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
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September 20, 2016

Lenne Bonner, Administrator
St Mary's Hospital
PO Box 137
Cottonwood, ID 83522

RE: St Mary's Hospital, Provider #131321

Dear Mr. Bonner:

Based on the survey completed at St Mary's Hospital, on September 2, 2016, by our staff, we have determined St Mary's Hospital, is out of compliance with the Medicare Hospital Conditions of Participation of **Organizational Structure (42 CFR 485.627) and Surgical Services (42 CFR 485.639)**. 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 Mary's Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;

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

Such corrections must be achieved and compliance verified by this office, before October 17, 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 October 9, 2016.

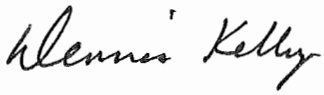
Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 3, 2016**.

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.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,



DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt
Enclosures
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Patrick Thrift, CMS Region X Office

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

PRINTED: 09/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131321	A. BUILDING--------- B. WING	09/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOSPITAL	701 LEWISTON ST COTTONWOOD, ID 83522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital conducted from 8/29/16 to 9/02/16. The surveyors conducting the Medicare recertification survey were: Gary Guiles, RN, HFS-Team Leader Brian Obsborn, RN, HFS Teresa Hamblin, RN, MS, HFS Kristin Inglis, RN, HFS Acronyms used in this report include: ABG - Arterial Blood Gas ACLS -Advanced Cardiac Life Support AORN- Association of periOperative Registered Nurses APIC- Association for Professionals in Infection Control and Epidemiology CAO - Chief Administrative Officer CAH - Critical Access Hospital CDC - Centers for Disease Control and Prevention C02 - Carbon Dioxide CRNA- Certified Registered Nurse Anesthetist DME - Durable Medical Equipment DO - Doctor of Osteopathy DON - Director of Nursing ED - Emergency Department EKG - Electrocardiogram EMLA- Eutectic Mixture of Local Anesthetics EMR - Electronic Medical Record EPA- Environmental Protection Agency ER - Emergency Room EVS - Environmental Services EZ- Easy F- Fahrenheit GA- Gauge	C 000		

RECEIVED
OCT 03 2016
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew W. Firge Matt Firge
TITLE: Chief Admin Officer
(X6) DATE: 9/20/16

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 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 000	Continued From page 1 GCA- General Consent for Authorization H&P - History and Physical IDAPA- Idaho Administrative Procedures Act IO - Intraosseous I/O - Input/Output IV - Intravenous Kg- Kilogram MAR- Medication Administration Record MD - Doctor of Medicine MG - Milligram ml - Milliliter mm - Millimeter NCP - Nursing Care Plan NP- Nurse Practitioner NS - Normal Saline O2- Oxygen OB- Obstetrics OR - Operating Room PA- Physician Assistant PACU- PostAnesthesia Care Unit PICC - Peripherally Inserted Central Catheter PPE - Personal Protective Equipment PRN - As Needed PT- Patient RN- Registered Nurse SMH - Saint Mary's Hospital SNF -Skilled Nursing Facility TPN -Total Parenteral Nutrition VAD- Vascular Access Device	C 000		
C 203	485.618(b)(1) DRUGS AND BIOLOGICALS [The items available must include the following:] Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics,	C 203	C 203 – 485.61 (b) (1) Drugs and Biologicals 1. Corrective action a. Emergency Code carts were pulled from the different units and inventoried. i. Emergency Department (4 units) ii. Nursery (1 unit) iii. Nursing Floor (1 unit) b. Inventory lists were updated and reflected to match products in carts. c. Audit sheets on carts confirming outdates were completed monthly. d. Reporting monthly to Quality Assurance, Director of Nursing, and ED committee along with posting results in the nurses report room. 2. Description of how the actions will improve process that led to deficiency: a. Audit process by posting as well as reporting results in committee will follow and ensure compliance. b. Deficiencies may impact re-credentialing possibilities. Individual corrective action process to engage with non-compliance. 3. Procedure for implementing the plan: a. Communications sent out the nursing staff September 21, 2016 regarding monthly code cart updates. Communication included monthly audit calendar and sample of audit tool. b. Policy was reviewed, and sent to nursing staff for required reading. c. Continue monthly audits d. Ongoing communication of deficiencies to Quality Assurance, Director of Nursing, and ED committee.	

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C 203	Continued From page 2 and electrolytes and replacement solutions. This STANDARD is not met as evidenced by: Based on observation, policy review, document review, and staff interview, it was determined the CAH failed to ensure all drugs and biologicals used in life-saving procedures were not expired and readily available for all patients receiving care in the CAH. This resulted in the potential for patients' health and safety to be compromised in the event of a medical emergency. Findings include: A policy "Crash Cart Check, Monthly/Daily," dated 1/27/14, was reviewed. The policy included the following information: - "All carts will be opened and checked for contents once monthly and following each use." - "These medications may also be removed, replaced or audited by the licensed pharmacist for the facility." The CAH failed to ensure all emergency medications were not expired and readily available for use in emergency situations as follows: An observation was conducted of Treatment Room #1 on 9/01/16, beginning at 1:30 PM, in the presence of the Director of Nursing. During the observation, Treatment Room #1's emergency crash cart was opened and contents inspected. A bag of Dopamine, a medication used in emergency situations to increase a patient's low blood pressure, was noted to have an expiration date of 5/2016, which was confirmed by the Director of Nursing at the time of the observation.	C 203	Continued C203 4. Completion date for correction: initial action plan complete October 3, 2016. a. Ongoing audits and reporting b. Results of CMS survey and plan of correction to be presented by October 3rd 5. Monitoring and tracking mechanism to ensure compliance with regulation a. Refer to plan of correction 1a-d 6. Include title of person responsible for implementing the plan a. Director of Quality Assurance b. Director of Nursing c. Emergency Department Coordinator d. Nursery Coordinator	

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C 203	Continued From page 3 The Director of Nursing stated the contents of crash carts were to be audited monthly to ensure no equipment or medications were outdated. She stated nursing staff were assigned monthly by the Emergency Department Coordinator to audit each crash cart's contents and medications. The Emergency Department Coordinator was interviewed on 9/01/16, beginning at 3:00PM. He stated he assigned nursing staff, on a monthly rotational basis, to open and inspect each crash cart for equipment and medication content as well as check for expired items. The Emergency Department Coordinator stated he used a CAH document, "Monthly Crash Cart 2016 Check List Schedule," to track the assignment and completion of crash cart checks. The CAH document was reviewed in the Emergency Department Coordinator's presence and noted to be blank. He confirmed the CAH document had not been filled out since the beginning of 2016. Four additional CAH documents were reviewed in the presence of the Emergency Department Coordinator: - "Main ER Crash Cart." The last date of entry on this form was 12/02/15. - "Treatment Room Crash Cart." The last date of entry on this form was 8/29/14. - "Floor Crash Cart." The last date of entry on this form was 1/05/16. - "Braslow Crash Cart." The last date of entry on this form was 11/25/15. The Emergency Department Coordinator confirmed the CAH documents did not have updated entries.	C 203		

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C 203	Continued From page 4 The CAH failed to ensure all drugs and biologicals used in life-saving procedures were not expired and readily available for all patients receiving care in the CAH.	C203		
C 204	485.618(b)(2) EQUIPMENT AND SUPPLIES [The items available must include the following:] Equipment and supplies commonly used in life saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters. This STANDARD is not met as evidenced by: Based on observations, document review, policy review, and staff interviews, it was determined the CAH failed to ensure emergency medical equipment was maintained. This resulted in the potential for patients' health and safety to be compromised in the event of a medical emergency. Findings include: A policy "Crash Cart Check, Monthly/Daily," dated 1/27/14, was reviewed. The policy included the following information: - "A Licensed Staff member as designated by the head of the department is responsible for checking the crash cart and documenting compliance on crash cart checklist." - "Crash cart/defibrillators daily checks will be performed every shift and recorded. This will document that all external supplies and equipment are present and in working order on a daily basis."	C204	C 204 – 485.618 (b) (2) Equipment and Supplies 1. Corrective Action a. Emergency code carts were pulled for nursing units i. Emergency Department (4) ii. Nursing Floor (1) iii. Nursery (1) b. Code cart check sheets were reviewed and updated to meet the checklist criteria. c. Audit sheets on carts confirming code care were reviewed daily. d. Reporting monthly to Quality Assurance, Director of Nursing, and ED committee along with posting results in the nurses report room. 2. Description of how the actions will improve process that led to deficiency: a. Posting results as well as reporting results in committee will ensure compliance. b. Deficiencies may impact re-credentialing possibilities. Individual corrective action process to engage with non-compliance.	

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C 204	Continued From page 5 - "All carts will be opened and checked for contents once monthly and following each use." - "Oxygen cylinders are replaced when the tank has emptied. This will be done with the daily cart checks." Additionally, a policy "Equipment and Supplies; Location, Storage, and Procurement," dated 11/04/13, was reviewed. The policy stated "Emergency equipment is checked every 8 - 12 hours and at the time of used [sic] to ensure functioning of the equipment." The CAH failed to follow their policies and ensure all emergency medical equipment was maintained for all patients. Examples include: 1. The Treatment Room #1 crash cart was observed in the presence of the Director of Nursing on 9/01/16, beginning at 1:30PM. The following items inside the crash cart were expired: - Two ABG needles, expired on 8/2016 and 10/2014. - Nasopharyngeal airway, expired on 5/2015. - NS 10 ml flush, expired on 8/2015. - Six 18 GA IV needles, each expired on 3/2016. - IV start kit, expired on 1/2014. During the observation the Director of Nursing stated the contents of crash carts were to be audited monthly to ensure no equipment or medications were outdated. She stated nursing staff were assigned monthly by the Emergency Department Coordinator to audit each crash cart's contents and medications. She confirmed the above items were expired. 2. The floor crash cart was observed in the presence of the Emergency Department	C204	3. Procedure for implementing the plan: a. Communications sent out the nursing staff September 21, 2016 regarding daily code cart updates. Communication included daily audit calendar and sample of audit tool. b. Policy was reviewed, and sent to nursing staff for required reading. c. Continue daily audits d. Ongoing communication of deficiencies to Quality Assurance, Director of Nursing, and ED committee. 4. Completion date for correction: Initial action plan completed by October 3, 2016. a. Ongoing audits and reporting monthly. b. Results of CMS survey and plan of correction to be presented by October 3rd 5. Monitoring and tracking mechanism to ensure compliance with regulation. a. Refer to plan of correction 1a-d 6. Include title of person responsible for implementing the plan a. Director of Quality Assurance b. Director of Nursing c. Emergency Department Coordinator d. Nursery Coordinator	

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C 204	Continued From page 6 Coordinator on 9/01/16, beginning at 11:25 AM. The following items inside the crash cart were expired: - Fluid transfer set with female luer lock, expired 3/2012. - A 25 mm 15 GA 10 needle set, expired 4/2016. - Colormetric, expired 2/2016. - C02 detector, expired 4/2016. - Three nasopharyngeal airways, expired on 4/2016,2/20/16, and 7/2011. The Emergency Department Coordinator confirmed the crash cart did not have an oxygen tank as part of its equipment and confirmed the above items were expired. 3. Four additional CAH documents were reviewed in the presence of the Emergency Department Coordinator: - "MainER Crash Cart." The last entry on this form was 12/02/15. - "Treatment Room Crash Cart." The last entry on this form was 8/29/14. - "Floor Crash Cart." The last entry on this form was 1/05/16. - "Braslow Crash Cart." The last entry on this form was 11/25/15. the Emergency Department Coordinator confirmed the 4 CAH documents did not have updated entries. 4. The CAH document "Daily Crash Cart Checklist" was reviewed for 3 crash carts. The documents were incomplete. Examples included: - "Main ER Crash Cart" checklist had missing entries on 6/29/16, 7/10/16, 7/13/16, 7/14/16, 7/24/16, 7/30/16, 8/06/16, 8/16/16, and 8/22/16. - "Treatment Room 1 Crash Cart" checklist had	C204		

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C 204	Continued From page 7 missing entries on 6/29/16, 7/01/16, 7/06/16, 7/09/16, 7/10/16, 7/14/16, 7/20/16, 7/22/16, 7/26/16, 7/30/16, 7/31/16, 8/01/16, 8/05/16, 8/06/16, 8/08/16, 8/16/16, 8/18/16, 8/22/16, 8/24/16, and 8/29/16-c. "Floor Crash Cart" checklist had missing entries on 6/29/16, 7/01/16, 7/04/16, 7/09/16, 7/10/16, 7/11/16, 7/12/16, 7/13/16, 7/16/16, 7/30/16, 8/01/16, 8/02/16, 8/08/16, 8/16/16, 8/18/16, and 8/28/16. The Emergency Department Coordinator was interviewed again on 9/01/16, beginning at 3:00 PM. He stated he assigned nursing staff to open and inspect each crash cart for equipment and medication content as well as check for expired items. The Emergency Department Coordinator confirmed the missing daily crash cart checklist entries. The CAH failed to follow their policies and ensure all emergency medical equipment was maintained for all patients receiving care at the facility.	C204		
C 224	485.623(b)(3) MAINTENANCE [The CAH has housekeeping and preventive maintenance programs to ensure that–] drugs and biologicals are appropriately stored; This STANDARD is not met as evidenced by: Based on observations, review of pharmaceutical security requirements referenced in IDAPA rules, and staff interviews, it was determined the CAH failed to develop a policy related to medication storage and security and failed to ensure all	C224		

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C 224	Continued From page 8 medications were properly stored and locked for all patients receiving care at the facility. This resulted in the potential for unsecured medications being accessible to the public and staff without accountability. Findings include: A policy was requested related to medication storage and security. None was provided. IDAPA 16.03.14.330.06 references pharmaceutical security requirements. It stated "All prescribed medications shall be under lock and schedule II drugs shall be double-locked." The CAH failed to ensure all medications were properly stored and locked. Examples include: 1. An observation was conducted of the Emergency Department, in the presence of the CAO, on 8/29/16, beginning at 2:00PM. During the observation, it was noted the medication cabinets located on the south wall were unlocked. Inside these cabinets were numerous intradermal anesthetics. The CAO confirmed, at the time of observation, the medications in the ED cabinets were not properly secured. 2. An observation was conducted of the CAH on-site, attached clinic, in the presence of the Clinic Manager and Clinic RN Supervisor, on 9/01/16, beginning at 10:01 AM. During the observation, the following unsecured medication locations were noted: a. Procedure Room - unlocked cabinets containing multiple intradermal anesthetics.	C224	**C 224 485.624 (b) (3) Maintenance** 1. Corrective Action a. Emergency Department cabinet was initially locked on date of inspection. A laceration cart has been assembled that will store numerous intradermal anesthetics. The laceration cart is locked with a key inaccessible to the general public and staff without accountability. b. Clinic procedure cabinet was fitted with a key lock. This locked cabinet will store numerous intradermal anesthetics. The key is inaccessible to the general public and staff without accountability. c. Supply closet in clinics with drug samples is now locked using the lock in the door knob in the door. d. Neonatal code cart was found without a red numeric key. A red numeric key was fastened to the cart. A daily check of this key is done and recorded on the Emergency Code cart daily check sheet. e. The OB delivery cart med box was unlocked with the keys inserted in the box. The box was locked and the key was removed and is now inaccessible to the general public and staff without accountability.	

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C 224	Continued From page 9 b. Supply Closet- unlocked closet containing multiple, non-narcotic "sample" medications. The categories of medications, labeled on shelves, included the following: - Respiratory - Antihypertensive - Antidepress mt - Anti-inflammatory - Diabetic - Cholesterol medications - Antibiotics The Clinic Manager and Clinic RN Supervisor confirmed the medications in these clinic areas were not properly secured. 3. An observation was conducted of the Nursery, in the presence of the Emergency Department Coordinator, on 9/01/16, beginning at 11:30 AM. During the observation, it was noted the neonatal cart was unlocked. Inside the unsecured cart were: - IV Epinephrine - IV Benadryl - IV Narcan The Emergency Department Coordinator confirmed the medications in the neonatal cart were not properly secured. 4. A second observation was conducted of the Nursery, in the presence of the DON, on 9/02/16, beginning at 10:00 AM. During the observation, it was noted the O8 delivery cart was unlocked. Inside the unsecured cart, in the top drawer, was an unlocked lock-box with the corresponding key inserted into the lock. Inside the lock-box were: - IV Epinephrine - IV Benadryl	C224	C224 Continued f. Cabinets containing newborn circumcision supplies with medications were found unlocked in the nursery workroom. This cabinet has been secured with a lock and the key is now inaccessible to the general public and staff without accountability. g. Cabinets in Purchasing containing overflow large volume medications were found unlocked and not properly secured. These medications have been moved to a secure cabinet that is locked. The key is located in a secure location. h. Policy for Management and Storage of Medication – In development. To be complete by October 17, 2016. 2. Description of how the actions will improve process that led to deficiency. a. By ensuring all medications are properly stored and locked, the safety of the general public and staff is improved. 3. Procedure for implementing plan a. Overall findings were presented to the Maintenance staff for assistance in securing medications. Locks were strategically placed to ensure medications were adequately secured.	

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	131321	A. BUILDING-------- B. WING	09/02/2016

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C 224	Continued From page 10 Additionally, during the same observation, several cabinets on the south wall of the Nursery Workroom were unlocked. The unsecured cabinets contained multiple, non-narcotic medications used for infant circumcision procedures. The DON confirmed, at the time of observation, the medications in the Nursery and Nursery Workroom were not properly secured. The CAH failed to ensure all medications were properly stored and locked.	C 224	C224 Continued b. Communication was sent to all nursing for assistance in securing medications. Nursing/Pharmacy was informed of location were keys are being kept. 4. Completion date for correction: All corrective action complete and operational by October 9, 2016. a. Locks were placed on clinic procedure cabinet, nursery circumcision cabinet, and pharmacy large volume cabinet in purchasing the week of September 22 2016. A red numeric key lock was placed on the nursery code cart September 6th. The clinic supply closet was locked by September 10th and labeled "To be locked at all times". The ED cupboards with medications remained lock until the laceration cart is assembled by October 3rd. 5. Monitoring and tracking mechanism to ensure compliance with regulations a. During code cart checks, the emergency room cupboard, laceration cart, nursery circumcision cupboard, and delivery cart will be checked for security, and recorded on the daily code cart check list for two months to ensure compliance. b. Clinic supply closet checked daily by clinic staff, and documented on the door weekly for two months to ensure compliance. 6. Include title of person responsible for implementing the plan a. Director of Maintenance b. Director of Pharmacy c. Director of Nursing	
C 240	485.627 ORGANIZATIONAL STRUCTURE Organizational Structure This CONDITION is not met as evidenced by: Based on review of policies and bylaws, staff interview, and observation, CAH leadership failed to ensure sufficient oversight to the functioning of the organization. This resulted in policies that were not developed, maintained, followed, or enforced related to surgical services, infection control, pharmaceutical services, and nursing services. This had the potential to interfere with quality and safety of patient care. Findings include: 1. Refer to C 203 as it relates to the failure of CAH leadership to ensure all drugs and biologicals used in life-saving procedures were not expired and readily available for all patients receiving care in the CAH in accordance with CAH policy. 2. Refer to C 204 as it relates to the failure of	C240		

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C 240	Continued From page 11 CAH leadership to ensure emergency medical equipment was maintained in accordance with CAH policy. 3. Refer to C 224 as it relates to the failure of CAH leadership to ensure a policy was developed for appropriate storage and security of medications and that medications were appropriately stored and secured. 4. Refer to C 271 as it relates to the failure of CAH leadership to ensure healthcare services were being provided in accordance with appropriately written policies. 5. Refer to C 272 as it relates to the failure of CAH leadership to ensure the policy development procedure addressed the requirement for NP/PA involvement and the failure to ensure policies were updated annually. 6. Refer to C 276 as it relates to the failure of CAH leadership to ensure pharmaceutical services were provided within standards of practice required by federal, state, and local laws. 7. Refer to C 278 as it relates to the failure of CAH leadership to ensure establishment of a current and reliable infection control system. 8. Refer to C 320 as it relates to the failure of CAH leadership to ensure surgical services were provided in a safe manner. The cumulative affect of these negative systemic practices resulted in the failure of CAH leadership to provide oversight to ensure care was provided in a safe and effective manner.	C240	C240: Please refer to the following corrective action plans: C203 C204 C224 C271 C272 C276 C278 C320 All corrective action plans will be complete by 10/9/2017, or as listed.	

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C 271	Continued From page 12	C 271	**C 271 485.635 (a) (1) Patient Care Policies**	
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on observation, policy review, and staff interview, it was determined the CAH failed to ensure healthcare services were provided in accordance with appropriately written policies. This resulted in services not being furnished in a consistent manner, and had the potential to result in avoidable, adverse patient outcomes. Findings include: The CAH failed to follow their policies. Examples include: 1. A policy "Terminal Cleaning," dated 4/15/09, was reviewed. The policy included "The disinfectant detergent solution used during terminal cleaning shall be freshly prepared, and shall be discarded immediately upon completion of the terminal cleaning." The following pre-mixed, terminal cleaning chemicals were noted during observations: a. An observation of Treatment Room #2 was conducted on 8/29/16, beginning at 2:30PM, in the presence of the CAO. An unlabeled spray bottle of Virex was noted with the word "Virex" handwritten on it. The spray bottle did not have the date and time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The CAO confirmed, at the time of observation, the spray bottle was not properly labeled, dated, timed, or discarded according to CAH policy.	C 271	1. Corrective Action a. Policy "Expired and Damaged Goods" was reviewed and updated. Department coordinators are to perform, or assign ancillary staff outdates monthly in their departments, and replace outdated supplies. b. Virex chemical to be eliminated, replaced by HDQC2, with dispensing machines. Tag will be placed on individual machines with appropriate information to meet code including product name, mix date, and expiration date. c. In-service to be completed October 6, 2016 to educate on updated chemicals and process. 2. Description of how the actions will improve process that led to a deficiency. a. Monthly outdate process will ensure products are not expired to prevent a potential adverse patient outcome. b. Deficiencies may impact re-credentialing possibilities. Individual corrective action process to be engaged for non-compliance.	

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C 271	Continued From page 13 b. An observation of Radiology was conducted on 8/29/16, beginning at 2:00PM, in the presence of the GAO. An unlabeled spray bottle of Virex was noted with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. Additionally, an unlabeled spray bottle of bleach was noted with the word "Bleach" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The GAO confirmed, at the time of observation, the spray bottles were not properly labeled, dated, timed, or discarded according to CAH policy. c. An observation of Ultrasound was conducted on 8/31/16, beginning at 9:36AM, in the presence of the Radiology Manager. An unlabeled spray bottle of Virex was noted with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The Radiology Manager confirmed, at the time of observation, the spray bottle was not properly labeled, dated, timed, or discarded according to CAH policy. d. An observation of room 147, in the ED, was conducted on 8/31/16, beginning at 2:00PM, in the presence of the GAO. An unlabeled spray bottle of Virex was noted with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. Additionally, an unlabeled spray bottle of Bleach was noted with	C 271	C271 Continued 3. Procedure for implementing the plan a. Communication was sent to Department coordinators, requiring monthly outdates. b. Outdate checklist was implemented for outdating process for Emergency Department and Labor/Delivery and Nursery. c. In-service to educate on new chemical and chemical dispensing process. Virex process to be eliminated. 4. Completion date for correction: Corrective action to be complete prior to October 9, 2017 a. Ongoing outdates and reports are done monthly b. In-service completed October 6, 2016 for new chemicals. c. New machines installed September 29, 2016. 5. Monitoring and Tracking mechanism to ensure compliance with regulations a. Refer to Plan of Correction 1a b. Outdate checklist are to be kept in the department for referral. c. Ongoing reporting to Quality Director monthly. d. New machines tags to be reviewed and updated daily, and upon refill. 6. Include the title of person responsible for implement the plan a. Director of Purchasing b. Director of Nursing c. Emergency Department Coordinator d. Labor/Delivery Coordinator e. Director of Environmental Service	

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C 271	Continued From page 14 the word "Bleach" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The CAO confirmed the spray bottles were not properly labeled, dated, timed, or discarded according to CAH policy. 2. A policy "Expiration Dates For Sterile Items," dated 12/11/14, was reviewed. The policy included "Items purchased as sterile should be used according to the manufacturer's directions. This may be either a designated expiration date, or a day-to-day expiration date such as 'sterile unless the integrity of the package is compromised.'" The following expired items were noted during observations: a. An observation of room 147, in the ED, was conducted on 8/29/16, beginning at 2:00PM, in the presence of the CAO. The following items were expired: - Two EZ Scrub 107, expired 3/2016 - Clorox Wipes for Healthcare, expired 6/22/16 The CAO confirmed the expired dates. b. An observation of room 147, in the ED, was conducted on 8/31/16, beginning at 2:00PM, in the presence of the CAO. The following items were expired: - All Sexual Assault Kits, expired 5/2015 The CAO confirmed the items were expired.	C 271		

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C 271	Continued From page 15 c. An observation of the CAH's attached clinic was conducted on 9/01/16, beginning at 10:01 AM, in the presence of the Clinic Manager. The following items were expired: - Two IV caps, expired 3/2015 - A bottle of 70% Isopropyl alcohol, expired 2/12/15 - Three containers of Clorox Wipes for Healthcare, expired 6/22/16 The Clinic Manager confirmed the items' expiration dates. d. An observation of the emergency equipment in the Nursery was conducted on 9/02/16, beginning at 10:00 AM, in the presence of the ED Coordinator. The following items were noted to be expired: - Needle Aspiration Kit, expired 7/2016 - Pneumothorax Needle, expired 8/2016 - Two Stylets, expired 3/24/16 The ED Coordinator confirmed the items were expired. e. An observation of the Chemical Closet was conducted on 9/01/16, beginning at 11:45 AM, in the presence of the EVS Manager. The following items were expired: - One bottle of 70% isopropyl alcohol, expired 10/2010 - Five bottles of Activate Bleach Hospital Cleaner and Disinfectant, expired 5/22/16 - Three containers of Clorox Wipes for Healthcare, expired 2/2015, 3/2016, and 11/05/15 - Two containers of Purel Gel, expired 2/2015	C 271		

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C 271	Continued From page 16 and 6/2015 The EVS Manager confirmed, at the time of the observation, the items' expiration dates. f. An observation of Treatment Room #1 was conducted on 9/01/16, beginning at 1:30PM, in the presence of the DON. The following items were expired: - Clorox Wipes for Healthcare, expired 6/22/16 The DON confirmed the items were expired. g. An observation of the Nursery was conducted on 9/01/16, beginning at 1:30PM, in the presence of the DON. The following items were expired: - Four 3.0 Chromic Gut, expired 1/2016 - Two 8.5 Sterile Gloves, expired 5/2016 - Two 8.5 Sterile Gloves, expired 3/2015 - Sterile Gown, expired 3/2014 The DON confirmed the items were expired. The CAH failed to follow their policies.	C 271		
C 272	485.635(a)(2), (a)(4) PATIENT CARE POLICIES §485.635(a)(2) The policies are developed with the advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff under the provisions of §485.631(a)(1). §485.635(a)(4) These policies are reviewed at least annually by the group of professional	C 272		

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C 272	Continued From page 17 personnel required under paragraph (a)(2) of this section, and reviewed as necessary by the CAH. This STANDARD is not met as evidenced by: Based on policy review and staff interview, the CAH failed to ensure the policy "Policy Development" addressed the requirement for NP/PA involvement. It also failed to ensure policies were updated annually. This had the potential for staff to operate on outdated information which could impact the quality and safety of patient care. Findings include: 1. The policy "Policy Development," dated 5/11/16, was reviewed. It stated the following: - "All clinical policies and procedures are reviewed a minimum [sic] every 12 months unless otherwise required by regulation." - The CAH's "Director of Nurses will approve clinical nursing policies." - The CAH's "Medical Staff, upon recommendation of the Hospital's respective Clinical Coordinators and Director of Nursing, will approve nursing policies with direct clinical care implications for patients, including nursing policies for IV medication administration, standing protocols and orders." The CAH's list of employees included one PA and 4 NPs. The policy did not address the requirement to have policies developed with the advice of members of the CAH's professional healthcare staff, including one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff.	C272	C272 485.635 (a)(2), (a)(4) Patient care Policies 1. Corrective Action: a. The policy "Policy Development" was reviewed. This policy was revised to include the wordage "the advice of members of SMH/CVHC professional health care staff". b. Policy review will be conducted in the monthly Medical Staff meeting and recorded in the minutes. c. Policy review and approval will be included in the monthly department meetings and recorded in the committee minutes. d. Nurse Practitioners and Physician Assistants added to departmental committees for October departmental meetings, to contribute to policy development and review. e. Clinical policies listed and action taken:	

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C 272	Continued From page 18 The President and GAO were interviewed together on 9/01/16 beginning at 4:12PM. They stated that the PA and NPs were not involved in policy development but they did have an opportunity to comment on policies prior to finalization. The policy did not address the requirement for policies to be developed with the advice of members of the CAH's professional healthcare staff, including one or more physician assistants or nurse practitioners who are on staff. 2. A 10 page list of policies was provided by the GAO for surveyor review. The list included the titles of the policies, the document owners, the dates submitted, and the dates approved. The date of last review was not specifically listed. The list did not separate clinical policies from operational policies. The CAO was interviewed on 8/29/16 at 3:50PM. He stated that the "date approved" was also the last revised or reviewed date. He stated the plan was to review the policies annually, he was aware some policies were outdated, and they were in the process of updating policies. The following is a sample of clinical policies and their last review/revision dates, showing they had not been reviewed within the prior year: - ACLS, 6/16/14 - Administration and Ordering ofTPN, 10/06/14 - Adverse Drug Reaction, 11/20/08 - Alcohol Withdrawal, 6/16/14 - Aminoglycosides (Collaborative Drug Therapy Management Protocol), 09/24/13 - Aspiration Precautions, 3/04/14	C272	C 272 Continued i. ACLS – reviewed 09/2016 ii. Administration and Ordering of TPN – reviewed 09/2016 iii. Adverse Drug Reaction – Action Completed by 10/9/2016 iv. Alcohol Withdrawal – reviewed 09/2016 v. Aminoglycosides (Collaborative Drug Therapy Management Protocol) Action Completed by 10/9/2016 vi. Aspiration Precaution – reviewed 8/2016 vii. Assessment Postpartum Patient – approved 09/2016 viii. Assessment, Surgical Patient in the OR – reviewed 7/7/2016 ix. Blood Transfusion - Reviewed 09/2016 x. Blood borne Pathogens – reviewed 09/2016 xi. Cardiac Rehab – Emergency Response – reviewed 09/2016 xii. Code Blue – Cardiac Arrest- reviewed 09/2016 xiii. Colostomy and Ileostomy – reviewed 09/2016 xiv. Crash Cart Check – reviewed 09/2016 xv. Dental Emergencies and Consults- reviewed 09/2016 xvi. Dietary Memo' – reviewed 09/2016 xvii. Dopamine Infusion – approved 09/2016 xviii. Electronic Fetal Monitoring – reviewed 09/2016 xix. Emergency Surgery – reviewed 09/2016 Action Completed by 10/9/2016 xx. Fall prevention – reviewed 12/2015 xxi. Group B strep – reviewed 09/2016 Action Complete by 10/9/2016 xxii. Hand Hygiene – reviewed and revised 09/2016 xxiii. Heparin Infusion – reviewed 09/2016 Action Complete by 10/9 2016 xxiv. Infection Control Program – reviewed 09/2016 xxv. Isolation precautions – revised 09/2016 xxvi. Labor Analgesia – reviewed – Action Complete by 10/9/2016 xxvii. Fall prevention – reviewed 12/2015 xxviii. Group B strep – reviewed 09/2016 Action Complete by 10/9/2016 xxix. Hand Hygiene – reviewed and revised 09/2016 xxx. Heparin Infusion – reviewed 08/2016 Action Complete by 10/9 2016 xxxi. Infection Control Program – reviewed 09/2016 xxxii. Isolation precautions – revised 09/2016 xxxiii. Labor Analgesia – reviewed – Action Complete by 10/9/2016 xxxiv. Management of Patient with Malignant Hyperthermia- reviewed, returned to draft for CRNA input and updates. xxxv. Mannitol, Dosage and Administration – sent to review by pharmacy xxxvi. MRSA – reviewed 09/2016 xxxvii. Newborn Daily Care – sent for review 09/2016 xxxviii. Nutritional Assessment – sent for review 09/2016 xxxix. Oxytocin Usage – sent for review 09/2016 xl. PICC line Insertion – reviewed 09/2016 xli. Postoperative care – reviewed 07/2016 xlii. Precipitous Delivery – Reviewed 09/2016 xliii. Pulmonary Function Test – revised 09/2016 xliv. Referral and Transfer of patients – reviewed 07/2016 xlv. Respiratory Therapy – Incentive Spirometer – Reviewed 12/2015 xlvi. Sexual Assault Victim – reviewed 05/23/2016 xlvii. Shortness of Breath Standing orders – revised, in review by Dr. Sanderson xlviii. Standard Precautions – sent for review xlix. Suicide Precautions – sent for review l. Surgical Hand Scrub – reviewed 07/2016 li. Terminal Cleaning – approved 9/2016 lii. Topical EMLA cream – approved 9/2016 liii. Tracheal Suctioning – reviewed 05/16/2016 liv. Transporting Surgical Patients to OR- reviewed 07/28/2016 lv. Vasopressin Infusion for Refractory Hypotension – sent for approval	

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C 272	Continued From page 19 - Assessment - Postpartum patient, 12/03/13 - Assessment, Surgical Patient in the OR, 10/22/13 - Blood Transfusion, 3/18/14 - Bloodborne Pathogens, 3/05/14 - Cardiac Rehab - Emergency Response, 3/10/14 - Code Blue - Cardiac Arrest, 6/04/14 - Colostomy and Ileostomy, Care of, 6/16/14 - Crash Cart Check, 1/27/14 - Dental Emergencies and Consults, 12/27/13 - Dietary Menus, 10/17/14 - Dopamine Infusion, 2/12/09 - Electronic Fetal monitoring, 12/03/13 - Emergency Surgery, 10/04/11 - Fall Prevention, 9/25/13 - Group B Strep - OB Patient, 10/31/13 - Hand Hygiene, 2/06/14 - Heparin, Continuous Infusion, 6/11/09 - Infection Control Program, 3/06/14 - Isolation Precautions, 10/31/13 - Labor Analgesia, 3/05/09 - Management of Patient with Malignant Hyperthermia, 4/30/09 - Mannitol, Dosage and Administration, 8/12/13 - MRSA (Methicillin-Resistant Staphylococcus Aureus), 8/07/13 - Newborn Daily Care, 10/22/13 - Nutritional Assessment, 4/23/12 - Oxytocin Usage, 5/30/14 - PICC Line Insertion, 6/29/11 - Postoperative Care, 11/18/13 - Precipitous Delivery - ER, 10/22/13 - Pulmonary Function Test Procedure, 3/18/14 - Referral and Transfer of Patients, 10/09/13 - Respiratory Therapy- Incentive Spirometry, 12/31/13 - Sexual Assault Victim, 11/18/13 - Shortness of Breath Standing Orders Protocol,	C 272	C272 Continued 2. Description of how the actions will improve process that led to deficiency a. Policy Tech is an electronic Policy program that allows creation, reviews, revisions and archiving of policies. Accurate use of the software program allows for easy access to employees and mass notification of any revisions or approvals of policies. When policies are correctly written to include the annual review date, this software electronically maintains this process. b. SMH Pharmacy is currently in transition of switching Pharmacist. The oncoming pharmacy company is contracted to provide policy maintenance and clinical education. 3. Procedure for implementing the plan a. Policies cited were reviewed. The review date was noted on many to be not set for review, set for 60 months, or set for 36 months. The review date was corrected and the policy was sent to the appropriate staff for review. b. Communication was sent to staff to respond to emails from Policy Tech, for review or revision of policies. c. The policy "Policy Development" was reviewed to ensure accuracy of review time frames.	

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	131321		09/02/2016

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C 272	Continued From page 20 11/26/13 - Standard Precautions, 9/06/11 - Suicide Precautions, 10/15/14 - Surgical Hand Scrub, 10/23/13 - Surgical Patient Preparation, 11/18/13 - Terminal Cleaning, 4/15/09 - Topical EMLA Cream, 10/21/14 - Tracheal Suctioning, 12/13/13 - Transporting Surgery Patient to OR, 1/08/14 - Vasopressin Infusion for Refractory Hypotension, 3/21/11 Policies were not reviewed at least annually.	C272	C 272 Continued 4. Completion date for correction: Corrective Action to be complete by October 9, 2017. a. See 1 above for description of action preformed. 5. Monitoring and Tracking mechanism to ensure compliance with regulation a. Refer to plan of correction in 1 above. b. Policy Tech is an electronic software that tracks reviewed, revised and approval dates, and will send electronic notification of these upcoming tasks to perform to assigned owners and reviewers of the policy. 6. Include title of the person responsible for implementing the plan a. President b. Chief Administrative Officer c. Chief of Staff d. Director of Nursing e. Clinical Coordinators f. Employees	
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] Rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on policy review, staff interview, review of IDAPA rules, review of the telepharmacy contract, and observation, it was determined that the CAH failed to ensure pharmaceutical services were provided in accordance with IDAPA rules which define standards of practice for pharmacies in CAHs, including storage of medications. This resulted in a lack of pharmaceutical oversight, unsecured and expired medications, and a lack of training to RN staff related to the mixing of medications. Findings include:	C276		

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C 276	Continued From page 21 1. There were inadequate pharmacy services to meet the needs of the CAH. Idaho State Hospital Rules define standards of practice for pharmacies in CAHs. IDAPA 16.03.14.330 stated the following, "Pharmacy Service: Pharmacy Services shall be under the overall direction of a pharmacist who is licensed in Idaho and is responsible for developing, coordinating and supervising all pharmaceutical services in the CAH ..." The regulations discuss such areas as supervision of staff, management of medications in all departments, involvement in the Pharmacy and Therapeutics Committee, providing the medical staff and nursing staff with education, pharmaceutical policy management, review of adverse drug reactions and medication errors, ordering, storing and dispensing medications according to state rules. The CAH contracted with a telepharmacy company to provide services 24 hours a day 7 days a week. The telepharmacy contract was dated 5/16/16, and stated they will "provide information and clinical support to Customer's staff with respect to Orders." It did not state the other requirements of pharmacy services as listed in the Idaho State Hospital Rules, as referenced above. The CAH policy "Pharmacy and Support Staff, responsibilities of Telepharmacy Protocol," version 1, reviewed 2/06/15, was written with the name of a previous telepharmacy company. The policy was not updated to reflect agreements with the current telepharmacy company. The in-house pharmacy staff was comprised of the Director of Pharmacy and the PRN	C276	**C276 485.635(a)(3)(iv) Patient Care Policies** 1. Corrective Action: a. Maintenance and Storage of Pharmaceutical Supplies was developed on September 27, 2016 and in the review process within Policy tech. b. St. Mary's entered into a contract with PharmD to manage all pharmacy services, and are under contract to meet all state and CMS related requirements, including policy and procedure development and management. PharmD will coordinate P and T committee meetings and work with SMH providers in policy development and management. c. PharmD generated and have presented job descriptions for pharmacy director and PRN positions. d. Cabinets in Purchasing containing overflow large volume medications were found unlocked and not properly secured. These medications have been moved to a secure cabinet that is locked. The key is located in a secure location.	

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C 276	Continued From page 22 Pharmacist. During an interview on 8/30/16 at 1:30 PM, the PRN Pharmacist stated she helped out by working about one day a month. She stated sometimes she worked for 2 hours, sometimes 5 hours, depending on how busy the CAH was. She stated the nurses never called her, rather they called the Director of Pharmacy. She stated the telepharmacy took care of the nursing questions and patient orders. During an interview on 9/01/16, at 1:30PM, the Director of Pharmacy stated he worked 2 - 3 days a week. When questioned regarding his availability to the CAH, he stated he was always available by phone. He stated if he could not get to the CAH, he called the PRN Pharmacist. However, he stated there was no set schedule or call schedule. The Director of Pharmacy stated there was no policy related to pharmacy staffing. The Director of Pharmacy stated the telepharmacy company reviewed direct copies of medication orders, checked for interactions and allergies, maintained the MAR, and programmed the Pyxis machine, an automated medication dispensing system, to deliver medications to nurses. The policy "Pharmacy and Support Staff, responsibilities of Telepharmacy Protocol" did not define the Director of Pharmacy's duties related to supervision and oversight of pharmacy services and personnel, or how he was to evaluate and provide oversight of the telepharmacy company. On 9/09/16, at 3:00PM, the CAO was interviewed. He confirmed there were no job descriptions for the Director of Pharmacy or for the PRN Pharmacist.	C276	C276 Continued e. The OB delivery cart med box was unlocked with the keys inserted in the box. The box was locked and the key was removed and is now inaccessible to the general public and staff without accountability. f. Cabinets containing newborn circumcision supplies with medications were found unlocked in the nursery workroom. This cabinet has been secured with a lock and the key is now inaccessible to the general public and staff without accountability. g. Medications located in the Panda Warming unit were removed from the unit and placed in the OB delivery cart. h. A written procedure to direct nurses in the mixing of parental products provided by PharmD. 2. Description of how the actions will improve process that led to deficiency: a. Experience of PharmD in meeting pharmacy requirements demonstrated and available upon review.	

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C 276	Continued From page 23 The CAH failed to provide pharmacy services to meet the needs of the patients. 2. The CAH had multiple areas with unsecured medications, potentially causing negative patient outcomes and harm to patient visitors. IDAPA 16.03.14.330.08 stated "All medications shall be under lock and schedule II medication shall be double locked." The "Pharmacy Services" policy, approved 4/01/16, stated "The door to the pharmacy shall remain locked at all times." The policy made no reference to securing medications stored outside the pharmacy including IV solutions, IV solutions mixed with medications, and medications stored in the CAH based clinics. Unsecured medications were observed in the following areas: a. The Central supply room, off the main CAH hallway; the medication supply included IV solutions, IV potassium mixtures, various antibiotics and IV Tylenol. During an interview with a Central Supply Employee on 8/31/16, at 2:05PM, she stated the door was never locked and always kept wide open. She stated "The nurses can come in at any time to get what they need." This was confirmed by observations on 8/30/16 at 11:00 AM, 8/31/16 at 8:00AM, and 9/01/16 at 4:45PM. The door was open and no staff was present. b. An observation was conducted of the ED, in the presence of the GAO, on 8/29/16, beginning at 2:00 PM. During the observation, it was noted	C276	C 276 Continued 3. Procedure for implementing plan with completion dates a. Contract between SMH and PharmD effective October 1, 2016. b. Locks were placed on clinic procedure cabinet, nursery circumcision cabinet, and pharmacy large volume cabinet in purchasing the week of September 22' 2016. A red numeric key lock was placed on the nursery code cart September 6th. The clinic supply closet was locked by September 10th and labeled "To be locked at all times". The ED cupboards with medications remained lock until the laceration cart is assembled by October 3rd. 4. Monitoring and tracking mechanism to ensure compliance with regulations a. Contract reviewed yearly. b. During code cart checks, the emergency room cupboard, laceration cart, nursery circumcision cupboard, and delivery cart will be checked for security, and recorded on the daily code cart check list for two months to ensure compliance. c. Clinic supply closet checked daily by clinic staff, and documented on the door weekly for two months to ensure compliance. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Pharmacy assigned by PharmD b. Director of Nursing c. President	

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C 276	Continued From page 24 the medication cabinets located on the south wall were unlocked. Inside these cabinets were numerous, non-narcotic medications, including forms of lidocaine and ethyl chloride spray. c. In the Mother Baby room 103, an antibiotic eye ointment and Vitamin K injectable were in an unlocked drawer lowest to the floor at a level potentially accessible to children in the CAH room. d. On 8/31/16 at 1:50PM the PRN Pharmacist was observed with bags of medications for delivery to the CAH clinics. Inside the CAH clinics, the procedure room contained unlocked cabinets with multiple, non-narcotic medications. There was an unlocked supply closet containing multiple, non-narcotic "sample" medications. During an interview with the Director of Pharmacy on 9/01/16 at 1:30PM, he stated he does not check on medications stored in areas outside of the pharmacy or Pyxis machines. He also stated neither he nor the PRN Pharmacist had any involvement with medications once they were delivered to the clinics. The CAH failed to ensure all medications stored in the CAH were securely stored. 3. There was no written procedure to direct nurses in the mixing of parental medications. IDAPA 16.03.14.330.06 stated "The pharmacist shall develop a procedure for the safe mixture of parental products." There was no procedure or policy developed by the pharmacy for mixing parental products.	C276		

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C 276	Continued From page 25 The PRN Pharmacist was interviewed on 8/31/16 at 1:30 PM. She stated the RNs did all of the mixing of IV medications. There was no documentation of RN competencies related to the mixing of IV medications. The Director of Pharmacy was interviewed on 9/01/16 at 1:30PM. He stated that he had not provided any guidelines or education to the RNs regarding the safe mixing of IV medications. He confirmed that there was no documentation of RN competencies. The CAH failed to ensure staff were competent to mixIVs.	C276	**C 278 485.635(a)(3)(vi) Patient Care Policies – (1)Infection Control Program Oversight** 1. Corrective Actions a. The Infection Control Nurse now has an updated and signed job description, see HR for verification. b. The Infection Control Nurse now reports to the Director of Quality for oversight and support. c. Due to the resignation of our current Infection control nurse, we are posting a full time Infection Control/Employee Health position. 2. Description of how the actions will improve process that led to deficiency: a. The Infection Control Nurse now has a clear description of her role and responsibilities and who to go to for oversight and direction. This will help significantly with role delineation and administrative support. b. Increased hours will support the Infection Control nurse in her duties and allow for a more robust program. 3. Procedure for implementing plan with Completion Dates a. The infection control nurse position will be posted by October 7th. b. Infection Control meetings have been scheduled out for the remainder of FY17 as follows: i. October 6th ii. January 12th iii. March 9th iv. May 14th will be the annual program review to include approval and review of the Infection Control plan and policy, applicable policies, and annual Infection control trends.	
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, review of policy and infection control standards of practice, and staff interview, it was determined the CAH failed to ensure a current and reliable infection control system was established to reduce the risk of infections. This impacted 1 of 1 surgical patient (#31) whose care was observed. It had the potential to impact all patients provided care in the CAH. Findings include: 1. The Infection Control RN was interviewed on 9/01/16 beginning at 9:30AM.	C278		

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C 278	Continued From page 26 During the interview, she stated when she was hired into the position she had no prior experience in infection control and she became an RN within the prior 2 years, and there was not anyone in the position to train her. She stated she was given an infection control binder, dated 2004, as a resource that had been used by the prior Infection Control Officer. The CAH also sent her to an APIC conference during 2016 to learn infection control. She stated she was working to get updated resources, researching online for current resources, such as CDC guidelines and CMS regulations, and it was taking time to learn the position and get current resources. When asked how much time she had been given to focus on infection control, she stated she had been delegated 8 hours per week for CAH infection control issues and she worked in the clinic for the other 32 hours. She stated there was not enough time allocated to deal with all of the needed infection control activities. She stated the DON was dealing with some of the infection control issues, such as employee health. When asked about the infection control committee, she stated it was the intention to meet quarterly but they were behind schedule. She stated they met last on 4/25/16. When asked about her involvement with housekeeping and laundry, she stated she had not been involved but she wanted to have time to review the cleaning products that had already been established to make sure standards were met. When asked who was responsible for infection	C278	C 278 Continued c. Facility wide infection control education topics have been scheduled out for the remainder of FY17 as follows: v. 2nd Quarter 1. Hand hygiene education and monitoring 2. Cleaning techniques to include handling, labeling, disposal etc. of cleaning supplies 3. Decontamination vi. 3rd Quarter 1. Isolation vii. 4th Quarter 1. MRSA handling, procedures, and cleaning d. The Infection Control Nurse has created a spreadsheet to track, trend, and share infection control data. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. The Director of Quality has a tracking spreadsheet to ensure all COPs related to Infection Control are met in a timely and satisfactory manner, including the annual review of the program. b. The Director of Quality will work with the Infection Control Nurse to ensure that infection control data is reviewed quarterly at the Executive Council. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Quality b. Director of Nursing c. Chief Administrative Officer	

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C 278	Continued From page 27 control in the clinics that were a part of the CAH, she said she thought the Clinic Manager was in charge. The Clinic Manager was interviewed on 9/01/16 beginning at 10:45 AM. When asked who was in charge of infection control for the clinics, she stated the Infection Control Officer was in charge. The Infection Control RN, who was present during the interview, replied "Oh" and stated she had not been aware of this responsibility. She also stated she not been provided a job description that described her responsibilities. The CAH failed to ensure adequate time, resources, structure, and support to adequately oversee an infection control program. 2. The CAH failed to ensure policies and practices related to hand hygiene were effective. Examples include: a. The policy, "Standard Precautions," dated 9/06/11, was reviewed. It stated "handwashing is the most important factor in reducing the risk of transmission of bacteria or virus from one person to another or from one site to another on the same patient." The policy, "Hand Hygiene," dated 2/06/14, was reviewed. The policy included the following information: - "All members of the healthcare team will comply with current Center for Disease Control and Prevention (CDC) hand hygiene guidelines." - "Handwashing may be used for routinely decontaminating hands in the following clinical situations:"	C278	C 278 Continued C 278 485.635(a)(3)(vi) Patient Care Policies – (2) Hand Hygiene Practice and Policy 1. Corrective Actions a. Hand hygiene policy was updated and approved on 9/23 to reflect CDC hand hygiene guidelines. b. Eight hand sanitizer dispensers have been ordered and will be installed on the Med-Surg floor and inside the OR, in addition to the dispensers currently located inside the patient rooms. 2. Description of how the actions will improve process that led to deficiency: a. The policy is no longer ambiguous and states that hand hygiene is not optional and is critical to patient and employee safety. b. Increased hand sanitizer dispensers, including inside the OR, will result in easier access to sanitizer therefore increase hand hygiene compliance. 3. Procedure for implementing plan with Completion Dates a. The updated policy is now in Policy Tech accessible to all employees. b. Hand sanitizer dispensers will be installed by October 7th. c. Facility wide hand hygiene campaign to include patients, visitors, and staff education using the CDCs "Clean Hands Save Lives" to begin October 3rd. d. All employees were sent an educational video on hand hygiene with a quiz. All staff will complete and return by October 7th. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Will measure compliance by using patient monitoring cards (see attached) and direct observation once a week in a variety of settings to include the OR. We will use the WHO observation form to track and measure our adherence. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Nursing/OR Supervisor b. Director of Quality c. Infection Control Nurse d. Maintenance Manager	

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C 278	Continued From page 28 - "Before having direct contact with patients" - "Before inserting indwelling urinary catheters, IV catheters or other invasive procedures" - "After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands are not visibly soiled" - "When moving from a contaminated body site to a clean body site during patient care." - "After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient." - "After removing gloves." The policy "Policy Development," dated 5/11/16, was reviewed. It included the following information: - "The terms 'shall', 'must', 'are', 'is', or 'will' are used to indicate a mandatory statement (i.e., the only acceptable method under the current standards)." - "The term 'should' reflects the commonly accepted method, yet allows for use of effective alternatives." - "'May' is a term used in the interpretation of a standard to reflect an acceptable method that is recognized but not necessarily preferred." The term "may" used in the policy, "Hand Hygiene," dated 2/06/14, was not consistent with the CDC recommendation (https://www.cdc.gov/handhygiene, accessed 9/07/16), which did not consider hand hygiene, in the circumstances listed in policy, as optional. The Infection Control RN was interviewed on 9/01116 beginning at 9:30 AM. She stated the term, may, in the handwashing policy was not accurate and it should say have said must.	C 278	**C 278 485.635(a)(3)(vi) Patient Care Policies -- (5)Ambulance Maintenance** 1. Corrective Actions a. All Swiffer wet jets have been removed from the facility. 2. Description of how the actions will improve process that led to deficiency: a. Inappropriate cleaning supplies are no longer accessible to EMS and Environmental Services therefore the appropriate supplies will be used. 3. Procedure for implementing plan with Completion Dates a. EMS and environmental services were notified of insufficient practice and removed the mop on 9/9/16. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. ED Manager will inspect the ambulance once a month to ensure compliance. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Nursing b. ED Manager c. Environmental Services Supervisor	

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	131321		09/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOSPITAL	701 LEWISTON ST COTTONWOOD, 10 83522

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C 278	Continued From page 29 When asked if there were any CAH activities related to handwashing, she stated new employees were educated on handwashing but there was no review of handwashing with existing employees and there was no monitoring of handwashing related to employees. She expressed an interest and desire to have time to do training and monitoring with existing employees. b. Patient #31 was a 57 year old male admitted to the facility on 8/31/16, for surgical repair of an inguinal hernia. The care of Patient #31 was observed on 8/31/16, from 7:30AM when he was in pre-op, until approximately 10:50 AM while Patient #31 was still in PACU. There were no episodes of handwashing observed by the RN OR Coordinator who provided care during this time. Examples include: - Prior to inserting an IV catheter in pre-op - Before clipping hair from the surgical site (pubic area) in pre-op - After removing gloves after clipping surgical site in pre-op - After working on the computer in pre-op or handling the camera in the surgical suite - Before inserting a urinary catheter in the surgical suite - Before direct contact with the patient, such as when applying blood pressure cuff and finger monitor, applying socks, before putting together the incentive spirometer, or before cleansing the surgical site in the surgical suite, or before physical assessment with a stethoscope in PACU There was no sink or hand cleanser observed in the surgical suite, except a portable hand cleanser kept on the anesthesia cart for use by	C 278	**C 278 485.635(a)(3)(vi) Patient Care Policies – (6)Clorox Wipes** 1. Corrective Actions a. All Clorox wipes have been removed from all patient care areas. 2. Description of how the actions will improve process that led to deficiency: a. Inappropriate cleaning supplies are no longer accessible to employees therefore the appropriate supplies will be used. 3. Procedure for implementing plan with Completion Dates a. Clorox wipes were removed on 9/9/16. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. The Infection Control Nurse will do a monthly audit/walk around of the facility to ensure appropriate cleaning supplies are being used in patient care areas. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Nursing b. ED Manager c. Environmental Services Supervisor d. Infection Control Nurse	

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C 278	Continued From page 30 the CRNA. The RN OR Coordinator, who provided care to Patient #31, was interviewed on 8/31/16 at 1:45 AM. He stated he washed his hands before coming into pre-op and after he left the room. He stated there was no hand dispenser available in the surgical suite. Hand washing policy and practice did not meet CDC standards. 3. A policy "Expiration Dates For Sterile Items," dated 12/11/14, was reviewed. The policy stated: - "Items purchased as sterile should be used according to the manufacturer's directions. This may be either a designated expiration date, or a day-to-day expiration date such as 'sterile unless the integrity of the package is compromised.'" An observation of the Chemical Closet was conducted on 9/01/16, beginning at 11:45 AM, in the presence of the EVS Manager. The following items were noted to be expired: - One bottle of 70% isopropyl alcohol, expired 10/2010 - Five bottles of Activate Bleach Hospital Cleaner and Disinfectant, expired 5/22/16 - Three containers of Clorox Wipes for Healthcare, expired 2/2015, 3/22/16, and 11/05/15 - Two containers of Purel Gel, expired 2/2015 and 6/2015 The EVS Manager confirmed, at the time of the observation, the items' expiration dates.	C 278	C278 483.65(a)(3)(vi) Patient Care Policies – (7)Appropriate Use of Cleaning Agents (Repeat) 1. Corrective Actions a. All insufficient cleaning products have been removed from patient care areas (all virex will be removed as of 9/9/16). b. An in-service will be held for all employees after the installation of the HDQC2 dispensers on appropriate use, handling, and disposal (to emphasize the disposal after terminal cleaning) of the chemical according to the manufacturer's instructions. 2. Description of how the actions will improve process that led to deficiency: a. Staff will be knowledgeable on the manufacturer's directions for appropriate use of the cleaning chemicals. This will support and protect employees, patients, and the spread of communicable diseases. b. Inappropriate cleaning supplies are no longer accessible to employees therefore the appropriate supplies will be used. c. Staff will be educated on the current policy and requirement for disposal of cleaning agents after terminally cleaning a patient care area. 3. Procedure for implementing plan with Completion Dates a. Blue Ribbon, one of our distributors, will be installing new cleaning chemical dispensers on 9/29/16; the dispensers will automatically mix HDQC2, the new cleaning product. b. Blue Ribbon will hold an in-service for all environmental services employees regarding appropriate use, handling, and disposal of the chemicals on 10/6/16. c. EVS training complete by 10/9/16 d. All virex bottles will be disposed of and replaced with appropriately labeled HDQC2 bottles by October 9th. e. The 1st and the 15th of the month chemicals will all be disposed of and refreshed by Environmental Services. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Environmental services will audit the appropriate labeling, use, and disposal of HDQC2 monthly. b. The Infection Control Nurse will do a monthly audit/walk around of the facility to ensure appropriate cleaning supplies are being used in patient care areas and staff can articulate the appropriate methods for cleaning with such chemicals. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Nursing b. Environmental Services Supervisor c. Infection Control Nurse	

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C 278	Continued From page 31 The CAH failed to ensure all healthcare cleaning agents used in patient care areas were not expired. 4. A policy "Terminal Cleaning," dated 4/15/09, was reviewed. The policy stated "The disinfectant detergent solution used during terminal cleaning shall be freshly prepared, and shall be discarded immediately upon completion of the terminal cleaning." a. An observation of Treatment Room #2 was conducted on 8/29/16, beginning at 2:30 PM, in the presence of the GAO. A spray bottle was observed with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The GAO confirmed the spray bottle was not properly labeled, dated, timed, or discarded according to CAH policy. b. An observation of Radiology was conducted on 8/29/16, beginning at 2:00PM, in the presence of the GAO. A spray bottle was observed with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. Additionally, a spray bottle was observed with the word "Bleach" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The GAO confirmed the spray bottles were not properly labeled, dated, timed, or discarded according to CAH policy. c. An observation of Ultrasound was conducted	C 278		

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C 278	Continued From page 32 on 8/31/16, beginning at 9:36AM, in the presence of the Radiology Manager. An unlabeled spray bottle of Virex was noted with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The Radiology Manager confirmed the spray bottle was not properly labeled, dated, timed, or discarded according to CAH policy. d. An observation of Emergency Room 147 was conducted on 8/31/16, beginning at 2:00PM, in the presence of the CAO. A spray bottle was observed with the word "Virex" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. Additionally, a spray bottle was observed with the word "Bleach" handwritten on it. The spray bottle did not have a date or time it was mixed. The spray bottle contents were not immediately discarded upon completion of terminal cleaning. The CAO confirmed the spray bottles were not properly labeled, dated, timed, or discarded according to CAH policy. The CAH failed to ensure healthcare cleaning agents were prepared and used as outlined in CAH policy and per manufacturer's instructions for use. 5. A policy "Ambulance Maintenance," dated 6/29/16, was reviewed. The policy stated "The ambulance interior will be cleaned at the completion of each run. This may include, but is not limited to, sweeping/mopping the pt. [sic] care area, wiping down surfaces with a disinfectant, and vacuuming the cab and module component."	C278		

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C 278	Continued From page 33 The "Guidelines for Environmental Infection Control in Health-Care Facilities (https://www.cdc.gov)," website accessed on 9/08/16, at 3:45PM, stated "Use a one-step process and an EPA-registered hospital detergenUdisinfectant designed for general housekeeping purposes in patient-care areas..." An observation of the Lab EVS Closet was conducted on 9/01/16, beginning at 11:45 AM, in the presence of the EVS Manager. Multiple containers of "Swiffer WetJet" cleaning solution and a "Swiffer WetJet" mop were noted alongside other healthcare cleaning agents. When asked what the "Swiffer WetJet" cleaning solution was used for, the EVS Manager stated it was for mopping and cleaning the Ambulances. She stated EVS and Infection Control followed CDC guidelines and confirmed "Swiffer WetJet" was not an EPA-registered hospital detergenUdisinfectant designed for use in patient care areas. The CAH failed to ensure only EPA-registered cleaning agents were used in patient care areas. 6. An observation of the nursing unit was conducted on 9/01/16, beginning at 9:30AM. Several containers of open green top "Clorox Disinfectant Wipes" were noted in this patient care area. These Clorox wipes were labeled for household use only and were not listed as an EPA-registered healthcare cleaning agent. The "Guidelines for Environmental Infection Control in Health-Care Facilities (https://www.cdc.gov)," website accessed on 9/08/16, at 3:45 PM, stated "1. Use a one-step	C278		

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C 278	Continued From page 34 process and an EPA-registered hospital detergent/disinfectant designed for general housekeeping purposes in patient-care areas..." A charge nurse was interviewed on 9/01/16, beginning at 9:30AM, regarding these "Clorox Disinfectant Wipes." When asked what they were used for, the charge nurse stated for cleaning keyboards, stethoscopes, blood pressure cuffs, Emergency Department oxygen saturation probes, and electronic cords. When asked if the "Clorox Disinfectant Wipes" were approved for cleaning these items, the charge nurse stated she did not know. An observation of the CAH was conducted on 9/01/16, beginning at 11:45 AM, in the presence of the EVS Manager. During this observation, multiple EVS chemical storage closets, patient care areas, and non-patient care areas were observed. Numerous containers of open green top "Clorox Disinfectant Wipes" were noted throughout these areas. These Clorox wipes were labeled for household use only and were not listed as an EPA-registered healthcare cleaning agent. The EVS Manager was interviewed on 9/01/16, beginning at 11:45 AM, regarding these "Clorox Disinfectant Wipes." When asked what they were used for, the EVS Manager stated for business office use only. She stated EVS and Infection Control followed CDC guidelines and confirmed "Clorox Disinfectant Wipes" was not an EPA-registered hospital detergent/disinfectant designed for use in patient care areas. The CAH failed to ensure only EPA-registered cleaning agents were used in patient care areas.	C 278		

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C 278	Continued From page 35 7. CAH employees from several departments were unable to provide consistent answers when questioned about cleaning agents being used in CAH patient care areas. Examples include the following: a. CAH employees were unable to provide consistent answers when questioned about the cleaning agent "Virex." Examples include: i. The EVS Manager was interviewed on 9/01/16, beginning at 8:30AM, regarding the cleaning agent, "Virex." When asked what "Virex" was used for, she stated RN staff were to use it for cleaning surfaces. When asked how long surfaces must remain wet for "Virex" to be effective, the EVS Manager stated 10 minutes. When asked what PPE was used in preparation of "Virex," she stated staff must wear a mask and gloves. ii. An EVS housekeeper was interviewed on 9/01/16, beginning at 9:05AM, regarding the cleaning agent, "Virex." When asked what "Virex" was used for, she stated EVS staff were to use it for cleaning surfaces. When asked how long surfaces must remain wet for "Virex" to be effective, the EVS housekeeper stated 7 minutes. When asked what PPE was used in preparation of "Virex," the EVS housekeeper stated gloves and "sometimes glasses." iii. A charge nurse was interviewed on 9/01/16, beginning at 9:30 AM, regarding the cleaning agent, "Virex." When asked what "Virex" was used for, she stated staff were to use it for cleaning the Emergency Department and ambulances only. The charge nurse stated	C 278		

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C 278	Continued From page 36 "Virex" was not used on the nursing unit. When asked how long surfaces must remain wet for "Virex" to be effective, she stated she was unsure. "Virex" manufacturer's instructions for use stated staff are to wear chemical splash-proof goggles or face shield, rubber gloves, and protective clothing when preparing. The instructions for use also stated all surfaces must remain wet for 10 minutes for "Virex" to be effective. CAH staff were inconsistent in their interpretation of preparing and using "Virex" and failed to follow manufacturer's instructions for use. b. CAH employees were unable to provide consistent answers when questioned about the cleaning agent "Clorox Disinfectant Wipes." Examples include: i. The EVS Manager was interviewed on 9/01/16, beginning at 8:30AM, regarding the cleaning agent, "Clorox Disinfectant Wipes." When asked what "Clorox Disinfectant Wipes" were used for, she stated for business office use only. ii. An EVS housekeeper was interviewed on 9/01/16, beginning at 9:05AM, regarding the cleaning agent, "Clorox Disinfectant Wipes." When asked what "Clorox Disinfectant Wipes" were used for, she stated "quick wipe-ups" in patient care areas. iii. A charge nurse was interviewed on 9/01/16, beginning at 9:30AM, regarding the cleaning agent, "Clorox Disinfectant Wipes." When asked what "Clorox Disinfectant Wipes" were used for, she stated for cleaning keyboards, stethoscopes,	C 278		

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C 278	Continued From page 37 blood pressure cuffs, Emergency Department oxygen saturation probes, and electronic cords. "Clorox Disinfectant Wipes" manufacturer's instructions for use stated the cleaning agent was for home use only. CAH staff were inconsistent in their interpretation of where "Clorox Disinfectant Wipes" were to be used and failed to follow manufacturer's instructions for use.	C 278		
C 291	485.635(c)(3) SERVICES PROVIDED THRU AGREEMENT/ARRANGEMENT The CAH maintains a list of all services furnished under arrangements or agreements. The list describes the nature and scope of the services provided. This STANDARD is not met as evidenced by: Based on review of the list of contracted services, email communication, and staff interview, it was determined the CAH failed to ensure maintenance of a current and complete list of contracted services and resulted in outdated information. This had the potential to interfere with full utilization of contracted services. Findings include: A list of contracted services was requested for review. A one page document, "List of Contracted Services- July 2014," was provided. The list included contracted services that were no longer being utilized by the CAH, for example vendors related to anesthesia call, EKG overreads, radiology services, transcription services, and disposal of pharmaceutical waste. The list did not include contracted services that	C 291	C 291- 485.635 (c)(3) Services Provided thru Agreement/Arrangement 1. Corrective Action a. List updated 9/12/2016 b. List to be updated when new services added and reviewed semi-annually. c. Up to date list able to be accessed upon request 2. Plan will ensure list of services provided by agreement/arrangement is continually updated. List can be run with updated services at any time. 3. Procedure implemented through request for updated list to accounting department. 4. Completion date- 9/12/2016 5. Tracking mechanism- President and CAO to request list 10/9/2016 and 11/1/2016 and review list for compliance. Will also review list semi-annually. 6. President and CAO responsible parties.	

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C 291	Continued From page 38 were currently being utilized by the CAH, for example, services related to medical coding, lab courier, pharmacy, laundry, radiology, information technology, and billing. The CAH President and CAO were interviewed on 9/01/16 at4:12 PM. The CAH President confirmed the list was outdated and she would update it. The CAH did not maintain a current list of all contracted services.	C 291		
C 294	485.635(d), (d)(1) NURSING SERVICES §485.635(d) Standard: Nursing Services Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on observation, record review, policy review, and staff interview, it was determined the CAH failed to ensure nursing needs were met for 2 of 6 surgical patients (#3 and #31) whose records were reviewed. This resulted in the potential for an increased risk of infection in one surgical patient and for inadequate discharge planning in another surgical patient. Findings	C294		

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C 294	Continued From page 39 include: 1. Patient #31 was a 57 year old male admitted to the facility on 8/31/16 for surgical repair of an inguinal hernia. The care of Patient #31 was observed on 8/31/16 from 7:30AM while he was in pre-op, until approximately 10:50 AM while Patient #31 was still in PACU, prior to transferring to the medical/surgical floor. The RN OR Coordinator provided care to Patient #31. Patient needs for nursing care were not met. Examples include: a. A CAH nursing policy, "Surgical Patient Preparation," dated 11/18/13, was reviewed. It included the expectation that vital signs be assessed immediately before going to OR, including temperature, blood pressure, pulse, and respiratory rate. It also included the expectation nursing staff would perform a physical examination, including assessment of heart and lungs. The RN did not take Patient #31's temperature or listen to Patient #31's heart and lungs in pre-op. The "Preop Physical Assessment," dated 8/31/16 at 7:51 AM, documented "breath sounds clear all lobes." The information that was documented did not match the observation. b. A CAH policy "Intravenous Therapy- Initiation," dated 6/16/14, was reviewed. The policy stated: - "Perform hand hygiene before patient contact." - "Verify the correct patient using two patient identifiers per institution policy." - "Apply label to IV tubing that indicates either when tubing was hung or when tubing should be changed."	C294	C 294 Nursing Services 1. Corrective Actions: a. Nursing Staff Training In-services will be scheduled to provide additional education to nursing staff on the following policies and procedures: *Surgical Patient Preparation, Intravenous Therapy-Initiation, Patient Identification, and Hand Hygiene by October 9th, 2016* b. Purchase of electronic amplified stethoscope and additional thermometers by October 9th 2016. c. Install wall mounted waterless alcohol-based hand sanitizer dispensers in Pre-OP/PACU, Minor Room, and Surgical Operating Room by October 9th, 2016. d. Make appropriate revisions to *Intravenous Therapy-Initiation* policy to reflect electronic documentation procedures and capabilities by October 3, 2016. e. Monitor Surgical and Out-Patient Department hand hygiene compliance at least two times a month and report findings to Infection Control Committee monthly beginning October 1, 2016. 2. Description of how the actions will improve process that led to deficiency: a. The In-services will provide additional education and defines the expectations of nursing care, including for example what is required in the preparation of a surgical patient, documentation requirements, and expected IV therapy techniques. i.e. taking vitals immediately before surgery. b. Having tools readily available i.e. stethoscopes and thermometers will promote compliance of policies and procedures. c. Installing wall mounted alcohol based hand sanitizer dispensers in the Pre-OP/PACU, Minor Room, and Surgical Operating room will readily encourage hand hygiene resulting in improved compliance.	

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ST MARY'S HOSPITAL	701 LEWISTON ST COTTONWOOD, ID 83522

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C 294	Continued From page 40 - "...don clean gloves." - "Swab injection cap with antiseptic swab." - "Label dressing. Include date and time of IV insertion, VAD gauge size and length, and nurse's initials." The RN did not follow the CAH policy related to intravenous therapy. Examples include: - The RN did not perform hand hygiene or don new gloves prior to IV therapy initiation. - The RN did not use 2 patient identifiers prior to IV therapy initiation. - The RN did not apply a label to the IV tubing indicating when it was hung or should be changed. - The RN did not swab the IV tubing injection cap with antiseptic swab prior to attaching secondary IV tubing which contained pre-operative antibiotics. - The RN did not label date and time of IV insertion, VAD gauge size, or nurse's initials on Patient #31's IV dressing. c. A CAH policy "Patient Identification," dated 12/16/13, was reviewed. The policy included the following information: - "Purpose: To provide accurate identification of patients prior to any surgical or invasive procedure, when drawing blood, and when administering medications and/or blood products..." - "To identify a patient, staff will ask the patient to state his or her name and date of birth and the staff will verify that it matches the identification band." The RN was observed to scan Patient #31's	C294	C 294 Continued d. Revisions to the *Intravenous Therapy-Initiation* policy will clarify that the documentation of when the next tubing change is due, date, time and gauge of VAD and dressing is defined in electronic documentation. e. On-going auditing and reporting of Hand-Hygiene in the Surgical and Out-Patient department will provide necessary oversight to ensure compliance. 3. Procedure for implementing plan with Completion Date a. All nursing staff present at the in-services will sign the meeting roster to verify that they have received the education on identified policies. Nursing staff that were not present for scheduled in-services will be provided paper copies of each of the above policies and will initial and return copy of each policy confirming they have received education. Competence of each of the above policies will be measured through a competencies based skills test. In-services and competencies will be completed by October 9th, 2016. b. Electronic amplified stethoscope ordered September 26, 2016. will be in serviced no later than October 9, 2016. Additional thermometers ordered September 26, 2016 and maintenance work order to mount units to wall sent September 27, 2016. The additional thermometers will be in service no later than October 9th, 2016.	

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C 294	Continued From page 41 Identification band, but was not observed to ask Patient #31 for his name and date of birth or compare that information against his armband prior to medication administration, including IV medication. d. The RN did not wash his hands (and/or use alcohol based hand gel) while in pre-op, the surgical suite, or in PACU. Examples include: - Prior to inserting an IV catheter in pre-op - Before clipping hair from surgical site (pubic area) in pre-op - After removing gloves after clipping surgical site in pre-op - After working on the computer in pre-op or handling the camera in the surgical suite - Before inserting a urinary catheter in the surgical suite - Before direct contact with the patient, such as when applying blood pressure cuff and finger monitor, applying socks, before putting together the incentive spirometer, or before cleansing the surgical site in the surgical suite, or before physical assessment with a stethoscope in PACU e. The RN listened to Patient #31's lungs in PACU and stated Patient #31 had crackles in his left lung. The "RECOVERY ROOM FLOWSHEET," dated 8/31/16 at 10:25 AM, documented Patient #31's lungs were "clear." The documentation did not match the observation. Patient#31's RN was interviewed on 8/31/16 at 11:45 AM. He stated he generally did use a stethoscope to listen to lungs prior to surgery. He stated he did not have a stethoscope with him while in pre-op caring for Patient #31. He	C 294	C294 Continued c. Wall mounted alcohol based hand sanitizer dispensers ordered September 13, 2016 for Pre-op/PACU, Minor Room and Operating room. Work-Order placed to install units upon arrival. Will be implemented no later than October, 9th, 2016. Prior to installation bottles of alcohol based hand sanitizers placed in each of the rooms and readily available to staff to perform hand hygiene. d. Appropriate revisions to Intravenous Therapy-Initiation policy to reflect electronic documentation procedures and capabilities will be completed by September 28, 2016. e. Surgical and Out-patient hand hygiene auditing tool will be developed by Sept 30, 2016 with auditing of hand hygiene to begin October 1, 2016 and reported monthly to Infection Control Nurse. 1. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Meeting roster of In-services will be recorded in OR Committee Meeting Minutes b. Staff Competencies of identified policies and procedures will be evidenced by written examination and recorded in staff education folders. c. Charts will be reviewed for accurate electronic documentation of expectations and procedures identified in *Surgical Patient Preparation, Intravenous Therapy-Initiation, Patient Identification,* and *Hand Hygiene*- Deficiencies will be tracked & reported through the Quality Improvement Committee. d. Surgical and Out-Patient Department Hand Hygiene will be audited two times a month and compliance reported monthly to Infection Control Committee. 2. Title of person(s) responsible for implementing acceptable plan of correction: a. OR RN Coordinator b. Infection Control RN c. Director of Nursing	

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C 294	Continued From page 42 confirmed he did not take Patient #31's temperature during pre-op. He stated the CRNA generally took the patient's temperature in the surgical suite. He stated he confirmed the patient's identity by checking date of birth prior to the surveyors entering pre-op. He confirmed he did not use a second patient identifier at the time of administration of the IV medication. He stated he washed his hands prior to entering pre-op and after leaving the room, prior to entering the surgical suite. Nursing care did not meet the needs of Patient #31 to ensure a thorough assessment, accurate documentation, appropriate identification of the patient, appropriate labeling of medications, and appropriate handwashing in accordance with CAH policy. 2. Patient #3 was a 56 year old female admitted to the CAH on 7/13/16 for a laparoscopic cholecystectomy. Patient #3's care plan stated nursing staff should call the physician for oxygen saturation levels that fell below 90%. An RN visit note, dated 7/14/16, stated "PT'S 02 SATS WILL DESAT TO MID 80'S WHEN SHE FALLS ASLEEP BUT COMES RIGHT BACK UP TO THE HIGH 90'S. NO COMPLAINTS OF PAIN. PT IS BEING DISCHARGED HOME NOW." There was no documentation to indicate Patient #3's physician had been contacted regarding saturation levels that fell below 90%. The Informatics RN was interviewed on 8/31/16 at 2:43 PM. She reviewed Patient #3's record	C 294		

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C 294	Continued From page 43 and stated she could not find any documentation to indicate the physician had been notified of the low oxygen saturation levels prior to discharge from the CAH. She stated she would have expected physician notification for oxygen saturation levels in the 80s and could have impacted discharge plans. Nursing staff did not alert physician to Patient #3's abnormal oxygen saturation levels in accordance with her plan of care.	C 294	C298 485.635(d)(4) Nursing Services 1) Corrective Action: a) A nursing care plan for each patient was not developed and kept current foreach inpatient. The nursing care plan was changed to a handwritten document that is updated at least minimally once a day and is a part of the patient's permanent chart. b) Nursing Care Plan policy was reviewed. This policy was updated to include how nursing care plans would be individualized and how the patient would participate in the development of the care plan. c) The EHR is in review with the informatics team to determine a better way to implement an electronic Nursing Care Plan. 2) Description of how the actions will improve process that led to deficiency: a) Using a paper version of Nursing Care plan, staff will have an opportunity to manually update the nursing care plan and use this form during nursing huddle. b) deficiencies may impact re-credentialing possibilities 3) Procedure for implementing the plan: a) Nurse Care Plan procedure was reviewed with the nurses involved in the care of the patients reviewed. b) The Director of Nursing reviewed the requirements with nursing that nursing care plans need to be comprehensive and individualized. c) Nursing Care Plan policy was sent to nursing staff to read and sign. 4) Completion date for correction (Within 45 days from September 2, 2016). a) Ongoing audit and reporting have been enhanced since September 28, 2016.	
C 298	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 interview and a review of policies and medical records, it was determined the CAH failed to ensure a nursing care plan was developed and kept current for 23 of 23 inpatients (#2,#3,#4,#5,#6,#7,#8,#9,#10,#11,#12, #13,#14,#15,#31,#32,#33,#34,#35,#36,#37, #38, and #39) whose records were reviewed. This resulted in a lack of direction to nursing staff and an inability to involve patients in their care planning. It had the potential to result in uncoordinated nursing care that did not meet the needs of patients. Findings include: The policy "Nursing Care Plan, Interdisciplinary Rounds," dated 4/13/15, defined NCP as "Utilization of the nursing process (assess, diagnose, plan, implement, evaluate) to provide a framework by which the professional nurse can connect clinical events and data obtained from a variety of sources with the appropriate interventions to safely manage and evaluate	C298		

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C 298	Continued From page 44 nursing care." The policy stated the RN would collaborate with the patient to individualize the NCP to the unique needs of the patient. The policy further stated an NCP with strategies, alternatives, and goals would be developed. The policy stated there were 15 available care plans in the EMR including a standard adult plan, a standard newborn plan, a standard postpartum plan, a standard adult outpatient observation plan, and others. The policy was not followed. Instead, the CAH's EMR took items from diagnoses and initial nursing assessments and automatically populated fields to remind nurses to enter information and perform tasks. The policy did not address how NCPs would be individualized. The policy did not address how patients would participate in the development of care plans when those care plans were not identified. Finally, the policy did not address how NCPs would be documented. Excluding ED patients and 1 baby, NCPs were not present in the medical records of acute inpatients #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12,#13,#14,#15, #31,#32,#33,#34,#35,#36, #37, #38, and #39. The EMR was confusing. For example, Patient #3 was a 56 year old female admitted to the CAH on 7/13/16 for a laparoscopic cholecystectomy. She was discharged on 7/14/16. Some of Patient #3's nursing notes referred to "CP" (care plan). These were items inserted by the computer. With 1 exception they did not direct care. For example, a nursing note, dated 7/13/16	C 298	C 298 Continued 5. Monitor and tracking mechanism to ensure compliance with regulation a. Refer to Plan of Correction 1a-c b. Ongoing audit reporting in Medical Swing Committee meeting. 6. Include title of person responsible for implementing the plan a. Director of Nursing b. Discharge Planner UR Nurse c. Informatics Nurse d. Charge Nurses	

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C 298	Continued From page 45 at 6:53AM, stated "IV peripheral site #1." The note did not state where the IV was or what gauge needle was used or whether any solutions were infused. It did not provide any direction to staff. However, it was labeled "CP." A nursing note, dated 7/13/16 at 2:28PM, stated "Pain Assessment/Management." Prepopulated fields stated pain score 0-10, acceptable pain level, location, level of sedation, and others. None of these fields was filled in except "Medicated" which was marked "no." While being labeled "CP," the note did not provide any information about the patient or any direction to nursing staff. A nursing note, dated 7/13/16 at 3:00 PM, stated "Dietary Intake...Meal+Snack Diet+ Nothing by Mouth." While being labeled "CP," the note did not provide any information about the patient or any direction to nursing staff. There was one exception, labeled "CP" that provided direction to staff in Patient #3's record. It gave direction to nursing staff to call a physician if vital signs fell outside of specified parameters. Other than this one example, an identifiable NCP was not documented for any patient. The Informatics RN was interviewed on 9/02/16 beginning at 10:45 AM. She stated no NCP documents were present for the above patients. She stated elements of NCPs were incorporated in other parts of the record but documents that included patients' problem lists, direction to nursing staff, and goals of care were not generated. The CAH failed to develop NCPs for patients.	C 298		

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C 302	Continued From page 46	C 302	**C302 485.638 (a)(2) Records Systems** 1. Corrective Action a. CAH policy Nursing Documentation – Electronic Medical record was reviewed and updated to address legibility, completeness, accuracy, accessibility and systematic organization. b. CRNA's were individually addressed regarding number values and unit of measurement for medication given. They were directed to write all unit values next to amount given to ensure accuracy in documentation. c. OR RN Coordinator was counseled regarding the accuracy of documentation in the clinical record. Nursing Documentation – Electronic Medical record was reviewed and read by the employee on October 3rd. d. The "Time Out" form was revised to include patient name, date, and time the form was used. 2. Description of how the actions will improve process that led to deficiency: a. Reviewing the policy will increase education and awareness of the documentation guidelines established by SMH. b. Deficiencies may impact re-credentialing possibilities	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, it was determined the facility failed to ensure records were complete and accurate for 4 of6 surgical inpatients (#5, #11, #14, and #31) and 1 of 17 non-surgical inpatients (Patient #7) whose records were reviewed. Incomplete and inaccurate documentation interfered with the clarity of the course of patient care and had the potential to impact the quality and safety of patient care. Findings include: The CAH did not have a policy that addressed the requirement that clinical records be legible, complete, accurately documented, readily accessible, and systematically organized. 1. Patient #31 was a 57 year old male who was admitted to the CAH on 8/31/16 for a right inguinal hernia repair, whose record was reviewed. a. Patient #31's record included a CAH document "ANESTHESIA RECORD," dated 8/31/16, which was reviewed. The document included a section "IV" where multiple anesthetic medications used during the procedure were documented. Number values were used next to medications administered instead of the number value and unit of measurement for the medication (i.e. milliliters, milligrams, micrograms, etc.). The documentation was incomplete.	C 302		

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C 302	Continued From page 47 b. Patient #31's record included a CAH document "Preop Physical Assessment," dated 8/31/16 at 7:51AM, which was reviewed. The document included the following: - "Cardia: ...Pulse regular and strong." - "Resp: ...Breath sounds clear to all lobes." Patient #31's pre-surgical period was observed on 8/31/16, beginning at 7:30AM. During this period, the OR RN Coordinator did not listen to Patient #31's heart and lungs and did not palpate Patient #31's pulse. The documentation did not match the observation that occurred during the pre-op period. The OR RN Coordinator was interviewed on 8/31/16, beginning at 11:45 AM. He confirmed he did not use a stethoscope when doing Patient #31's pre-operative physical assessment. When asked about pre-surgical physical assessments, the OR RN Coordinator stated "I usually do." Additionally, he stated he did not take Patient #31's pre-surgical temperature as it was usually done by the CRNA in the operating room. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #31's record was reviewed in her presence. She confirmed the nursing documentation in pre-op for Patient #31 did not accurately reflect care. The record documentation for Patient #31 was not complete and accurate. 2. Patient #14 was a 19 year old female who was admitted to the CAH on 7/30/16 for pregnancy, failure to progress, and caesarian section, whose record was reviewed.	C 302	C 302 Continued 3. Procedure for implementation of the plan: a. This policy was made a required read for all nursing staff through Policy Tech b. Reviewed at Nursing Staff meeting – October 5th. 4. Completion date for correction by October 9th. 5. Monitoring and tracking mechanism to ensure compliance with regulation a. Refer to plan of correction 1a-d b. Charts will be reviewed for accurate electronic documentation of expectations and procedures identified in Nursing Documentation-Electronic Medical Record. Deficiencies will be tracked & reported through the Quality Improvement Committee. 6. Include title of person responsible for implementing the plan a. Director of Nursing b. OR Coordinator c. Lead CRNA	

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C 302	Continued From page 48 a. Patient #14's record included a CAH document used for "time-out" (verification pause immediately prior to surgical procedure) purposes which was unnamed, undated, which was reviewed. The document included a section "Before induction of anesthesia." Under this section, the following "Yes" and "No" checkboxes were left blank: - "Does patient have a known allergy" - "Does the patient have a difficult airway/aspiration risk?" - "Does the patient have a risk of >500ML blood loss (7ML/KG in children)" The CAH document also included a section "Before skin incision." Under this section, all checkboxes were left blank. Additionally, the document was undated and untimed, making it difficult to ascertain if the "time out" procedure was performed prior to the surgical procedure. c. Patient #14's record included a CAH document "ANESTHESIA RECORD," dated 7/31/16, which was reviewed. The document included a section "IV" where multiple anesthetic medications used during the procedure were documented. Number values were used next to medications administered instead of the number value and unit of measurement for the m dication (i.e. milliliters, milligrams, micrograms, etc.). d. Patient #14's record included a CAH document "RECOVERY ROOM FLOWSHEET," dated 7/31/16, which was reviewed. The document included a section "1/0." This section was left blank. The document also included a section "OUTCOMES." This section was left	C 302		

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C 302	Continued From page 49 blank. The DON was interviewed on 9/01/16, beginning at 1:40PM, and Patient #14's record was reviewed in her presence. She confirmed the missing documentation. The record documentation for Patient #14 was not complete and accurate. 3. Patient #11 was a 78 year old female who was admitted to the CAH on 4/11/16 for hyponatremia, heart failure, and bilateral pneumonia whose record was reviewed. a. Patient #11's record included a CAH document "Swing Bed Orders," dated 4/11/16, which was reviewed. The document included "Allergies" next to a blank line. This line was left blank; however Patient #11's record included an allergy to Macrobid (an antibiotic). The DON was interviewed on 9/01/16, beginning at 1:40 PM, and the patients' records were reviewed in her presence. She confirmed the inaccurate and missing documentation. The record documentation for Patient #11 was not complete and accurate. 4. Patient #5 was a 7 year old male who was admitted to the facility on 7/20/16 to have has tonsils removed. The pre-anesthesia assessment, dated 7/26/16, was reviewed. The time of the assessment was not documented. The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She reviewed Patient #5's record. She confirmed the missing documentation.	C 302		

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C 302	Continued From page 50 The timing of the pre-anesthesia assessment for Patient #5 was not included. The documentation was incomplete 5. Patient #7 was a 66 year old male who was admitted to the facility on 4/18/16 for care related to pancreatic cancer. The discharge summary, dated 4/22/16, was not signed. The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She reviewed Patient #7's record. She confirmed the discharge summary was not signed. The discharge summary for Patient #7 was not signed. The documentation was incomplete.	C 302		
C 304	485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- 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; 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 properly executed informed consent forms were completed for 8 of 23 inpatients (#1, #5, #6, #7, #11, #14, #22, and #28) whose records were	C 304		

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FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING--------- B. WING	(X3) DATE SURVEY COMPLETED
	131321		09/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOSPITAL	701 LEWISTON ST COTTONWOOD, ID 83522

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C 304	Continued From page 51 reviewed. This resulted in a lack of clarity as to whether patients or their representatives were fully informed prior to signing documents and prior to treatment. Findings include: A policy, "Surgery- Rules and Regulations," dated 10/07/13, was reviewed. It stated "Except in emergencies, surgical procedures shall not be performed until an informed consent of the patient or patient's legal representative has been obtained and documented." A policy "General Consent and Authorization," dated 11/19/13, was reviewed. The policy stated: "VI. When a patient is not able to consent due to age, mental status or other legitimate reason, the following may sign the GCA on the patient's behalf: a. In the case of a minor, the parent or legal guardian. b. A court-appointed guardian. c. A person designated in writing by the patient (i.e. advanced directive). d. In the event of an unplanned event rendering the patient unable to make medical decisions, the family member who has legal authority to make medical decisions on the patient's behalf." Patient consent forms were not appropriately completed. Examples include: 1. Patient #6 was a 92 year old male who was admitted to the facility on 7/22/16 for surgery on an incarcerated inguinal hernia.	C 304	C 304 485.638 Records Systems 1. Corrective Action a. Engage consent and authorization committee to review consent policy and process b. Update consent policy and process as necessary to meet CMS and state guidelines including but not limited collecting informed consent. c. Inservice to be completed to educate on new process 2. Description of how the actions will improve the process that led to deficiency a. Committee will conduct analysis and implement improvements to meet state and federal regulations. Process to be updated. 3. Procedure for implementing plan and completion dates a. Committee to be established by October 5, 2016. b. Committee to update policy and procedure for review by October 9, 2016. c. Educational in-service to be completed by October, 17. 4. Monitoring and tracking mechanism to ensure compliance with regulation a. Consents to be reviewed by HIM staff for two months for compliance 5. Title of person responsible for implementing plan a. Director of Nursing b. Director of Revenue Cycle c. Director of Quality	

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C 304	Continued From page 52 The surgical consent form was signed by the patient on 7/22/16 at 5:12PM. However, the anesthesia consent form was not signed by the patient or a patient representative. A handwritten note on the form documented the following: "UNABLE TO HAVE PT. SIGN DUE TO HARD OF HEARING (SEVERE) & NEED TO PROCEED QUICKLY. PT. APPEARS TO UNDERSTAND THAT HE IS HAVING SURGERY & APPEARS TO AGREE." Patient #6's record included "ANESTHESIA PROGRESS NOTES," dated 7/22/16 and untimed. The notes included checked boxes for the following: "POSSIBLE COMPLICATIONS EXPLAINED, QUESTIONS ANSWERED YES, and "RISKS, BENEFITS & ALTERNATIVES EXPLAINED." There was no documentation that explained how the surgical consent form could be signed by Patient #6, there was a discussion related to anesthesia risk, and the anesthesia consent form could not be signed. The CRNA who cared for Patient #6 was interviewed on 9/29/16 at 9:48AM. When asked to clarify how he was able to answer Patient #6's questions and explain risks and benefits to Patient #6 but was unable to get written consent, he stated he was not able to explain complication or risks because Patient #6 was hard of hearing and he checked the boxes as a matter of routine and should not have done so. He could not explain how surgical consent was able to be given. Consent for Patient #6 was not properly obtained.	C 304		

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C 304	Continued From page 53 2. Patient #5 was a 7 year old male who was admitted to the facility on 7/20/16 to have his tonsils removed. a. The "GENERAL CONSENT AND AUTHORIZATION," was signed on 7/20/16 by an individual other than the patient. The relationship to Patient #5 was not indicated on the form. b. The "Surgical-Procedural Informed Consent," dated 7/20/16, was signed by an individual other than the patient. The relationship of the individual to Patient #5 was not indicated on the form. The time consent was given was not documented. c. The "CONSENT FOR ANESTHESIA SERVICES," was signed by an individual identified as Patient #5's grandmother. The date and time consent was given was not documented. The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She reviewed Patient #5's record. She confirmed the missing documentation on the consent forms. Consent for Patient #5 was not properly executed. 3. Patient #7 was a 66 year old male who was admitted to the facility on 4/18/16 for care related to pancreatic cancer. The "GENERAL CONSENT AND AUTHORIZATION," was signed on 4/22/16 by an individual other than the patient. The relationship to Patient #7 was not indicated on the form. The form was incomplete.	C 304		

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C 304	Continued From page 54	C304		

The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She reviewed Patient #7's record. She confirmed the missing documentation on the consent forms.

Consent for Patient #7 was not properly executed.

4. Patient #1 was a 40 year old female who was admitted to the CAH on 8/25/16 for acute alcohol intoxication and anemia, whose record was reviewed.

Patient #1's record included a CAH document "History & Physical," dated 8/25/16, which was reviewed. The CAH document included "GENERAL: The patient is an intoxicated 40-year-old [ethnicity] female who appears her stated age. Difficult to carry on a conversation with the patient because she is so intoxicated."

Patient #1's record included a CAH document "Discharge Summary," dated 8/29/16, which was reviewed. The CAH document included "HOSPITAL COURSE: Patient admitted to [Hospital] on 08/25/16, with acute alcohol intoxication. Patient's blood alcohol level at the time was noted to be 304."

Patient #1's record included a CAH document "GENERAL CONSENT AND AUTHORIZATION," dated 08/25/16 at 1:45AM, which was reviewed. The CAH document included the line "Signature Patient or Authorized Representative." Although she was described as "highly intoxicated," Patient #1's signature appeared on this line.

Patient #1's record included a CAH document

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C 304	Continued From page 55 "GENERAL CONSENT AND AUTHORIZATION," dated 08/25/16 at 3:10AM, which was reviewed. The CAH document included the line "Signature (Patient or Authorized Representative)." Although she was described as "highly intoxicated," Patient #1's signature appeared on this line. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #1's record was reviewed in her presence. She confirmed the conflicting consent and record documentation. Consent for Patient #1 was not properly executed. 4. Patient #11 was a 78 year old female who was admitted to the CAH on 4/11/16 for hyponatremia, heart failure, and bilateral pneumonia whose record was reviewed. a. Patient #11's record included a CAH document "GENERAL CONSENT AND AUTHORIZATION," dated 04/26/16 at 2:00 PM, and signed by Patient #11. The consent was signed on the date she was discharged on 4/26/16 rather than the date she was admitted on, 4/11/16. The DON was interviewed on 9/01/16, beginning at 1:40PM, and Patient#11's record was reviewed in her presence. She confirmed the conflicting consent and record documentation. Consent for Patient #11 was not properly executed. 5. Patient #14 was a 19 year old female who was admitted to the CAH on 7/30/16 for pregnancy, failure to progress and caesarian section, whose record was reviewed.	C 304		

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C 304	Continued From page 56 Consents related to blood administration were inconsistent. Examples include: a. Patient #14's record included a CAH document "CONSENT FOR ANESTHESIA SERVICES," dated 7/30/16, which was reviewed. The CAH document stated, "I give consent to receive blood or blood products only as an emergency life-saving measure" with a checked checkbox next to it and Patient #14's handwritten initials. b. Patient #14's record included a document "Surgical-Procedural Informed Consent," dated 7/30/16. The CAH document stated: "I have been told how likely it is that I may need a blood transfusion (initial one box) [sic] Yes, you may give me blood (blood products). I have received and read the pre-transfusion information sheet. No, I ask that no blood or blood products be given to me. I do not hold SMH, its staff and/or its doctors responsible in any way for any bad results, or even death, which may occur as the result of my choice not to receive blood. The possible problems that can result from not receiving blood have been explained to me." Next to the "Yes" statement was a checked checkbox and Patient #14's handwritten initials. However, the "Yes" statement in this CAH document was not consistent with the previous document "CONSENT FOR ANESTHESIA SERVICES." c. Patient #14's record included a CAH document "CLEARWATER VALLEY/ST. MARY'S	C 304		

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C 304	Continued From page 57 HOSPITALS Consent/Refusal for Blood Transfusion," dated 7/31/16 and signed by Patient #14, which was reviewed. The CAH document included risks and benefits of receiving a blood transfusion, but did not include an option to receive blood or blood products only in the event to save the patient's life, as previously indicated by Patient #14 in the "CONSENT FOR ANESTHESIA SERVICES" CAH document. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #14's record was reviewed in her presence. She confirmed the conflicting consent and record documentation. Consent for Patient #14 was not properly executed. 5. Patient #22 was a 41 year old female who was admitted to the CAH on 7/05/16 for altered mental status, whose record was reviewed. a. Patient #22's record included a CAH document "History of Present Illness," dated 7/05/16, signed by the physician. The document stated "Again, history was very difficult to obtain from patient. She was confused, and crying out for her cat..." b. Patient #22's record included a CAH document "GENERAL CONSENT AND AUTHORIZATION," dated 7/05/16, at 10:00 AM. The CAH document included the line "Signature (Patient or Authorized Representative." Although Patient #22 was described as "confused," her signature appeared on this line. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #22's record was	C 304		

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C 304	Continued From page 58 reviewed in her presence. She confirmed the conflicting consent and record documentation. Consent for Patient #22 was not properly executed. 6. Patient #28 was a 79 year old female who was admitted to the CAH on 7/18/16, for care related to hip surgery, whose record was reviewed. a. Patient #28's record included a CAH document "List Patient Notes," dated 7/18/16 at 10:09 AM, signed by an RN. The document included "PATIENT CONFUSED IN BED, WONDERING WHERE [sic] IS AT." b. Patient #28's record included a CAH document "GENERAL CONSENT AND AUTHORIZATION," dated 7/18/16 at 3:30PM, which was reviewed. The CAH document included the line "Signature (Patient or Authorized Representative." Although Patient #28 was described as "confused," her signature appeared on this line. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #28's record was reviewed in her presence. She confirmed the conflicting consent and record documentation. Consent for Patient #28 was not properly executed.	C 304		
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-]	C 307		

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C 307	Continued From page 59 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 medical records and medical staff rules, and staff interview, it was determined the facility failed to ensure physician and CRNA entries in the medical record were timed, dated, and authenticated for 5 of 23 inpatients (#4, #5, #11, #14, and #18) whose records were reviewed. This resulted in a lack of clarity as to whether H&Ps were reviewed immediately prior to surgery. It also resulted in invalid physician orders, incomplete consents and progress notes. Findings include: The "MEDICAL STAFF RULES," dated 2/07/05, were reviewed. They stated "Signature requirements 7.4.1. Physician shall sign and date entries the physician makes, or directs to be made." Dated physician and CRNA signatures were missing. Examples follow: 1. Patient #5 was a 7 year old male who was admitted to the facility on 7/20/16 to have his tonsils removed. His H&P, dated 5/26/16, had a handwritten note, signed by the surgeon, indicating Patient #5 did not have any new signs and symptoms. The note was not dated. It could not be determined the timing of the physician's findings and whether the H&P was reviewed immediately prior to surgery. The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She confirmed the physician's note	C 307	C307 485.639 Records System 1. Corrective Actions: a. Immediately require that H&P (meeting all requirements set forth by CMS) be present on the medical chart prior to minor procedures and surgeries. Held discussion with Medical Staff on H&P and sign and date Requirements on September 28, 2016 at the General Medical Staff Meeting. The *Surgical Services Policy* and *Medical Staff Bylows* were reviewed as they relate to CMS pre-surgical H&P requirements. Revisions made on September 28, 2016 to *Medical Staff Bylows* and *Surgical Services Policy* to ensure Bylaws and Policy align with CMS H&P requirements. i.e 30 day H&P with 7 day addendum for out-patient procedures and surgeries, and are all signed and dated. b. Nursing Pre-Surgical check-list revised to include check box for "Current H&P on Chart" and accompanying definition defining requirements of H&P. (Defined by being performed within 7 days for inpatient surgery and no more than 30 days WITH an attached addendum performed within 7 days of outpatient surgery/procedure." All to be signed and dated appropriately c. Policy in-services will be provided to Medical and Nursing staff on H&P requirement with signature and date. d. Beginning Sept 26, 2016 all procedure and surgical charts will be audited to verify all components of H&P requirement (including date, time and signature of addendums) are met and will be reported monthly through QI Department.	

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C 307	Continued From page 60 on the H&P was not dated. A physician entry on Patient #5's H&P was signed but not dated. 2. Patient #4 was a 54 year old male admitted to the facility on 6/07/16 for surgical repair of an inguinal hernia. The H&P, dated 4/07/16, had a handwritten note, signed by the surgeon, indicating Patient #4 did not have any new signs and symptoms. The note was not dated. It could not be determined the timing of the physician's findings and whether the H&P was reviewed immediately prior to surgery. The Informatics RN was interviewed on 8/03/16 at 3:10 PM. She confirmed the physician's note on the H&P was not dated. A physician entry on Patient #4's H&P was signed but not dated. 3. Patient #18 was a 66 year old female who was admitted to the CAH on 8/05/16 for depression with history of suicidal thoughts and hypoxia. a. Patient #18's record included a CAH document "LINCARE," dated 8/05/16, which was reviewed. The document was an order form for home oxygen DME. The document was not signed, dated, or timed by the ordering physician. The DON was interviewed on 9/01/16, beginning at 1:40PM, and Patient#11's record was reviewed in her presence. She confirmed the missing physician signature, date, and time. Physician orders for Patient #18 did not include date, time, or signature.	C 307	C 307 Continued 2. Description of how the actions will improve process that led to deficiency: a. Discussion on H&P, signature and dating requirement at General Medical Staff meeting and resulting action of aligning the Bylaws and Surgical Services Policy provides clarity and eliminates any confusion around the H&P, signature, dating requirement. b. Addition of the word *"Current"* and definition of H&P requirement to the pre-surgical checklist "H&P on Chart" will queue the pre-surgical nurse to verify that an H&P is on the chart <u>and</u> that it is *Current* and meets all the defined requirements. c. Providing in-service to nursing and medical staff on revised Surgical Services Policy and pre-surgical checklist encourages compliance of H&P, signature, dating requirements. d. Tracking and reporting compliance of H&P requirement through Quality Department and subsequent reporting at Medical Staff meetings will highlight any deficiencies and encourage compliance through peer pressure. Identified deficiencies may also impact re-credentialing. 3. Procedure for implementing plan with Completion Dates a. The need to revise the Bylaws and make revisions to the Surgical Services policy to meet H&P requirements presented to Medical Staff at General Medical Staff meeting on September 28, 2016. b. Nursing Informatics notified to make revisions to pre-surgical checklist. Revisions completed September 30, 2016. c. Director of Nursing and OR RN Coordinator will provide in-service on H&P, signing, and dating requirement and revised OR Checklist to All OR Staff by October 9th, 2016. d. OR RN Coordinator will develop appropriate audit tool and begin auditing all procedure and surgical charts for 100% H&P compliance beginning September 28, 2016 and report monthly to Qual. Department.	

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C 307	Continued From page 61 4. Patient #11 was a 78 year old female who was admitted to the CAH on 4/11/16 for hyponatremia, heart failure, and bilateral pneumonia. a. Patient #11's record included a CAH document "Swing Bed Orders," dated 4/11/16. The document was not dated or timed by the ordering physician. b. Patient #11's record included a CAH document "Physician Medication Order Sheet," dated 4/11/16. The document was not signed, dated, or timed by the ordering physician. The DON was interviewed on 9/01/16, beginning at 1:40PM, and Patient#11's record was reviewed. She confirmed the missing physician information. Physician orders for Patient #11 did not include dated signatures. 5. Patient #14 was a 19 year old female who was admitted to the CAH on 7/30/16 for pregnancy, failure to progress and caesarian section. a. Patient #14's record included a CAH document "ANESTHESIA PROGRESS NOTES," dated 7/30/16. The document was not signed, dated, or timed by the CRNA. b. Patient #14's record included a CAH document "Surgical-Procedural Consent," dated 7/30/16. The document was not signed, dated, or timed by the ordering physician. c. Patient #14's record included a CAH document "Surgical-Procedural Consent," dated	C 307	C307 Continued 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: e. Chart reviews of all in-patient and out-patient surgeries and procedures will be conducted to verify compliance of pre-surgical History and Physical requirements beginning 9/28/16. f. On-going audit will be reported at monthly Medical Staff meeting through Quality Department. g. Any identified deficiencies will be reported to the Chief of Medical Staff and may impact re-credentialing. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. OR RN Coordinator b. Chief of Staff c. Quality Director	

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C 307	Continued From page 62 7/31/16. The document was not signed, dated, or timed by the ordering physician. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and Patient #14's record was reviewed in her presence. She confirmed the missing physician and CRNA information. Anesthesia progress notes and Surgical Consents for Patient #14 did not include dated signatures.	C 307	C320 485.639 SURGICAL SERVICES (H&P Requirements) 2. Corrective Actions: a. Immediately require that H&P (meeting all requirements set forth by CMS) be present on the medical chart prior to minor procedures and surgeries. Held discussion with Medical Staff on H&P Requirements on September 28, 2016 at the General Medical Staff Meeting. The *Surgical Services Policy* and *Medical Staff Bylaws* were reviewed as they relate to CMS pre-surgical H&P requirements. Revisions made on September 28, 2016 to *Medical Staff Bylaws* and *Surgical Services Policy* to ensure Bylaws and Policy align with CMS H&P requirements. i.e 30 day H&P with 7 day addendum for out-patient procedures and surgeries. b. Nursing Pre-Surgical check-list revised to include check box for "Current H&P on Chart" and accompanying definition defining requirements of H&P. (Defined by being performed within 7 days for inpatient surgery and no more than 30 days WITH an attached addendum performed within 7 days of outpatient surgery/procedure." c. Policy in-services will be provided to Medical and Nursing staff on H&P requirement. d. Beginning Sept 26, 2016 all procedure and surgical charts will be audited to verify all components of H&P requirement (including date, time and signature of addendums) are met and will be reported monthly through QI Department.	
C 320	485.639 SURGICAL SERVICES If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section. This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of policies, surgical standards of practice, medical staff bylaws, and medical records, it was determined the CAH failed to ensure surgical services were provided in a safe manner. This impacted 4 of 6 surgical patients (#4, #5, #14, and #31) whose records were reviewed which had the potential to interfere with the quality and safety of patient care in the surgical setting. Findings include: 1. The "Surgical Services Policy," dated 6/16/14, was reviewed. It stated the "H&P is to be performed and recorded within the previous seven (7) days prior to the surgery or procedure. An addendum to the H&P can be done by the	C 320		

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C 320	Continued From page 63 surgeon if the H&P is more than seven (7) days out." The "MEDICAL STAFF BYLAWS," dated 2/07/05, were reviewed. They stated it was the basic responsibility of medical staff to "ensure that a physical examination and medical history (or updated note for a physical examination and medical history done within the prior 30 days) is done no more than 7 days before or 48 hours after an admission for each patient by a physician in accordance with state law." The H&P pre-surgical requirements were not met. Examples include: a. Patient #5 was a 7 year old male who was admitted to the facility on 7/20/16 to have his tonsils removed. The H&P, dated 5/26/16, was performed 55 days prior to surgery. The H&P had a handwritten note, signed by the surgeon, at the end of the document, indicating Patient #5 did not have any new signs and symptoms. The note was not dated and did not indicate a physical examination was performed. The Informatics RN was interviewed on 8/03/16 at 3:05 PM. She confirmed the outdated H&P and the undated physician's note handwritten on the H&P. b. Patient #4 was a 54 year old male admitted to the facility on 6/07/16 for surgical repair of an inguinal hernia. The H&P, dated 4/07/16, was performed 61 days prior to surgery. The H&P had a handwritten note, signed by the surgeon, indicating Patient #4 did not have any new signs and symptoms. The note was not dated and there was no documentation of a physical	C 320	C 320 Continued 4. Description of how the actions will improve process that led to deficiency: e. Discussion on H&P requirement at General Medical Staff meeting and resulting action of aligning the Bylaws and Surgical Services Policy provides clarity and eliminates any confusion around the H&P requirement. f. Addition of the word *"Current"* and definition of H&P requirement to the pre-surgical checklist "H&P on Chart" will queue the pre-surgical nurse to verify that an H&P is on the chart and that it is *Current* and meets all the defined requirements. g. Providing in-service to nursing and medical staff on revised Surgical Services Policy and pre-surgical checklist encourages compliance of H&P requirements. h. Tracking and reporting compliance of H&P requirement through Quality Department and subsequent reporting at Medical Staff meetings will highlight any deficiencies and encourage compliance through peer pressure. Identified deficiencies may also impact re-credentialing. 5. Procedure for implementing plan with Completion Dates a. The need to revise the Bylaws and make revisions to the Surgical Services policy to meet H&P requirements presented to Medical Staff at General Medical Staff meeting on September 28, 2016. b. Nursing Informatics notified to make revisions to pre-surgical checklist. Revisions completed September 30, 2016. c. Director of Nursing and OR RN Coordinator will provide in-service on H&P requirement and revised OR Checklist to All OR Staff by October 9th, 2016. d. OR RN Coordinator will develop appropriate audit tool and begin auditing all procedure and surgical charts for 100% H&P compliance beginning September 28, 2016 and report monthly to Qual. Department.	

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C 320	Continued From page 64 examination. The Informatics RN was interviewed on 8/03/16 at 3:10 PM. She confirmed the outdated H&P and the undated physician's note handwritten on the H&P. 2. Nursing care observed in the surgical setting did not meet patient needs and/or CAH policy requirements. Patient #31 was a 57 year old male admitted to the facility on 8/31/16 for surgical repair of an inguinal hernia. The care of Patient #31 was observed on 8/31/16 from 7:30AM while he was in pre-op, until approximately 10:50 AM while Patient #31 was still in PACU, prior to transferring to the medical/surgical floor. The RN (OR Coordinator) provided care to Patient #31. Patient needs for nursing care were not met. Examples include: a. A CAH nursing policy, "Surgical Patient Preparation," dated 11/18/13, was reviewed. It included the expectation that vital signs be assessed immediately before going to OR, including temperature, blood pressure, pulse, and respiratory rate. It also included the expectation nursing staff would perform a physical examination, including assessment of heart and lungs. The RN did not take Patient #31's temperature or listen to Patient #31's heart and lungs in pre-op. The "Preop Physical Assessment," dated 8/31/16 at 7:51 AM, documented "breath sounds clear all lobes." The information that was documented did not match the observation.	C 320	C320 Continued 6. Monitoring and tracking of procedures to ensure sustained compliance of regulations: e. Chart reviews of all in-patient and out-patient surgeries and procedures will be conducted to verify compliance of pre-surgical History and Physical requirements beginning 9/28/16. f. On-going audit will be reported at monthly Medical Staff meeting through Quality Department. g. Any identified deficiencies will be reported to the Chief of Medical Staff and may impact re-credentialing. 7. Title of person(s) responsible for implementing acceptable plan of correction: a. OR RN Coordinator b. Chief of Staff c. Quality Director	

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C 320	Continued From page 65 b. A CAH policy "Intravenous Therapy- Initiation," dated 6/16/14, was reviewed. The policy stated: - "Perform hand hygiene before patient contact." - "Verify the correct patient using two patient identifiers per institution policy." - "Apply label to IV tubing that indicates either when tubing was hung or when tubing should be changed." - "...don clean gloves." - "Swab injection cap with antiseptic swab." - "Label dressing. Include date and time of IV insertion, VAD gauge size and length, and nurse's initials." The RN did not follow the CAH policy related to intravenous therapy. Examples include: - The RN did not perform hand hygiene or don new gloves prior to IV therapy initiation. - The RN did not use 2 patient identifiers prior to IV therapy initiation. - The RN did not apply a label to the IV tubing indicating when it was hung or should be changed. - The RN did not swab the IV tubing injection cap with antiseptic swab prior to attaching secondary IV tubing which contained pre-operative antibiotics. - The RN did not label date and time of IV insertion, VAD gauge size, or nurse's initials on Patient #31's IV dressing. c. A CAH policy "Patient Identification," dated 12/16/13, was reviewed. The policy included the following information: - "Purpose: To provide accurate identification of patients prior to any surgical or invasive	C 320	C 320 Continued C320 SURGICAL SERVICES (Nursing Care) 3. Corrective Actions: a. Nursing Staff Training In-services will be scheduled to provide additional education to nursing staff on the following policies and procedures; *Surgical Patient Preparation, Intravenous Therapy-Initiation, Patient Identification,* and *Hand Hygiene by October 9th, 2016* b. Purchase of electronic amplified stethoscope and additional thermometers by October 9th 2016. c. Install wall mounted waterless alcohol-based hand sanitizer dispensers in Pre-OP/PACU, Minor Room, and Surgical Operating Room by October 9th, 2016. d. Make appropriate revisions to *Intravenous Therapy-Initiation* policy to reflect electronic documentation procedures and capabilities by October 9, 2016. e. Monitor Surgical and Out-Patient Department hand hygiene compliance at least two times a month and report findings to Infection Control Committee monthly beginning October 1, 2016. 4. Description of how the actions will improve process that led to deficiency: a. The in-services will provide additional education and defines the expectations of nursing care, including for example what is required in the preparation of a surgical patient, documentation requirements, and expected IV therapy techniques, i.e. taking vitals Immediately before surgery. b. Having tools readily available *i.e.* stethoscopes and thermometers will promote compliance of policies and procedures. c. Installing wall mounted alcohol based hand sanitizer dispensers in the Pre-OP/PACU, Minor Room, and Surgical Operating room will readily encourage hand hygiene resulting in improved compliance.	

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C 320	Continued From page 66 procedure, when drawing blood, and when administering medications and/or blood products..." - "To identify a patient, staff will ask the patient to state his or her name and date of birth and the staff will verify that it matches the identification band." The RN was observed to scan Patient #31's identification band, but was not observed to ask Patient #31 for his name and date of birth or compare that information against his armband prior to medication administration, including IV medication. d. The RN did not wash his hands (and/or use alcohol based hand gel) while in pre-op, the surgical suite, or in PACU. Examples included: - Prior to inserting an IV catheter in pre-op - Before clipping hair from surgical site (pubic area) in pre-op - After removing gloves after clipping surgical site in pre-op - After working on the computer in pre-op or handling the camera in the surgical suite - Before inserting a urinary catheter in the surgical suite - Before direct contact with the patient, such as when applying blood pressure cuff and finger monitor, applying socks, before putting together the incentive spirometer, or before cleansing the surgical site in the surgical suite, or before physical assessment with a stethoscope in PACU e. The RN listened to Patient #31's lungs in PACU and stated Patient #31 had crackles in his left lung. The RN visit, "RECOVERY ROOM FLOWSHEET," dated 8/31/16 at 10:25 AM,	C 320	C 320 Continued d. Revisions to the *Intravenous Therapy-Initiation* policy will clarify that the documentation of when the next tubing change is due, date, time and gauge of VAD and dressing is defined in electronic documentation. e. On-going auditing and reporting of Hand-Hygiene in the Surgical and Out-Patient department will provide necessary oversight to ensure compliance. 5. Procedure for implementing plan with Completion Date a. All nursing staff present at the in-services will sign the meeting roster to verify that they have received the education on identified policies. Nursing staff that were not present for scheduled in-services will be provided paper copies of each of the above policies and will initial and return copy of each policy confirming they have received education. Competence of each of the above policies will be measured through a competencies based skills test. In-services and competencies will be completed by October 9th, 2016. b. Electronic amplified stethoscope ordered September 26, 2016, will be in serviced no later than October 9, 2016. Additional thermometers ordered September 26, 2016 and maintenance work order to mount units to wall sent September 27, 2016. The additional thermometers will be in service no later than October 9th, 2016.	

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C 320	Continued From page 67 indicated Patient #31's lungs were "clear." The documentation did not match the observation. Patient#31's RN was interviewed on 8/31/16 at 11:45 AM. He stated he generally did use a stethoscope to listen to lungs prior to surgery. He stated he did not have a stethoscope with him while in pre-op caring for Patient #31. He confirmed he did not take Patient #31's temperature during pre-op. He stated the CRNA generally took the patient's temperature in the surgical suite. He stated he confirmed the patient's identity by checking date of birth prior to the surveyors entering pre-op. He confirmed he did not use a second patient identifier at the time of administration of the IV medication. He stated he washed his hands prior to entering pre-op and after leaving the room, prior to entering the surgical suite. Nursing care did not meet the needs of Patient #31 to ensure a thorough assessment, accurate documentation, appropriate identification of the patient, appropriate labeling of medications, and appropriate handwashing in accordance with CAH policy. 3. Environmental cleaning issues were identified as they related to storage and handling of supplies. A policy "Storage and handling of sterile equipment and supplies," dated 12/17/14, was reviewed. The policy included "The temperature shall be controlled between 65 and 72 degrees F. [sic] and the relative humidity between 40% and 70% at all times." An observation of the OR sterile supply area was	C 320	C320 Continued f. Wall mounted alcohol based hand sanitizer dispensers ordered September 13, 2016 for Pre-op/PACU, Minor Room and Operating room. Work-Order placed to install units upon arrival. Will be implemented no later than October, 9th, 2016. Prior to installation bottles of alcohol based hand sanitizers placed in each of the rooms and readily available to staff to perform hand hygiene. g. Appropriate revisions to Intravenous Therapy-Initiation policy to reflect electronic documentation procedures and capabilities will be completed by September 28, 2016. h. Surgical and Out-patient hand hygiene auditing tool will be developed by Sept 30, 2016 with auditing of hand hygiene to begin October 1, 2016 and reported monthly to Infection Control Nurse. 6. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Meeting roster of in-services will be recorded in OR Committee Meeting Minutes b. Staff Competencies of identified policies and procedures will be evidenced by written examination and recorded in staff education folders. c. Charts will be reviewed for accurate electronic documentation of expectations and procedures identified in *Surgical Patient Preparation, Intravenous Therapy-Initiation, Patient Identification,* and *Hand Hygiene*- Deficiencies will be tracked & reported through the Quality Improvement Committee. d. Surgical and Out-Patient Department Hand Hygiene will be audited two times a month and compliance reported monthly to Infection Control Committee. 7. Title of person(s) responsible for implementing acceptable plan of correction: a. OR RN Coordinator b. Infection Control RN c. Director of Nursing	

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C 320	Continued From page 68 conducted on 8/31/16, beginning at 10:20 AM, in the presence of the OR Tech. A humidity log was noted, however, a temperature log could not be located. When asked if temperature was being recorded for this area, the OR Tech stated no. She stated temperature was being visually monitored and pointed out the display device for temperature in the area. However, the OR Tech stated, during the time of the observation, the temperature information was not being recorded for reference and/or maintenance control. Temperature was not monitored in accordance with CAH policy. 4. Environmental issues were identified as they related to cleaning procedures to maintain a sanitary environment. A policy "Operating Room Sanitation," dated 12/17/14, was reviewed. The policy included "All horizontal surfaces on moveable and mounted equipment and overhead lights will be damp dusted with bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant." An observation of the OR was conducted on 8/31/16, beginning at 8:35AM, and ending at approximately 10:45 AM. During the observation, a bottle of 70% isopropyl alcohol was noted next to the cleaning supplies. The OR Tech was interviewed on 8/31/16, beginning at 10:20 AM. When asked what the 70% isopropyl alcohol was used for, she stated it was used to clean the OR surgical lights. When asked what guidelines the CAH used for surgical services, the OR Tech stated they used AORN standards. When asked if the 70% isopropyl	C 320	C 320 Continued C320 SURGICAL SERVICES (Environmental Cleaning) 1. Corrective Actions: a. The *Storage and Handling of Sterile Equipment and Supplies* Policy was reviewed and revised on 9/28/2016 to include "The temperature shall be controlled and *[recorded]* between 65 and 72 degrees F. and the relative humidity between 40% and 70%." Hygrometers and thermometers were ordered and installed September 27, 2016 where sterile supplies are stored. Humidity and temperature of Operating Room and OR sterile supply areas will be monitored and logged on newly created log sheets daily. Variances from stated ranges will be immediately addressed with corrective measures to maintain stated ranges. b. The *Operating Room Sanitation* policy and operating room sanitation procedure was reviewed September 13, 2016. All horizontal surfaces on movable and mounted equipment and the overhead lights, except for the glass surface of the lights themselves have been routinely damp dusted with virex (a bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant.) The lens of the light is the only portion of the light that was damp dusted with 70% isopropyl alcohol per manufacturer representative recommendations at time lights were purchased. Effective September 13, 2016 OR light surfaces including lens will be cleaned and damp dusted with virex until an alternative OR approved bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant agent is recommended by the OR light manufacturer.	

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C 320	Continued From page 69 alcohol was approved for use in the OR as a disinfectant, she stated she did not know. The EVS Manager was interviewed on 9/01/16, beginning at 8:30AM. When asked what the 70% isopropyl alcohol was used for in the OR, she stated she did not know. The EVS Manager stated she was unsure what cleaning agents were used in the OR due to the fact EVS staff did not clean the OR. When asked if the 70% Isopropyl alcohol was approved for use in the OR as a disinfectant, she stated she did not know. The Infection Control RN was interviewed on 9/01/16, beginning at 9:37AM. When asked if she had reviewed OR cleaning procedures, cleaning agents used, and EVS policies, she stated she had not done so. The Infection Control RN stated she was planning on reviewing those items in the future, but had not gotten to it yet. When asked if the 70% isopropyl alcohol was approved for use in the OR as a disinfectant, she stated she did not know. The website "AORN (https://www.aorn.org)," accessed on 9/06/16, included the following: "Alcohol should not be used for cleaning and disinfecting surfaces in the operating room because alcohol is not an adequate cleaning and disinfecting agent." Cleaning procedures were not conducted in accordance with CAH policy and standards of practice. 5. Refer to C 322 as it relates to the failure of the CAH to ensure each patient was examined immediately prior to surgery by an MD/DO to	C 320	C320 Continued 2. Description of how the actions will improve process that led to deficiency: a. Hygrometers and thermometers placed in Sterile Supply Areas in addition to OR allow humidity and temperature to be monitored and logged. b. Cleaning OR Light horizontal surfaces, including lenses of lights with virex or alternative OR approved bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant agent ensures that cleaning procedures to maintain a sanitary environment in the Operating Room, as outlined in the *Operating Room Sanitation* policy, is maintained. 3. Procedure for implementing plan with Completion Dates a. Staff notified at the OR Committee Meeting held September 27, 2016 of *Storage and Handling of Sterile Equipment and Supplies Policy* change and expectation to log temperature as well as humidity in the operating room and sterile supply areas. b. Staff education provided on *Operating Room Sanitation policy* and procedural change at September 27th 2016 OR Committee Meeting to use OR approved bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant agent on all horizontal surfaces including the lenses of the OR lights.	

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C 320	Continued From page 70 determine the risk of the procedure and by a qualified anesthesia provider to determine the risk of anesthesia. The cumulative affect of these negative systemic practices resulted in the failure of surgical services being provided in a safe and effective manner.	C 320	C 320 Continued 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Staff was required to read and initial change in policy and keep record in their Staff Education Folder. b. Staff signed updated procedure to use approved bacterial, tuberculocidal, pseudomonacidal and fungicidal disinfectant agent on all horizontal surfaces including the lenses of the OR lights and place acknowledgment in their Staff Education Folder. c. Random surveillance of Operating Room Sanitation activities will be audited and reported monthly through the Infection Control Committee.	
C 322	485.639(b) ANESTHETIC RISK & EVALUATION (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (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. This STANDARD is not met as evidenced by: Based on observation, staff interview, policy review, and medical record review, it was determined the CAH failed to ensure each patient was examined immediately prior to surgery by an MD/DO to determine the risk of the procedure and by a qualified anesthesia provider to determine the risk of anesthesia for 4 of 6 surgical patients (#5, #6, #14, and #31) whose records were reviewed. This had the potential to interfere with patient safety. Findings include: The "Surgical Services Policy," dated 6/16/14, was reviewed. It included the following	C 322	5. Title of person(s) responsible for implementing acceptable plan of correction: a. OR RN Coordinator b. Infection Control Nurse c. Director of Nursing C322 485.639(b) Anesthetic Risk & Evaluation 1. Corrective Actions: a. Pre-Surgical Checklist revised to include box for *"Patient Examination by Physician Complete"* Y N ; The doctor identified on the Informed Consent will exam the patient just before the specified procedure/surgery to evaluate the risk of the procedure and document assessment on the current H&P. b. Pre-Surgical Checklist revised to include box for *"Pre-Anesthesia Assessment Complete"* Y N; The CRNA who will be providing the anesthesia will perform an assessment of the patient just before the specified procedure/surgery to evaluate the risk of anesthesia and document on the *Pre- Anesthesia Progress* Note form.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY'S HOSPITAL	701 LEWISTON ST COTTONWOOD, ID 83522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 322	Continued From page 71 information: - It is the CAH's policy "to assure that each patient undergoing operative and/or invasive procedures requiring anesthesia is appropriately assessed for clinical stability prior to the procedure." - "Anesthetist will complete a pre-anesthesia evaluation and document the evaluation on the appropriate form. The pre-anesthesia evaluation will include notation of anesthesia risk; anesthesia, drug and allergy history; and potential anesthesia problems identified; and the patient's condition prior to induction of anesthesia." - "Upon arrival to PACU the CRNA and Circulating and/or PACU nurse will immediately assess patient's cardiopulmonary status, level of consciousness, and provide any needed care (e.g. Oxygen, Pain Control)." A policy "Surgery- Rules and Regulations," dated 10/07/13, was reviewed. It stated "The Anesthesia Department shall record a complete anesthesia record, which includes pre-anesthetic evaluation and a post-operative follow-up." Pre-surgical, pre-anesthesia, and post-anesthesia assessment requirements were not met. Examples include: 1. Patient #31 was a 57 year old male admitted to the facility on 8/31/16 for surgical repair of an inguinal hernia. The care of Patient #31 was observed on 8/31/16 from 7:30AM while he was in pre-op until approximately 10:50 AM while Patient #31 was in PACU, prior to being moved to a medical/surgical floor. The surgeon and CRNA did not use a	C 322	C 322 Continued c. Verify post-anesthesia evaluation and accompanying documentation is complete and accurate anesthesia risk and physical assessment on the d. The CRNA will perform post-anesthesia evaluation on all inpatients and out-patients prior to discharge from surgery and anesthesia services. e. Perform compliance audits on (a,b,c) and report monthly to Quality Committee. 2. Description of how the actions will improve process that led to deficiency: a. When completing the pre-surgical checklist the RN Circulator will review and confirm if the pre-surgical exam by the doctor just prior to the surgery has been done by reviewing the hand written note on the H&P. If not done or documented will encourage doctor to complete prior to taking patient to surgery. b. When completing pre-surgical checklist RN circulator will verify with CRNA that pre-anesthesia risk and physical assessment is complete prior to taking patient to surgery or scheduled procedure. c. Posting results of the compliance audits in the Quality Committee Meeting (minutes) will enforce compliance.	

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C 322	Continued From page 72 stethoscope to auscultate Patient #31's heart and lungs prior to surgery or in PACU following surgery. Patient #31's record included a CAH document "ANESTHESIA PROGRESS NOTES," dated 8/31/16. Consistent with the observation, the anesthesia notes did not document a pre-anesthesia physical assessment by the CRNA, or indicate if there were any post-procedure anesthesia complications, as the "Yes" and "No" checkboxes were blank. Consistent with the observation, there was no documentation of a physician's physical assessment of Patient #31 immediately prior to surgery to determine the risk of the procedure. 2. Patient #6 was a 92 year old male who was admitted to the facility on 7/22/16 for surgery related to an incarcerated inguinal hernia. The surgical consent form was signed by the patient on 7/22/16 at 5:12PM. The pre-anesthesia assessment, dated 7/22/16, was reviewed. There was no documentation of a pre-anesthesia physical assessment of Patient #6, such as, auscultation of heart and lungs with a stethoscope. 3. Patient #5 was a 7 year old male who was admitted to the facility on 7/20/16 to have his tonsils removed. There was no documentation of a physician's physical assessment of Patient #5 immediately prior to surgery to determine the risk of the procedure.	C 322	C 322 Continued 3. Procedure for implementing plan with Completion Dates a. Provide education to Medical and CRNA Staff at September 28, 2016 Medical Staff Meeting on Anesthetic Risk and Evaluation requirements, including pre-anesthesia risk and physical assessment and post-anesthesia evaluation requirements. b. Request revisions to the Pre-Surgical Checklist be completed by September 30, 2016. c. Present the changes of the Pre-Surgical Checklist to ALL Circulating RN's by October 5th, 2016. d. Compliance audits of (a,b,c) will begin October, 1, 2016 and will be reported monthly to Quality Committee. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. Beginning October 1, 2016 will audit 100% of Out-Patient and In-Patient procedures (requiring anesthesia) and surgical charts for compliance with pre-surgical exam just prior to surgery to evaluate the risk of the procedure/surgery to be performed. b. Beginning October 1, 2016 will conduct monthly audits on all Anesthesia Progress Notes for compliance with pre-anesthesia risk and physical assessment, and post-anesthesia follow-up reports. Results will be reported through Quality Improvement Committee. Any future deficiencies if any will be reported at monthly Medical Staff Meetings. 5. Title of person(s) responsible: a. Lead CRNA b. Chief of Staff c. OR RN Coordinator d. Quality Director	

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C 322	Continued From page 73 The pre-anesthesia assessment, dated 7/26/16, was reviewed. There was no documentation of a pre-anesthesia physical examination, such as auscultating heart and lungs, to determine the risk of anesthesia. 4. Patient #14 was a 19 year old female who was admitted to the CAH on 7/30/16 for pregnancy, failure to progress and caesarian section. Patient #14's record included a CAH document "ANESTHESIA PROGRESS NOTES," dated 7/30/16, which was reviewed. The document did not include documentation of a pre-anesthesia physical assessment by the CRNA, or indicate if there were any post-procedure anesthesia complications, as the "Yes" and "No" checkboxes were blank. Additionally, there was no documentation in Patient #31's record of physical assessment by the physician immediately prior to surgery to determine the risk of the procedure. The surgeon was interviewed on 9/01/16 at 10:55 AM. He stated he did not typically do a physical assessment in pre-op. He stated he typically did a physical assessment in the clinic, days before surgery. A CRNA was interviewed on 9/02/16 at 9:40AM. He stated he did not routinely listen to heart and lungs in pre-op. Instead, he stated he auscultated for breath sounds after intubation in the OR. He explained he was hard of hearing and the equipment in the pre-op area (which is also the PACU area) was not sufficient to allow him to hear breath sounds. He stated he had a "300 dollar stethoscope" that he used in the OR that allowed him to hear breath sounds.	C 322		

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C 322	Continued From page 74 The DON was interviewed on 9/01/16, beginning at 1:40 PM. She confirmed the missing documentation in patient records. Pre-surgical, pre-anesthesia, and post-anesthesia assessments were incomplete as patients were not physically examined immediately prior to surgery by the MD/DO and prior to anesthesia by a qualified anesthesia provider and in the post-operative setting by qualified anesthesia provider.	C 322	C385 485.645(d)(4) Patient Activities 1. Corrective Action a. Swing Bed Activities policy was reviewed and sent for revision – 09/2016 b. The on-staff Activities Program Director was interviewed and schedule discussed. Availability of Director or designee to be 4 days a week. c. Education was provided to the nursing staff about the importance of the completion of the activities assessment. d. Education was provided to the nursing staff regarding the activities needs of the resident need to be individualized and goals met. e. Education was provided to the nursing staff of "copying" from one screen to the next screen. Data must be factual and consistent with the resident's status at that moment. 2. Description of how the actions will improve process that led to deficiency: a. Nurses and Certified Nurse's aides will provide and document comprehensive, individualized activities. b. Deficiencies may impact re-credentialing possibilities 3. Procedure for implementation of the plan: a. Communications were sent out both electronically and individually to all nursing staff September 20, 2016. b. Reviewed at Nursing Staff meeting – October 5th. c. Continuing ongoing audits and reporting	
C 385	485.645(d)(4) PATIENT ACTIVITIES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:) Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. Quality of Life- activities (§483.15(f)) "(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who-	C 385		

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C 385	Continued From page 75 (i) Is a qualified therapeutic recreation specialist or an activities professional who- (A) Is licensed or registered, if applicable, by the State in which practicing; and (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State." This STANDARD is not met as evidenced by: Based on record reviews, staff interview, patient interview, and policy review, it was determined the CAH failed to provide an ongoing program of activities for 4 of 4 swing bed patients (Patient #11, #28, #29, and #30) whose records were reviewed. This resulted in the lack of recreational activities for swing bed patients, and had the potential to result in unmet patient needs. Findings include: A policy "Swing bed- Policies and Procedures," dated 4/29/09, was reviewed. The policy included the following information:	C 385	C385 Continued 4. Completion date for correction by October 9th. a. Ongoing audits and reporting of processes done monthly by Activities Director and reported to Medical Committee monthly. 5. Monitoring and tracking mechanism to ensure compliance with regulation a. Refer to plan of correction 1a-e. b. Ongoing reporting to Committee and Quality Committee to ensure participation. 6. Include title of person responsible for implementing the plan a. Director of Nurses b. Discharge Planner c. Activities Director	

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C 385	Continued From page 76 - "An Activities Program will be available to all residents." - "An assessment will be done and an individualized activities plan will be developed for each Resident." - "The resident is encouraged to participate in activities at their discretion unless medically contraindicated." The CAH failed to follow their policy and ensure swing bed patients' activity program needs were individualized and met. Examples include: a. Patient #11 was a 78 year old female who was admitted to the CAH on 4/11/16 for hyponatremia, heart failure, and bilateral pneumonia whose record was reviewed. Patient #11's record included a CAH document "Discharge Summary," multiple dates, which was reviewed. The document included the questions "Visited with Patient About [sic] +" and "Response [sic]+." Examples include: - "4/12/16 5:48AM Visited with Patient About [sic] + Personalized to Patient Response [sic] + Smiled" - "4/21/16 2:07AM Visited with Patient About [sic] + Personalized to Patient Response [sic] + Smiled" The same, predetermined drop-down options were used for both of these questions for the duration of Patient #11's admission. Patient #11's record did not include an activities	C 385		

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C 385	Continued From page 77 assessment or a plan to provide activities. b. Patient #28 was a 79 year old female who was admitted to the CAH on 7/18/16 for status post hip surgery rehab, whose record was reviewed. Patient #28's record included a CAH document "Discharge Summary," multiple dates, which was reviewed. The document included the questions "Visited with Patient About [sic] +" and "Response [sic]+." Examples include: - "7/19/16 5:08AM Visited with Patient About [sic]+ Personalized to Patient Response [sic] + Smiled" - "7/24/16 2:29AM Visited with Patient About [sic] + Personalized to Patient Response [sic] + Smiled" The same, predetermined drop-down options were used for both of these questions for the duration of Patient #28's admission. Patient #28's record did not include an activities assessment or a plan to provide activities. c. Patient #29 was a 95 year old male who was admitted to swing bed services on 6/16/16 for continued care of a pelvic fracture. He was discharged on 7/05/16. Patient #29's record did not include an activities assessment or a plan to provide activities. Patient #29's record included a CAH document "Discharge Summary," multiple dates, which was	C 385		

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C 385	Continued From page 78 reviewed. On 6/17/16 at 7:29AM, the document by the RN stated "One to One Program for Swing Bed...Visited with Patient About +...PT SLEEPING AT THIS TIME." On 6/17/16 at 10:00 AM, the document by the RN stated "One to One Program for Swing Bed...Visited with Patient About +newspaper Response+ laughing." The same, predetermined drop-down options were used for these questions for the duration of Patient #29's admission. d. Patient #30 was a 65 year old female who was admitted to swing bed services on 8/25/16 for continued care of kidney pain. She was currently a patient as of 9/02/16. Patient #30's record did not include an activities assessment or a plan to provide activities. Patient #30's record included a CAH document "Discharge Summary," multiple dates, which was reviewed. On 8/25/16 at 9:07 PM, the document by the RN stated "One to One Program for Swing Bed...Visited with Patient About +...Personalized to patient...Angry" The note did not explain why Patient #30 was angry. On 8/26/16 at 6:30AM, the document by the RN stated "One to One Program for Swing Bed...Visited with Patient About +...Personalized to patient...Frowned" The note did notexplain why Patient #30 frowned. The same, predetermined drop-down options were used for these questions for the duration of Patient #30's admission. The Informatics RN was interviewed on 8/30/16, beginning at 10:50 AM. When asked how swing	C 385		

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C 385	Continued From page 79 bed patients' ongoing activities program was individualized, she stated RNs would utilize the predetermined EMR drop-down options for the activities section. The Informatics RN confirmed the predetermined activity options were not individualized and the free-form section for "comments" was not utilized. The DON was interviewed on 9/01/16, beginning at 1:40 PM, and the patients' records were reviewed in her presence. She stated a patient specific activities assessment was not conducted for swing bed residents. She stated a patient specific activities POC was not developed for swing bed residents. She confirmed the swing bed patients' ongoing activities program were not individualized to meet patients' specific needs. The CAH failed to follow their policy and ensure swing bed patients' activity program needs were individualized and met.	C 385		
C 395	485.645(d)(6) COMPREHENSIVE CARE PLANS [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b)).] Comprehensive care plans (§483.20(k)(1))	C 395		

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C 395	Continued From page 80 "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4)." This STANDARD is not met as evidenced by: Based on staff interview, review of policies, and review of medical records, it was determined the CAH failed to ensure comprehensive care plans including measurable objectives and timetables were developed for 4 of 4 swing bed residents (#11, #28, #29 and #30), whose medical records were reviewed. This resulted in a lack of direction to staff and an inability to involve residents in their care planning. Findings include: A policy addressing care plans for swing bed residents had not been developed and was not present at the CAH. Care plans were not present in the medical records of swing bed residents #11, #28, #29 and #30.	C 395	**C395 485.645(d)(6) Comprehensive Care Plan** 1. Corrective Action a. A policy "Swing Bed Care Plans" was developed and in review. b. A written Swing bed care plan was developed and will be reviewed at the nursing staff meeting October 5th and implemented on the 6th. 2. Description of how the actions will improve process that led to deficiency: a. Using a paper version of Nursing Care plan, staff will have an opportunity to manually update the nursing care plan and use this form during nursing huddle. b. Deficiencies may impact re-credentialing possibilities. 3. Procedure for implementing the plan: a. Nurse Care Plan procedure was reviewed with the nurses involved in the care of the patients reviewe. b. The Director of Nursing reviewed the requirements with nursing that nursing care plans need to be comprehensive and individualized. c. Nursing Care Plan policy was sent to nursing staff to read and sign through Policy Tech.	

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C 395	Continued From page 81 The Informatics RN was interviewed on 9/02/16 beginning at 10:45 AM. She stated no care plan documents were present for the above patients. The DON was interviewed on 9/02/16 beginning at 10:20 AM. She stated no specific care plans were present for swing bed residents. She stated swing bed policies did not address care plans. The CAH failed to develop care plans for swing bed residents.	C 395	C 395 Continued 1. Completion date for correction October 9th, 2016 a. Ongoing audit and reporting have been enhanced since September 28, 2016. 2. Monitor and tracking mechanism to ensure compliance with regulation a. Refer to Plan of Correction 1a-b b. Ongoing audit reporting in Medical Swing Committee meeting. 3. Include title of person responsible for implementing the plan a. Director of Nursing b. Discharge Planner UR Nurse c. Informatics Nurse d. Charge Nurses	

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Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER: ST MARY'S HOSPITAL

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the State licensure survey of your Critical Access Hospital conducted from 8/29/16 to 9/02/16. The surveyors conducting the survey were: Gary Guiles, RN, HFS-Team Leader Brian Obsborn, RN, HFS Teresa Hamblin, RN, MS, HFS Kristin Inglis, RN, HFS Acronyms used in this report include the following: CAH - Critical Access Hospital ED - Emergency Department ER - Emergency Room HFS - Health Facility Surveyor PRN - As Needed RN - Registered Nurse	B 000		
BB117	16.03.14.200.03 Chief Executive Officer or Administrator 03. Chief Executive Officer or Administrator. The governing body through the chief executive officer shall establish the following policies, procedures or plans: (10-14-88) a. The hospital shall adopt a written personnel policy concerning qualification, responsibility, and condition of employment for each category of personnel. The policy and/or procedures shall contain the following elements: (10-14-88) i. Documentation of orientation of all employees to policies, procedures and objectives of the hospital. (10-14-88) ii. Job descriptions for all categories of personnel.	BB117	**BB117 Patient Care Policies –(1)Infection Control Program Oversight** 1. Corrective Actions a. The Infection Control Nurse now has an updated and signed Job description, see HR for verification. b. The Infection Control Nurse now reports to the Director of Quality for oversight and support. c. Due to the resignation of our current infection control nurse, we are posting a full time Infection Control/Employee Health position. 2. Description of how the actions will improve process that led to deficiency: a. The Infection Control Nurse now has a clear description of her role and responsibilities and who to go to for oversight and direction. This will help significantly with role delineation and administrative support. b. Increased hours will support the Infection Control nurse in her duties and allow for a more robust program. 3. Procedure for Implementing plan with Completion Dates a. The infection control nurse position will be posted by October 7th. b. Infection Control meetings have been scheduled out for the remainder of FY17 as follows: i. October 6th ii. January 12th iii. March 9th iv. May 14th will be the annual program review to include approval and review of the Infection Control plan and policy, applicable policies, and annual infection control trends.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Matthew W. Forge Matt Forge — TITLE: Chief Admin Officer — (X6) DATE: 9/30/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:-------- B. WING	(X3) DATE SURVEY COMPLETED
	IDM7XR		09/02/2016

NAME OF PROVIDER OR SUPPLIER: ST MARY'S HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 701 LEWISTON ST, COTTONWOOD, ID 83522

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BB117	Continued From page 1 (10-14-88) iii. Documentation of continuing education (inservice) for all patient care personnel. (10-14-88) b. There shall be a personnel record for each employee, which shall contain at least the following: (10-14-88) i. Current licensure and/or certification status. (10-14-88) ii. The results of a Tuberculin Skin Test which shall be determined either by history of a prior positive, or by the application of a skin test prior to or within thirty (30) days of employment. If the skin test is positive, either by history or by current test, a chest X-ray shall be taken, or a report of the result of a chest X-ray taken within three (3) months preceding employment, shall be accepted. The Tuberculin Skin Test status shall be known and recorded and a chest X-ray alone is not a substitute. No subsequent annual chest X-ray or skin test is required for routine surveillance. (10-14-88) c. There shall be regularly scheduled departmental and interdepartmental meetings, appropriate to the needs of the hospital, and documentation of such meetings shall be available. (10-14-88) d. The chief executive officer shall serve as liaison between the governing body, medical staff and the nursing staff, and all other departments of the hospital. (10-14-88)	BB117	B117 c. Facility wide infection control education topics have been scheduled out for the remainder of FY17 as follows: v. 2nd Quarter 1. Hand hygiene education and monitoring 2. Cleaning techniques to include handling, labeling, disposal etc. of cleaning supplies 3. Decontamination vi. 3rd Quarter 1. Isolation vii. 4th Quarter 1. MRSA handling, procedures, and cleaning d. The Infection Control Nurse has created a spreadsheet to track, trend, and share infection control data. 4. Monitoring and tracking of procedures to ensure sustained compliance of regulations: a. The Director of Quality has a tracking spreadsheet to ensure all COPs related to Infection Control are met in a timely and satisfactory manner, including the annual review of the program. b. The Director of Quality will work with the Infection Control Nurse to ensure that infection control data is reviewed quarterly at the Executive Council. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Quality b. Director of Nursing c. Chief Administrative Officer	

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NAME OF PROVIDER OR SUPPLIER: ST MARY'S HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 701 LEWISTON ST, COTTONWOOD, ID 83622

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BB117	Continued From page 2 e. Written policies and procedures shall be reviewed as needed. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of job descriptions, it was determined the CAH failed to ensure job descriptions were provided for all categories of personnel. 1. Refer to C 278 as it relates to the failure of the CAH to ensure a job description was developed for the Infection Control Officer. 2. Refer to C 276 as it relates to the failure of the CAH to ensure a job description was developed for the Director of Pharmacy and the PRN pharmacist.	BB117	B152, BB284 (Review C307/320) 1. Corrective Actions: a. Immediately require that H&P (meeting all requirements set forth by CMS) be present on the medical chart prior to minor procedures and surgeries. Held discussion with Medical Staff on H&P and sign and date Requirements on September 28, 2016 at the General Medical Staff Meeting. The *Surgical Services Policy* and *Medical Staff Bylaws* were reviewed as they relate to CMS pre-surgical H&P requirements. Revisions made on September 28, 2016 to *Medical Staff Bylaws* and *Surgical Services Policy* to ensure Bylaws and Policy align with CMS H&P requirements. i.e 30 day H&P with 7 day addendum for out-patient procedures and surgeries, and are all signed and dated. b. Nursing Pre-Surgical check-list revised to include check box for "Current H&P on Chart" and accompanying definition defining requirements of H&P. (Defined by being performed within 7 days for inpatient surgery and no more than 30 days WITH an attached addendum performed within 7 days of outpatient surgery/procedure." All to be signed and dated appropriately c. Policy in-services will be provided to Medical and Nursing staff on H&P requirement with signature and date. d. Beginning Sept 26, 2016 all procedure and surgical charts will be audited to verify all components of H&P requirement (including date, time and signature of addendums) are met and will be reported monthly through QI Department.	
BB152	16.03.14.250.09 Medical Orders 09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospitall,s policy. (5-3-03) This Rule is not met as evidenced by: Refer to C 307 as it relates to the failure of the CAH to ensure appropriately authenticated physician orders.	BB152		

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STREET ADDRESS, CITY, STATE, ZIP CODE: 701 LEWISTON ST, COTTONWOOD, ID 83522

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BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to C 298 as it relates to the failure of the CAH to ensure nursing care plans were developed and kept current.	BB175	BB152, 284 Continued- Review C307/C320 2. Description of how the actions will improve process that led to deficiency: i. Discussion on H&P, signature and dating requirement at General Medical Staff meeting and resulting action of aligning the Bylaws and Surgical Services Policy provides clarity and eliminates any confusion around the H&P, signature, dating requirement. j. Addition of the word "*Current*" and definition of H&P requirement to the pre-surgical checklist "H&P on Chart" will queue the pre-surgical nurse to verify that an H&P is on the chart <u>and</u> that it is *Current* and meets all the defined requirements. k. Providing in-service to nursing and medical staff on revised Surgical Services Policy and pre-surgical checklist encourages compliance of H&P, signature, dating requirements. l. Tracking and reporting compliance of H&P requirement through Quality Department and subsequent reporting at Medical Staff meetings will highlight any deficiencies and encourage compliance through peer pressure. Identified deficiencies may also impact re-credentialing. 4.Procedure for implementing plan with Completion Dates m. The need to revise the Bylaws and make revisions to the Surgical Services policy to meet H&P requirements presented to Medical Staff at General Medical Staff meeting on September 28, 2016. n. Nursing informatics notified to make revisions to pre-surgical checklist. Revisions completed September 30, 2016. o. Director of Nursing and OR RN Coordinator will provide in-service on H&P, signing, and dating requirement and revised OR Checklist to All OR Staff by October 9th, 2016. p. OR RN Coordinator will develop appropriate audit tool and begin auditing all procedure and surgical charts for 100% H&P compliance beginning September 28, 2016 and report monthly to Qual. Department.	
BB221	16.03.14.330.01 Organization and Supervision 330. PHARMACY SERVICE. The hospital shall provide an organized pharmaceutical service that is administered in accordance with accepted professional principles and appropriate federal, state, and local laws. (10-14-88) 01. Organization and Supervision. Pharmacy services shall be under the overall direction of a pharmacist who is licensed in Idaho and is	BB221		

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NAME OF PROVIDER OR SUPPLIER: STMARY'S HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 701 LEWISTON ST, COTTONWOOD, ID 83522

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BB221	Continued From page 4 responsible for developing, coordinating, and supervising all pharmaceutical services in the hospital. (10-14-88) a. The director of the pharmaceutical service, whether a full, part-time or a consultant member of the staff, shall be responsible to the chief executive officer or his designee. (10-14-88) b. The pharmacist shall be responsible for the supervision of the hospital drug storage area in which drugs are stored and from which drugs are distributed. (10-14-88) c. If trained pharmacy assistants, pharmacy students, or pharmacy interns are employed, they shall work under the direct supervision of a pharmacist. (10-14-88) d. If the director of the pharmaceutical service is part-time, sufficient time shall be provided by the pharmacist to fulfill the responsibilities of the director of pharmaceutical services. (10-14-88) e. The director of the pharmaceutical service shall be responsible for maintaining records of the transactions of the pharmacy as required by law and as necessary to maintain adequate control and accountability of all drugs. This includes a system of control and records for the requisitioning and dispensing of drugs and supplies to nursing units and to other department/services of the hospital, as well as records of all prescription drugs dispensed to the patient. (10-14-88) f. The pharmacist shall periodically check drugs and drug records in all locations in the hospital where drugs are stored, including but not limited	BB221	**BB 175-Nursing Services Patient Care Plan** 1. Corrective Action: b) A nursing care plan for each patient was not developed and kept current for each inpatient. The nursing care plan was changed to a handwritten document that is updated at least minimally once a day and is a part of the patient's permanent chart. c) Nursing Care Plan policy was reviewed. This policy was updated to include how nursing care plans would be individualized and how the patient would participate in the development of the care plan. d) The EHR is in review with the Informatics team to determine a better way to implement an electronic Nursing Care Plan. 2. Description of how the actions will improve process that led to deficiency: a. Using a paper version of Nursing Care plan, staff will have an opportunity to manually update the nursing care plan and use this form during nursing huddle. b. deficiencies may impact re-credentialing possibilities 3. Procedure for implementing the plan: a. Nurse Care Plan procedure was reviewed with the nurses involved in the care of the patients reviewed. b. The Director of Nursing reviewed the requirements with nursing that nursing care plans need to be comprehensive and individualized. c. Nursing Care Plan policy was sent to nursing staff to read and sign. 4. Completion date for correction (Within 45 days from September 2, 2016). a. Ongoing audit and reporting have been enhanced since September 28, 2016 5. Monitor and tracking mechanism to ensure compliance with regulation a. Refer to Plan of Correction 1a-c b. Ongoing audit reporting in Medical Swing Committee meeting. 6. Include title of person responsible for implementing the plan a. Director of Nursing b. Discharge Planner UR Nurse c. Informatics Nurse d. Charge Nurses	

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BB221	Continued From page 5 to nursing stations, emergency rooms, outpatient departments, operating suites. (10-14-88) This Rule is not met as evidenced by: Refer to C-276 as it relates to the failure of the CAH to provide an organized pharmaceutical service that was administered in accordance with accepted standards of practice.	BB221	BB117,BB221, BB223, BB 276, BB228 1. Corrective Action: a. Maintenance and Storage of Pharmaceutical Supplies was developed on September 27, 2016 and in the review process within Policy tech. b. St. Mary's entered into a contract with PharmD to manage all pharmacy services, and are under contract to meet all state and CMS related requirements, including policy and procedure development and management. PharmD will coordinate P and T committee meetings and work with SMH providers in policy development and management. c. PharmD generated and have presented job descriptions for pharmacy director and PRN positions. d. Cabinets in Purchasing containing overflow large volume medications were found unlocked and not properly secured. These medications have been moved to a secure cabinet that is locked. The key is located in a secure location.	
BB223	16.03.14.330.03 Scope of Services 03. Scope of Services. (10-14-88) a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91) This Rule is not met as evidenced by: Refer to C 276 as it relates to a failure of the CAH to ensure a program was established for control and accountability of drug products throughout the hospital.	BB223		
BB226	16.03.14.330.06 Safe Handling of Drugs 06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures which govern the safe dispensing and	BB226		

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88226	Continued From page 6 administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88) a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88) b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88) c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88) d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate and distinct part of the patient's medical record; and (10-14-88) e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88) This Rule is not met as evidenced by: Refer to C-276 as it relates to the failure of the CAH to ensure the pharmacist developed a procedure for the safe mixture of parenteral products and to ensure nursing staff training related to the mixing of medications.	BB226	e. The OB delivery cart med box was unlocked with the keys inserted in the box. The box was locked and the key was removed and is now inaccessible to the general public and staff without accountability. f. Cabinets containing newborn circumcision supplies with medications were found unlocked in the nursery workroom. This cabinet has been secured with a lock and the key is now inaccessible to the general public and staff without accountability. g. Medications located in the Panda Warming unit were removed from the unit and placed in the OB delivery cart. h. A written procedure to direct nurses in the mixing of parental products provided by PharmD. 2. Description of how the actions will improve process that led to deficiency: a. Experience of PharmD in meeting pharmacy requirements demonstrated and available upon review.	
BB227	16.03.14.330.07 Inservice/Continuing Education 07. Inservice/Continuing Education. The	BB227		

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BB227	Continued From page 7 pharmacist shall provide inservice/continuing education for medical and nursing staff at least once quarterly. (10-14-88) This Rule is not met as evidenced by: Based on interview, the CAH failed to ensure the pharmacist provided education to medical and nursing staff. Lack of education led to potential negative outcomes with patients related to medications. There was no record provided of pharmacy education for medical and nursing staff on a quarterly basis. The Hospital had no policy or agreement with any part of pharmacy services to provide education to staff. During and interview on 9/01/16, at 1:50PM, the Director of Pharmacy stated he had not provided any scheduled education to the medical or nursing staff. He stated he did provide consultation in person or on the phone if staff had questions related to medications. He stated many questions were taken by the telepharmacy. The Hospital failed to ensure its pharmacy services provided education to staff quarterly.	BB227	3. Procedure for implementing plan with completion dates a. Contract between SMH and PharmD effective October 1, 2016. b. Locks were placed on clinic procedure cabinet, nursery circumcision cabinet, and pharmacy large volume cabinet in purchasing the week of September 22'2016. A red numeric key lock was placed on the nursery code cart September 6th. The clinic supply closet was locked by September 10th and labeled "To be locked at all times". The ED cupboards with medications remained lock until the laceration cart is assembled by October 3rd. 4. Monitoring and tracking mechanism to ensure compliance with regulations a. Contract reviewed yearly. b. During code cart checks, the emergency room cupboard, laceration cart, nursery circumcision cupboard, and delivery cart will be checked for security, and recorded on the daily code cart check list for two months to ensure compliance. c. Clinic supply closet checked daily by clinic staff, and documented on the door weekly for two months to ensure compliance. 5. Title of person(s) responsible for implementing acceptable plan of correction: a. Director of Pharmacy assigned by PharmD b. Director of Nursing c. President	
BB228	16.03.14.330.08 Security 08. Security. The pharmacist is responsible for the drug storage security elements of the designated areas. Access to the pharmacy shall be gained only by him and by individuals designated by him. All prescribed medications shall be under lock and schedule II drugs shall be double-locked. (10-14-88)	BB228		

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BB228	Continued From page 8 This Rule is not met as evidenced by: 1. Refer to C 224 as it relates to the failure of the CAH to ensure all prescribed medications were appropriately secured. 2. Refer to C-276 as it relates to the failure of the CAH to ensure appropriate oversite of drug storage.	BB228	BB 227 We entered into a pharmacy management service with PharmD who will organize and direct, as practicable, an education and information program for the Hospital and Pharmacy staff relating to new development in the field of pharmacy. We will ensure this education is delivered quarterly and will track attendance.	
BB272	16.03.14.360.01 Medical Records Service, Facilities 360. MEDICAL RECORDS SERVICE. The hospital shall maintain medical records that are documented accurately and timely, and that are readily accessible and retrievable. (12-31-91) 01. Facilities. The hospital shall provide a medical record room, equipment, and facilities for the retention of medical records. Provision shall be made for the safe storage of medical records. (10-14-88) This Rule is not met as evidenced by: Refer to C 302 as it relates to the failure of the CAH to ensure medical record entries were complete and accurate.	BB272		
BB284	16.03.14.360.13 Signature on Records 13. Signature on Records. Signatures on medical records shall be noted as follows: (10-14-88) a. Every physician shall sign and date the entries which that physician makes, or directs to be made. (10-14-88)	BB284		

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BB284	Continued From page 9 b. A single signature on the face sheet record does not authenticate the entire record. (10-14-88) c. Any person writing in a medical record shall sign his name to enable positive identification by name and title. (10-14-88) d. If initials are used, an identifying signature shall appear on each page. (10-14-88) e. Rubber stamp signatures can be used only by the person whose signature the stamp represents. A signed statement to this effect shall be placed on file with the hospital administrator. (10-14-88) This Rule is not met as evidenced by: Refer to C 307 as it relates to the failure of the CAH to ensure signed and dated physician signatures.	BB284		
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88) 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and	BB297		

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BB297	Continued From page 10 procedures shall include but are not limited to, the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88) g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving	BB297		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:---------- B. WING	(X3) DATE SURVEY COMPLETED
	IDM7XR		09/02/2016

NAME OF PROVIDER OR SUPPLIER: ST MARY'S HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE: 701 LEWISTON ST, COTTONWOOD, ID 83522

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BB297	Continued From page 11 toxicology; and (10-14-88) j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: Based on obseNation, staff inteNiew, and review of ED policies, it was determined the hospital failed to ensure policies and procedures addressed persons contaminated by radioactive and other hazardous materials. This decreased the ability of the hospital to decontaminate patients in order to prevent exposure of staff and other patients. Findings include: A tour of the ED was conducted with the ER Coordinator on 9/01/16 beginning at 3:40PM. During the tour, it was noted the hospital did not have an accessible decontamination shower to cleanse patients of hazardous materials prior to bringing them into the ED. The ER Coordinator stated he thought a portable shower was in the ambulance shed. However, when we looked in the shed he stated he could not find the shower. The Director of Nursing was inteNiewed on 9/02/16 beginning at 10:20 PM. She stated the hospital did not have a policy addressing the decontamination of patients who were exposed to hazardous materials. The hospital did not have policies and procedures directing staff on the treatment of patients	BB297	BB297 1. Corrective Actions c. ED policies were reviewed. Emergency Decontamination policy was created and sent through Policy Tech for review. d. Appropriate equipment and supplies were ordered. A demonstration is to be held during nursing staff meeting October 5th. e. Mosby's nursing skill on Decontamination was assigned to nursing staff to review and complete by 10/20/2016 2. Descriptions of how the actions will improve process that led to deficiency a. Creating policy will help guide staff during Emergency Event. b. Hands on and written education will give staff the ability to practice and ask questions. 3. Procedure for implementing the plan. a. Communication sent out to staff on September 28, 2016 of requirement to complete Mosby's Decontamination module. 4. Completion date for correction- October 9th. a. Results of CMS survey and plan of correction to be reviewed at nursing staff meeting. 5. Monitoring and tracking mechanism to ensure compliance with regs. a. Refer to plan of correction 1a-c 6. Include title of person responsible for implementing the plan a. Director of Nursing b. Clinical Coordinator of Emergency Department.	

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BB297	Continued From page 12 exposed to radiation and hazardous materials.	BB297	**BB 303- Equipment and Supplies** Corrective action a. Emergency Code carts were pulled from the different units and inventoried. i. Emergency Department (4 units) ii. Nursery (1 unit) iii. Nursing floor (1 unit) b. Inventory lists were updated and reflected to match products in carts. c. Audit sheets on carts confirming outdates were completed monthly. d. Reporting monthly to Quality Assurance, Director of Nursing, and ED committee along with posting results in the nurses report room. 2. Description of how the actions will improve process that led to deficiency: a. Audit process by posting as well as reporting results in committee will follow and ensure compliance. b. Deficiencies may impact re-credentialing possibilities. Individual corrective action process to engage with non-compliance. 3. Procedure for implementing the plan: a. Communications sent out the nursing staff September 21, 2016 regarding monthly code cart updates. Communication included monthly audit calendar and sample of audit tool. b. Policy was reviewed, and sent to nursing staff for required reading. c. Continue monthly audits d. Ongoing communication of deficiencies to Quality Assurance, Director of Nursing, and ED committee.	
BB303	16.03.14.370.07 Equipment and Supplies 07. Equipment and Supplies. (10-14-88) a. Parenterals, drugs, instruments, equipment, and supplies shall be readily available to the emergency room for use. (10-14-88) b. Emergency drugs shall be available based upon a formulary designed by medical staff and pharmacy staff. (10-14-88) This Rule is not met as evidenced by: Refer to C 203 as it relates to the failure of the CAH to ensure all drugs and biologicals used in life-saving procedures were not expired and readily available for all patients receiving care in the CAH.	BB303		
BB317	16.03.14.380.04 Records 04. Records. Prior to surgery patient records shall contain the following: (10-14-88) a. A properly executed informed consent; and (10-14-88) b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) c. Appropriate screening tests, based on patient needs, completed and recorded prior to surgery. (10-14-88) d. Record requirements may be modified in	BB317		

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BB317	Continued From page 13 emergency surgery cases to the extent necessary under the circumstances. (10-14-88) This Rule is not met as evidenced by: 1. Refer to C 270 as it relates to the failure of the CAH to ensure a current medical history and physical examination was on patient records prior to surgery. 2. Refer to C 304 as it relates to the failure of the CAH to ensure properly executed consent forms.	BB317	Continued B303 1. Completion date for correction: Initial action plan complete October 3, 2016. a. Ongoing audits and reporting b. Results of CMS survey and plan of correction to be presented by October 3rd 2. Monitoring and tracking mechanism to ensure compliance with regulation a. Refer to plan of correction 1a-d 3. Include title of person responsible for implementing the plan a. Director of Quality Assurance b. Director of Nursing c. Emergency Department Coordinator d. Nursery Coordinator BB317- Review C270 and C304	