IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

January 31, 2013

James Adamson, Administrator
Mountain View Hospital
2325 Coronado Street
Idaho Falls, ID 83404-1389

RE: Mountain View Hospital, Provider #130065

Dear Mr. Adamson:

This is to advise you of the findings of the Medicare/Licensure survey at Mountain View Hospital, which was concluded on January 10, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

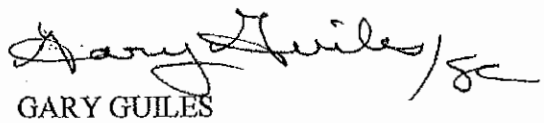
An acceptable plan of correction (PoC) contains the following elements:

- 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 facility into compliance, and that the facility 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 the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **February 13, 2013**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,

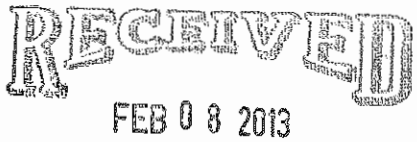


GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/
Enclosures

Mountain View Hospital



February 5, 2013

Sylvia Cresswell
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, Idaho 83720-009

FACILITY STANDARDS

Re: Response to deficiencies cited on January 10, 2013

Ms. Cresswell,

This letter is in response to a complaint investigation survey performed on January 10, 2013. Immediately after our survey was complete, we began our "Plan of Correction." The following is an overview of our process and immediate plan of correction:

1. **Discovery:** During the survey, a review of multiple medical records determined a process failure in the following areas:
   - Operative Notes not being completed in a timely manner, as set forth by hospital policy (482.24b)
   - Physician Entries into the medical record not containing date or time stamp (482.24c)
   - Physician Entries into the medical record not containing physician signature (482.24C)

   It was determined that changes in our education and monitoring of medical records must occur. *Completed on 01/11/2013*

   a. **Response:** *Education-* All credentialed providers at Mountain View Hospital will be re-educated on hospital policy for having all medical records completed within 30 days in accordance with our *Medical Staff Rules and Regulations.* The letter to the providers from our Chief of Medical Staff also addressed the necessity of all physician entries into the medical record containing a date, time entered, and signature, and containing a complete Operative Note, as stated in our policy *"Legal Medical Record Standards." Completion Date: 02/06/2013*

   b. **Response:** *CPOE-*The second phase of our Electronic Health Record will contain a Computerized Physician Entry system that will automatically time stamp, date, and sign all provider entries into the medical record. *Completion date: 05/01/2013*

2. **Monitoring:** A committee was formed to determine the best method for auditing medical records, and setting up a timeline to track, and notify providers when a record is deficient. The committee also revised our Post-Operative Progress Note to make the documentation process more complete. All data will be gathered and compiled and used for Process Improvement. *Completion date: 03/01/2013*

*Please see attachments for documentation to support responses and Plan of Correction

If you have any concerns or questions, please feel free to contact me. Thank you.

Sincerely,

Jessica Burnell

Jessica Burnell
Risk Management/ Compliance Department
Phone: 208-557-2835
Fax: 208-557-2889

CC: Ned Hillyard, Chief Compliance Officer
Board of Managers

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

PRINTED: 01/16/2013
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
	130065		C 01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW HOSPITAL	2325 CORONADO STREET IDAHO FALLS, ID 83404

(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
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation survey of your hospital. Surveyors conducting the review were: Gary Guiles, RN, BS, HFS Team Leader Libby Doane, RN, BSN, HFS Aimee Hastriter, RN, BSN, HFS Acronyms used in this report include: PCA - Patient Controlled Analgesia	A 000	RECEIVED FEB 0 8 2013 FACILITY STANDARDS	
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on staff interview, review of medical records, policies and medical staff rules and regulations, it was determined the hospital failed to ensure that medical records were completed in a timely manner for 3 of 20 patients (#7, #15, and #19) whose surgical records were reviewed. This failure had the potential to interfere with subsequent medical treatment by preventing medical providers from obtaining timely information about procedures and courses of treatment. Findings include: 1. "Mountain View Hospital Medical Staff Rules	A 438	PLAN OF CORRECTION: Steps: 1. Education: All credentialied providers at Mountain View Hospital will be reeducated on hospital policy for having all medical records completed within 30 days via letter from Chief of Medical Staff (see attachment Letter to Providers, and Medical Record Documentation Delinquency) Completion: February 6, 2013 2.Implement weekly medical record audit. Audits will be completed weekly, monthly, and quarterly for compliance. Through the audit, personnel will specifically note deficiencies for Post Operative Note and/or dictation, Dated and Timed Orders, and Discharge Summaries. Data will be sent to QA department to be used for trending purposes, as well as Process Improvement Completion Date: March 1, 2013 Monitoring of Plan of Correction: Audits will be send to Compliance Department for review. (see attachment Medical Record Correction Flow Sheet, and MR Deficiency Tracking Record.) A. If deficiency exists, medical record will be sent back to physician with notification of deficiencies B. If deficiency is not corrected within 7 days, verbal notification will be given to provider C. If deficiency is not corrected within 14 days, letter will be sent to provider D. If deficiency is not corrected within 14-21 days, provider will be reported to Chief of Medical Staff and/or Credentialing/QA Committee. After 45 days, MEC may be notified. Personnel Responsible: Ned Hillyard, Chief Compliance Officer Board of Managers	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
NH	ECO/CCO	2/6/2013

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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A 438	Continued From page 1 and Regulations," section 5.5, dated 8/07/02, stated "Operative Reports shall be legibly written or dictated immediately following surgery..." The Chief Compliance Officer was interviewed at 11:40 AM on 1/10/13. He stated the expectation was that surgeons would either dictate or hand write an operative report immediately following surgery. The hospital did not complete operative reports promptly as follows: a. Patient #15's medical record documented a 26 year old female who was admitted on 10/25/12 for breast augmentation surgery. She was discharged the same day. Her "OPERATIVE REPORT" stated it was dictated on 12/20/12, 55 days after the surgery was performed. Also, the operative report was not signed by the surgeon as of 1/10/13. The Chief Compliance Officer reviewed the record at 11:40 AM on 1/10/13. He confirmed the "OPERATIVE REPORT" was not dictated until 12/20/12 and had not been signed. The Chief Compliance Officer confirmed that Patient #15's medical record did not contain a "Post-Operative Progress Note" written by the surgeon immediately following surgery. Patient #15's medical record was not completed in a timely manner. b. Patient #7 was a 70 year old male admitted to the facility for right shoulder surgery on 4/04/12 and discharged 4/05/12. His medical record contained a document titled "OPERATIVE	A 438	(See Page 1 of Deficiencies)	

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A 438	Continued From page 2 REPORT," which described the procedures performed, estimated blood loss and complications of the procedure. This document was dictated on 7/01/12, 87 days after Patient #7's surgery. The Chief Compliance Officer reviewed Patient #7's record and was interviewed on 1/10/13 at 11:40 AM. He confirmed the "OPERATIVE REPORT" was not dictated until 7/01/12. The Chief Compliance Officer also confirmed the lack of a hand written "Post-Operative Progress Note" completed immediately after surgery. Patient #7's record was not completed in a timely manner. 2. The facility policy "LEGAL MEDICAL RECORD STANDARDS," approved 8/20/09, stated "All inpatient Medical Records must be completed within 30 days from the date of discharge." The hospital did not complete discharge summaries promptly as follows: a. Patient #19 was a 46 year old female admitted to the facility on 9/12/12 for a thyroidectomy. She was discharged on 9/14/12. Her medical record contained a "DISCHARGE SUMMARY," originally dictated 10/24/12, and revised on 11/05/12. The "DISCHARGE SUMMARY" was completed 40 days after Patient #19's discharge. The physician signed the discharge summary but did not indicate the date or time it was signed. The Chief Compliance Officer was interviewed on 1/10/13 at 1:55 PM. He reviewed Patient #19's medical record and confirmed the "DISCHARGE	A 438	See Page 1 of Deficiencies	

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A 438	Continued From page 3 SUMMARY" had been dictated more than 30 days after Patient #19's discharge from the facility. He acknowledged this was outside of the timeframe established by hospital policy. Patient #19's medical record was not completed in a timely manner.	A 438	SEE PAGE 1 OF DEFICIENCIES	
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview, and review of policies and medical records it was determined the facility failed to ensure completion of all entries in the medical record for 15 of 20 patients (#1, #2, #3, #4, #5, #6, #7, #9, #11, #12, #14, #16, #18, #19, and #20) whose records were reviewed. Failure to ensure completion of all entries in the medical record resulted in lack of clarity of hospital events and incomplete medical records. Findings include: The facility policy "LEGAL MEDICAL RECORD STANDARDS," approved 8/20/09 stated, "All Medical Records entries are to be dated, the time entered, and signed." Medical record entries were incomplete as follows: 1. Patient #18 was a 58 year old male admitted on 9/12/12 for right knee surgery and 11/12/12 for	A 450	PLAN OF CORRECTION: Steps: 1. Education: All credentialied providers at Mountain View Hospital will be reeducated on hospital policy for having all medical record entries having a date, time entered, and signature which was issued by the Chief of Medical Staff. Providers were also advised of changes made to the Post Operative Progress Note for more complete documentation. (see attachment Letter to Providers, Post Operative Progress Note, Medical Record Documentation Delinquency) Completion: February 6, 2013 2.Implement weekly medical record audit. Audits will be completed weekly, monthly, and quarterly for compliance. Through the audit, personnel will specifically note deficiencies for Post Operative Note and/or dictation, Dated and Timed Orders, and Discharge Summaries. Data will be sent to QA department to be used for trending purposes, as well as Process Improvement Completion Date: March 1, 2013 Monitoring of Plan of Correction: Audits will be send to Compliance Department for review. (see attachment Medical Record Correction Flow Sheet, and MR Deficiency Tracking Record.) A. If deficiency exists, medical record will be sent back to physician with notification of deficiencies B. If deficiency is not corrected within 7 days, verbal notification will be given to provider C. If deficiency is not corrected within 14 days, letter will be sent to provider D. If deficiency is not corrected within 14-21 days, provider will be reported to Chief of Medical Staff and/or Credentialing/QA Committee. After 45 days, MEC may be notified. 3. Implement second phase of our Electronic Medical Record, which will consist of a Physician Order Entry system. Upon utilization of this system, date, time, and signatures will automatically be entered upon entry approval. Completion Date: May 1, 2013 Personnel Responsible: Ned Hillyard-Chief Compliance Officer Board of Managers	

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A 450	Continued From page 4 left knee surgery. a. The medical record for the admission on 9/12/12 contained the following incomplete documentation: i. A document titled "OPERATIVE REPORT," dictated 9/27/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed the time and date were missing from the report. He agreed this led to a lack of clarity as to when the report was authenticated. ii. A document titled "PCA ORDERS" was signed by the physician and dated 9/12/12 but was not timed. This order specified the type, amount, and frequency of pain medication that Patient #18 could self-administer via a PCA pump. iii. A document titled "Social Service Order/Referral Form" was signed by the physician's assistant on 9/14/12 but was not timed. iv. A document titled "DISCHARGE ORDERS" was signed by the physician's assistant on 9/14/12 but not timed. The document contained orders for medication, durable medical equipment, weight bearing status and dressing changes. v. A document titled "Admit Orders" was signed by the physician on 9/12/12 but was not timed. The orders contained medications to be administered, sequential compression devices for	A 450	See Page 4 of Deficiencies	

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A 450	Continued From page 5 prophylaxis of deep vein thrombosis, an anesthesia pain consult and dressing reinforcement. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the times were missing from these orders. He agreed this led to a lack of clarity as to when the orders were written and signed by the physician or physician's assistant. b. The medical record for the admission on 11/12/12 contained the following incomplete documentation: i. A document titled "OPERATIVE REPORT," dictated 11/12/12, was not signed, dated, or timed by the physician as of 1/10/13. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed that the physician's signature, date and time were missing from the report. He agreed Patient #18's record was not complete. ii. A document titled "PCA ORDERS" was signed by the physician on 11/12/12 but was not timed. This order specified the type, amount, and frequency of pain medication Patient #18 could self-administer via a PCA pump. iii. A document titled "Social Service Order/Referral Form" was signed by the physician's assistant on 11/14/12 but was not timed. iv. A document titled "DISCHARGE ORDERS" was signed by the physician's assistant on	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 6 11/14/12 but was not timed. The document contained orders for medication, durable medical equipment, weight bearing status and dressing changes. v. A document titled "Admit Orders" was signed by the physician on 11/12/12 but was not timed. The orders contained medications for administration, sequential compression devices for prophylaxis of deep vein thrombosis, an anesthesia pain consult and dressing reinforcement orders. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the times were missing from these orders. He agreed that this led to a lack of clarity as to when the orders were written and signed by the physician or physician's assistant. Medical record entries for Patient #18 were not complete. 2. Patient #7 was a 70 year old male admitted on 4/04/12, 7/20/12, and 11/16/12 for right shoulder surgery. a. The medical record contained the following incomplete documentation for the admission on 4/04/12: i. A document titled "PHYSICIAN ORDERS" was signed by the physician on 4/04/12 but did not include a time. This document contained orders for activities, intravenous fluids, vital signs, medications and discharge instructions. In an interview beginning at 1:45 PM on 1/10/13,	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 7 the Chief Compliance Officer confirmed that the time was missing from the orders. He agreed that this led to a lack of clarity as to when the orders were written. ii. A document titled "OPERATIVE REPORT," dictated 7/01/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed the date and time were missing from the report. He agreed that this led to a lack of clarity as to when the report was authenticated. b. Patient #7's medical record contained the following incomplete documentation for the admission on 7/20/12: i. A document titled "PHYSICIAN ORDERS" was signed by the physician and dated 7/20/12 but did not include a time. This document contained orders for activities, intravenous fluids, vital signs, medications, an anesthesia pain consult and discharge instructions. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the time was missing from the orders. He agreed that this led to a lack of clarity as to when the orders were written. ii. A document titled "OPERATIVE REPORT," dictated 8/14/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed the date	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 8 and time were missing from the report. He agreed that this led to a lack of clarity as to when the report was authenticated. c. Patient #7's medical record contained the following incomplete documentation for the admission on 11/16/12: i. A document titled "PeriOp Form/Physician's Orders" was dated 11/16/12 but was not signed by a physician or timed as of 1/10/13. This document contained orders for Patient #7 to continue his home medication after discharge. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed that the signature and time were missing, which caused this order to be incomplete and lack authentication and clarity as to when the orders were written. ii. A document titled "PCA ORDERS" was signed by the physician on 11/16/12 but was not timed. This order specified the type, amount, and frequency of pain medication that Patient #7 could self-administer via a PCA pump. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the time was missing from the order. He agreed that this led to a lack of clarity as to when the order was written and signed by the physician. iii. A document titled "OPERATIVE REPORT," dictated 12/18/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13,	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 9 the Chief Compliance Officer confirmed the time and date were missing from the report. He agreed that this led to a lack of clarity as to when the report was authenticated. Medical record entries for Patient #7 were incomplete. 3. Patient #2 was a 26 year old male admitted on 7/12/12 for left shoulder surgery. The medical record contained the following incomplete documentation: a. A document titled "OPERATIVE REPORT," dictated on 7/12/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed the time and date were missing from the report. He agreed that this led to a lack of clarity as to when the report was authenticated. b. A document titled "PCA ORDERS" was signed by the physician but was not dated or timed. This order specified the type, amount, and frequency of pain medication Patient #2 could self-administer via a PCA pump. c. A document titled "Day Surgery Orders & Instructions" was signed by the physician but was not dated or timed. This document contained orders for medication, incision care, activity and physical therapy treatments for Patient #2 after discharge. d. A document titled "Admission Orders" was signed by the physician but was not dated or	A 450	See Page 4 of Deficincies	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 10 timed. This document included orders for medication, activity, wound care and discharge procedures. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the dates and times were missing from these orders. He agreed that this led to a lack of clarity as to when the orders were written and signed by the physician. Medical record entries for Patient #2 were incomplete. 4. Patient #1 was an 80 year old female admitted 7/12/12 as an outpatient for sinus surgery. The medical record contained the following incomplete documentation: a. A document titled "OPERATIVE REPORT," dictated 7/19/12, was signed by the physician but was not dated or timed. In an interview beginning at 2:30 PM on 1/14/13, the Chief Compliance Officer confirmed the time and date were missing from the report. He agreed that this led to a lack of clarity as to when the report was authenticated. b. A document titled "PHYSICIAN ORDERS" contained a list of orders for activities, intravenous fluids, vital signs, medications and discharge instructions. Orders were selected from this list but the document was not signed, dated or timed. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the	A 450	See Page 4 of Deficincies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130065	A. BUILDING B. WING	C 01/10/2013

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A 450	Continued From page 11 signature, date and time were missing. He stated this order was incomplete and lacked authentication and clarity as to when the order was written. Medical record entries for Patient #1 were incomplete. 5. Patient #16 was a 56 year old male admitted on 10/25/12 as an outpatient for sinus surgery. His medical record contained a document titled "PHYSICIAN ORDERS" that was signed by the physician but was not dated or timed. This document contained orders for activities, intravenous fluids, vital signs, medications and discharge instructions. In an interview beginning at 1:45 PM on 1/10/13, the Chief Compliance Officer confirmed the date and time were missing from the order. He agreed that this led to a lack of clarity as to when the order was written and signed by the physician. Medical record entries for Patient #16 were incomplete. 6. Patient #19 was a 46 year old female admitted to the facility on 9/12/12 for a thyroidectomy. She was discharged on 9/14/12. Her record lacked dated and timed medical record entries as follows: a. Patient #19's medical record contained a "PHYSICIAN ORDERS" form. The physician selected orders from a pre-printed list for Patient #19's admission, monitoring during the peri-operative phase, medications to be administered as needed, and discharge orders.	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 12 The physician signed the orders but did not date or time the orders. In an interview beginning at 1:55 PM on 1/10/13, the Chief Compliance Officer confirmed the date and time were missing from the physician orders. He agreed this led to a lack of clarity as to when the order was written and signed by the physician. b. Patient #19's medical record contained a detailed "OPERATIVE REPORT" dictated on 10/09/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. c. Patient #19's medical record contained a "DISCHARGE SUMMARY" originally dictated 10/24/12, and revised on 11/05/12. The physician signed the document but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated reports. Medical record entries were not dated and timed for Patient #19. 7. Patient #9 was a 13 year old female admitted to the facility on 10/17/12 for outpatient sinus surgery. Her record lacked dated and timed medical record entries as follows: a. Patient #9's medical record contained a "PHYSICIAN ORDERS" form. The physician	A 450	See Page 4 of Defincies	

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A 450	Continued From page 13 selected orders from a pre-printed list for Patient #9's admission, monitoring during the peri-operative phase, medications to be administered as needed, and discharge orders. The physician signed the orders but did not date or time the orders. In an interview beginning at 1:55 PM on 1/10/13, the Chief Compliance Officer confirmed the date and time were missing from the physician orders. He agreed this led to a lack of clarity as to when the order was written and signed by the physician. b. Patient #9's medical record contained a detailed "OPERATIVE REPORT" dictated by the physician on 10/17/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated report. Medical record entries were not dated and timed for Patient #9. 8. Patient #12 was a 57 year old female admitted to the facility on 9/20/12 for outpatient sinus surgery. Her record lacked dated and timed medical record entries as follows: a. Patient #12's medical record contained a "PHYSICIAN ORDERS" form. The physician selected orders from a pre-printed list for Patient #12's admission status, monitoring during the peri-operative phase, medications to be administered as needed, and discharge orders.	A 450	See Page 4 of Deficincies	

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A 450	Continued From page 14 The physician signed the orders but did not date or time the orders. In an interview beginning at 1:55 PM on 1/10/13, the Chief Compliance Officer confirmed the date and time were missing from the physician orders. He agreed this led to a lack of clarity as to when the order was written and signed by the physician. b. Patient #12's medical record contained a detailed "OPERATIVE REPORT" dictated by the physician on 9/20/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated report. Medical record entries were not dated and timed for Patient #12. 9. Patient #3 was a 61 year old male admitted to the facility on 10/10/12 for outpatient sinus surgery. His record lacked dated and timed medical record entries as follows: a. Patient #3's medical record contained a "PHYSICIAN ORDERS" form. The physician selected orders from a pre-printed list for Patient #3's admission status, monitoring during the peri-operative phase, medications to be administered as needed, and discharge orders. The physician signed the orders but did not date or time the orders. In an interview beginning at 1:55 PM on 1/10/13,	A 450	See Page 4 of Deficiencies	

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A 450	Continued From page 15 the Chief Compliance Officer confirmed the date and time were missing from the physician orders. He agreed this led to a lack of clarity as to when the order was written and signed by the physician. b. His medical record contained a detailed "OPERATIVE REPORT" dictated by the physician on 10/10/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated report. Medical record entries were not dated and timed for Patient #3. 10. Patient #14 was a 65 year old male admitted to the facility on 9/26/12 for outpatient hernia surgery. His record lacked authentication, dates, and times as follows: a. Patient #14's medical record contained a form titled, "Post-Operative Progress Note." There was documentation of the pre-operative and post-operative diagnoses, the procedure performed, and details of the surgical procedure. The form was not signed, dated or timed as of 1/10/13. In an interview beginning at 1:55 PM on 1/10/13, the Chief Compliance Officer confirmed the physician failed to sign, date, and time the progress note. He agreed this led to a lack of clarity as to when the note was written and signed by the physician.	A 450	See page 4 of Deficiencies	

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A 450	Continued From page 16 b. Patient #14's medical record contained an "OPERATIVE REPORT" dictated by the physician on 9/26/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated report. Medical record entries were not dated and timed for Patient #14. 11. Patient #11 was a 73 year old female admitted to the facility on 9/18/12 for left knee surgery. She was discharged on 9/20/12. Her record lacked dated and timed medical record entries as follows: a. Patient #11's medical record contained an "OPERATIVE REPORT" dictated by the physician on 9/18/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. b. Patient#11's medical record contained a "DISCHARGE SUMMARY" dictated by the physician on 9/29/12. The physician signed the document but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated reports.	A 450	See Page 4 of Deficiencies	

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A 450	Continued From page 17 Medical record entries were not dated and timed for Patient #11. 12. Patient #6 was a 35 year old female admitted to the facility on 10/09/12 for a hysterectomy. She was discharged from the facility on 10/10/12. Her medical record contained an "OPERATIVE REPORT" dictated by the physician on 10/09/12. The physician signed the report but the physician's signature was not dated or timed. It was not possible to know when the dictation was authenticated. During an interview on 1/14/13 at 2:30 PM, the Chief Compliance Officer confirmed the physician failed to date and time the dictated report. Medical record entries were not dated and timed for Patient #6. 13. Patient #20's medical record documented a 40 year old female who had outpatient septoplasty (nose surgery) performed on 9/14/12. Her medical record contained the following incomplete documentation: a. Her medical record contained "PHYSICIAN PREPRINTED ORDERS" which included admission orders, treatment orders, diet orders, intravenous fluid orders, medication orders for post- anesthesia care as well as following discharge, and discharge orders. The orders were signed by the physician but they were not dated or timed. The Chief Compliance Officer was interviewed beginning at 1:45 PM on 1/10/13. He confirmed	A 450	See Page 4 of Deficiencies	

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A 450	Continued From page 18 Patient #20's orders were not dated or timed. b. In addition, Patient #20's "OPERATIVE REPORT," dictated 9/14/12, was signed by the physician but the physician's signature was not dated so it was not possible to know when the dictation was authenticated. The Chief Compliance Officer was interviewed at 2:30 PM on 1/14/13. He confirmed Patient #20's "OPERATIVE REPORT" was not dated to indicate when it was signed. 14. Patient #4's medical record documented a 14 year old female who had an outpatient tonsillectomy and adenoidectomy performed on 11/16/12. Her medical record contained "DISCHARGE ORDERS" to discharge her and for five different medications. The orders were signed by the physician but they were not dated or timed. The Chief Compliance Officer was interviewed beginning at 1:45 PM on 1/10/13. He confirmed Patient #4's orders were not dated or timed. 15. Patient #5's medical record documented a 31 year old female who had outpatient sinus surgery and nasal surgery performed on 11/15/12. Her medical record contained "PHYSICIAN ORDERS" for discharge and two different medications. The orders were signed by the physician but they were not dated or timed. The Chief Compliance Officer was interviewed beginning at 1:45 PM on 1/10/13. He confirmed Patient #5's orders were not dated or timed.	A 450	See Page 4 of Deficiencies	

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A 450	Continued From page 19 Medical record entries were incomplete.	A 450	See Page 4 of Deficiencies	

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation survey of your hospital. Surveyors conducting the review were: Gary Guiles, RN, BS, HFS Team Leader Libby Doane, RN, BSN, HFS Aimee Hastriter, RN, BSN, HFS Acronyms used in this report include: PCA - Patient Controlled Analgesia	B 000	RECEIVED FEB 0 8 2013 FACILITY STANDARDS	
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) 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)	BB284	PLAN OF CORRECTION: Steps: 1. Education: All credentialied providers at Mountain View Hospital will be reeducated on hospital policy for having all medical record entries having a date, time entered, and signature which was issued by the Chief of Medical Staff. Providers were also advised of changes made to the Post Operative Progress Note for more complete documentation.(see attachment Letter to Providers, Post Operative Progress Note, Medical Record Documentation Delinquency) Completion: February 6, 2013 2.Implement weekly medical record audit. Audits will be completed weekly, monthly, and quarterly for compliance. Through the audit, personnel will specifically note deficiencies for Post Operative Note and/or dictation, Dated and Timed Orders, and Discharge Summaries. Data will be sent to QA department to be used for trending purposes, as well as Process Improvement Completion Date: March 1, 2013 Monitoring of Plan of Correction: Audits will be send to Compliance Department for review. (see attachment Medical Record Correction Flow Sheet, and MR Deficiency Tracking Record.) A. If deficiency exists, medical record will be sent back to physician with notification of deficiencies B. If deficiency is not corrected within 7 days, verbal notification will be given to provider C. If deficiency is not corrected within 14 days, letter will be sent to provider D. If deficiency is not corrected within 14-21 days, provider will be reported to Chief of Medical Staff and/or Credentialing/QA Committee. After 45 days, MEC may be notified. 3. Implement second phase of our Electronic Medical Record, which will consist of a Physician Order Entry system. Upon utilization of this system, date, time, and signatures will automatically be entered upon entry approval. Completion Date: May 1, 2013 Personnel Responsible: Ned Hillyard-Chief Compliance Officer Board of Managers	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO/COO — (X6) DATE: 2/6/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130065	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 01/10/2013
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BB284	Continued From page 1 This Rule is not met as evidenced by: Refer to A 450 for the facility's failure to ensure completion of all entries in the medical record.	BB284	See page 1 State form -Deficiencies	
BB318	16.03.14.380.05 Records Following Surgery 05. Records Following Surgery. Patient records following surgery shall contain the following: (10-14-88) a. Operative report of techniques and findings shall be recorded directly after surgery; and (10-14-88) b. All tissues and foreign bodies shall be sent to a pathologist in accordance with Subsection 350.08; and (12-31-91) c. Sponge and needle count, if appropriate. (10-14-88) This Rule is not met as evidenced by: Based on staff interview, review of medical records, policies and medical staff rules and regulations, it was determined the hospital failed to ensure that medical records were completed in a timely manner for 2 of 20 patients (#7 and #15) whose surgical records were reviewed. This failure had the potential to interfere with subsequent medical treatment by preventing medical providers from obtaining timely information about procedures and courses of treatment. Findings include: 1. "Mountain View Hospital Medical Staff Rules and Regulations," section 5.5, dated 8/07/02, stated "Operative Reports shall be legibly written or dictated immediately following surgery..." The Chief Compliance Officer was interviewed at	BB318	PLAN OF CORRECTION: Steps: 1. Education: All credentialied providers at Mountain View Hospital will be reeducated on hospital policy for having all medical records completed within 30 days via letter from Chief of Medical Staff, including changes to Post Operative Progress Note (see attachment Letter to Providers, and Medical Record Documentation Delinquency) Completion: February 6, 2013 2.Implement weekly medical record audit. Audits will be completed weekly, monthly, and quarterly for compliance. Through the audit, personnel will specifically note deficiencies for Post Operative Note and/or dictation, Dated and Timed Orders, and Discharge Summaries. Data will be sent to QA department to be used for trending purposes, as well as Process Improvement Completion Date: March 1, 2013 Monitoring of Plan of Correction: Audits will be send to Compliance Department for review. (see attachment Medical Record Correction Flow Sheet, and MR Deficiency Tracking Record. A. If deficiency exists, medical record will be sent back to physician with notification of deficiencies B. If deficiency is not corrected within 7 days, verbal notification will be given to provider C. If deficiency is not corrected within 14 days, letter will be sent to provider D. If deficiency is not corrected within 14-21 days, provider will be reported to Chief of Medical Staff and/or Credentialing/QA Committee. After 45 days, MEC may be notified. Personnel Responsible: Ned Hillyard, Chief Compliance Officer Board of Managers	

Bureau of Facility Standards

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BB318	Continued From page 2 11:40 AM on 1/10/13. He stated the expectation was that surgeons would either dictate or hand write an operative report immediately following surgery. The hospital did not complete operative reports promptly as follows: a. Patient #15's medical record documented a 26 year old female who was admitted on 10/25/12 for breast augmentation surgery. She was discharged the same day. Her "OPERATIVE REPORT" stated it was dictated on 12/20/12, 55 days after the surgery was performed. Also, the operative report was not signed by the surgeon as of 1/10/13. The Chief Compliance Officer reviewed the record at 11:40 AM on 1/10/13. He confirmed the "OPERATIVE REPORT" was not dictated until 12/20/12 and had not been signed. The Chief Compliance Officer confirmed that Patient #15's medical record did not contain a "Post-Operative Progress Note" written by the surgeon immediately following surgery. Patient #15's medical record was not completed in a timely manner. b. Patient #7 was a 70 year old male admitted to the facility for right shoulder surgery on 4/04/12 and discharged 4/05/12. His medical record contained a document titled "OPERATIVE REPORT," which described the procedures performed, estimated blood loss and complications of the procedure. This document was dictated on 7/01/12, 87 days after Patient #7's surgery. The Chief Compliance Officer reviewed Patient	BB318	See page 2 of State form-deficiencies	

Bureau of Facility Standards

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BB318	Continued From page 3 #7's record and was interviewed on 1/10/13 at 11:40 AM. He confirmed the "OPERATIVE REPORT" was not dictated until 7/01/12. The Chief Compliance Officer also confirmed the lack of a hand written "Post-Operative Progress Note" completed immediately after surgery. Patient #7's record was not completed in a timely manner.	BB318	See page 2 of State form-deficiencies	

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
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February 1, 2013

James Adamson, Administrator
Mountain View Hospital
2325 Coronado Street
Idaho Falls, ID 83404-1389

Provider #130065

Dear Mr. Adamson:

On **January 10, 2013**, a complaint survey was conducted at Mountain View Hospital. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005745

ALLEGATION: Physicians did not complete post operative notes in a timely manner.

FINDINGS: An unannounced visit was made to the hospital on 1/10/12. Staff were interviewed. Medical records of 20 surgical patients were reviewed. Hospital policies were reviewed.

"Mountain View Hospital Medical Staff Rules and Regulations," section 5.5, dated 8/07/02, stated "Operative Reports shall be legibly written or dictated immediately following surgery..."

Two medical records documented significant delays between the date of surgery and the date that a post operative report was written. One patient had shoulder surgery performed on 4/04/12. His "OPERATIVE REPORT" was dictated on 7/01/12, 87 days after the surgery was performed. Another patient had breast augmentation surgery performed on 10/25/12 . Her "OPERATIVE REPORT" stated it was dictated on 12/20/12, 55 days after the surgery was performed. Also, her operative report was not signed by the surgeon as of 1/10/13.

The Chief Compliance Officer was interviewed at 11:40 AM on 1/10/13. He stated the

expectation was that surgeons would either dictate or hand write an operative report immediately following surgery. He confirmed the records with the late operative reports.

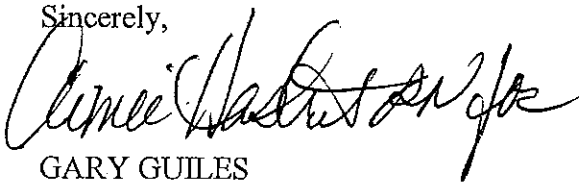
Post operative physician notes were not written in a timely manner. Deficiencies was cited at 42 CFR Part 482.24(b) and IDAPA 16.03.14.300.05 as they relate to records following surgery.

CONCLUSION: Substantiated. Federal and State deficiencies related to the allegation are cited.

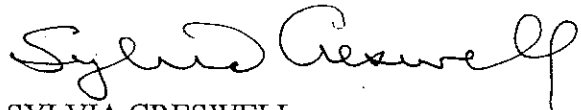
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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