July 1, 2019

North Canyon Medical Center
267 North Canyon Drive
Gooding, ID 83313
CMS Certification Number: 13-1302

Re: Rescind Termination Action
    Restore Deemed status through DNV-GL
    Remove from the State Survey Agency Jurisdiction

Dear Administrator:

The Idaho Bureau of Facility Standards (State survey agency) completed a revisit survey at North Canyon Medical Center on June 28, 2019. The State survey agency determined that North Canyon Medical Center has met the Medicare Hospital Conditions of Participation following the complaint survey completed May 10, 2019.

Based on the State survey agency's revisit findings and recommendation, the Centers for Medicare and Medicaid Services (CMS) is rescinding the termination action; will reinstate North Canyon Medical Center’s Medicare "deemed" status through DNV-GL; and remove the hospital from the State survey agency's survey jurisdiction. Copies of this letter are being provided to the State survey agency and to DNV-GL.

Your team is to be commended for all of their hard work. If you have any questions, please contact me via email at: CMS_RO10_CEB@cms.hhs.gov, attention Karen Roe.

Sincerely,

Karen W. Roe
Karen W. Roe, RN, MHA
Nurse Consultant
Division of Survey, Certification & Enforcement
Regional Office - Seattle

Cc: Idaho Bureau of Facility Standards
DNV-GL

THIS SERVES AS OFFICIAL NOTICE SENT VIA EMAIL OR FACSIMILE PURSUANT TO 42 CFR §488. NO HARD COPY TO FOLLOW.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:**

131302

**MULTIPLE CONSTRUCTION**

A. BUILDING

B. WING

**DATE SURVEY COMPLETED:**

R-C

06/28/2019

**NAME OF PROVIDER OR SUPPLIER:**

NORTH CANYON MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

267 NORTH CANYON DR

GOODING, ID 83330

**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)

**ID**

**PREFIX**

**TAG**

**COMPLETION DATE**

{C 000} INITIAL COMMENTS

The following deficiencies were cited during the follow up survey conducted at your facility on 6/24/19 to 6/28/19. Surveyors conducting the follow up survey were:

Trish O'Hara, RN, Team Lead
Nancy Bax, RN
Weslianne Lewis, RN

Acronyms used in this report include:

- CAH - Critical Access Hospital
- CCO - Chief Compliance Officer
- CNA - Certified Nurses Aide
- CNO - Chief Nursing Officer
- ED - Emergency Department
- EMR - Electronic Medical Record
- ER - Emergency Room
- IT - Information Technology
- IV - Intravenous
- LPN - Licensed Practical Nurse
- mcg - micrograms
- MVA - Motor Vehicle Accident
- OTPO - Organ and Tissue Procurement Organization
- P&T - Pharmacy and Therapeutics
- RN - Registered Nurse

**C 277 PATIENT CARE POLICIES**

CFR(s): 485.635(a)(3)(v)

[The policies include the following:]

Procedures for reporting adverse drug reactions and errors in the administration of drugs. This STANDARD is not met as evidenced by:

Based on medical record review, review of the facility's occurrence log and policies, facility P&T

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.
meeting minutes, and staff interview, it was determined the facility failed to ensure all medication errors were identified and reported. This failure directly impacted 1 patient (Patient #10) and had the potential to impact all patients receiving treatment at the facility by placing them at risk of incorrect medication administration. The findings include:

Facility policy #PH-121R3 Medication Errors, dated 7/07/17, stated "All medication errors will be reported on the Occurrence/Close Call Report... Chief Compliance Officer and Pharmacist will report to P & T committee quarterly."

Patient #10 was a 10 year old male who was admitted to the ED on 5/31/19 for treatment of injuries received in an MVA.

Patient #10's medical record documented "Fentanyl 15 mcg IV was order (sic), patient was given 50 mcg IV due to communication error. This was recognized within minutes... patient was placed on cardiac monitoring and pulse ox and respiratory therapy stayed at the bedside throughout the rest of his hospital stay."

Minutes of the P&T committee meeting, held on 6/17/19, documented "May 2019 - no med errors reported."

In an interview on 6/24/19 at 10:00 A.M., the facility pharmacist stated he had not received an occurrence report related to the medication error documented in Patient #10's medical record.

The facility failed to ensure all medication errors were reported per policy.
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<td>C 307</td>
<td>RECORDS SYSTEMS</td>
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<td>CFR(s): 485.638(a)(4)(iv)</td>
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For each patient receiving health care services, the CAH maintains a record that includes, as applicable-

dated signatures of the doctor of medicine or osteopathy or other health care professional.

This STANDARD is not met as evidenced by:

Based on medical record review and staff interview, it was determined the facility failed to ensure medical record entries were completed by health care professionals for 8 of 10 patients (Patients #5, #6, #8, #13, #14, #18, #19, and #20) who presented to the ED and whose records were reviewed. This resulted in a lack of clarity regarding triage care and allowed the potential for a lack of continuity of care. Findings include:

a) Patient #5 was a 25 year old male who was admitted to the ED on 5/22/19 following an MVA.

Review of his medical record showed a handwritten form, titled "ER Nursing Record," that had been scanned into the record. The form documented triage level, vital signs, pain level, and a systems assessment. The form documented the first name of the nurse assigned to his care. The form was not authenticated by signature and was not dated.

b) Patient #6 was a 56 year old male who was admitted to the ED on 5/29/19 following a Code Blue in the radiology department of the facility.

Review of his medical record showed a hand
Summary Statement of Deficiencies

**Patient #8**
- A 42-year-old male who presented to the ED on 5/31/19 complaining of a headache.
- Review of his medical record showed a handwritten form titled "ER Nursing Record," that had been scanned into the record. The form documented vital signs, but did not include triage level, pain level, or system assessment. The form was not authenticated by signature and was not dated or timed.

**Patient #13**
- A 37-year-old female who presented to the ED on 4/05/19 for a change in mental status.
- Review of her medical record showed a handwritten form titled "ER Nursing Record," that had been scanned into the record. The form documented vital signs only with no triage level, pain level, or system assessment. The form documented the first name of the nurse assigned to her care but the form was not authenticated by signature and was not dated or timed.

**Patient #14**
- A 55-year-old female who presented to the ED with the complaint of fever and chills.
- Review of her medical record showed a handwritten form, titled "ER Nursing Record," that had been scanned into the record. The form documented triage level, vital signs, pain level, and a systems assessment. The form documented the first name of the nurse assigned to his care but the form was not authenticated by signature and was not dated or timed.
C 307 Continued From page 4

written form, titled "ER Nursing Record," that had been scanned into the record. The form documented vital signs, triage level, and pain level. No systems assessment was documented. The form documented the first name of the nurse assigned to her care but the form was not authenticated by signature and was not dated or timed.

f) Patient #18 was a 16 year old male who presented to the ED with the complaint of fever.

Review of his medical record showed a hand written form, titled "ER Nursing Record," that had been scanned into the record. The form documented triage level, vital signs, pain level, and a systems assessment. The form documented the first name of the nurse assigned to his care but the form was not authenticated by signature and was not dated or timed.

g) Patient #20 was a 27 year old female who presented to the ED with the complaint of tongue swelling.

Review of her medical record showed a hand written form, titled "ER Nursing Record," that had been scanned into the record. The form documented vital signs, triage level, pain level and a partial systems assessment. The form documented the first name of the nurse assigned to her care but the form was not authenticated by signature and was not dated or timed.

h) Patient #20 presented to the ED with the complaint of weakness and fatigue.

Review of her medical record showed a hand written form, titled "ER Nursing Record," that had
C 307 Continued From page 5

been scanned into the record. The form documented vital signs, triage level, pain level and a systems assessment. The form did not document the name of the nurse assigned to her care, was not authenticated by signature and was not dated or timed.

In an interview on 6/28/19 at 10:00 A.M., the Clinical IT nurse, who was performing CNO duties, confirmed the incomplete ER Nursing Records. She said the form was designed to be a guide for nurses and the expectation was for the nurses to transfer the information to the EMR.

In an interview on 6/27/19 at 9:05 A.M., the Director of Health Information said the hand written forms were scanned into the record when the information was not transferred to the EMR by the nurses.

In an interview on 6/26/19 at 5:05 P.M., the CCO confirmed the lack of complete triage and the lack of signature, date and time.

The facility failed to ensure patient records were complete.

C 349 ORGAN, TISSUE, EYE PROCUREMENT CFR(s): 485.643(e) & (f)

[The CAH must have and implement written protocols that ensure that:]

(e) the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential...
C 349 Continued From page 6

**donated organs, tissues, and eyes takes place.**

(f) For purposes of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

This STANDARD is not met as evidenced by:

Based on OTPO agreement review, Eye Bank agreement review, and staff interview, it was determined the facility failed to work cooperatively with the designated OTPO and Eye Bank in educating staff on donation issues. This failure had the potential for CAH staff to not identify potential donors, as well as failure to inform potential donor families of their donation options.

Findings include:

The CAH/OTPO agreement, dated 10/23/17, stated "With the support of Hospital administration, [name of OTPO] will provide Hospital education for hospital staff by providing educational programs, in-services, and attending skills day when invited by the Hospital. These educational services are available to the Hospital at least annually, but may occur more frequently per hospital needs."

The CAH/Eye Bank agreement, signed 06/2017, stated "[name of Eye Bank] RESPONSIBILITIES: Provide [name of CAH] with periodic education to hospital [sic] medical [sic] and nursing staff members regarding eye donation."

In an interview on 6/26/19 at 5:00 P.M., the CCO stated facility staff had not received education from the OTPO or Eye Bank organizations.

The facility failed to ensure staff received
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<tr>
<td>C349</td>
<td>Continued From page 7 education related to donation issues.</td>
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<tr>
<td>C1001</td>
<td>PATIENT VISITATION RIGHTS CFR(s): 485.635(f)(1), (f)(2)</td>
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[A CAH must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the CAH may need to place on such rights and the reasons for the clinical restriction or limitation.] A CAH must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, in advance of furnishing patient care whenever possible.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

This STANDARD is not met as evidenced by:

Based on staff interview and admission documentation review, it was determined the facility failed to ensure visitation rights were provided to each patient or his/her representative for 20 of 20 patients (Patients # 1-20) whose records were reviewed. This had the potential to interfere with the patients' choice to receive or not receive specified visitors, as well as patient
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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**NAME OF PROVIDER OR SUPPLIER:**

**NORTH CANYON MEDICAL CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

267 NORTH CANYON DR
GOODING, ID 83330

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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- Continued From page 8
- Understanding of the facility’s possible need to restrict visitation. Findings include:

  - Consent forms were reviewed for admission to the facility and to swing bed status.

  - A pamphlet, available in the facility lobby, titled "Patient Rights and Responsibilities" was reviewed.

  - A pamphlet, available in the facility lobby, titled "Notice of Privacy Practices" was reviewed.

  - None of the documents reviewed contained information for patients related to visitation rights.

  - In an interview on 6/27/19 at 2:50 P.M., the CCO confirmed that patients were not informed of their visitation rights.

  - The facility failed to ensure patients, or their representatives, did not receive information related to their visitation rights.