



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 4, 2012

Louis Kraml, Administrator
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221

CMS Certification Number: 13-1325

**Re: Complaint survey 03/20/2012 and CoPs not met
Deemed status removed and placed under State survey jurisdiction
Full health and life safety code survey to be conducted**

Dear Mr. Kraml:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau Facilities Standards, Department of Health and Welfare (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on March 14-20, 2012. Based on a review of the deficiencies identified during this investigation, CMS has determined that Bingham Memorial Hospital **is not in substantial compliance** with the Medicare Critical Access Hospital (CAH) Conditions of Participation – Clinical Records (42 Code of Federal Regulations (CFR) § 485.638).

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospitals/CAHs accredited by the Joint Commission will be “deemed” to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital/CAH participating in Medicare if there is a substantial allegation of a serious deficiency that would, if found to be present, adversely affect the health and safety of patients.

As a result of the March 14-20, 2012, complaint survey findings CMS is required, following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

Denver Regional Office
1600 Broadway, Suite 700
Denver, CO 80202

San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Page 2 – Mr. Kraml

The deficiencies cited limit the capacity of Bingham Memorial Hospital to furnish services of an adequate level or quality. The deficiencies that led to CMS' decision are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement that the provider submit a plan of correction (PoC). However, under federal disclosure rules findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable if requested within 90 days of completion.

Bingham Memorial Hospital may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited.
- The plan should address improving 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.
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Linda Bedker
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Further, in accordance with § 1865(b) of The Act, the Idaho Bureau Facilities Standards, Department of Health and Welfare and Facility Fire Safety Program will conduct a full unannounced health and life safety code survey of your CAH to assess compliance with all the Medicare Conditions of Participation. This unannounced survey shall occur within the next 60 days.

The recommendation that Bingham Memorial Hospital submit a plan to correct its Medicare deficiencies does not affect its accreditation, Medicare payments, or current status as a participating provider of CAH services in the Medicare program. When Bingham Memorial Hospital has been found to meet all the Medicare Conditions of Participation for CAHs, the State agency will discontinue its survey jurisdiction.

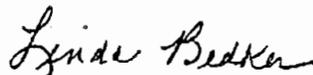
Page 3 – Mr. Kraml

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and the Joint Commission. You can also pursue any concerns you may have with the Joint Commission at any time.

If you have any questions, please contact me by email at linda.bedker@cms.hhs.gov or telephone at (206) 615-2090.

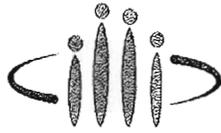
Sincerely,



Linda Bedker, RN, MN, MPH
Nurse Consultant
Survey, Certification and Enforcement Branch

Enclosure

cc: Idaho Bureau Facilities Standard Department of Health & Welfare
Idaho Facility Fire Safety & Construction Program
Joint Commission



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98 Poplar Street
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May 2, 2012

CMS-Survey and Certification
Attention: Amy Hastriter
Fax: 208.364.1888

Re: CMS Certification Number 13-1325

Dear Ms. Hastriter:

Enclosed is our Plan of Corrections Formal Addendum from the acute-care survey on March 20, 2012. I trust that the changes to our processes, the development of improved policies and procedures, staff training, and the implementation of this plan will better meet the needs of the communities we serve.

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

Sincerely,

A handwritten signature in black ink, appearing to read "L. Kraml". The signature is fluid and cursive.

Louis D. Kraml, CEO
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221
208-785-3804



BINGHAM MEMORIAL HOSPITAL

PLAN OF CORRECTIONS FORMAL ADDENDUM
May 1, 2012RECEIVED
MAY 02 2012
FACILITY STANDARDS

ATTN: Amy Hastriter

RE: Provider Number 13-1325
CMS Form: 2567
Survey Completion Date of March 20, 2012

Good morning, Amy. Here are the amendments to clarify issues found in our Plan of Correction that were brought to my attention during our phone call this morning. Thank you so much for your kind education on these issues.

Per your recommendation, you will find our clarifications in numerical tag order. I am also referencing the POC page number where the clarification should be inserted.

C 294, page 9/41:

Policy #3098 - Physician Notification Criteria of Patient Change in Condition does state that "If any change in condition warrants that the nurse requests the physicians come to see the patient, then the physician must come in to evaluate the patient within thirty (30) minutes." The thirty (30) minute time frame is correct and should replace the one hour time frame originally listed.

C 301 #1, page 23/41:

The Medical Staff Rules and Regulations were reviewed as it relates to History and Physicals, Progress Notes and Discharge Summaries. Documentation education for all medical staff members will be communicated from the Medical Executive Committee by April 17, 2012 and discussed at the general medical staff meeting on June 13, 2012. Packets with all information to be discussed at this meeting are sent to the medical staff approximately two (2) weeks prior to the meeting.

Education will provided to the general medical staff at the June 13th meeting will reinforce Medical Staff Rules and Regulations, Number 12 and Number 34, which outline medical records completion expectations including dating and timing, content for H & Ps, Progress Notes, and Discharge Summaries.

The completeness of the medical record, including dating and timing of all physician orders is verified daily by the Health Information Department during the indexing process.

All charts are reviewed twice during Quality Control indexing. The audit tool (enclosure #8 of original POC) allows for comprehensive chart review and proof that the chart was complete will be recorded in the last column of the audit tool.

C 302, #a, page 25/41:

Policy #3098 - Physician Notification Criteria of Patient Change in Condition was revised and approved on April 10, 2012 by Clinical Practice Council. The revision includes: If any change in condition warrants that the nurse requests the physician come see the patient, then the physician must come in to evaluate the patient within thirty (30) minutes. "Change in Condition" posters with policy information and notification requirements were posted in nursing specific areas before April 30, 2012. Informal nursing education on actions to take when a patient's condition changes began on March 21, 2012 and formal nursing education was completed by April 30, 2012.

Nursing staff was also re-educated on correct electronic health record documentation practices, proper saving of information, and clinical wound assessment. Each nurse attended a two-hour re-education followed by a one-hour competency class to demonstrate their ability to correctly document and save patient care information. The classes were completed by April 30, 2012. Each staff member completed a competency.

A "Change in Condition" tab was added to the electronic Clinical Care module which added the capability to document a change in condition and document the notification of the physician. Nurse education on this issue was completed by April 30, 2012.

The quality control manager will audit 30 medical records per month to determine if the change in Condition tab is appropriately being utilized and proper documentation of physician calls are present. Results will be reported monthly to Performance Improvement Committee beginning May 24th, 2012.

Policy #3434 - Patient Care Plans was revised and approved on April 10, 2012 by Clinical Practice Council. Policy revisions included "a focus on individualizing care to the patient's needs." Care planning collaboration is ongoing with the interdisciplinary team. The interdisciplinary review team includes Case Management/Social Services, Hospitalist, Quality Services Manager, Infection Preventionist, House Supervisor, Pharmacist, Staff Nurse and Acute Care Manager.

The Interdisciplinary Team reviews the plan of care, patient status, diagnoses and treatments. Information discussed by the team is shared with each nurse

and care plans are amended according to the personalized information acquired through the interdisciplinary team process.

Each nurse also attests that the daily assessments for his/her patients are complete. Audit tool is attached.

C 304, page 31/41:

An audit of form #1028, Radiology Contrast Screening Record, will be conducted by the Radiology Manager. Ninety percent (90%) of all contrast records will be audited. Results will be reported monthly to Performance Improvement Committee beginning May 24th, 2012. Audit tool is attached.

C306, page 37/41:

An audit of all patient transfers will be conducted to guarantee that occurrence reports have been completed. Results will be reported monthly to Performance Improvement Committee beginning May 24th, 2012. The CNO will be responsible for this part of the Plan of Correction. Audit tool is attached.

C307, page 39/41:

An audit of all patient photographs will be conducted by the Health Information Department. Results will be reported monthly to Performance Improvement Committee beginning May 24th, 2012. The Director of Health Information Department will be responsible for this part of the Plan of Correction. Audit tool is attached.

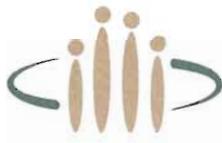
C307, page 40/41:

The Medical Staff Rules and Regulations were reviewed as it relates to History and Physicals, Progress Notes and Discharge Summaries. Documentation education for all medical staff members will be communicated from the Medical Executive Committee by April 17, 2012 and discussed at the general medical staff meeting on June 13, 2012. Packets with all information to be discussed at this meeting are sent to the medical staff approximately two (2) weeks prior to the meeting.

Education will provided to the general medical staff at the June 13th meeting will reinforce Medical Staff Rules and Regulations, Number 12 and Number 34, which outline medical records completion expectations including dating and timing, content for H & Ps, Progress Notes, and Discharge Summaries.

The completeness of the medical record, including dating and timing of all physician orders is verified daily by the Health Information Department during the indexing process.

All charts are reviewed twice during Quality Control indexing. The audit tool (enclosure #8 of original POC) allows for comprehensive chart review and proof that the chart was complete will be recorded in the last column of the audit tool.



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FACILITY STANDARDS

April 18, 2012

Idaho Department of Health & Welfare
Bureau of Facility Standards
Attention: Teresa Hamblin, RN/ Gary Giles, RN
3232 Elder Street
Boise ID, 83720-0036

Re: CMS Certification Number 13-1325

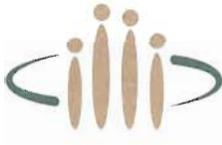
Dear Ms. Hamblin & Mr. Giles:

Enclosed is our corrective action plan from the acute-care survey on March 20, 2012. I trust that the changes to our processes, the development of improved policies and procedures, staff training, and the implementation of this plan will better meet the needs of the communities we serve.

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

Sincerely,

Louis D. Kraml, CEO
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221
208-785-3804



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APR 19 2012

FACILITY STANDARDS

April 18, 2012

Teresa Hamblin
Sylvia Creswell
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720

Re: Bingham Memorial Hospital CCN #131325

Dear Ms. Hamblin & Ms. Creswell:

Enclosed is our corrective action plan from the I trust that the changes to our processes, the procedures, staff training, and the implementation needs of the communities we serve.

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

Sincerely,

Louis D. Kraml, CEO
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221
208-785-3804

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

PRINTED: 04/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/20/2012
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221
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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
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C 000	INITIAL COMMENTS The following deficiencies were cited during a complaint survey from 3/14/12-3/20/12 at your hospital. Surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Gary Guiles, RN, HFS Acronyms used in this report include: CAH = Critical Access Hospital CNA = Certified Nursing Assistant CNO = Chief Nursing Officer DON = Director of Nursing CT = Computed Tomography ED = Emergency Department ER = Emergency Room H&P = History and Physical Examination ICU = Intensive Care Unit mg = Milligrams IV = Intravenous line	C 000		
C 259	485.631(b)(1)(iii) RESPONSIBILITIES OF MD OR DO [The doctor of medicine or osteopathy--] In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; [and] This STANDARD is not met as evidenced by: Based on record review and interview of staff from the CAH and a psychiatric hospital, it was determined the CAH failed to ensure physicians	C 259	Policy #3887 - Obtaining a Consult & Physician to Physician Communication was developed to ensure direct physician to physician communication when a physician transfers the care of a patient. This policy requires written or verbal orders, direct physician to physician communication and documentation of discussion. This policy was reviewed by the Chief of Staff on April 11, 2012 and the Medical Executive Committee on April 17, 2012 for approval. The Medical Staff membership will be educated regarding this policy at the General Medical Staff Meeting on June 13, 2012. (Policy attached #1).	Med Staff 6/13/2012 Hosp Staff 4/30/2012



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. Name</i>	TITLE CEO	(X8) DATE 4-17-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 259 Continued From page 1
provided prompt care to 1 of 5 patients (#1) whose records were reviewed. This may have resulted in the patient's worsening hand injury requiring transfer to another acute care hospital for specialized hand surgery. Findings include:

Patient #1's record documented a 76 year old female who was transferred to the ED on 2/27/12 from a psychiatric facility for evaluation of low oxygen saturation levels. She was scheduled for CT scan with IV contrast due to concern she might have a blood clot in her lung (pulmonary embolism). In preparation for the contrast procedure, she received sodium bicarbonate in the ED at 6:07 PM on 2/27/12, followed by infusion of Ultravist contrast in the Radiology Department, both of which can cause tissue injury in the case of IV infiltration. A written statement by the Radiology Technician, attached to an Occurrence Report, dated 3/24/12, indicated at the end of the infusion on 2/27/12, Patient #1's right hand was found to be swollen and it was determined the line had infiltrated.

An ED physician was interviewed by telephone on 3/15/12 at 3:50 PM. He stated he recalled Patient #1 from her visit to the ED on 2/27/12. He stated he was aware the IV had infiltrated, and thought someone told him it infiltrated during a contrast procedure. He reported assessing Patient #1's hand after the infiltration. He stated, Patient #1's hand had good color and capillary refill when she left the ED.

According to a "Daily Focus Assessment Report, "Patient #1 was transferred from the ED to Observation in the Medical/Surgical Unit on 2/27/12 at 11:04 PM.

C 259 The Hospitalist will meet with the Emergency Room Physician at 0700 every morning beginning April 16, 2012 to discuss all patients admitted to the hospital overnight.

Policy #3098 - Physician Notification Criteria of Patient Change in Condition was revised and approved on April 10, 2012 by Clinical Practice Council. The revision includes: The attending/delegated on-call physician will be notified immediately of any significant change in the patient's condition. If the physician can't be reached or doesn't respond in 30 minutes, then the Hospitalist will be notified to come and evaluate the patient for any immediate interventions. Simultaneously, the chief of the attending physician's service, Vice Chief of Staff, then the Chief of Staff will be called in that order to handle the situation. If no physician responds the Administrator on call will be contacted to locate an appropriate physician for that patient.

The revision includes an amendment which states: An occurrence report will be completed in the event the attending physician can't be notified, or doesn't come in an appropriate amount of time. All such occurrences will be reviewed and reported to the Peer Review Committee by the Quality Services Manager and added to the quarterly QA/PI report. The Acute Care Nurse Managers began informal nursing education on actions to take when a patient's condition changes on March 21, 2012 and formal nursing education on these

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 259	Continued From page 2 The following RN notes and staff interviews reflect the worsening condition of Patient #1's right hand over the course of care. 2/28/12 at 2:07 AM: Patient #1's right hand was described as "swollen with blisters on it." This was the first time in the record, staff documented the presence of blisters. 2/28/12 at 7:15 AM: The top of Patient #1's right hand was described as "swollen and huge blister." 2/28/12 at 11:25 AM: "Blister on the right hand still intact. Right hand still swollen and bruised." The patient reported a pain score of "4" on a scale of 1-10. 2/28/12 12:10 PM: An RN documented notifying a physician about Patient #1's hand pain and requesting he come and evaluate her. This was the first documentation an RN had notified the physician regarding the appearance of blisters. A verbal order was obtained for pain medication, Norco 1 tablet 5 mg/325 one time now. 2/28/12 12:20 PM: An RN note described Patient #1's emotional state as "restless, anxious, agitated, uncooperative." 2/28/12 1:30 PM: An RN documented receiving verbal physician orders for Xanax .5 mg by mouth now. In addition, verbal physician orders were received for a chest X-ray stat, duoneb (inhaler) treatment every 4 hours, and oxygen to keep saturation greater than 90 percent.	C 259	on these policies including a change of patient condition will be completed by April 30, 2012. (Policy attached #2). The CNO is responsible for the implementation of this Plan of Correction.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 259	<p>Continued From page 3</p> <p>2/28/12 1:58 PM: An RN documented a physician was present in Patient #1's room. It did not state whether Patient #1's hand was specifically evaluated. No new orders related to her hand were documented as received.</p> <p>2/28/12 7:15 PM: An RN documented Patient #1's right radial pulse was "weak," right upper extremity had "edema +4," and the "right hand which hand contrast infiltrate IV previously, is swollen, large blister present, top of hand is dark purple, fingers have capillary refill." This was the first nursing note that described Patient #1's hand as dark purple.</p> <p>2/28/12 7:30 PM: An RN documented Patient #1 had pain in her right hand and she was "groaning and restless."</p> <p>2/28/12 7:35 PM: An RN documented calling a physician for intravenous pain medication and telling the physician that Patient #1's hand was edematous with blisters and black/purple skin to back of hand. She documented receiving orders to elevate Patient #1's hand, and give morphine 1 mg IV every 2 hours, as needed, for pain and ativan 1-2 mg IV every 4 hours, as needed, for anxiety.</p> <p>2/28/12 8:01 PM: An RN documented administered pain medication.</p> <p>2/28/12 2:30 PM to 10:00 PM: A CNA sitter from the transferring psychiatric hospital, who reported sitting with Patient #1 from 2/28/12 at 2:30 PM until 10:00 PM, was interviewed on 3/15/12 at 2:15 PM. He stated Patient #1's hand was swollen and black and he did not see a physician</p>	C 259			

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C 259	<p>Continued From page 4</p> <p>come in and evaluate Patient #1 during his time sitting with the patient. He reported seeing a nurse give Patient #1 a shot of morphine.</p> <p>The CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed Patient #1's record and confirmed there was no documentation physician staff assessed Patient #1's hand after nursing staff reported the darkening hand on 2/28/12 at 7:35 PM.</p> <p>2/29/12 12:10 AM: An RN documented "Patient groaning and restless. IV pain medication given."</p> <p>2/29/12 2:40 AM: An RN documented "the back of right hand throughout shift has increasingly darkened in color, capillary refill still present in fingertips. Hand is extremely edematous, large blisters present, hand elevated on pillows." There was no documentation the physician had been contacted regarding the worsening condition.</p> <p>2/29/12 3:23 AM: An RN documented "IV pain medication given."</p> <p>2/29/12 7:26 AM: An RN documented "Right radial pulse absent. Please review pictures. Edema to top of right hand, large blister along full length of knuckles. Skin on top of hand tight and shiny in appearance. Dark purple coloring to top of hand."</p> <p>The first documentation that a physician specifically assessed Patient #1's right hand was documented by a surgeon, in a report "SURGICAL CONSULTATION," dictated 2/29/12 at 12:52 PM. The report stated the reason for the consultation was "Right hand blistering and</p>	C 259		

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C 259	<p>Continued From page 5</p> <p>change in skin color after IV infiltration." The report included the following description of Patient #1's hand: "The right upper extremity shows significant blistering of her right hand, primarily on the dorsum of her right hand. The degree of blistering could be beyond partial thickness. There is also mild mottling and venous congestion on the dorsum of the hand. The blistering extends to the proximal phalanges on the dorsum. Pulses are appreciated only by Doppler, both the radial and ulnar pulses bilaterally. Capillary refill is also sluggish bilaterally. Her hands are cold, however the right hand is cooler. The patient is not moving her fingers, but she does move her forearm. The extent of the swelling appears to have improved on the forearm, however not in the hand per assessing the previous films from yesterday. The patient does have braciocephalic pulses."</p> <p>Six photographs of Patient #1's hand were present in her record. Two of the photographs had the date 2/28/12 hand written next to them. Four of the photographs had the date 2/29/12 hand written next to them. The record did not document the time the photographs were taken.</p> <p>The House Supervisor of the Medical/Surgical Unit was interviewed on 3/15/12 between 11:15 AM and 11:30 AM. She stated she received Patient #1 from the ED RN on the evening of 2/27/12 and continued as Patient #1's nurse until 2/28/12 at about 6 AM. She acknowledged documenting blistering of the right hand on 2/28/12 at 2:07 AM. She reported taking pictures of Patient #1's hand about 6:00 AM and giving report to the incoming RN.</p>	C 259		

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C 259	<p>Continued From page 6</p> <p>On 3/15/12 at 11:45 AM, the RN who cared for Patient #1 during the morning of 2/28/12 beginning at about 5:45 AM, was interviewed. She reported taking pictures of the hand sometime that morning before noon.</p> <p>.A "HISTORY AND PHYSICAL," for Patient #1, dictated on 2/28/12 at 2:49 PM, did not specifically address the right hand. It stated there was no edema or cyanosis in the extremities and pulses were appreciated +2 bilaterally. Although the H&P did not state the time the H&P was conducted, the RN documentation indicated a physician was in Patient #1's room at 1:58 PM on 2/28/12.</p> <p>The hospitalist who dictated the H&P on 2/28/12 was interviewed on 3/15/12 at 1:15 PM. When asked about the H&P documentation which stated no edema was present in the extremities, he replied "I don't neglect my patients." When asked to review the pictures of Patient #1's right hand, dated 2/28/12, showing swelling and blistering, he stated the pictures must have been taken after his evaluation because there was no blistering present when he saw her hand during his visit on 2/28/12 (at 1:58 PM per nursing documentation of physician presence). This information contrasts with RN documentation referenced above indicating blistering was present as of 2/28/12 at 2:07 AM and also documented as present throughout the day at 7:15 AM, 11:25 AM, and 12:10 PM.</p> <p>The ED physician who initially treated Patient #1 was interviewed by telephone on 3/15/12 at 3:50 PM. When asked how a blistered hand after an IV infiltration would be treated, he stated the</p>	C 259			

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C 259	Continued From page 7 patient's hand would have be evaluated for the depth of injury to determine if there was vascular compromise. If the blistering appeared to be superficial without further compromise, he might treat blistering like a burn. If he determined there was more depth to the injury and there was vascular compromise, he would refer out to a hand surgeon or vascular surgeon for evaluation. He agreed with the decision to move Patient #1 to another facility for evaluation by a specialist. The "Interfacility Transfer Consent and Checklist," was dated 2/29/12 at 12:45 PM. It indicated Patient #1 was being transferred to an acute care hospital for "right hand necrotizing fasciitis" because specialty services were not offered at the sending hospital. The "HISTORY AND PHYSICAL," from the receiving acute care hospital, dated 2/29/12, described the chief complaint as a "painful right hand." The Discharge Summary from the receiving hospital's records for Patient #1, dated 3/13/12, indicated Patient #1 had hand surgery and a discharge diagnosis of "hand wound secondary to intravenous bicarbonate infiltration, status post fasciotomy with intention to heal by secondary intent." The DON from the transferring psychiatric facility was interviewed on 3/15/12 at 8:45 AM. He stated Patient #1 had not yet returned to the facility and he expected her to return soon, possibly that day, and she would require continued wound care related to her hand injury and subsequent surgery. The CAH CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed Patient #1's record and stated she would have	C 259			

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C 259	Continued From page 8 liked to have seen quicker responsiveness by physician staff to the changes in Patient #1's hand. There was a delay in medical evaluation of Patient #1's worsening hand condition. An RN contacted a physician to assess Patient #1's hand on 2/28/12 at 12:10 PM. There was no documented physician assessment of Patient #1's hand until 24 hours later, on 12/29/12 at 12:52 PM.	C 259		
C 294	485.635(d) NURSING SERVICES Nursing services must meet the needs of patients. This STANDARD is not met as evidenced by: Based on record review, policy review, and interview of CAH staff and staff from a transferring psychiatric hospital, it was determined the CAH failed to ensure nursing services met the needs of patients for 1 of 5 patients (#1) whose records were reviewed. This resulted in a delay in reporting changes in a patient's condition and may have contributed to a delay in physician evaluation and subsequent worsening of a patient's hand injury. Findings include: Patient #1's record documented a 76 year old female who was transferred to the ED on 2/27/12 from a psychiatric facility for evaluation of low oxygen saturation levels. She was scheduled for CT scan with IV contrast due to concern she might have a blood clot in her lung (pulmonary embolism). In preparation for the contrast procedure, she received sodium bicarbonate in the ED at 6:07 PM on 2/27/12, followed by	C 294	Policy #3098 - Physician Notification Criteria of Patient Change in Condition was revised and approved on April 10, 2012 by Clinical Practice Council. The revision includes: If any change in condition warrants that the nurse requests the physician come to see the patient, then the physician must come in to evaluate the patient within one hour. "Change in Condition" posters with policy information and notification requirements will be posted in nursing specific areas by April 30, 2012. informal nursing education on actions to take when a patient's condition changes began on March 21, 2012 and formal nursing education on these policies including a change of patient condition will be completed by April 30, 2012 (Policy attached #2). By April 30, 2012, a "Change in Condition" tab will be added to the electronic Clinical Care module adding the capability to document a change in condition and document the notification of the physician. Nurse education on the new tab in the	4/30/2012

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C 294 Continued From page 9
infusion of Ultravist contrast in the Radiology Department. A written statement by the Radiology Technician, attached to an Occurrence Report, dated 3/24/12, indicated at the end of the infusion on 2/27/12. Patient #1's right hand was found to be swollen and it was determined the line had infiltrated.

On 3/15/12 at 2:45 PM, a CNA sitter was interviewed who was from the transferring psychiatric hospital and reported being with Patient #1 during the ambulance transport to the hospital on 2/27/12 and staying with her until going off shift at 11:00 PM on 2/27/12. He stated when Patient #1 was taken to radiology for the contrast procedure, he remained in the ED and waited for her return. When she returned, he heard the ED physician say the IV flush had infiltrated. The CNA said Patient #1's right hand was swollen but she had not complained of pain while he was sitting with her.

On 3/15/12 at 1:30 PM, an interview was conducted with the CAH CNA who cared for Patient #1 on the Medical/Surgical Observation Unit from 2/27/12 around 11:00 PM until 2/28/12 at 2:30 AM. She stated she noticed blistering of Patient #1's right hand before she left shift at 2:30 AM. She stated the appearance of the hand worsened during her shift.

The following documentation, present in Patient #1's record, reflects the worsening condition of her hand and nursing staff's response:

2/28/12 at 2:07 AM: An RN documented the "right hand is swollen with blisters on it." This is the first time in the record, staff documented the

C 294 electronic medical record will be completed by April 30, 2012. A screen shot of this tab is attached (Attached #3).

Nursing staff will be re-educated on correct electronic health record documentation practices, proper saving of information, and clinical wound assessment. Each nurse will attend a two-hour re-education class followed by a one-hour competency class to demonstrate their ability to correctly document and save patient care information. These classes will be completed by April 30, 2012. Each staff member will be required to complete a competency.

The quality control manager will audit 30 medical records per month to determine if the Change in Condition tab is appropriately being utilized and proper documentation of physician calls are present. Results will be reported monthly to the Performance Improvement Committee beginning May 24, 2012. (Audit Tool attached #4)

The CNO is responsible for the implementation of this Plan of Correction.

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C 294	<p>Continued From page 10 presence of blisters.</p> <p>2/28/12 at 7:15 AM: An RN documented the top of the right hand was swollen with a huge blister.</p> <p>2/28/12 at 11:25 AM: An RN documented "Blister on the right hand still intact. Right hand still swollen and bruised." The patient reported a pain score of "4" on a scale of 1-10.</p> <p>2/28/12 12:10 PM: An RN documented she notified the doctor about Patient #1's pain and requested he come and evaluate her. This was the first documentation an RN had notified the physician since the appearance of blisters, 10 hours prior. A verbal order was obtained for pain medication, Norco 1 tablet 5 mg/325 one time now.</p> <p>2/28/12 12:20 PM: An RN note described Patient #1's emotional state "restless, anxious, agitated, uncooperative."</p> <p>2/28/12 1:30 PM: Verbal physician orders were received for Xanax .5 mg by mouth now. In addition, verbal physician orders were received for a chest X-ray stat, duoneb (inhaler) treatment every 4 hours, and oxygen to keep saturation greater than 90 percent.</p> <p>2/28/12 1:58 PM: RN documentation indicated a physician was present in Patient #1's room. It did not state whether Patient #1's hand was specifically evaluated. No new orders were received related to the hand.</p> <p>2/28/12 7:15 PM: RN documentation indicated Patient #1's right radial pulse was "weak" and her</p>	C 294		
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C 294	<p>Continued From page 11</p> <p>right upper extremity had "edema +4" in her hand. The documentation further stated "Right hand which had contrast infiltrate IV previously, is swollen, large blister present, top of hand is dark purple, fingers have capillary refill." This is the first note describing the hand as dark purple.</p> <p>2/28/12 7:30 PM: An RN documented Patient #1 was "groaning and restless" and had pain in her right hand.</p> <p>2/28/12 7:35 PM: An RN documented calling the physician for intravenous pain medication and receiving orders to elevate Patient #1's hand. She also documented telling the physician about Patient #1's hand being edematous with blisters and black/purple skin to the back of her hand. The RN documented receiving verbal orders for morphine 1 mg IV every two hours, as needed, for pain and ativan 1-2 mg IV every 4 hours, as needed, for anxiety.</p> <p>2/28/12 8:01 PM: An RN documented "IV pain medication administered."</p> <p>2/29/12 12:10 AM: An RN documented Patient #1 was "groaning and restless" and "IV pain medication given."</p> <p>2/29/12 2:40 AM: An RN documented the back of Patient #1's right hand throughout the shift had "increasingly darkened in color," and capillary refill still present in fingertips. She further documented Patient #1's hand was "extremely edematous, large blisters present, hand elevated on pillows."</p> <p>2/29/12 3:23 AM: An RN documented "IV pain</p>	C 294		
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C 294	Continued From page 12 medication given." 2/29/12 7:26 AM: An RN documented Patient #1's right radial pulse was absent. She documented "Please review pictures. Edema to top of right hand, large blister along full length of knuckles. Skin on top of hand tight and shiny in appearance. Dark purple coloring to top of hand." A CAH policy, "Patient Assessment," dated 1/07/12, stated "the assessment of the care or treatment required to meet the needs of the patient will be ongoing throughout the patient's hospital stay, with the assessment process individualized to meet the needs of the patient population. It also stated physicians will be notified by telephone within 15 minutes of significant changes in patient condition for patients on the Medical/Surgical Unit. The CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed Patient #1's record and confirmed the timeline of events. She stated she "would have liked to have seen more aggressive reporting" of Patient #1's condition by nursing staff. Nursing staff did not meet the needs of Patient #1 in relation to a worsening hand condition. There was a delay in reporting findings and continued advocacy when physician staff was slow to respond.	C 294		
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient.	C 298	Policy #3434 - Patient Care Plans was revised and approved on April 10, 2012 by Clinical Practice Council. This policy was revised after our electronic medical records	4/30/2012

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C 298	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the CAH failed to ensure nursing care plans were individualized and kept current for 5 of 5 inpatients (#1, #2, #3, #4, and #5) whose records were reviewed. This resulted in care plans that did not meet individualized patient needs. Findings include:</p> <p>1. Patient #3's medical record documented a 65 year old female who was admitted to the CAH on 2/03/12 and was transferred to another hospital on 2/07/12. Her diagnosis was a necrotizing ulcer on her left thigh. The discharge summary, dated 2/07/12, stated she also had uncontrolled diabetes. Untimed wound measurements, dated 2/05/12, documented the wound was 13 by 27 centimeters with the necrotic area of the wound 7 by 13 centimeters. During her stay, her blood glucose levels ranged between 73 on 2/05/12 at 12:10 PM and 264 on 2/05/12 at 9:20 PM. According to www.WebMd.com, normal blood glucoses range from 70-99 for fasting levels and 70-125 for random blood sugar levels. A nursing note, dated 2/06/12 at 2:10 AM, stated an IV in her left hand was found "...to be severely infiltrated and swollen, Coban [a self adherent elastic wrap] that had been around wrist had tightened with arm swelling and was cutting off circulation to the extremity. Coban removed. Fingertips were dark purple and unblanchable. Warm compress applied. IV discontinued." The physician was notified at the time.</p> <p>Patient #3's "Patient Care Plan Report," initiated on 2/04/12 at 7:15 AM, included problems of skin integrity, safety, pain, change in physiologic status, and knowledge deficit. The plan did not</p>	C 298	<p>vendor experts demonstrated how the system can individualize care plans and the method for carrying changes over to the action list on the Clinical Care Station module. The revision includes this quality control: Care plans are printed from the electronic health record for the interdisciplinary team meeting. Daily interdisciplinary care planning rounds will be conducted where care plans are reviewed, evaluated and discussed to meet policy guidelines and the needs of the patient. Hard copy care plans will also be used at shift change to inform incoming staff of changes (Policy attached, #5).</p> <p>Nursing staff education of individualizing care plans will be completed by April 30, 2012. Staff will be required to complete a competency test.</p> <p>Ninety percent (90%) of care plans will be audited during daily rounds. Audits will be compiled by the Acute Care Manager and reported to Performance Improvement Committee on a monthly basis (Audit Tool attached, #6).</p> <p>The CNO is responsible for the implementation of this Plan of Correction.</p>		

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C 298	Continued From page 14 direct staff to take any specific action. It only directed staff to assess the patient. For example, the section labeled "SKIN INTEGRITY" directed nursing staff to assess skin integrity each shift using a "BRADEN SCALE," a tool to assess the risk of pressure ulcers. This section also directed staff to assess the IV site each shift and to assess nutritional intake. The plan was not specific about any of these items. The overall plan did not address Patient #3's thigh wound or her diabetes. The plan was not updated following the infiltrated IV to address treatment of her injured hand. Patient #3's care plan was reviewed with the Quality Services Manager on 3/20/12 beginning at 9:05 AM. She confirmed the care plan did not individually address Patient #3's specific medical problems. Patient #3's care plan did not provide direction to staff. 2. Patient #5's medical record documented a 77 year old male who was admitted to the CAH on 2/04/12 and was transferred to another hospital on 2/08/12. His diagnoses included acute renal failure, dehydration, chronic diarrhea, and diabetes. An "EMERGENCY DEPARTMENT ADDENDUM," written by the physician and dated 2/04/12 at 10:26 AM, stated Patient #5 took blood thinning medication. The addendum stated Patient #5's INR was 11.36 or approximately 11 times longer than it would take a normal person to clot. This significantly increased the chance of bleeding for Patient #5. Patient #5's "Patient Care Plan Report," initiated	C 298			

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C 298	<p>Continued From page 15</p> <p>on 2/04/12 at 12:14 PM, included problems of skin integrity, safety, pain, change in physiologic status, and knowledge deficit. The plan did not direct staff to take any specific action. It only directed staff to assess the patient. For example, the section labeled "SKIN INTEGRITY" directed nursing staff to assess skin integrity each shift using a "BRADEN SCALE." This section also directed staff to assess the IV site each shift and to assess nutritional intake. The section labeled "SAFETY" directed staff to assess for special equipment needs and to assess the patient for fall risk. The increased risk of bleeding was not addressed.</p> <p>Patient #5's care plan was reviewed with the Director of the Medical Surgical Unit on 3/16/12 beginning at 9:47 AM. She confirmed the care plan did not specifically address Patient #5's risk of bleeding.</p> <p>Patient #5's care plan did not provide direction to staff.</p> <p>3. Patient #2's medical record documented a 75 year old male who presented to the emergency department on 2/27/12, after he fell and struck his head. He was admitted to the CAH as an inpatient on 2/28/12. He expired on 3/16/12. A physician consultation, dated 3/06/12 at 9:44 AM, stated Patient #2 became confused and agitated in the evenings. The consultation stated Patient #2 became lethargic on 3/04/12 and did not wake up on 3/05/12. The consultation stated Patient #2 was transferred to the Intensive Care Unit on 3/05/12. The consultation stated Patient #2's oxygen levels declined and he had been intubated and placed on a ventilator.</p>	C 298			

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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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C 298	Continued From page 16 Patient #2's "Patient Care Plan Report," initiated on 2/29/12 at 3:44 AM, included problems of skin integrity, safety, pain, change in physiologic status, knowledge deficit, therapy-impaired physical mobility, therapy-activity intolerance, and fall risk. When transferred to the ICU, Patient #2's plan was updated on 3/06/12 at 8:28 AM. Problems included ICU-skin integrity, ICU-safety, ICU- knowledge deficit, ICU-pain, ICU-change in physiologic status. The plans did not direct staff to take any specific action. They only directed staff to assess the patient. For example, the section labeled "SKIN INTEGRITY" on the plan initiated on 2/29/12, directed nursing staff to assess skin integrity each shift using a "BRADEN SCALE." This section also directed staff to assess the IV site each shift and to assess nutritional intake. The section labeled "SAFETY" directed staff to assess for special equipment needs and to assess the patient for fall risk. The ICU care plan, dated 3/06/12, was similar to the first care plan. The section labeled "ICU-SKIN INTEGRITY" directed staff to assess invasive lines, assess nutritional intake, and to assess skin integrity each shift using a "BRADEN SCALE." The section labeled "ICU-CHANGE IN PHYSIOLOGIC STATUS" directed staff to monitor Patient #2's intake and output, to monitor his vital signs, and to weigh him daily. None of the sections provided specific care directions. Patient #2's care plan was reviewed with the Director of the Medical Surgical Unit on 3/15/12 beginning at 2:45 PM. She confirmed the care	C 298			

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C 298	Continued From page 17 plan did not provide specific direction to staff. Patient #2's care plan did not provide direction to staff. 4. Patient #4's medical record documented a 78 year old male who presented to the emergency department on 2/29/12 after a fall. Diagnoses included a fractured right shoulder and fractures of the first 2 ribs on the right. He also had diagnoses of slow heart rate and low blood pressure. After treatment for the cardiac problems, he was taken to surgery to repair his shoulder on 3/02/12. The Operative Report, dated 3/02/12, stated during the surgery, Patient #4's blood pressure dropped and the procedure was discontinued without repairing the fracture. Patient #4 was transferred to the ICU on a ventilator. The physician progress note, dated 3/03/12 at 8:36 AM, diagnosed Patient #4 with pneumonia and acute renal failure due to septic shock. He was currently a patient as of 3/15/12. Patient #4's "Patient Care Plan Report," initiated on 3/01/12 at 12:21 AM, included problems of skin integrity, safety, pain, change in physiologic status, and knowledge deficit. While in ICU, initiated on 3/03/12 at 1:32 AM, Patient #4's plan included ICU-skin integrity, ICU-safety, ICU-knowledge deficit, ICU-pain, ICU-change in physiologic status, and impaired respiratory status. The plans did not direct staff to take any specific action. They only directed staff to assess the patient. For example, the section labeled "SKIN INTEGRITY" on the 3/01/12 care plan, directed nursing staff to assess skin integrity each shift using a "BRADEN SCALE." This section also directed staff to assess the IV site	C 298			

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C 298	<p>Continued From page 18</p> <p>each shift and to assess nutritional intake. The section labeled "SAFETY" directed staff to assess for special equipment needs and to assess the patient for fall risk. The section labeled "CHANGE IN PHYSIOLOGIC STATUS" directed staff to monitor Patient #4's intake and output, monitor his vital signs as his condition dictates, and to perform a full assessment each shift.</p> <p>The 3/03/12 ICU care plan was similar to the first care plan. The section labeled "ICU-SKIN INTEGRITY" directed staff to assess invasive lines, assess nutritional intake, and to assess skin integrity each shift using a "BRADEN SCALE." The section labeled "ICU-CHANGE IN PHYSIOLOGIC STATUS" directed staff to monitor Patient #4's intake and output, to monitor his vital signs, and to weigh him daily. None of the sections provided specific care directions.</p> <p>Neither care plan directed staff how to care for Patient #4's fractured shoulder and ribs or how to care for his renal failure.</p> <p>Patient #4's care plan was reviewed with the Director of the Medical Surgical Unit on 3/15/12 beginning at 2:45 PM. She confirmed the care plan did not provide specific direction to staff.</p> <p>Patient #4's care plan was incomplete.</p> <p>5. Patient #1's medical record documented a 76 year old female who was transferred to the ED on 2/27/12, from a psychiatric facility for evaluation of low oxygen saturation levels. She was subsequently admitted to the hospital on 2/28/12. An IV was found to have infiltrated in Patient #1's right hand after infusion of a contrast material and</p>	C 298		
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C 298	<p>Continued From page 19</p> <p>a saline flush in the Radiology Department on 2/27/12 (time not documented). Patient #1's hand was reported to be swollen after the infiltration prior to transferring her for observation/admission on the Medical/Surgical Unit. After transfer, RN's documented development of blisters, discoloration, and worsening swelling of the hand.</p> <p>Patient #1's "Patient Care Plan Report," dated 2/28/12 and 2/29/12 included a nursing diagnosis related to Potential Alterations in Skin Integrity. Interventions included assessing skin integrity using the braden scale every shift (for pressure ulcers), assessing the IV site every shift and as needed, and assessing nutritional intake. It did not address the need to assess the infiltrated right hand, such as assessing for swelling, discoloration, capillary refill, or changes in temperature, or interventions such as elevation or warm or cool compresses.</p> <p>An RN who cared for Patient #1 during the 5:45 AM to 5:45 PM shift on 2/28/12, was interviewed on 3/15/12 at 11:45 AM. She reviewed Patient #1's record and confirmed the care plan was not updated to specifically include assessment of Patient #1's right hand, but stated there was a care plan for Skin Integrity and nursing assessment of the hand was documented.</p> <p>The CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed Patient #1's record and confirmed the care plan did not specifically address the IV infiltration of the right hand. She stated she noticed some nursing notes documented taking Patient #1's blood pressure on the upper left extremity. She stated</p>	C 298			

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C 298	<p>Continued From page 20</p> <p>this was typically done when there was a problem and should have been indicated on the nursing care plan.</p> <p>Patient #1's care plan was not developed or updated to address the hospital acquired injury to her hand.</p> <p>6. The policy "Patient Care Plans," dated 9/19/11, stated "The plan of care/problem list shall be individualized, based on the diagnosis, patient assessment, and personal goals of the patient and his/her family." It also stated "The plan of care/problem list shall be updated daily, with revisions reflecting the reassessment of needs of the patient."</p> <p>As noted above, care plans were not individualized.</p> <p>7. The Director of Medical-Surgical Nursing and the CNO were interviewed together on 3/16/12 beginning at 11:25 AM. They stated care plans were generated using an electronic medical record that had been implemented in January 2012. They stated care plan options were pre-built by the software company and nurses could only select care plan items that had been pre-built into the program. They stated they were not sure how specific directions, such as, how to turn a patient with a fracture or how to manage a hand severely damaged by an IV infiltration, could be included in the care plan. They stated nurses could enter comments in the care plan but the comments did not carry forward in the task list for nurses to see. The comments could only be accessed by opening the care plan and looking for past comments. In addition, they stated the</p>	C 298			

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C 298	Continued From page 21 policy "Patient Care Plans" had not been updated since the electronic medical record had been implemented and the care planning process had changed.	C 298			
C 300	The CAH did not provide directions to staff regarding how to individualize care plans. 485.638 CLINICAL RECORDS Clinical Records This CONDITION is not met as evidenced by: Based on record review, policy review, and interview of CAH staff and staff from a psychiatric hospital, it was determined the CAH failed to ensure 1) a clinical record system was maintained in accordance with written policies and procedures; 2) complete and accurate documentation was present in clinical records; 3) consent was properly executed; 4) nursing notes and documentation of complications were included; 5) clinical entries and photographs were timed. 1. Refer to C 301 as it relates to the failure of the CAH to maintain a clinical record system in accordance with written policies and procedures 2. Refer to C 302 as it relates to a failure of the CAH to ensure patient records contained complete and accurate documentation. 3. Refer to C 304 as it relates to failure of the CAH to ensure the hospital maintained evidence of properly executed informed consent and pertinent medical history.	C 300	<u>Overview (Details Provided Under Standards C301, C302, C304, C306, C307):</u>		

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C 300	Continued From page 22 4. Refer to C 306 as it relates to the failure of the CAH to ensure records included all nursing notes, documentation of complications, and other pertinent information. 5. Refer to C 307 as it relates to the failure of the CAH to ensure entries and photographs were timed. The cumulative effect of these negative systemic practices seriously interfered with quality and coordination of patient care.	C 300			
C 301	485.638(a)(1) RECORDS SYSTEMS The CAH maintains a clinical records system in accordance with written policies and procedures. This STANDARD is not met as evidenced by: Based on review of patient records and "Medical Staff Rules and Regulations," and staff interview, it was determined the CAH failed to maintain a clinical record system in accordance with written policies and procedures. This impacted 5 of 5 patients (#1, #2, #3, #4, and #5) whose records were reviewed. This resulted in nursing care plans that were not individualized and missing physician progress notes. It had the potential to interfere with quality and coordination of patient care. Findings include: 1. "Medical Staff Rules and Regulation," "Number.34 PROGRESS NOTES," stated "progress notes are vital to the medical care and record so that caregivers can reference notes of other caregivers in order to coordinate care and facilitate communication between physicians, nurses, physical therapists, pharmacists, social	C 301	Policy #3886, Legal Health Record, was developed and approved on April 10, 2012 by the Clinical Practice Council. Policy includes: 1) Current patient records will reside in the electronic health record as an active patient; 2) Once a patient is discharged, the patient's record will go into Horizon Patient Folder (electronic health record long term storage); 3) Scanned documents go into the patient's medical record in Horizon Patient Folder, and 4) The documents merge as one complete medical record in Horizon Patient Folder. Quality Control Indexing is performed daily in the Health Information Department. Comparisons are made of the scanned documents to a formal electronic index page by page. Any missing documentation is added at this time. The medical record is not considered complete until the index is verified in this real time process. Accuracy of the medical record is verified twice using this process. (Policy attached #7, Audit Tool	4/30/2012	

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C 301 Continued From page 23

workers, and others involved in the particular patient's care. Because of the need to communicate the patient's status and treatment plan to other caregivers, dictating the progress note is not a sufficient manner to fulfill this requirement, and a brief yet pertinent progress note must be legibly written in the patient record. A more detailed dictated note may be appropriate in medically complex cases, but a concise written entry in the progress note section is still necessary to facilitate coordination of care between staff members. Progress notes should give a pertinent chronological report of the patient's course in the hospital, and should reflect any changes in the condition and the results of treatment. There would be enough detail to justify the length of stay, and document evidence that sufficient treatment was rendered to justify the level of care provided. Daily dated and timed progress notes are required for all inpatient admissions."

"Medical Staff Rules and Regulations," Number: 12 MEDICAL RECORDS, dated 10/04/11, included medical record completion policies. It also stated physician progress notes were required daily and should be dated and timed.

Patient #1's medical record documented a 76 year old female who was transferred to the ED on 2/27/12 from a psychiatric facility for evaluation of low oxygen saturation levels. She was admitted on 2/28/12. The record documented an IV in Patient #1's right hand infiltrated during or after a 2/27/12 CT scan which included contrast medication. The condition of her hand worsened until she was transferred to another acute care hospital on 2/29/12 for surgery on the infiltrated

C 301 attached #8)

We conducted a review regarding transfer of information from active patient medical record to final medical record (FMR) via interface and electronic storage/transfer process. A new system was implemented to facilitate transfer of reports nightly rather than every 3-7 days. After implementation, the Acute Care Manager conducted daily audits of final closed records through April 11, 2012. All active electronic records were found to be transferring to final electronic storage. The Acute Care Manager will periodically audit the final medical record and report finding to the PI committee quarterly.

Policy #3434 - Patient Care Plans was revised and approved on April 10, 2012 by Clinical Practice Council. This policy was revised after our electronic medical records vendor experts demonstrated how system can individualize care plans and the method for carrying changes over to the action list on Clinical Care Station module. Review of the active medical records now show individualized care plans with action lists on the Clinical Care Station module.

For quality control and performance improvement purposed, Care plans are printed from the electronic health record for the interdisciplinary team meeting. Daily interdisciplinary care planning rounds will be conducted where care plans are reviewed, evaluated and discussed to meet policy guidelines and the needs of the patient.

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C 301	Continued From page 24 right hand. The hospitalist who cared for Patient #1 on 2/28/12 and 2/29/12 was interviewed on 3/15/12 at 1:15 PM. When asked about physician progress notes on Patient #1, he explained he did not write progress notes because he dictated an H&P on 2/28/12 and a discharge summary on 2/29/12, and therefore progress notes were not necessary. Daily dated and timed progress notes were not present in Patient #1's record. 2. Refer to C298 as it relates to the failure of the CAH to ensure nursing care plans for Patients #1 through #5 were individualized and complete.	C 301	(Policy attached #5) Nursing staff education of individualizing care plans will be completed by April 30, 2012. Staff will be required to complete a competency test. Ninety percent (90%) of care plans will be audited during daily rounds. Audits will be compiled by the Acute Care Manager and reported to Performance Improvement Committee on a monthly basis. (Audit Tool attached #6) The CNO is responsible for the implementation of this Plan of Correction.		
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the CAH failed to ensure records were complete, accurate, or readily accessible for 3 of 5 patients (#1, #2, and #5) whose records were reviewed. This had the potential to interfere with quality, safety, and coordination of patient care. Findings include: 1. Patient #1 was a 76 year old female who was transferred to the ED on 2/27/12 from a psychiatric facility for evaluation of low oxygen saturation levels. She was scheduled for CT scan with IV contrast due to concern she might have a pulmonary embolism (a blood clot in her	C 302	The Medical Staff Rules and Regulations were reviewed as it relates to History and Physicals, Progress Notes and Discharge Summaries. Documentation education for all medical staff members will be communicated from the Medical Executive Committee by April 17, 2012 and discussed at the general medical staff meeting on June 13, 2012. Beginning April 3, 2012 all transcriptions will include the date and time of dictation in the header of every dictated report. Date and time documentation education for all medical staff members will be communicated from the Medical Executive Committee by April 17, 2012 and discussed at the general medical staff meeting on June 13, 2012 (Attachment #9).	6/13/2012	

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C 302	<p>Continued From page 25</p> <p>(lung). In preparation for the contrast procedure, she received sodium bicarbonate in the ED at 6:07 PM on 2/27/12, followed by infusion of Ultravist contrast in the Radiology Department. At the end of the procedure, Patient #1's right hand was found to be swollen. It was determined the IV line had infiltrated.</p> <p>Patient #1's record was incomplete and inconsistent as follows:</p> <p>a. The record did not document who started her original IV after arriving at the ED, when it was started, and that it was in her right hand. It did not document the IV infiltration at the time it occurred or that the infiltration had been reported to the physician. Subsequent documentation in Patient #1's records indicated an IV had been in her right hand. For example, the "SURGICAL CONSULTATION," dated 2/29/12, stated Patient #1 "received IV contrast as well as bicarb, and afterwards this line infiltrated into the tissue. The patient subsequently had swelling in her right hand at the IV access site."</p> <p>A hospital policy, "IV therapy-starting a peripheral IV line/Saline-Heparin," dated 3/21/11, was reviewed. It included the expectation nursing staff document the location of the insertion site and the date and time of insertion.</p> <p>The Quality Services Manager was interviewed on 3/15/12 at 4:35 PM. She stated Radiology Technicians only documented on the Informed Consent or Screening tool document. She stated there was not a process in place for the Radiology Technician to chart progress notes, such as to write an infiltration occurred during or</p>	C 302	<p>Also see C301</p> <p>The Chief of Staff, CNO and Medical Staff Secretary are responsible for the implementation of this Plan of Correction.</p>		

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C 302	<p>Continued From page 26</p> <p>after administration of IV contrast as was the case for Patient #1. She confirmed there was no documentation in Patient #1's record related to who started the IV in her right hand, when it was started, when it infiltrated, or that the infiltration was reported to the ED physician caring for her at the time of the infiltration.</p> <p>The Quality Services Manager further stated that since the hospital converted to an electronic medical record on 1/16/12, the hospital had incidents where nurses told them they charted information, but the information could not be found in the record. During the survey, hospital staff had been consulting with the software company to find documentation requested by surveyors. She explained the system was supposed to "auto-save" so they would not lose data. During a separate interview on 3/15/12 at 5:00 PM, the Quality Services Manager stated she and the administrative team just found out the way nurses were exiting the software system was not saving all entries. She stated one of the software trainers had incorrectly trained nursing staff how to exit entries. This resulted in lost nursing documentation.</p> <p>b. Patient #1's record did not include a physician entry that Patient #1's hand had been evaluated after infiltration of the IV. The ED physician was interviewed by telephone on 3/15/12 at 3:50 PM. He recalled being notified Patient #1's IV infiltrated during a contrast procedure. He could not recall whether he heard this from nursing or radiology staff. He said he examined Patient #1's hand and stated her hand had excellent capillary refill, color, and circulation and he was not concerned at the time he examined it. He did not</p>	C 302		
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NAME OF PROVIDER OR SUPPLIER BINGHAM MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 98 POPLAR STREET BLACKFOOT, ID 83221		
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C 302	<p>Continued From page 27</p> <p>see blistering. He expressed regret for not having documented his examination.</p> <p>c. On 2/28/12 at 7:15 AM, an RN documented edema was absent in the right upper extremity. Another note, at the same time by the same nurse, documented "swollen and huge blisters noted on top of right hand." The information was inconsistent and, therefore, one of the entries was not accurate.</p> <p>d. The "HISTORY AND PHYSICAL," dictated 2/28/12 at 2:29 PM, stated there was no edema in the extremities. This information was not consistent with nursing documentation of Patient #1's right hand or pictures of her right hand present in her record. For example, RN documentation on 2/28/12 at 2:07 AM, stated "Pts right hand is swollen with blisters on it." RN documentation on 2/28/12 at 11:25 AM stated "Right hand is still swollen and bruised."</p> <p>e. The "DISCHARGE SUMMARY," dated 2/29/12, stated Patient #1 was brought into the emergency room "yesterday." However, the emergency room visit was 2 days prior, on 2/27/12. It also stated "...it looks like the IV was infiltrated and so the patient's right hand was getting more swollen. Yesterday, she had a pulse and warm and I had her elevated all night with compression. This morning, the hand started to develop dark black blisters and it was more cold and difficult to palpate the pulse."</p> <p>There was no physician or nursing documentation the temperature of the hand had been warm the day prior or that the temperature had been assessed. There was no documentation</p>	C 302			

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C 302	<p>Continued From page 28</p> <p>compression had been applied to the hand or that there had been physician orders to do so.</p> <p>Blisters had been documented as present on Patient #1's hand since 2/28/12 at 2:07 AM, when an RN note stated "Pts right hand is swollen with blisters on it." RN documentation at 2/28/12 at 7:15 AM stated "swollen and huge blisters noted on top of right hand."</p> <p>The CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed the physician orders in Patient #1's record. She confirmed there were no physician orders for compression present in Patient #1's record or nursing documentation indicating compression had been applied to her right hand. She confirmed nursing documentation indicated blisters began on 2/28/12 at 2:07 AM rather than on 2/29/12.</p> <p>Patient #1's medical record was not complete or accurate.</p> <p>2. Patient #5's medical record documented a 77 year old male who was admitted to the CAH on 2/04/12 and was transferred to another hospital on 2/08/12. His diagnoses included acute renal failure, dehydration, chronic diarrhea, and diabetes. A "DISCHARGE SUMMARY," dated 2/07/12 at 10:26 AM, stated Patient #5 was discharged home on that date. A "Physician Progress Note," dated 2/08/12 at 9:15 AM, stated Patient #5 was feeling well and was being transferred by ambulance to an out of state hospital on that date. The events and reasons explaining why Patient #5 was not discharged on</p>	C 302			

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C 302	<p>Continued From page 29</p> <p>2/07/12 were not documented in physician progress notes. Also, the "DISCHARGE SUMMARY" was not amended to include events after it was written on 2/07/12.</p> <p>Patient #5's medical record was reviewed with the Director of the Medical Surgical Unit on 3/16/12 beginning at 9:47 AM. She confirmed the incomplete discharge summary and stated an explanation for Patient #5 not being discharged home on 2/07/12 was not documented.</p> <p>Patient #5's medical record was not complete.</p> <p>3. Patient #2's medical record documented a 75 year old male who presented to the emergency department on 2/27/12 after a fall. He was admitted to the CAH as an inpatient on 2/28/12. He expired on 3/16/12.</p> <p>Patient #2's medical record did not contain a H&P. This was confirmed by interview with the Director of Health Information Management at 12:05 PM on 3/20/12. She stated hospital policy required admitting physicians to complete H&Ps within 48 hours of a patient's admission.</p> <p>Patient #2's medical record was not complete.</p> <p>4. Complete legal medical records for Patients #2 and #4 were requested from the Quality Services Manager on 3/15/12 at 4:15 PM. On 3/16/12 at 11:30 AM, the Quality Services Manager stated the CAH had experienced problems printing the records and they were not ready. It was arranged for the CAH to send the 2 records to the survey office by overnight mail.</p>	C 302			

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C 302	Continued From page 30 The records arrived on compact disk at 11:00 AM on 3/20/12. Neither of the 2 records contained plans of care. In addition, the medical record for Patient #4 was missing "Daily Focus Assessment Report" pages 57-303. The Director of Health Information Management was interviewed on 3/21/12 at 9:55 AM. She confirmed the missing documentation and stated she was working with the software vendor to correct the problems. The hospital was not able to print complete legal medical records.	C 302		
C 304	485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient; This STANDARD is not met as evidenced by: Based on record review, policy review, and interview of CAH staff and staff from a psychiatric hospital, it was determined the CAH failed to ensure informed consent was properly executed and pertinent medical history obtained for 1 of 5 patients (#1) whose records were reviewed. This resulted in incomplete screening for an IV contrast procedure and improperly executed	C 304	Policy #3627 - Consent for Treatment was reviewed. Education on this policy will be completed for all staff involved in consenting for medical treatment by April 30, 2012. (Policy attached #10) Form #1028, Radiology Contrast Screening Record, was amended to include the following information: 1) Who started the IV and IV site location, 2) The time and administration rate of the IV contrast which includes any flushes, 3) Method of injection, 4) A specific question asking if an IV infiltration occurred, and, 5) When the physician was notified of the infiltration. This form will be scanned into the Electronic Medical record. This amended form will be in use beginning April 16, 2012 and staff will begin documenting any patient events in Clinical Care Station on this date, as well. This form was approved by Forms Committee on April 10, 2012 (Form attached, #11).	4/30/2012

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C 304	<p>Continued From page 31 consent. Findings include:</p> <p>Patient #1 was a 76 year old women who was transferred to the ED from a psychiatric facility for evaluation of low oxygen saturation levels. A physician's order, dated 2/27/12 at 6:07 PM, included orders for IV contrast for diagnostic purposes due to concern for a possible pulmonary embolism (blood clot in the lung).</p> <p>A hospital policy, "Consent for IV Contrast," dated 1/11/12, included the following statements:</p> <ul style="list-style-type: none"> > "All procedures involving contrast administration, with the exception of barium procedures, requires a contrast history form and an Informed Consent signed by the patient (or patient's guardian) prior to the exam. > A Contrast Screening Record will be filled out for each patient receiving contrast material. > In the event a patient is unable to sign the consent because of incompetence, unconsciousness, or other reasons, consent may be given by a competent spouse, parent, guardian, or a competent relative or person representing his or her self to be responsible for the health care of the patient. The technologist is responsible to explain the procedure and get consent in this circumstance. When there is no person readily available to give consent, the attending physician will determine whether or not to continue the procedure and may give valid consent in accordance with hospital policy title "Consent Policy." Such consent by the physician must be documented in the record. <p>Patient #1's record included an incomplete and untimed screening form, "Radiology Contrast</p>	C 304	<p>Policy #251, Authorization for Administration of Contrast, was reviewed and amended. These amendments include: 1) A yearly skills lab for all Radiologist Technologists will be required to increase IV training and identify complications during contrast administration, 2) ensure a proper medical history for the radiologist, 3) require personnel to be physically in the scan room when IVs of over 3mls/second are administered. This policy was approved by the Clinical Practice Council on April 10, 2012. Skills Lab will be held on May 15-16, 2012. All personnel will review policy changes and sign statements of understanding at this time (Policy attached #12).</p> <p>Policy #254, Consent for IV Contrast, was reviewed and amended to include the name of the new contrast media used in Radiology. This policy was approved by the Clinical Practice Council on April 10, 2012 (Policy attached, #13).</p> <p>The Radiology Manager began informal technologist education on these changes on March 21, 2012 and formal education on these policies will be completed by April 30, 2012.</p> <p>The Radiology Manager is responsible for the implementation of this Plan of Correction.</p>		

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C 304	Continued From page 32 Screening Record," dated 2/27/12. The following information was left blank: > Allergies > Previous reaction to contrast media: () yes () no > Please check all that apply: history of allergy to drugs. Specify: history of allergy to contrast history of allergy other than drugs > Must mark one of these for questions above dermatitis/rash history of asthma sickle cell anemia diabetes, not insulin dependent allergic rhinitis heart disease generalized severe debilitation diabetes, insulin dependent hives > Check all that apply Cardiac disease Asthma/respiratory disease Renal disease Cancer/multiple myeloma The question regarding previous surgeries was marked "unknown." A "Patient Profile" report, dated 2/27/12 at 4:33 PM, entered by an RN in the ED, included a list of surgeries Patient #1 had (cataract, left hip replacement, right hip surgery, tonsillectomy). It also stated she had no known drug allergies. The CNO was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She reviewed Patient #1's record and confirmed medical/surgical history was available from the psychiatric hospital that transferred Patient #1 to the CAH and should	C 304			

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C 304	<p>Continued From page 33</p> <p>have been available to the Radiology Technician during the screening process.</p> <p>Pertinent Medical/Surgical History information was not obtained for the screening procedure.</p> <p>A written statement by the Radiology Technician and attached to an Occurrence Report, dated 3/14/12, referenced contact with Patient #1 on the evening of 2/27/12 for a procedure. It stated "The exam was ordered around 7:00 PM and I went to the emergency department to get the patient shortly thereafter. Upon arriving at the emergency department the nurses informed me that they would need to draw blood and some other things with the patient before I could take her. They said that they would let me know when they were done with those things. During this time it was learned that the patient had an elevated d-dimer, and thus had to have our bicarb protocol done, which takes about 30 minutes. About 40 minutes later the ER called to inform me that she was ready to come down. I then went and got her for the exam. In the CT room I explained to the patient what we were going to be doing, even though she gave no inclination that she was coherent enough to understand what was going on."</p> <p>The "Radiology Consent for Special Procedures" did not include Patient #1's name, the date of the procedure, the doctor's name, or the name of the procedure. The patient's signature was documented with an "X" and the Radiology Tech's signature was on the form as having witnessed the consent. There was no evidence another competent adult had been engaged to give consent, per hospital policy.</p>	C 304			

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C 304	Continued From page 34 The Radiology Technician, who signed the consent form and infused contrast in Patient #1 on 2/27/12, was interviewed on 3/15/12 at 9:40 AM. He stated he thought Patient #1 was able to give consent and she communicated primarily by nodding. He said he asked her the screening questions but did not document her answers and usually he did. He explained he did not include Patient #1's name, date, or procedure on the consent form because the information was listed on the contrast screening record on the opposite side. A CNA sitter from the transferring psychiatric hospital, who reported being with Patient #1 during the ambulance transport to the hospital on 2/27/12 and staying with her until going off shift at 11:00 PM on 2/27/12, was interviewed on 3/15/12 at 2:45 PM. He described Patient #1 as "really confused and not able to give consent." He stated he signed papers on behalf of Patient #1 upon arrival at the hospital giving permission for the ED evaluation and he, also, brought her medical information from the sending facility, including a face sheet, progress notes, information on medical history, surgical history, drug allergies, and medication list. He stated it was standard information sent with patients when they transferred to another facility. He stated when Patient #1 was taken to radiology for the contrast procedure, he remained in the ED and waited for her return and was not involved in the consent process. On 3/15/12 at 9:40 AM, the Chief Operating Officer confirmed the screening form and consent form were not complete. He stated the history	C 304			

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C 304	Continued From page 35 information was important to the radiologist when evaluating the report but was not critical information in order to do the exam. He stated the most important piece of information prior to the contrast procedure was to find out if the patient was allergic to iodine. Allergies were not listed on the screening form. Consent for the infusion of contrast was incomplete and informed consent was not properly executed for Patient #1.	C 304		
C 306	485.638(a)(4)(iii) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] all orders of doctors of medicine or osteopathy or other practitioners, reports of treatments and medications, nursing notes and documentation of complications, and other pertinent information necessary to monitor the patient's progress, such as temperature graphics and progress notes describing the patient's response to treatments; [and] This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure records included all nursing notes, documentation of complications, and other pertinent information necessary to monitor patient progress for 1 of 5 patients (#1) whose records were reviewed. This resulted in an inability to clearly determine the course of patient care. Findings include:	C 306	We conducted a review of the active medical record regarding saving of nursing documentation. A re-mapping correction, systems update and new saving protocol now provides for a complete active medical record. Each nurse will attend a two-hour re-education class followed by a one-hour competency demonstrating their ability to correctly document and save patient care information. These classes will be completed by April 30, 2012. We conducted a review regarding nursing documentation in the Clinical Care Station transferring to the final electronic medical record. A re-mapping correction and system update in the electronic medical record and transfer of reports nightly instead of every 3-7 days now provides for automatic transfer of all nursing documentation to the final electronic medical record. After implementation, the Acute Care Manager conducted daily audits of final closed records through April 11, 2012. All electronic medical	4/30/2012

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C 306	<p>Continued From page 36</p> <p>Patient #1 was a 76 year old female who was transferred to the ED on 2/27/12 from a psychiatric hospital for evaluation of low oxygen saturation levels.</p> <p>a. An ED RN was interviewed who worked the evening shift on 2/27/12 arriving at 5:45 PM. She stated she began caring for Patient #1 in the ED as bicarbonate was running into her IV. She reported contacting radiology to get Patient #1 to run IV contrast, as ordered by the ED physician. She stated it ran in fine and after the contrast had gone in and the saline had been used to flush the line, Patient #1's hand looked swollen. She stated the Radiology Technician told her he did not think any contrast ran into her vein, just saline. She stated she removed the IV from Patient #1's right hand, reported the infiltration to the ED MD, put a hot pack on it, and later started an IV in the left hand. She stated she charted the information about the infiltration, removal of IV and reporting to the physician. There was no documentation present in Patient #1's record to validate the course of events described by the ED RN.</p> <p>The Director of ICU and the ED was interviewed on 3/14/12 at 4:45 PM. She reviewed ED nursing documentation for Patient #1 and stated she could not find documentation as to who started an IV in Patient #1's right hand. She could not find any reference to an IV in the right hand, either starting it, discontinuing it, that it had infiltrated, or that the infiltration had been reported to the physician. She confirmed the IV infiltration was reported to have been in the right hand. She stated nursing staff reported having documented the information but the documentation could not</p>	C 306	<p>records were found to have all the nursing documentation.</p> <p>Nursing staff will be re-educated on correct electronic health record documentation practices, proper saving of information, and clinical wound assessment. Each nurse will attend a two-hour re-education class followed by a one-hour competency class to demonstrate their ability to correctly document and save patient care information. These classes will be completed by April 30, 2012. Each staff member will be required to complete a competency.</p> <p>Policy #126-Transfers of Patients to Another Hospital, Policy #3098-Physician Notification Criteria of Patient Change in Condition, and Policy #3490-Admission Criteria-Intensive Care Unit .Policies were amended to include the requirement that an occurrence report be completed with every transfer to a higher level of care. These policies were approved by the Clinical Practice Council on April 10, 2012. Nurse education on these policies will be completed by April 30, 2012 and each nurse will sign that they received the new and/or revised policies (Policies #14, #2 & #15 Attached).</p> <p>A protocol will be developed by nursing and pharmacy for the care of IV infiltrations by April 30, 2012. The protocol includes proper documentation of IV infiltrations and physician notification of IV infiltrations. An algorithm for the care of various IV</p>		

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C 306 Continued From page 37
be found.

b. There was no documentation in Patient #1's record regarding the right hand IV infiltration by the Radiology Technician who infused the contrast and first discovered the infiltration. A statement written and attached to an Occurrence Report, dated 3/14/12 (during the survey), stated when disconnecting the contrast line from the IV site, he noticed some swelling in the patient's hand. He thought that perhaps the line or vein had blown during the last part of the saline injection. He then took the patient back to the emergency department. While placing the patient back in a room, a female staff came in to help him and he showed her the hand and explained to her what had happened. She then stated she would take care of it or have the doctor look at it. This information was not documented prior to the survey at the time this event occurred.

c. The House Supervisor of the Medical/Surgical Unit was interviewed on 3/15/12 between 11:15 AM and 11:30 AM. She stated she received Patient #1 from the ED RN on the evening of 2/27/12 and continued as Patient #1's nurse until 2/28/12 at about 6 AM. She acknowledged documenting blistering of the right hand on 2/28/12 at 2:07 AM. She reported taking pictures of Patient #1's hand about 6:00 AM and giving report to the incoming RN. There was no documentation in the record that the pictures had been taken. The photograph was hand dated 2/28/12. It did not indicate the time the photograph was taken or list the name of the photographer.

d. On 3/15/12 at 11:45 AM, the RN who cared for

C 306 infiltrations is part of this protocol. The algorithm will be laminated and posted at each medication administration station and ancillary departments that give IV's. Each staff member involves with IV administration, including any ancillary departments will be educated on this protocol by April 30, 2012 and each staff member will sign that they received the new protocol.

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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
C 306	Continued From page 38 Patient #1 during the morning of 2/28/12 beginning at about 5:45 AM, was interviewed. She reported taking pictures of the hand sometime that morning before noon but did not document the time she took pictures. The photograph of the hand was dated 2/28/12. It did not indicate the time the photograph was taken or list the name of the photographer. e. On 3/15/12 at 1:05 PM, the ED RN was interviewed who cared for patient #1 on 2/29/12 beginning at 6:00 AM. She stated the pictures of Patient #1's hand, dated 2/29/12, had been taken by another nurse before she arrived at 6:00 AM. She acknowledged the photograph and the nursing notes did not indicate the time the photograph was taken. Nursing notes, documentation of an infiltration, and timing of photographs of the hand injury were not included in Patient #1's record.	C 306		
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] dated signatures of the doctor of medicine or osteopathy or other health care professional. 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 physician entries and photographs taken by RN staff were timed, dated, and authenticated for 1 of 5 patients (#1). This resulted in a lack of	C 307	Policy #3436 - Skin Assessment, Prevention and Management was revised and approved on April 10, 2012 by Clinical Practice Council. The revision includes: 1) Nursing staff will date and time all pictures taken of the patient. 2) A signed consent must be signed prior to photographing a wound, 3) The patient's face and label with name must also be photographed, 4) When taking photos of the wound, the following must be included: Patient label, date and time; A wound ruler for Measurement; Patient's face with label for identification purposes; and the name of the staff nurse taking the photograph. (Policy attached #16).	4/30/2012

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

PRINTED: 04/04/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2012
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C 307	Continued From page 39 clarity as to the course of patient care. Findings include: Patient #1 was a 76 year old female who was transferred to the ED from a psychiatric facility on 2/27/12, admitted 2/28/12, and transferred to another acute care facility on 2/29/12. The timing of examinations and photographs were not documented, as follows: a. A "HISTORY AND PHYSICAL," for Patient #1 was documented to have been dictated on 2/28/12 at 2:49 PM. The date and time the examination was conducted was not stated in the report or in physician progress notes. b. A surgical consultation, dated 2/29/12, was documented to have been dictated on 2/29/12 at 12:52 PM. The date and time of the examination was not stated in the report or in physician progress notes. c. A "DISCHARGE SUMMARY," dictated 2/29/12, was documented to have been dictated 2/29/12 at 12:39 PM. In the report, the physician referenced seeing Patient #1 that morning. The date and time of the examination was not stated in the report or in physician progress notes. d. Patient #1's record contained 6 photographs. Two of the photographs had an identifying number indicating they had been taken in either the ED or in the observation unit prior to hospital admission. Four of the photographs had a second identifying number indicating they had been taken after the patient was admitted to the hospital. The first two photographs were dated 2/28/12 and four of the photographs were dated	C 307	The Acute Care Nurse Managers began informal nursing education on this policy on March 21, 2012 and formal nursing education will be by the completed by April 30, 2012. The CNO is responsible for the implementation of this Plan of correction.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 307	Continued From page 40 2/29/12. The times the photographs were taken and the names of the photographers were not indicated. A hospital policy, "Skin Assessment, Prevention and Management," dated 3/16/12, addressed the taking of photographs in the context of skin breakdown. It stated that for management of skin integrity, nursing staff will take initial pictures and, as needed, identify, date, and mount for medical treatment of the patient. It does not address the need to identify the time the pictures were taken or the nurse taking the pictures. The Director of Nursing was interviewed on 3/16/12 between 8:45 AM and 11:00 AM. She stated it was nursing practice to take photographs when a break in skin was identified. She also stated it was practice to write in the patient's record when the photographs were taken. She reviewed the pictures for Patient #1 and confirmed there was no documentation as to the times the photographs were taken.	C 307			

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments The following deficiencies were cited during a complaint survey of your hospital. Surveyors conducting the survey were: Teresa Hamblin, RN, MS, HFS, Team Leader Gary Guiles, RN, HFS	B 000		
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to C 298.	BB175		4/30/2012
BB272	16.03.14.360.01 Medical Records Service, Facilities 360. MEDICAL RECORDS SERVICE. The hospital shall maintain medical records that	BB272		

Bureau of Facility Standards

[Signature]
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

[Signature]

(X6) DATE

4-17-12

Bureau of Facility Standards

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B 000		B 000		
BB175		BB175	<p>Nursing staff education of individualizing care plans will be completed by April 30, 2012. Staff will be required to complete a competency test.</p> <p>Ninety percent (90%) of care plans will be audited during daily rounds. Audits will be compiled by the Acute Care Manager and reported to Performance Improvement Committee on a monthly basis. (Policy attached #1 & Audit Tool attached #2)</p> <p>The CNO is responsible for the implementation of this Plan of Correction.</p> <p>*This page was added to accommodate the response*</p>	
BB272	<p>16.03.14.360.01 Medical Records Service, Facilities</p> <p>360. MEDICAL RECORDS SERVICE. The hospital shall maintain medical records that</p>	BB272	<p>Policy #3886, Legal Health Record, was developed and approved on April 10, 2012 by the Clinical Practice Council. Policy includes: 1) Current patient records will reside in the electronic health record as an active patient;</p>	6/13/2012

Bureau of Facility Standards

TITLE

(X6) DATE

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

Bureau of Facility Standards

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BB272	Continued From page 1 are documented accurately and timely, and that are readily accessible and retrievable. (12-31-91) 01. Facilities. The hospital shall provide a medical record room, equipment, and facilities for the retention of medical records. Provision shall be made for the safe storage of medical records. (10-14-88) This Rule is not met as evidenced by: Refer to C 302.	BB272	2) Once a patient is discharged, the patient's record will go into Horizon Patient Folder (electronic health record long term storage); 3) Scanned documents go into the patient's medical record in Horizon Patient Folder, and 4) The documents merge as one complete medical record in Horizon Patient Folder. Quality Control Indexing is performed daily in the Health Information Department. Comparisons are made of the scanned documents to a formal electronic index page by page. Any missing documentation is added at this time. The medical record is not considered complete until the index is verified in this real time process. Accuracy of the medical record is verified twice using this process (et Policy #3, Audit tool attached #4). We conducted a review regarding transfer of information from active patient medical record to final medical record (FMR) via interface and electronic storage/transfer process. A new system was implemented to facilitate transfer of reports nightly rather than every 3-7 days. After implementation, the Acute Care Manager conducted daily audits of final closed records through April 11, 2012. All active electronic records were found to be transferring to final electronic storage. The Acute Care Manager will periodically audit the final medical record and report finding to the Performance Improvement Committee quarterly. The Medical Staff Rules and Regulations were reviewed as it relates to History and Physicals, Progress Notes and Discharge Summaries. Documentation education for all medical staff	

Bureau of Facility Standards

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BB272		BB272	<p>meeting on June 13, 2012.</p> <p>Beginning April 3, 2012 all transcriptions will include the date and time of dictation in the header of every dictated report. Date and time documentation education for all medical staff members will be communicated from the Medical Executive Committee by April 17, 2012 and discussed at the general medical staff meeting on June 13, 2012.</p> <p>The Chief of Staff, CNO and Medical Staff Secretary are responsible for the implementation of this Plan of Correction.</p> <p>*This page was added to accommodate the response*</p>	

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
3232 Elder Street
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April 5, 2012

Louis Kraml, Administrator
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221

Provider #131325

Dear Mr. Kraml:

On **March 20, 2012**, a complaint survey was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005445

Allegation #1: Deficient facility practice contributed to a patient's hand injury.

Findings #1: An unannounced complaint investigation survey was completed at the critical access hospital (CAH) on March 14 through March 20, 2012. During the complaint investigation, surveyors reviewed 5 patient records, interviewed staff, reviewed policies, procedures, and incident reports.

One record documented a 76 year old woman who was transferred from a psychiatric facility on 2/27/12 to the emergency department of the hospital to evaluate low oxygen saturation levels. In order to rule out a pulmonary embolism (a blood clot in the lung), the emergency physician ordered a procedure that involved infusing bicarbonate followed by a contrast material and saline into the patient's intravenous line in her right hand. After the procedure was completed, it was determined the intravenous line infiltrated into the patient's right hand. Nursing staff removed the intravenous line and re-started a line in her left hand.

Nursing documentation indicated the appearance of her right hand worsened after she transferred from the emergency department to the Medical/Surgical floor of the hospital. The right hand

Louis Kraml, Administrator
April 5, 2012
Page 2 of 2

became blistered, swollen and dark. It was determined there was a delay by nursing staff in reporting changes to the physician. It was also determined there was a delay by physician staff in evaluating the patient's hand after being informed of the changes.

The hospital was cited at 42 CFR 485.635(d) for failure of nursing staff to meet patient needs by promptly reporting changes in the patient's condition and at 42 CFR 485.635(d)(4) for the failure to ensure nursing care plans were individualized and kept current. The hospital was also cited at 42 CFR 485.631(b)(1)(iii) for failure of physician staff to provide prompt evaluation of deteriorating patient symptoms. Related deficiencies were also cited at Condition of Participation of Clinical Records 42 CFR 485.638 and related standard level deficiencies at 42 CFR 485.638(a)(1)(2)(4)(i)(iii) and (iv).

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,



TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/srm