORRECTIVE ACTION PLAN for BB115, BB144, BB180**

The Governing Body of St. Luke's Jerome is accountable for immediate implementation of these Plans of Correction and has delegated direct oversight and responsibility to the St. Luke's Jerome Site Administrator. Supporting the implementation are the Interim Regional CEO, Medical Executive Committee (MEC) and related medical staff departments, and Hospital leadership. The MEC has direct physician oversight responsibility related to this plan and is assigned to review all results and direct further action to assure improvement and to sustain this action. The Leadership has delegated assignments and action to all appropriate clinical leadership to resolve, monitor, report, and sustain improvements documented in the Plan of Correction. Our Leadership team is committed to do everything within our ability to ensure a successful implementation of the Plan of Correction.

*See Corrective Action Plan for C 152*

*See Corrective Action Plan for C 240*

*See Corrective Action Plan for C 241*

*See Corrective Action Plan for C 253*

*See Corrective Action Plan for C 257*

*See Corrective Action Plan for C 265*

*See Corrective Action Plan for C 275*

*See Corrective Action Plan for C 296*

*See Corrective Action Plan for C 297*

*See Corrective Action Plan for C 298*

*See Corrective Action Plan for C 304*

*See Corrective Action Plan for C 307*

*See Corrective Action Plan for C 322*

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APR 11 2016

FACILITY STANDARDS

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**CORRECTIVE ACTION PLAN for C 152 (Curtis Moler, Site Administrator, is responsible for the completion of this corrective action plan)**

1. Institute defined practice and scope for certified nurse midwives (CNM) at Jerome:
  - a. Scope document will specifically state the facility's level of care. Document to be disseminated to, and signed by, CNMs practicing at St. Luke's Jerome with a goal of 100% by 04/20/2016
  - b. Scope document will outline when a consult, referral, or co-management is required with a physician. The goal will be approval of scope document at the Department of Primary Care and subsequently reported in the General Medical Staff meeting both on 4/19/2016. Document to be disseminated to in-scope staff at St. Luke's Jerome with a goal of 90% by 04/20/2016.

**Completion Date: 4/20/2016**

2. Staff educational document (Single-point lesson) will be disseminated to in-scope staff covering:
- a. CNM scope of practice
  - b. process to verify provider privileges
  - c. chain of command for the CNM

Document to be disseminated to in-scope staff at St. Luke's Jerome with a goal of 90% capture.

Completion Date: 4/20/2016

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***CORRECTIVE ACTION PLAN for C 240 (Curtis Maier, Site Administrator, is responsible for the completion of this corrective action plan)***

A comprehensive process for analysis and improvement of the facility's diversion status will be formalized. The process will involve the following elements:

- a. Revision of the diversion log that includes re-evaluation of diversion status every 12 hours.
- b. Risk Assessment Mapping Tool was demonstrated to the East Region senior leadership and Board to assess key facility risks. The tool identified diversion and staffing as risks. The summary of this exercise was discussed at the Finance and Planning Committee on 4/7/16.
- c. Facility capacity for swing bed has been defined by MEC on 4/5/16. Outside swing bed referrals will be capped when the swing bed census reaches 6.
- d. Presentation to East Region Finance and Planning Board Committees on 4/7/16 covering the facility's identification and actions to mitigate diversion.
- e. Create a presentation that addresses diversion by 4/20/16 for the East Region Quality, Safety and Service Excellence Committee Board.

Diversion will be logged, tracked by number of hours, service line and the number of patients diverted. This data will be reported monthly to Quality Assurance and Performance Improvement (QAPI) and MEC for recommendations and action. The goal is to have accurate and timely data presented to QAPI and MEC for recommendations and action planning with an overarching goal to reduce diversion. QAPI and MEC minutes are reported to the East Region Quality, Safety, and Service Excellence Committee Board. Minutes will reflect acknowledgement and approval of identified actions to address diversions.

Completion Date: 4/20/2016

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***CORRECTIVE ACTION PLAN for C 241 (Curtis Maier, Site Administrator, is responsible for the completion of this corrective action plan)***

A comprehensive process for analysis and improvement of the facility's diversion status will be formalized. The process will involve the following elements:

- a. Revision of the diversion log that includes re-evaluation of diversion status every 12 hours.
- b. Risk Assessment Mapping Tool was demonstrated to the East Region senior leadership and Board to assess key facility risks. The tool identified diversion and staffing as risks. The summary of this exercise was discussed at the Finance and Planning Committee on 4/7/16.
- c. Facility capacity for swing bed has been defined by MEC on 4/5/16. Outside swing bed referrals will be capped when the swing bed census reaches 6.
- d. Presentation to East Region Finance and Planning Board Committees on 4/7/16 covering the facility's identification and actions to mitigate diversion.
- e. Create a presentation that addresses diversion by 4/20/16 for the East Region Quality, Safety and Service Excellence Committee Board.

Diversion will be logged, tracked by number of hours, service line and the number of patients diverted. This data will be reported monthly to Quality Assurance and Performance Improvement (QAPI) and MEC for recommendations and action. The goal is to have accurate and timely data presented to QAPI and MEC for recommendations and action planning with an overarching goal to reduce diversion. QAPI and MEC minutes are reported to the East Region Quality, Safety, and Service Excellence Committee Board.

Minutes will reflect acknowledgement and approval of identified actions to address diversions.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 253 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

The facility staffing model is currently under review. As part of the staffing plan review, a proposal has been submitted and approved for an additional 12 hours per day RN coverage to support bedside nursing needs.

Review will be made to ensure:

a. An adequate number of staff are scheduled who have obstetrical training to provide quality of care for births and expecting mothers

b. An OB trained RN is available for care or as a nursing resource for Mother/Baby patients during each shift

c. Increase cross training of staff for wider distribution of nursing skill sets. Recent education consists of: simulation on "Abrupton Delivery -- NRP/ Stables" conducted 3/2/16 and 3/31/16 with 41 participants including nursing, respiratory, laboratory, imaging, CNM and physicians.

Diversion related to staffing concerns will be logged, tracked by number of hours, service line and the number of patients diverted. This data will be reported monthly to QAPI and MEC for recommendations and action. The goal is to have accurate and timely data presented to QAPI and MEC for recommendations and action planning with an overarching goal to reduce diversion.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 257 (Joshua Kern, Chief of Staff, is responsible for the completion of this corrective action plan)***

Institute defined practice and scope for CNMs at Jerome which will include MD/DO role in providing medical direction. CNM defined scope will be submitted for approval to the Department of Primary Care and then subsequently reported to the General Medical Staff both on 04/19/2016. A goal of 100% for dissemination to MD/DOs deemed to be in-scope.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 265 (Joshua Kern, Chief of Staff, is responsible for the completion of this corrective action plan)***

1. Institute defined practice and scope for CNMs at Jerome. Document to be disseminated to, and signed by, CNMs practicing at St. Luke's Jerome with a goal of 100% by 04/20/2016.

**Completion Date: 4/20/2016**

2. Staff educational document (Single-point lesson) will be disseminated to in-scope staff covering: CNM scope of practice and privileges, how to verify provider privileges, and medical staff peer review process. Results to be reported to Jerome leadership by 4/20/2016. A goal of 100% for dissemination to in-scope nursing staff. Results to be reported to Jerome leadership by 4/20/2016.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 275 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

A medical management policy will be drafted and then presented for approval to the Department of Primary Care and subsequently reported to the General Medical Staff both on 04/19/2016. Document to be disseminated to all in-scope staff practicing at St. Luke's Jerome with a goal of 100% by 04/20/2016.  
**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 296 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

1. Staff educational documents (Single-point lesson) will be disseminated to in-scope staff covering: MDRO (MRSA/ VRE) Screening Process, use of Terbutaline, use of Magnesium Sulfate, and use of Fentanyl specific to nursing considerations for monitoring and assessment including vital signs. Instructor led education sessions will be held for all in-scope staff. Attendance rosters will be maintained with goal of 90% in-scope staff participation by 4/20/2016. Results to be reported to Jerome leadership by 4/20/2016.  
**Completion Date: 4/20/2016**

2. A self-guided educational document titled Fundamentals of Documentation – Risk Management & Legal Issues was disseminated on 3/21/2016. Documents to be disseminated to all in-scope staff practicing at St. Luke's Jerome with a goal of 100% capture. Results to be reported to Jerome leadership by 4/20/2016.  
**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 297 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

1. The Policy # PC 113 JR Magnesium Sulfate Administration for Pre-Eclampsia and Preterm Labor will be reviewed and, if necessary, revised by the Department of Primary Care Chair with finalization and dissemination of the policy to all in-scope staff.  
**Completion Date: 4/20/2016**

2. Staff educational documents (Single-point lesson) will be disseminated to in-scope staff covering complete medication orders, required elements for medication orders, medication administration clinician commitment, provider orders and documentation. Instructor led education sessions will be held for all in-scope staff. Attendance rosters will be maintained with a goal of 90% in-scope staff participation by 4/20/2016. Results to be reported to Jerome leadership by 4/20/2016.  
**Completion Date: 4/20/2016**

3. A self-guided educational document titled Fundamentals of Documentation – Risk Management & Legal Issues was disseminated on 3/21/2016. Documents to be disseminated to all in-scope staff practicing at St. Luke's Jerome with a goal of 100% capture.  
**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 298 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

1. Implementation of a Documentation Chart Audit Tool. A sample size of 5 Med-Surg /swing bed chart and 100% of Mother/Baby chart audits will occur weekly. Audit results will be reported along with subsequent corrective action plans to QAPI on a monthly basis with a goal of 90% compliance over a consecutive 3-month period.

**Completion Date: 4/20/2016**

2. Staff educational documents (Single-point lesson) will be disseminated to in-scope staff practicing at St. Luke's Jerome covering requirements of an individualized care plan with a goal of 100% capture.

**Completion Date: 4/20/2016**

3. Instructor led education sessions will be held for all in-scope staff. Attendance rosters will be maintained with a goal of 90% in-scope staff participation by 4/20/2016. Results to be reported to Jerome leadership by 4/20/2016.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 304 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

1. A printer issue was identified in which only page 2 of the admission consent form was being printed. This issue was corrected on 04/01/2016. The current admission consent form was reviewed. Inclusion of complete and appropriate admission consent forms have been audited weekly with a 100% success rate. The audits will continue for approximately one month to ensure the issue has been resolved.

**Completion Date: 4/1/2016**

2. Staff educational documents (Single-point lesson) will be disseminated to in-scope staff covering requirements of a complete consent with a goal of 100% capture. Review and revision of current consents is in progress to ensure a place to document date and time with a goal of 90% compliance over a consecutive 3-month period.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 307 (Jill Howell, Director of Nursing Services, is responsible for the completion of this corrective action plan)***

1. Implementation of a Documentation Chart Audit Tool. A sample size of 5 Med-Surg /swing bed chart and 100% of Mother/Baby chart audits will occur weekly. Audit results will be reported along with subsequent corrective action plans to QAPI on a monthly basis with a goal of 90% compliance over a consecutive 3-month period.

**Completion Date: 4/4/2016**

2. Staff educational documents (Single-point lesson) will be disseminated to in-scope staff which includes read-back telephone orders, correction of mistakes, sign/date/time, noting and authentication of physician orders with a goal of 100% capture.

**Completion Date: 4/20/2016**

3. Instructor led education sessions will be held for all in-scope staff. Maintain attendance rosters with goal of 90% in-scope staff participation by 4/20/2016. Results to be reported to Jerome leadership by 4/20/2016.

**Completion Date: 4/20/2016**

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***CORRECTIVE ACTION PLAN for C 322 (Joshua Kern, Chief of Staff, is responsible for the completion of this corrective action plan)***

Chart audits of surgical and inpatient charts will occur to ensure there is a post-anesthesia evaluation. Audits of 100% of surgery charts including C-sections will occur following each surgery. Audit results will be reported along with subsequent corrective action plans to Jerome's QAPI Committee each month until the goal of 100% completion over 3 consecutive months has been reached.

**Completion Date: 4/20/2016**