DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

April 10, 2012

Timothy Sayler, President and CEO
St. Joseph Regional Medical Center
415 Sixth Street (PO Box 816)
Lewiston, ID 83501

CMS Certification Number: 13-0003

Re: Restore "deemed" status through Joint Commission accreditation

Dear Mr. Sayler:

The Idaho Bureau of Facility Standards (State survey agency) completed a full health and life safety code survey on February 10, 2012. The State survey agency determined that St. Joseph Regional Medical Center has met all the Medicare Hospital Conditions of Participation following the complaint survey conducted December 9, 2011.

As a result of St. Joseph Regional Medical Center's compliance with federal requirements, the Centers for Medicare and Medicaid Services (CMS) will reinstate the hospital's Medicare "deemed" status through The Joint Commission 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 the Joint Commission.

If you have any questions, please contact me at (206) 615-2432.

Sincerely,

Kate Mitchell

Kate Mitchell, Health Insurance Specialist
Survey, Certification, and Enforcement Branch - Seattle

cc: Idaho Bureau of Facility Standards
The Joint Commission

COPY

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

February 28, 2012

Timothy Sayler, Administrator
St Joseph Regional Medical Center
PO Box 816
Lewiston, ID 83501

RE: St Joseph Regional Medical Center, Provider #130003

Dear Mr. Sayler:

This is to advise you of the findings of the Medicare/Licensure survey at St Joseph Regional Medical Center, which was concluded on February 10, 2012.

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 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 the Form CMS-2567 and State Form 2567.

After you have completed your Plan of Correction, return the original to this office by **March 11, 2012**, 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,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm
Enclosures

People committed to life

St. Joseph
Regional Medical Center
Member of ASCENSION HEALTH

415 6th Street ~ P.O. Box 816 ~ Lewiston, Idaho 83501
(208)743-2511 ~ www.sjrmc.org

March 9, 2012

RECEIVED
MAR 12 2012
FACILITY STANDARDS

Teresa Hamblin
Health Facility Surveyor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
Boise ID 83720-0009

RE: Provider Number: 13-0003

Dear Ms. Hamblin,

Enclosed please find the St. Joseph Regional Medical Center Plan of Correction (PoC) in response to the statement of deficiencies resulting from the on-site survey completed on February 10, 2012.

Should there be any questions regarding the enclosed POC, please do not hesitate to contact me (208-799-5485).

Sincerely,

Kathleen Connerley, RN, MS
Vice President, Patient Care Services

KC/tf

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130003	A. BUILDING _____ B. WING _____	02/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH REGIONAL MEDICAL CENTER	415 SIXTH STREET LEWISTON, ID 83501

(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 recertification survey of your hospital. The surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Susan Costa, RN, HFS Aimee Hastriter, RN, BS, HFS Gary Guiles, RN, HFS Acronyms used in this report include the following: CDC - Centers for Disease Control and Prevention ICU - Intensive Care Unit IP - Inpatient NP - Nurse Practitioner PCU - Progressive Care Unit PPS - Prospective Payment System RN - Registered Nurse	A 000	RECEIVED MAR 12 2012 FACILITY STANDARDS	
A 046	482.12(a)(2) MEDICAL STAFF - APPOINTMENTS [The governing body must] appoint members of the medical staff after considering the recommendations of the existing members of the medical staff. This STANDARD is not met as evidenced by: Based on staff interview and review of credentials files and hospital policies, it was determined the governing body failed to ensure 4 of 6 non-physician members of the medical staff (Non-physician practitioners A, B, C, and D) had been appointed to the medical staff and had been granted privileges to practice at the hospital. This resulted in a lack of oversight of these	A 046	**A 046 Medical Staff Appointments** For the actions associated with non-physician practitioners, A, B, C and D, appointment to the Medical Staff and granting of privileges is as follows: 1. The files associated with practitioners A, B & C were taken to the Credentials Committee meeting on 2/9/12 and the Credentials Committee approved their application. Attachment 1. 2. The governing body reviewed the recommendation for privileging and the credentialing files on February 27, at their monthly meeting and the applications were approved. 3. The file associated with Practitioner D was	2/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/9/12

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 046	Continued From page 1 practitioners by the governing body. Findings include: The credentials files for 6 non-physician practitioners were reviewed. Four of the credentials files did not contain documentation that they had been appointed to the medical staff and had been granted privileges to practice at the hospital. Examples include: a. Non-physician practitioner A, an NP, practiced on the Mental Health Unit. His credentials file documented he was an employee of the hospital who was hired on 6/07/10. Documentation that he had been granted privileges to practice and had been appointed to the medical staff was not present. b. Non-physician practitioner B, an NP, practiced on the Mental Health Unit. Her credentials file documented she was an employee of the hospital who was hired on 10/31/11. Documentation that she had been granted privileges to practice and had been appointed to the medical staff was not present. c. Non-physician practitioner C, an NP, practiced on the Mental Health Unit. Her credentials file documented she was an employee of the hospital who was hired on 1/03/12. Documentation that she had been granted privileges to practice and had been appointed to the medical staff was not present. d. Non-physician practitioner D, an RN, practiced in the operating room and served as a first assistant to surgeons who practiced at the hospital. She was a hospital employee who was	A 046	taken to Credentials Committee on 3/8/12 and application was approved. Attachment 2. 4. The governing body will review the recommendation for practitioner D on 3/26/12. The process associated with privileging of mid-levels will be monitored through the Medical/Dental Staff office and mid-levels or other practitioners who require credentialing will not be allowed to begin practice until credentialing has been fully completed. Responsible person for implementing the plan of correction is Sandy Gordon.	

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A 046	Continued From page 2 hired in August 2005. Her "POSITION DESCRIPTION & ANALYSIS [job description]," revised 10/04, stated she was responsible for duties such as clamping blood vessels, suturing, and coagulating bleeding points. Documentation that she had been granted privileges to practice and had been appointed to the medical staff was not present. The Medical Staff Coordinator reviewed the files with the surveyor on 2/09/12 beginning at 10:30 AM. She confirmed the above practitioners had not been appointed to the medical staff and had not been granted privileges to practice at the hospital. The hospital did not appoint non-physician practitioners to the medical staff and did not grant them privileges.	A 046		
A 117	482.13(a)(1) PATIENT RIGHTS: NOTICE OF RIGHTS A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the hospital failed to ensure each patient was given patient rights information in advance of care for 1 of 2 patients in isolation (#5) whose records were reviewed. This had the potential to interfere with awareness and understanding of patient rights. Findings include: Patient #5 was a 55 year old male who was	A 117	**A 117 Patient Rights: Notice of Rights** The corrective action for the finding associated with the patient in isolation is as follows: 1. The procedure previously entitled Infection Control: Isolation - Daily Practices has had a title amendment and is now called Infection Control: Isolation - Patient Care and Daily Practices. Attachment 3. 2. In addition to the title change, a section associated with obtaining consent signatures for patients in isolation has been added. This section details the obligation of the care provider to review the content associated with patient rights and any other consenting document with the patient and note on the associated form that it was reviewed with the patient, but notes that the patient didn't sign because they were in isolation.	3/5/12

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A 117	Continued From page 3 admitted to the hospital on 2/04/12 for fever and chills. There was an undated, unsigned copy of a form titled "Notification of Patient Rights and Responsibilities" present in Patient #5's record. The word "Isolation" was hand written in the area of the form designated for a patient's signature. There was no nursing documentation in Patient #5's record to indicate the information on the form had been discussed with Patient #5 or that the form had been given to him for review. The Director of the Medical/Surgical Department was interviewed on 2/06/12 at 2:30 PM. She reviewed Patient #5's record and explained it was not the hospital's practice to get signatures on documents from patients who were in contact isolation, such as Patient #5, to reduce the risk of infection transmission. She confirmed there was no evidence of nursing documentation to validate patient rights information had been discussed with or distributed to Patient #5. A policy that addressed this process was requested. The Director of the Medical/Surgical Department stated the process was not addressed in hospital policy but probably should be addressed in the isolation policy. A system was not in place to assure patients in isolation were informed of their rights.	A 117	3. This change in policy has been communicated to the staff on March 7, 2012 (Attachment IV). The Infection Control Department will review all patients in isolation from March 7 until March 31 and will further monitor 25% of patients in isolation through April, May and June to assure that nursing documentation reflects the necessary documentation associated with the patient being in isolation when a signature is not obtained. Responsible person, Barb Boland, Infection Control Practitioner.	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital	A 144	**A 144 Patient Rights: Care in Safe Setting** The corrective action for the finding associated with the use of manually operated hospital beds in the Mental Health Unit is as follows: 1. A purchase order has been placed to obtain replacement beds that are designed for a psychiatric environment. Attachment V.	3/5/12

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A 144	Continued From page 4 failed to ensure care was provided in a safe setting for 2 of 3 patients on the Mental Health Unit (#7 and #15) whose records were reviewed. This resulted in increased opportunities for patients to harm themselves. Findings include: 1. Patient #15's medical record documented a 47 year old male who was admitted to the hospital on 1/27/12. He had been treated on a medical floor for alcohol withdrawal and then had been transferred to the Mental Health Unit on 1/30/12. He was currently a patient as of 2/08/12. His "IP PSYCH INTAKE REPORT," written by a psychiatrist and dated 1/30/12, stated he was found by police in a state park on 1/27/12. It said his plan was "to drink until he could drive himself into the water and commit suicide." When Patient #15 was asked about suicide during the examination, the psychiatrist documented Patient #15 stated he would not think about it, he would just do it. The psychiatrist documented Patient #15 "conveys a strong picture of emotional devastation." The intake also stated his "Insight and judgement [sic] appear clearly affected by severe depression." A tour of the Mental Health Unit was conducted by the Unit Director on 2/07/12 beginning at 10:45 AM. All of the rooms were constructed with special door knobs, sinks, curtain rods, etc. that were designed so patients could not attach anything to surfaces in an attempt to hang themselves. Most of the rooms had beds built with a wooden frame with no springs or attachable surfaces. However, Patient #15's room, 504, contained a hospital bed with a metal frame and springs. It was a manual bed which could be raised or lowered. In addition, the head	A 144	2. The hospital beds have been removed and place in storage and will be used only when a hospital bed is necessary to support the delivery of patient care. 3. A policy describing the use of a hospital bed has been developed (Attachment VI). In the event a hospital bed is used for a patient, an appropriate and individualized care plan will be developed to assure that the patient's safety is considered and all necessary interventions are put into place. 100% of hospital beds use in Mental Health will be monitored through FY 2012. Use and documentation of care planning will be reported in the MHQI Committee. Responsible person, Randy Davis, Director of Mental Health Program.	

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A 144	Continued From page 5 and foot of the bed could manually be raised or lowered. A pair of shoes was present with the shoelaces removed, but clothing could easily be tied to the bed in an attempt to harm himself. During the tour, the Unit Director identified 5 rooms that contained hospital beds. These rooms included 501, 503, 504, 505, and 506. He said no policy was in place regarding the use of hospital beds or medical equipment on the Mental Health Unit. He said no assessment of patients for suitability and risk of the use of hospital beds was conducted prior to placing patients in rooms with hospital beds. The hospital placed Patient #15 in a room with a hospital bed which increased his risk of self harm. 2. Patient #7's medical record documented a 52 year old female who was admitted to the hospital on 1/27/12 with diagnoses of mood disorder and personality disorder. She was currently a patient as of 2/08/12. Her medical record did not contain an assessment of the risk for using a hospital bed. Her room, 503, was observed with the Unit Director on 2/07/12 beginning at 10:45 AM. Her room contained a hospital bed. He confirmed an assessment for suitability and risk of the use of hospital beds had not been conducted for Patient #7. The hospital had not ensured patients on the Mental Health Unit were treated in a safe environment.	A 144		
A 147	482.13(d)(1) PATIENT RIGHTS: CONFIDENTIALITY OF RECORDS	A 147	**A 147 Patient Rights: Confidentiality of Records**	3/8/12

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A 147	Continued From page 6 The patient has the right to the confidentiality of his or her clinical records. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure patient's medical information remained confidential. The potential for patients/family members to view other patients' information was witnessed in 2 of 4 observations where patient information was accessed from the electronic medical record in patients' rooms. Failure to ensure patient confidentiality had the potential to result in disclosure of private information to unauthorized individuals. Findings include: 1. On 2/07/12 at 8:30 AM, an RN in the ICU was observed during a medication administration. She explained the medication administration record was electronic and demonstrated how to document the administration of a medication. She began by selecting the patient from her list of two patients being cared for on 2/07/12. For several seconds the full names of both patients were available to view on the screen. The family member of one of the listed patients was seated in a position that allowed for visualization of the computer screen. It was possible for this individual to read information related to the RN's other patient. The ICU RN observed during a medication administration on 2/07/12 was interviewed on 2/09/12 at 1:30 PM. She confirmed that a screen containing the full names of her patients was accessed and potentially available to be viewed by unauthorized individuals. She stated she tried	A 147	The corrective action associated with the findings under A 147 are as follows: Privacy screens have been ordered and placed on all computer screens in the ICU, PCU and Outpatient Surgery patient rooms. These are the computer screens in the hospital that have potential view capability by guests. The privacy screen blocks visualization of the computer screen unless the individual is directly in front of the screen and working with the electronic medical record. No monitoring and tracking procedures have been implemented because the corrective action plan modified the environment to prevent any reoccurrence. Responsible person for implementing the plan of correction is Misty Robertson, Director of ICU/PCU.	

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A 147	Continued From page 7 to remember to turn the screen away from patients/family members to limit inappropriate visualization of patient information. 2. On 2/08/12 at 9:10 AM, an RN was observed to complete a preoperative evaluation of a patient in the Outpatient Surgery Department. The patient was lying in the hospital bed and the patient's spouse was seated in the room. The RN was observed to select the patient's name from a list of full names of patients scheduled for surgery on 2/08/12. The names were available to be viewed from the spouse's position. On 2/08/12 at 2:10 PM, the Charge Nurse for the Outpatient Surgery Department was interviewed. She confirmed that at times during the admission and discharge process screens with a list of patient's full names were accessed. She stated staff attempted to move through these screens quickly to limit the possibility of unauthorized visualization of personal patient information. An RN who worked in the PCU was interviewed on 2/09/12 at 2:00 PM. She demonstrated the process of accessing medication administration screens in the computer. She stated a "status board" was compiled by each RN which contained only the patient's cared for by that RN. She stated the "status board" was accessed when the RN entered documentation into the computer. She accessed her "status board." The list of patients included the patient's first and last name, diagnosis, age, diet, physician, and code status. She stated she was aware this information was potentially available for view when the "status board" was accessed in patients' rooms. She stated she attempted to	A 147		

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A 147	Continued From page 8 position the screen in such a way as to not be viewed by unauthorized individuals. The facility failed to ensure that personal information was not available to unauthorized individuals.	A 147		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure restraint orders were complete and in accordance with physician orders for 2 of 5 restrained patients (#16 and #27) whose records were reviewed. This resulted in patients being restrained without clear authorization or direction as to type of restraints. Findings include: A hospital policy, "RESTRAINTS," dated 3/01/11, stated "restraints require an order by the physician responsible for the patient." Restraint orders were incomplete or missing as follows: 1. Patient #27 was a 72 year old male who was admitted to the hospital on 12/11/11 after a motor vehicle accident. Nursing documentation indicated Patient #27 had bilateral soft wrist restraints 12/12/11 through 12/18/11.	A 168	**A 168 Patient Rights: Restraint or Seclusion** Corrective action plan associated with the findings related to restraint and seclusion include: 1. A memorandum has been distributed to all members of the Medical Staff (Attachments VII & VIII) reinforcing the requirement that the restraint orders must include the type of restraint. Additionally, the memorandum reviews all requirements for ordering of restraints, including the need to assure that there is review of the order and reordering of a restraint if it continues to be necessary every calendar day. Attachment VI 2. A concurrent 100% audit process has been put into place to assure that all orders are complete and contain all necessary elements for ordering and documentation of use of restraints. This 100% concurrent audit will continue through the calendar year of 2012. Responsible party: Vice President of Patient Care Services.	3/9/12

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A 168	Continued From page 9 The restraint orders on 12/15/11, 12/16/11, and 12/17/11 did not state the type of restraints. There was no order for restraints present in Patient #27's record for 12/18/11. The Director of Nursing Operations and the Vice President of Patient Care Services were interviewed together on 2/08/12 at 3:45 PM. After review of Patient #27's record, the Director of Nursing Operations confirmed the restraint order for 12/18/11 was missing from the record. The Vice President for Patient Care Services confirmed the type of restraint was not stated on the physician orders for 12/15/11, 12/16/11, and 12/17/11. She explained there was a flaw in the form that led to the incomplete orders. The use of restraints was not in accordance with complete physician orders. 2. Patient #16 was a 61 year old male who was admitted to the hospital on 1/07/12 for care related to confusion and a fall. Physician restraint orders, dated 1/09/12, 1/10/12, 1/11/12, and 1/16/12, did not specify the type of restraints. Nursing documentation indicated Patient #16 had soft restraints on both wrists during the dates referenced above. The Vice President of Patient Care Services was interviewed on 2/08/12 at 2:35 PM. She reviewed Patient #16's record and confirmed the restraint orders did not include the type of restraints, including the initial order on 1/09/12. Restraint orders were incomplete, not specifying the type of restraints.	A 168		
A 396	482.23(b)(4) NURSING CARE PLAN	A 396	**A 396 Nursing Care Plan**	**3/9/12**

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A 396	Continued From page 10 The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospital failed to ensure nursing staff developed or kept current nursing care plans for 7 of 31 patients (#5, #7, #9, #10, #11, #31 and #38) whose care plans were reviewed. This had the potential to result in unmet patient needs. Findings include: 1. Patient #10 was an 88 year old male who was admitted to the Medical/Oncology Unit of the hospital on 2/05/12 for care primarily related to chronic obstructive pulmonary disease, pneumonia, and diabetes. The initial RN assessment, dated 2/05/12 at 10:06 AM, included the following information: Patient #10 reported being "basically blind" and being incontinent of urine and using pads for his incontinence. The nursing care plan, dated 2/06/12 did not include nursing diagnoses or goals to address either issue. A staff RN from the Medical/Oncology Unit was interviewed on 2/07/12 at 3:20 PM. He reviewed Patient #10's record and stated the care plan should have included a diagnosis to address the urinary incontinence. He stated he did not realize Patient #10 was blind and it should have been addressed in the care plan. Patient #10's nursing care plan was incomplete.	A 396	Actions taken associated with findings related to Nursing Care Plans are as follows: 1. Patients affected: #10, #31, #7 Education has been provided to Critical Care, Medical/Surgical and Obstetrical nursing staff. This is provided through the venue of staff meeting and provision of written information. The content that was covered included information on Attachment IX & X. Content specifically included instruction on how to add and remove a nursing diagnosis, and a review of how to document to the patient's plan of care. Staff were also instructed on how to individualize the goal for the patient. A copy of the available nursing diagnosis, (Attachment XI) which have been developed and are integrated into the EMR has been laminated and placed on all nursing units. In addition, instruction on to add a nursing diagnosis to the plan of care, how to complete a nursing diagnosis from the plan of care and how to view entire goal description has been made available and by laminating the document and placing it on all nursing departments. Monitoring of performance associated with updating the plan of care will occur through weekly audit of 20% of active patients on each unit for two months or until performance is demonstrated to be in full compliance with requirements and there is presence of accurate review, documentation and updating of plan of care. This information will be reported to Patient Quality Improvement Committee. Responsible person associated with assuring monitoring is occurring is Misty Robertson, Director of ICU; Bonnie Cleveland, Director of Med/Surg; and Earlene Pedersen, Director of Obstetrics.	

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A 396	Continued From page 11 2. Patient #11 was a 62 year old male who was admitted to the hospital on 2/06/12 for a course of chemotherapy. The initial RN assessment, dated 2/06/12 at 5:44 PM, documented "Diarrhea: Y [yes]" and "Constipation: N [no]." It also described Patient #11 as "calm" and "relaxed." The nursing care plan, dated 2/05/12 (the date may have been a documentation error since the admission date was 2/06/12), included a nursing diagnoses of "Bowel: Constipation" and "Anxiety/Fear." The nursing diagnoses did not say "Potential for Constipation" or "Potential for Anxiety/Fear" or address diarrhea. The Director of the Medical/Surgical Department was interviewed on 2/07/12 at 10:00 AM. She explained the nursing diagnosis of "Bowel: Constipation" automatically populated for every patient admitted to the Medical - Oncology unit, where Patient #11 was receiving care. She also stated that the nursing diagnosis of "Anxiety/Fear" automatically populated for patients on chemotherapy because of the potential for anxiety and fear. A staff RN on the Medical/Oncology Unit was interviewed on 2/07/12 at 10:20 AM. She stated it was possible for nursing staff to change some of the information after it auto-populated. They could delete a nursing diagnosis by marking it as "complete" and then enter another nursing diagnosis that was determined to be more relevant or accurate. Patient #11's nursing care plan did not accurately reflect his nursing assessment data.	A 396	2. ~~Patients affected: #11, #5,~~ #9 The Medical Center has added a nursing diagnosis entitled "Bowel function altered actual/potential related to medications and inactivity" with the stated goal as "Patients bowel patterns will achieve or remain at an accepted normal level for that patient". This change was made to assure the nursing diagnosis could address the individual bowel function status of each patient and the appropriate interventions will be integrated associated with the patient's goal and status to assure bowel function for each patient is individually addressed. The nursing diagnosis, "bowel constipation and bowel diarrhea" have been removed from the lookup of available diagnosis. This was communicated to the nursing staff through a Meditech memorandum (Attachment XII) to assure they were aware of the change. This change will be monitored through a weekly monitor of 20% of all active patients on the unit for two months or until performance is demonstrated to be in full compliance with requirements and there is presence of accurate review, documentation and updating of plan of care. This information will be reported to Patient Quality Improvement Committee. Responsible person associated with assuring monitoring is occurring is Bonnie Cleveland, Director of Med/Surg.	

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A 396	Continued From page 12 3. Patient #38 was a 64 year old female who was admitted to the hospital on 12/23/11 after a motor vehicle accident. A nursing care plan, dated 12/25/11 included restraints as an intervention. Physician orders for a left soft wrist restraint, dated 12/24/11, 12/25/11, 12/26/11, and 12/27/11, were present in Patient #38's record. There were gaps in nursing documentation of restraints between 7:00 PM and 8:00 AM the following morning on 12/26/11, 12/27/11, and 12/28/11. On 2/09/12 at 8:15 AM, the staff RN who provided care to Patient #38 on the night shifts for 12/26/11, 12/27/11, and 12/28/11 was interviewed. He stated Patient #38's restraints had been removed on 12/25/11 at 6:00 PM by another nurse. He explained at the time restraints were removed, the care plan was changed to "prn [as needed]" in the computer instead of being "completed" as it should have been. He stated that when a restraint care plan changes to "prn," then the cues disappear that remind nurses to monitor restrained patients hourly. When restraints were restarted on 12/26/11 at 8:00 AM, the care plan was not updated to reflect the active use of restraints. He stated he thought the lack of appropriate updating of the care plan may have contributed to him not charting on restraints during his shifts on 12/26/11, 12/27/11, and 12/28/11. He stated he could not remember whether Patient #38 was in restraints during those shifts and he didn't remember whether he removed the restraints. He acknowledged he did not document either scenario and it would have been one or the other. Patient #38's nursing care plan was not updated	A 396	3. Patient affected: #38 The individual who omitted the documentation three consecutive shifts did not perform in a manner that is consistent with SJRMC standards. Appropriate counseling and action have been taken to address this individual nurse's performance. SJRMC has added hard coded text directly below the restraint intervention to remind staff that they may not alter the documentation frequency on restraint intervention. The documentation frequency provides a prompt for nurses to appropriately and comprehensively document on the patient's status when they are in restraints. Monitoring of restraint intervention and associated documentation will occur on 100% concurrent monitoring process. This content associated with the monitoring will include: a. Complete initial order for use of restraints. b. Presence of an appropriate nursing diagnosis related to the need for restraints. c. Documentation is present and accurate associated with the care patients received. d. Charting is in place associated with the nursing diagnosis, prompting the need for restraint at a minimum every 24 hours and more frequently as appropriate. e. Physician documentation of restraint use is complete, accurate and consistent with the restraint that is in use. This concurrent audit (Attachment XIII) will continue indefinitely and will be reported to Patient Quality Improvement Committee on a quarterly basis. Responsible person: Paula Hornbeck, Director of PCS Quality/Supervisor.	

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A 396	Continued From page 13 to reflect the change in restraint status. 4. Patient #5 was a 55 year old male who was admitted to the hospital on 2/04/12 for fever and chills. The nursing care plan, dated 2/05/12, included a nursing diagnosis of "Bowel, Constipation." RN documentation, dated 2/06/12 at 11:50 AM stated Patient #5 was "having loose stools" and refused lactulose and stool softener (treatments for constipation). The nursing care plan was not updated to reflect the change in bowel status from constipation to diarrhea. The Director of Nursing Operations was interviewed on 2/08/12 at 11:00 AM. She explained a group of professionals in the hospital determined pre-set nursing diagnoses as they related to medical diagnoses. The Meditech computer system was programmed to automatically bring up nursing diagnoses linked to medical diagnoses. She stated, for example, "Bowel: Constipation," was a pre-set nursing diagnoses for patients who were admitted to the Medical-Oncology Unit because most patients were prescribed pain medication that could have a constipating effect. When asked if nursing staff could change the nursing diagnosis to: "Potential for Constipation," to more accurately reflect actual health status when the patient was not constipated, she stated the professional group made a decision to leave out the words "Potential for" because the additional words took up too many spaces and Meditech was limited. When asked if nursing staff could delete the pre-selected diagnoses and enter more individualized diagnoses, such as delete "Bowel: Constipation" and enter "Bowel: Diarrhea," she stated that was an option.	A 396		

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A 396	Continued From page 14 Patient #5's care plan did not accurately reflect the findings of his nursing assessment. 5. Patient #9 was an 80 year old female who was admitted to the Medical/Oncology Unit of the hospital on 2/03/12 for care primarily related to pneumonia and a urinary tract infection. The initial RN assessment, dated 2/03/12 at 10:10 AM, stated Patient #9 had normal bowel sounds and denied having constipation or diarrhea. A nursing care plan, dated 2/06/12, included a nursing diagnosis of "Bowel: Constipation" and a corresponding goal for Patient #9's bowel pattern to "return to acceptable normal level." There was no evidence Patient #9 was constipated. A staff RN from the Medical/Oncology Unit was interviewed on 2/07/12 at 3:05 PM. He explained that nurses could not select "Potential for Constipation" in their computer system. He acknowledged that would have been more accurate. Patient #9's care plan did not accurately reflect the findings of his nursing assessment. 6. Patient #31 was a 21 year old female who was admitted to the hospital on 2/07/12, in labor with her second baby. Patient #31's record included a social worker note dated 1/23/11 which stated she had adopted out her first baby, had financial difficulties, needed a car seat, and suffered from depression. The note further stated Patient #31 was physically abused by the father of her baby and had recently left him to live with her parents. Patient #31's History and Physical, dated 2/07/12	A 396		

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A 396	Continued From page 15 at 10:05 PM, stated she had a significant medical history for a blood clot in her brain that developed three weeks after her first baby was delivered. The physician stated in her note she had started Patient #31 on anticoagulant therapy before the delivery, and the therapy would continue through this hospitalization and into her post partum period. A nursing care plan, dated 2/08/12 for Patient #31 did not address the history of domestic violence, financial concerns, the adoption of her first baby, depression, or anticoagulant therapy. In an interview on 2/09/12 at 1:55 PM, the Patient Care Coordinator reviewed Patient #31's record and confirmed no care plans had been developed to address the history of domestic violence, financial concerns, coping related to adopting out her first baby, depression and anticoagulant therapy. She stated the plan of care for Patient #31 was inadequate and should have been more specific for the patient. The nursing care plan was not updated to reflect the unique and individual physical and psychological needs of Patient #31. 7. Patient #7's medical record documented a 52 year old female who was admitted to the hospital on 1/27/12 with diagnoses of mood disorder and personality disorder. She was currently a patient as of 2/08/12. Her "IP PSYCH INTAKE," dated 1/28/12, stated she had a history of methamphetamine and cocaine use and had been hospitalized in 2006 for physical symptoms related to their use. It stated Patient #7 had a long history of methamphetamine dependence	A 396		

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A 396	Continued From page 16 and said she was currently on opiates (oral morphine) for a back injury. The intake also stated Patient #7 had been hospitalized on the Mental Health Unit from 1/20/12 to 1/25/12. It said following discharge, she was arrested in a nearby town, on 1/26/12, for driving under the influence. She was readmitted to the Mental Health Unit on 1/27/12. Patient #7's "Treatment Plan Report," dated 1/30/12, listed amphetamine dependence and "Sedative, Hypnotic, or Anxiolitic Dependence" as diagnoses. (Anxiolitics are drugs used to reduce anxiety.) The treatment plan, which included the nursing care plan, listed 1 problem-"Altered mood -depressed with psychotic features ..." The plan did not address addiction or pain. The Nurse Manager for the Mental Health Unit was interviewed on 2/07/12 beginning at 9:00 AM. She confirmed Patient #7's treatment plan did not address addiction or pain. Patient #7's nursing care plan was not complete.	A 396		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation, review of kitchen logs and hospital policies, and staff interviews, it was determined the hospital failed to ensure 1 of 1 kitchen evaluated for environmental issues was maintained in such a manner as to ensure the	A 701	**A 701 Maintenance of Physical Plant 3/8/12** The following actions have been taken to correct finding A 701: 1.a&b. On 2/7/12, a complete audit of all areas within the kitchen housing food products was conducted to verify compliance with food labeling and dating practices. On 2/8/12, daily inservices (Attachment XIV) were conducted with instructions on how to properly label and date food items that were in the refrigerators, freezers and dry storage areas. Weekly inservices continue to be conducted on an ongoing basis.	

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A 701	Continued From page 17 safety and well-being of patients. Failure to maintain a clean food storage and preparation environment had the potential to negatively impact the well-being of all patients receiving care in the hospital. Findings include: 1. During a tour of the hospital's kitchen, on 2/07/12 beginning at 2:00 PM, with the Dietary Manager and the Dietitian, the following concerns were noted: a. In the walk-in freezer the following food was observed to be undated and/or expired: i. An opened package of sausage crumbles, label dated 4/01/11. There was no clarification on the package if the date was the open date or expiration date. ii. An opened bag of sliced pepperoni, labeled with an expiration date of 11/11. iii. An opened bag of zucchini, label dated 2/27 but no year was included on the label. iv. An opened package of pie shells, no open date or expiration date. v. An opened box with pieces of chocolate cake, expiration date of 1/30/12. b. In the walk in refrigerator the following food was observed to be undated or expired: i. A package of beef tips, opened and undated. ii. An unopened package of flour tortillas, dated 11/15/11.	A 701	An audit tool (Attachment XV) was developed and the Assistant Manager is weekly auditing the entire kitchen for compliance with food labeling and dating practices. These results are shared with the front line staff and reported to the Quality Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services	

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A 701	Continued From page 18 iii. A container of custard, undated. A policy titled "PRODUCTION, PURCHASING, STORAGE," dated 5/95 and revised 1/12, addressed food and supply storage procedures. The policy stated foods were to be dated when opened, and food would be discarded past the use-by or expiration date. The policy did not define time frame from package opening to discard date. The Dietary Manager, who was present during the tour, discarded the foods upon discovery of missing or expired labels. c. The triple sink for pot and utensil sanitizing was observed to be in use by a kitchen worker cleaning utensils. Upon surveyor request, the kitchen worker tested the sanitizer side of the triple sink and the result was greater than 400 ppm (parts per million). The Dietary Manager stated the results should have been 200 ppm, and the water was too warm and instructed the worker to change the water and retest for appropriate level of sanitizer. d. The pot and utensil washing sinks had a form titled "POT SINK TEMP & SANITIZER LOG" posted which indicated the wash water, rinse water, and sanitizer was to be refilled and quality checked each meal time. The log had columns to include the quat (sanitizer) reading, water temperature of the wash and rinse sinks, and the temperature of the sanitizer sink. The log for February 2012 was missing entries for the following dates:	A 701	1.c. On 2/8/12, the chemical vendor re-calibrated the sanitizer solution for the pot and pans sink to the proper range. An inservice for all staff was conducted on 2/8/12 on the proper use of the pot and pan sink with regards to the sanitizer compartment. A monitoring process was implemented where the supervisor on each shift is responsible for daily monitoring of the accuracy and completeness of the sanitation log (Attachment XVI). The Assistant Manager reviews the log weekly for compliance and the results are reported to the Qaulity Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services	

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A 701	Continued From page 19 -2/01/12 breakfast and lunch meals -2/02/12 breakfast, lunch and dinner meals -2/03/12 dinner meal -2/06/12 breakfast and dinner meals -2/07/12 breakfast meal. During the tour on 2/07/12 the Dietary Manager confirmed the log was not completed and stated the system of measuring the sanitizer level was a new practice for their kitchen staff. e. The Dietary Manager stated the kitchen staff cleaned work areas with a sanitizing solution that was in red buckets throughout the kitchen. He tested a bucket in the dirty dish handler area. The test indicated the sanitizing solution was less than 100 ppm. The Dietary Manager stated the worker had left for the day, and should have discarded the sanitizing solution before leaving. A policy titled "SANITATION AND INFECTION CONTROL," dated 5/95, and reviewed 3/11, addressed cleaning of work areas and the use of sanitizer solutions. The policy stated the sanitizer in red buckets was to be replaced every 2-4 hours. The policy did not define the parameters for acceptable levels of sanitizer concentration. According to the FDA (Food and Drug Administration) 2009 food safety standards, the sanitizing solution must be 200 ppm. If the concentration is too weak, it can result in an inadequate reduction of harmful microorganisms, and too much may be toxic. In addition, the water temperature for chemical sanitizers work best in water that is between 55 and 120 degrees. f. The floors behind the grills and oven unit and	A 701	1.e. On 2/8/12, the policy titled "Sanitation and Infection Control" (Attachment XVII & XVIII) was revised to include the parameters for acceptable levels of sanitizer concentration. On 2/8/12, Dietary staff was inserviced on the process for using the red buckets for sanitation including the parameters for acceptable levels of sanitizer concentration. A weekly monitoring process was initiated to ensure compliance with the results being reported to the Quality Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services	

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A 701	Continued From page 20 behind the vending machines contained dust and food items. The debris was verified by the Dietary Manager during the tour. He stated housekeeping was responsible for cleaning the department after the kitchen was closed. The nightly cleaning included scrubbing and moping the floors and behind the equipment. The physical environment of the dietary department was not adequately maintained to ensure the safety and well-being of patients.	A 701	1.f. On 2/7/12, the area behind the grill in the cafe and the vending machines in the cafe were cleaned. Weekly monitoring (Attachment XIX) for cleanliness compliance is conducted by the Environmental Services evening supervisor and reported to the Director of Environmental Services. Results from the monitoring are reported to the Quality Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services	
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop 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 staff interview, observation, and review of facility policy and procedures, it was determined the hospital failed to ensure an infection control surveillance program for Laboratory, Radiology and Nutritional Services was developed. The failure to develop a program to monitor these departments had the potential to expose hospital patients and staff to infection. Findings include: 1. During a tour of the Laboratory with the Chief Scientist on 2/07/12 beginning at 11:00 AM, the following infection control concerns were noted: a. The room in which biological specimens were received and logged in had one sink that was designated as a "dirty" sink with a red sign on the	A 749	**A 749 Infection Control Officer Responsibilities** The following actions associated with the findings in the laboratory have been implemented to address deficiencies found in A 749. 1.a. The area around the designated "dirty" sink has been cleared so that no items such as	3/8/12

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A 749	Continued From page 21 wall above the sink. A "dirty" sink is a sink which is used for biohazardous chemicals or specimens, and cannot be used for hand washing. However, a paper towel dispenser, soap dispenser, and three bottles of hand moisturizer (two of which were commercial hand lotions without antibacterial properties) were noted on back portion of the sink beside the faucet. The presence of the above items indicated the sink was used as a hand washing area. The Chief Scientist was present during the tour and confirmed the sink was designated as a dirty sink and immediately removed the items from the sink area. She stated the sink was not to be used as a hand washing area, and confirmed there was no clean sink in the specimen receiving room. The main lab area had multiple sinks, designated as "dirty" sinks with red signs posted above them. The Chief Scientist pointed out the one sink in the entire laboratory facility that was designated as a "clean" sink for staff hand washing. The identified sink was close to the entrance and exit and traffic flow area for the staff. The Chief Scientist stated the entire staff would use the sink at the beginning of the shift, when going to breaks and lunch, and at the end of the shift. The laboratory lacked sufficient access to designated "clean" sinks for staff to perform appropriate hand hygiene. b. The process of obtaining a blood specimen by venipuncture was observed four times. Blood draws were not completed in a clean manner as follows:	A 749	hand moisturizers or lotions are in the area. Appropriate signage has been put into place to remind people that those items are not allowed in that area. In regards to the observation that there the "clean" sink for staff handwashing is limited to one sink in the area, there has been an additional "clean" sink designated for staff to perform hand hygiene located within that area and there was a review of availability of hand santizers to assure that it is located and available throughout the laboratory. It is also mounted on the wall as staff enter, so availability is assured as staff enter and exit rooms. Monitoring associated with assuring no hand moisturizer or commercial hand lotions or other items that may create an impression that a "dirty" sink can be used as a handwashing sink will be done by the Chief Scientist on a daily basis. Any identification of items located there will result in their immediate discard and communication with the housekeeping staff who from time to time locate items there as a standard stocking function related to sinks in the organization. Monitoring of availability of sinks is not required because the deficiency was corrected. Responsible person: Delores Davis, Chief Scientist, Pathology Laboratory 1.b. The procedure entitled "Venipuncture Procedure" has been revised to state "Do not touch the venipuncture site once it the area has been cleaned. If you need to re-palpate the vein, you must decontaminate the site	

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A 749	Continued From page 22 On 2/07/12 at 10:00 AM, a phlebotomist was observed to attempt a blood draw on a patient in the ICU. She donned gloves and wiped the area on the patient's arm down with an alcohol pad. She then palpated the area with her gloved finger prior to inserting the needle, but was unable to withdraw any blood. At 10:15 AM, a second phlebotomist arrived to complete the blood draw. She was observed to don gloves, wipe an area of the patient's arm with alcohol and then palpate with her gloved finger over the cleaned area prior to inserting the needle. On 2/08/12 at 8:50 AM, during a tour of the laboratory, a third phlebotomist was noted to cleanse the site on a patient's arm then palpate the vein just prior to venipuncture without re-cleansing the site, thus contaminating the site. A Clinical and Laboratory Standards Institute publication, dated 5/27/11, states after cleansing the venipuncture site, if the phlebotomist needs to palpate the vein, the site will need to be decontaminated again. During an interview directly after the tour, the Laboratory General Manager stated the phlebotomy staff was directly observed for technique as part of the orientation process. He stated the staff would then be permitted to draw patient specimens on the hospital units and in the outpatient areas. The General Manager stated gloves were used as protection of the phlebotomist, and that he did not think the palpation of the site was contaminating the specimen.	A 749	again." (Attachment XX) Staff have been notified of this change. Monitoring of performance will be done through the regular observation that is carried out for each phlebotomist as a section associated with observation to assure a cleanse site is not re-palpated has been added to the competency checklist (Attachment XXI). Any deviation from this performance will be corrected immediately and appropriately documented for identification of performance deficiencies, which may require additional action. The procedure entitled "Post Phlebotomy Care/Specimen Labeling" has been revised to state "Use Virex to disinfect the phlebotomy chair, counter, computer, writing utensil and any other items that may have become contaminated before calling in the next patient." (Attachment XXII) The Phlebotomy Competency has been revised to include a section that requires observation on each phlebotomist on a weekly basis associated with wiping down keyboard, pens, draw chair counter, etc. after a patient leaves. Staff were notified and reminded of this requirement. These observations will result in immediate counseling if deviations from the practice occurs and will be trended to monitor if there is any chronicity in performance that needs to be addressed further. Responsible person: Delores Davis, Chief Scientist, Pathology Laboratory	

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A 749	Continued From page 23 c. During observation of venipuncture by phlebotomy staff on 2/07/12 at 8:50 AM and at 9:30 AM in the laboratory outpatient area, it was noted staff wore gloves during data entry on the computer, and when using writing utensils after obtaining the specimen. The computer and writing utensils were not cleaned after the patient was dismissed from the room. One phlebotomist was noted to have artificial nails. The Chief Scientist was unaware of the staff with artificial nails, and stated there was no policy regarding staff with artificial nails. A hospital policy titled "INFECTION CONTROL Artificial Nails," dated 6/13/02, stated "Individuals who are employed and assigned to roles which include delivery of direct patient care are not allowed to wear artificial fingernails or long natural fingernails." The laboratory did not monitor venipuncture practice, cleansing of work areas, and hand hygiene/artificial nails. 2. During a tour of the hospital's kitchen with the Dietary Manager and Dietician, on 2/07/12 beginning at 2:00 PM, the following infection control concerns were noted in the kitchen: a. The triple sink for pot and utensil sanitizing was observed to be in use by a kitchen worker cleaning utensils. Upon surveyor request, the kitchen worker tested the sanitizer side of the triple sink and the result was greater than 400 ppm (parts per million). The Dietary Manager stated the results should have been 200 ppm, and the water was too warm and instructed the worker to change the water and retest for	A 749	1.c. A policy was implemented on 2/16/12 that states that "Artificial nail enhancements are not to be worn by anyone working at the laboratory that has direct patient contact" (Attachment XXIII). The policy also states that natural nails of the healthcare worker to be kept neatly manicured and should not extend past the fingertips. This policy was implemented on 2/16/12. All staff were notified and are currently in compliance with the policy. This policy change will not require continuous monitoring because it has been made a standard employment requirement. Responsible person: Delores Davis, Chief Scientist, Pathology Laboratory 2.a&b. On 2/8/12, the chemical vendor re-calibrated the sanitizer solution for the pot and pans sink to the proper range. An inservice for all staff was conducted on 2/8/12 on the proper use of the pot and pan sink with regards to the sanitizer compartment. A monitoring process was implemented where the supervisor on each shift is responsible for daily monitoring of the accuracy and completeness of the sanitation log (Attachment XVI). The Assistant Manager reviews the log weekly for compliance and the results are reported to the	

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A 749	Continued From page 24 appropriate level of sanitizer. b. The pot and utensil washing sinks had a form titled "POT SINK TEMP & SANITIZER LOG" posted which indicated the wash water, rinse water, and sanitizer was to be refilled and quality checked each meal time. The log had columns to include the quat (sanitizer) reading, water temperature of the wash and rinse sinks and the temperature of the sanitizer sink. The log for February 2012 was missing entries for the following dates: -2/01/12 breakfast and lunch meals -2/02/12 breakfast, lunch and dinner meals -2/03/12 dinner meal -2/06/12 breakfast and dinner meals -2/07/12 breakfast meal. During the tour on 2/07/12 the Dietary Manager confirmed the log was not completed and stated the system of measuring the sanitizer level was a new practice for their kitchen staff. c. The Dietary Manager stated the kitchen staff cleaned work areas with a sanitizing solution that was in red buckets throughout the kitchen. He tested a bucket in the dirty dish handler area. The test indicated the sanitizing solution was less than 100 ppm. The Dietary Manager stated the worker had left for the day, and should have discarded the sanitizing solution before leaving. A policy titled "SANITATION AND INFECTION CONTROL," dated 5/95, and reviewed 3/11, addressed cleaning of work areas and the use of sanitizer solutions. The policy stated the sanitizer in red buckets was to be replaced every 2-4	A 749	Qaulity Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services 2.c. On 2/8/12, the policy titled "Sanitation and Infection Control" (Attachment XVIII) was revised to include the parameters for acceptable levels of sanitizer concentration. On 2/8/12, Dietary staff was inserviced on the process for using the red buckets for sanitation including the parameters for acceptable levels of sanitizer concentration. A weekly monitoring process was initiated to ensure compliance with the results being reported to the Quality Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services	

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A 749	Continued From page 25 hours. The policy did not define the parameters for acceptable levels of sanitizer concentration. According to the FDA (Food and Drug Administration) 2009 food safety standards, the sanitizing solution must be 200 ppm. If the concentration is too weak, it can result in an inadequate reduction of harmful microorganisms, and too much may be toxic. In addition, the water temperature for chemical sanitizers work best in water that is between 55 and 120 degrees. d. Food and debris was noted on the floor behind the grills, oven unit, and vending machines. The debris was verified by the Dietary Manager during the tour. He stated housekeeping was responsible for cleaning the department after the kitchen was closed. The nightly cleaning included scrubbing and mopping the floors and behind the equipment. Infection control practices in the dietary area of the hospital were not effectively monitored. 3. During a tour of the Diagnostic Imaging Department with the Manager and the Chief Radiological Technician on 2/07/12 beginning at 9:45 AM, the following infection control concerns were noted: a. The Chief Radiological Technician stated the lead aprons and other non-critical patient care equipment were cleaned on a weekly and "as needed" basis. She was not able to produce a schedule for the equipment cleaning. The Chief Radiological Technician described the cleaning solution used to clean the equipment. She stated the concentrated cleaning solution was diluted	A 749	2.d. On 2/7/12, the area behind the grill in the cafe and the vending machines in the cafe were cleaned. Weekly monitoring (Attachment XIX) for cleanliness compliance is conducted by the Environmental Services evening supervisor and reported to the Director of Environmental Services. Results from the monitoring are reported to the Quality Improvement Committee. Responsible person: Randy Southall, Director of Environmental Services 3.a. The following corrective actions have been taken to address the finding that patient care equipment in the diagnostic imaging department was not sufficiently disinfected. 1) The cleaning agent that was stated to be in use during the survey has been removed and replaced with Sani-Cloth Plus Germicidal Disposable Cloths and hospital selected EPA-registered hospital disinfectants, depending on the equipment being cleaned. 2) The Radiology Infection Control policy (Attachment XXIV) has been amended to include an additional purpose statement that	

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A 749	Continued From page 26 with tap water, and then dispensed into the refillable bottles. The Chief Radiological Technician provided a bottle of the diluted cleaning solution. The label was faded, and it was not clear when the mixture had been replenished or when it expired. The Director of Nursing Operations was present during the tour of Diagnostic Imaging on 2/07/12 beginning at 9:45 AM. After the tour she stated she had placed a call to the manufacturer of the product. She stated the representative she spoke with had instructed her that sterile or distilled water was to be used for dilution, and the expiration date of the cleaning solution was seven days after dilution. The representative also told the Director of Nursing Operations the cleaning solution was to be used for hard surfaces only, therefore the lead aprons would require a different cleaning agent. The CDC "Guideline for Disinfection and Sterilization in Healthcare Facilities," dated 2008, describes noncritical items as patient items that come in contact with intact skin. Examples of noncritical patient-care items are blood pressure cuffs, lead aprons, and computers. The article stated the noncritical reusable items should be cleaned after each use with a low level disinfectant. Patient care equipment in the diagnostic imaging department was not sufficiently disinfected.	A 749	reads "To define process for cleaning of lead aprons and other noncritical patient care equipment". 3) A specific section associated with cleaning lead aprons and noncritical patient care equipment has been added to that policy. The policy differentiates equipment used by staff that is not in direct intact patient skin contact and equipment has direct contact with patient skin, the cleaning frequency is adjusted according to its use. 4) Patient equipment that is in direct contact with patient skin is wiped down after each use. Other equipment is wiped down on an as needed basis and at least weekly. Staff received education on the new policy and cleaning process on 3/8/12. These process changes will be monitored through the use of a monitoring tool (Attachment XXV). The documentation of cleaning of equipment will be reviewed regularly by the Department Director or his designee and deviations will be immediately addressed. Findings associated with monitoring for continued compliance will be reported through 2012 at the Radiology Quality Improvement Committee. Responsible person: Bob Jones, Director of Imaging Services.	
A9999	CLOSING COMMENTS A1180 42 CFR 412.27(d)(2) Director of Inpatient Psychiatric Services; Medical Staff. Inpatient psychiatric services must be under the	A9999	**A9999 Closing Comments**	3/8/12

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A9999	Continued From page 27 supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services. This standard is not met as evidenced by: Based on staff interview and review of contracts, it was determined the hospital failed to ensure a clinical director had been appointed to oversee psychiatric services on the PPS excluded psychiatric unit. This resulted in a lack of leadership and direction for services on the unit. Findings include: 1. The surveyor requested the contract for the clinical director, called the Medical Director, of the PPS excluded psychiatric unit from the Vice President of Patient Care Services on 2/07/12 at 1:35 PM. She stated the Medical Director had resigned in October 2011 and a new Medical Director had not been appointed. She stated a psychiatrist had assumed the role of Medical Director but he had not been formally appointed to the position. She stated a the hospital did not have a contract or formal agreement with a physician to serve as Medical Director for the psychiatric unit. 2. The psychiatrist who had assumed the role of Medical Director was interviewed on 2/08/11 beginning at 1:30 PM. He stated he was acting as the Medical Director. He stated this was not a formal arrangement. He also said there was no record of his activities as Medical Director, such	A9999	The following action has been taken to address the requirement of having a qualified Medical Director: 1. Dr. [redacted] Board Certified Psychiatrist has been appointed as Mental Health Medical Director, effective March 5, 2012. 2. A formal agreement related to the appointment has been completed (attachment XXVI). No followup monitoring is required because the action addressed the requirement.	

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A9999	Continued From page 28 as time sheets or documentation of activities such as reviewing policies or participation in leadership discussions. The PPS excluded psychiatric unit did not have a clinical director. A1181 42 CFR 412.27(d)(2)(i) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. This standard is not met as evidenced by: Based on staff interview, it was determined the hospital failed to ensure a clinical director who met training and experience requirements had been appointed to oversee psychiatric services on the PPS excluded psychiatric unit. This resulted in a lack of leadership for the unit. Findings include: The Vice President of Patient Care Services was interviewed on 2/07/12 at 1:35 PM. She stated the Medical Director had resigned in October 2011 and a new Medical Director had not been appointed to oversee the PPS excluded psychiatric unit. The PPS excluded psychiatric unit did not have a qualified clinical director. A1182 42 CFR 412.27(d)(2)(ii) The director must monitor and evaluate the quality and	A9999	The following action has been taken to address the requirement of having a qualified Medical Director: 1. Dr. [redacted] Board Certified Psychiatrist has been appointed as Mental Health Medical Director, effective March 5, 2012. 2. A formal agreement related to the appointment has been completed (attachment XXVI). No followup monitoring is required because the action addressed the requirement.	

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A9999	Continued From page 29 appropriateness of services and treatment provided by the medical staff. This standard is not met as evidenced by: Based on staff interview and review of contracts, it was determined the hospital failed to ensure a clinical director had been appointed to evaluate the quality and appropriateness of services and treatment provided by the medical staff. on the PPS excluded psychiatric unit. This resulted in a lack of oversight of medical staff services. Findings include: The Vice President of Patient Care Services was interviewed on 2/07/12 at 1:35 PM. She stated the Medical Director had resigned in October 2011 and a new Medical Director had not been appointed to oversee medical staff services on the PPS excluded psychiatric unit. She stated a the hospital did not have a contract or formal agreement with a physician to serve as Medical Director for the psychiatric unit and to evaluate the quality and appropriateness of services and treatment provided by the medical staff. The PPS excluded psychiatric unit did not have a clinical director to oversee medical staff services.	A9999	The following action has been taken to address the requirement of having a qualified Medical Director: 1. Dr. [redacted] Board Certified Psychiatrist has been appointed as Mental Health Medical Director, effective March 5, 2012. 2. A formal agreement related to the appointment has been completed (attachment XXVI). No followup monitoring is required because the action addressed the requirement.	

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BB145	16.03.14.250.02 Medical Staff Appointments and Reappointments 02. Medical Staff Appointments and Reappointments. Medical staff appointments and reappointments shall be made by the governing body upon the recommendation of the active medical staff, or a committee of the active staff. (10-14-88) a. Appointments to the medical staff shall include a written delineation of all privileges including surgical procedures, and governing body approval shall be documented. (10-14-88) b. Reappointments to the medical staff shall be made at least every two (2) years with appropriate documentation indicating governing body approval. (10-14-88) c. Reappointment procedures shall include a means of increasing or decreasing privileges after consideration of the member's physical and mental capabilities. (10-14-88) d. The medical staff and administration with approval of the governing body shall develop a written procedure for temporary or emergency medical staff privileges. (10-14-88) This Rule is not met as evidenced by: Refer to A-046 as it relates to the failure to ensure non-physician members of the medical staff had been appointed to the medical staff and had been granted privileges to practice at the hospital.	BB145	**BB145 Medical Staff Appointments and Reappointments** See Tag A 046 RECEIVED MAR 12 2012 FACILITY STANDARDS	
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept	BB175	**BB175 Patient Care Plans** See Tag A 396	

Bureau of Facility Standards

Loretta P. Smith

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 3/9/12

Bureau of Facility Standards

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BB175	Continued From page 1 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 A-396 as it refers to Nursing Care Plans	BB175		
BB208	16.03.14.320.07 Food Preparation and Service 07. Food Preparation and Service. (10-14-88) a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. (10-14-88) b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value. (10-14-88) This Rule is not met as evidenced by: Refer to A-701 as it refers to food storage and preparation of foods.	BB208	**BB208 Food Preparation and Service** See Tag A 701	

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BB210	Continued From page 2	BB210		
BB210	16.03.14.320.09 Dietary Santiation 09. Dietary Sanitation. Sanitary standards for hospitals shall be those found in Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Rules Governing Food Sanitation Standards Food Establishments (UNICODE)". (12-31-91) This Rule is not met as evidenced by: Refer to A-749 as it relates to the failure of the facility to maintain clean food storage and preparation areas.	BB210	**BB210 Dietary Sanitation** See Tag A 749	
BB541	16.03.14.540.04 Infection Control Committee Responsibilities 04. Infection Control Committee Responsibilities. The infection control committee shall be responsible for at least the following: (10-14-88) a. Designate one (1) person to act as the surveillance officer; and (10-14-88) b. Evaluating antibiotic susceptibility/resistance trends; and (10-14-88) c. Review of all infection control procedures for all departments, including housekeeping and laundry procedures, at least annually; and (10-14-88) d. Development of procedures for defining and controlling hazardous and infectious wastes; and (10-14-88) e. Continuing education for all appropriate personnel. (10-14-88) This Rule is not met as evidenced by:	BB541	**BB541 Infection Control Committee Responsibilities** See Tag A 701 and A 749	