



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

April 3, 2013

Charles Lloyd, Administrator
Mountain View Center For Geriatric Psychiatry
500 Polk Street East
Kimberly, ID 83341

RE: Mountain View Center For Geriatric Psychiatry, Provider #134014

Dear Mr. Lloyd:

This is to advise you of the findings of the Medicare/Licensure survey at Mountain View Center For Geriatric Psychiatry, which was concluded on March 21, 2013.

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

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the sc into compliance, and that the facility remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

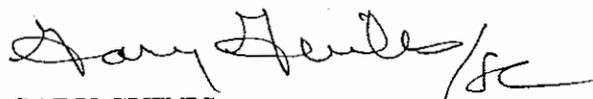
After you have completed your Plan of Correction, return the original to this office by

Charles Lloyd, Administrator
April 2, 2013
Page 2 of 2

April 16, 2013, and keep a copy for your records.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC

Enclosures



MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY

A BRP Health Management Care Center

April 16, 2013

Sylvia Creswell
Co-Supervisor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

RECEIVED

APR 16 2013

FACILITY STANDARDS

Dear Ms. Creswell,

Enclosed is the plan of correction for cited deficiencies for our Medicare/Licensure survey that was conducted at Mountain View Center for Geriatric Psychiatry on March 21, 2013.

If you have any other questions please call me at (208) 423-5591.

Sincerely,

Charles D. Lloyd, Jr., MBA/HCM
Administrator
Mountain View Hospital for Geriatric Psychiatry
Oak Creek Rehabilitation Center of Kimberly

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

PRINTED: 04/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY		STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341	
(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)
A 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your hospital. Surveyors conducting the recertification were: Rebecca Lara, RN, BA, HFS Gary Guiles, RN, BS, HFS, Team Leader The following acronyms were used in this report: CPI = Crisis Prevention Institute Training DNS = Director of Nursing Services LIP = Licensed Independent Practitioner MAR = Medication Administration Record pat = patient Pt = patient QAPI = Quality Assessment Performance Improvement SNF =skilled nursing facility	A 000	The following represents the actions taken by the facility to correct and bring to complete compliance the practices in the facility, and in response to the findings as a result of the Idaho Department of Health and Welfare, Bureau of Facility Standards Non-Long Term Care Recertification Survey. The signing of this plan of correction is not an admission or agreement by facility of the truth of the facts alleged in this statement of deficiency and plan of correction. This plan of correction is submitted exclusively to comply with state and federal law. This plan of correction serves as the facilities credible allegation of compliance.
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and review of hospital policies, the facility's grievance log, and administrative documents, it was determined the hospital failed to ensure grievances were identified and promptly resolved for at least 1 of 15 patients (Patient #9) whose medical records were reviewed. This lack of identification resulted in the facility's failure to recognize a family's concerns as a grievance, prevented prompt resolution of grievances and had the potential to interfere with the rights of all patients in the facility. Findings include:	A 118	<u>A118 482.13(a) (2) PATIENT RIGHTS: GRIEVANCES</u> The hospital will make every effort to meet and comply with the Federal Statutes to ensure a grievance process provides a prompt resolution of patient grievances and that informs patients whom to contact to file a grievance.

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APR 18 2013

04/7/13

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

TITLE

(X6) DATE

[Signature] MBA/Hcm

Administrator

4/16/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 118	<p>Continued From page 1</p> <p>Patient #9's physician history and physical evaluation completed on 9/05/12, documented a 71 year old male who was admitted to the hospital on 9/04/12. The history and physical stated Patient #9 resided in a SNF prior to admission to the facility. It indicated he was admitted to the hospital for treatment related to verbal and physical aggression, anxiety, agitation and mental confusion. On 10/01/12, Patient #9 was discharged to a different SNF.</p> <p>The facility's "Grievance Log" was reviewed. The log contained forms for 2012 and 2013. There were no documented grievances entered on the forms. Other administrative documents were provided along with the "Grievance Log". One of the documents was titled "Potential Patient Abuse Report Form." One of these forms, dated 9/24/12, was completed by the Director of Social Services. The form documented family concerns about Patient #9. The documentation included allegations made by Patient #9's family related to care and potential abuse. The form included documentation of an investigation of all allegations and patient, family and staff interviews. There was no evidence the allegations were entered as a grievance and results of the investigation provided to Patient #9 or his family.</p> <p>The policy, "GRIEVANCE PROCEDURE," last revised 12/08, included "Any patient or family member expressing concern regarding any part of [name of the facility's] patient care procedures or practices is encouraged to complete a Grievance Form, available at the nurses' station or from any staff member. ...and a formal letter</p>	A 118	<p>Corrective Action</p> <p>The Administrator, Director of Nursing, and Social Services Director re-wrote the Grievance Policy and Procedure. The grievance procedure was posted in the hospital. The Patient Rights and Responsibilities were updated to include the right to file a grievance and how to file a grievance with the State agency. This is given to all patient's and/or patient's representatives on admission. The Director of Nursing will inservice all hospital staff in regards to the grievance policy and procedure bringing the facility into compliance with the regulatory requirement.</p> <p>Monitoring</p> <p>The Grievance Policy and Procedures along with Grievances that are filed will be monitored by the QAPI committee on a monthly basis and quarterly through the Medical Executive Committee. This will ensure that the hospital remains in compliance with this Federal</p>	

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A 119	<p>Continued From page 3</p> <p>facility. This failed practice resulted in the lack of documentation of grievances and failed to establish resolution of the grievance process. Findings include:</p> <p>Patient #9's physician history and physical evaluation completed on 9/05/12, documented a 71 year old male who was admitted to the hospital on 9/04/12. The history and physical stated Patient #9 resided in a SNF prior to admission to the facility. It indicated he was admitted to the hospital for treatment related to verbal and physical aggression, anxiety, agitation and mental confusion. On 10/01/12, Patient #9 was discharged to a different SNF.</p> <p>The facility's "Grievance Log" was reviewed. The log contained forms for 2012 and 2013. There were no documented grievances entered on the forms. Other administrative documents were provided along with the "Grievance Log". One of the documents was titled "Potential Patient Abuse Report Form." One of these forms, dated 9/24/12, was completed by the Director of Social Services. The form documented family concerns about Patient #9. The documentation included allegations made by Patient #9's family related to care and potential abuse. The form included documentation of an investigation of all allegations and patient, family and staff interviews. There was no evidence the allegations were entered as a grievance.</p> <p>"Governing Body Meeting Minutes" for 2012 were reviewed during the survey. Documentation that patient and/or family grievances were discussed was not present.</p>	A 119	<p>monthly basis for review along with the quarterly Medical Executive meeting. This will ensure that the hospital remains in compliance with this Federal regulation. The Administrator is responsible for compliance.</p>	

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A 119	Continued From page 4 The grievance process was discussed with the Administrator on 3/22/13, beginning at approximately 12:45 PM. He confirmed patient and family concerns were not being identified as grievances and therefore, were not a topic of discussion in Governing Body meetings.	A 119			
A 168	The governing body did not ensure a comprehensive and effective grievance process was utilized by the facility. 482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure restraints were utilized in accordance with orders of physicians or authorized LIPs. This affected the care of 1 of 2 patients (Patient #2) who were placed in restraints and whose records were reviewed. The use of restraints without proper authorization had the potential to result in the inappropriate use of restraints. Findings include: Patient #2's Psychiatric Evaluation, dated 1/03/13, documented an 84 year old male who was admitted to the facility on 1/03/13. It stated Patient #2 was admitted for evaluation to rule out dementia. Patient #2's Discharge Summary,	A 168	<u>A 168 482.13(e) (5) PATIENT RIGHTS: RESTRAINT OR SECLUSION</u> The hospital will make every effort to meet and comply with the Federal Statutes regarding ensuring that restraints are in accordance with the order of a physician or other licensed independent practitioner. Corrective Action The Director of Nursing in-serviced the facility psychiatric medical director, family nurse practitioners, and charge nurses on the correct way to write a restraint order. The order will identify the specific method of restraint that should be used. The Director of Nursing will add restraints as a quality indicator to monitor every month and review in QAPI.	6/7/13	

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A 168	<p>Continued From page 5</p> <p>completed on 2/15/13, indicated Patient #2 was discharged from the facility on 2/14/13 and returned to an assisted living facility.</p> <p>"NURSES NOTES," dated 1/28/13 at 8:30 PM, documented Patient #2 became increasingly agitated and aggressive toward staff. The note also indicated Patient #2 was unsteady on his feet. Documentation stated "Pt hitting and attempting to squeeze/crush staffs hands. CPI controlled position used at this time for pat and staff safety. Pt assisted in sitting position on bed in attempt to divert pt's attention into conversation. [Physician's name] notified 7:15 PM." The note said Patient #2 continued to exhibit agitation and aggressive behavior until 8:00 PM, when he was released from the CPI controlled position.</p> <p>"DOCTOR'S ORDERS AND PROGRESS NOTES," dated 1/28/13, were reviewed. A physician progress note, dated 1/28/13 at 8:00 PM, described the events and the use of 2 staff members to "sit and restrain" Patient #2. However, there was no order for the CPI hold/physical restraint found in the record.</p> <p>The DNS was interviewed on 3/20/13, beginning at 8:30 AM. She reviewed Patient #2's medical record and confirmed there was no order for CPI hold/physical restraint on 1/28/13.</p>	A 168	<p>Monitoring</p> <p>Restraint orders will be reviewed on a monthly basis in the QAPI committee and on a quarterly basis in the Medical Executive Committee to ensure compliance with this Federal regulation. The Administrator and Director of Nursing Services are responsible for compliance.</p>	
A 266	<p>Physical restraint was used for Patient #2 without a qualifying order from a physician or LIP.</p> <p>482.21(a)(1) QAPI MEDICAL ERRORS</p> <p>Identify and reduce medical errors.</p>	A 266	<p><u>A266 482.21(a) (1) QAPI MEDICAL ERRORS</u></p> <p>The hospital will make every effort to meet and comply with the Federal Statutes regarding the identification and reduction of medical errors.</p>	<p>04/9/13</p>

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A 266	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review QAPI documents, it was determined the hospital failed to ensure its QAPI program measured and tracked quality indicators including adverse patient events in order to reduce medical errors. This prevented the hospital from analyzing categories of events in order to decrease their occurrence. Findings include:</p> <p>The document "QAPI REPORT FOR THE YEAR OF 2012," not dated, listed the number of medical records that were audited in 2012 for medication errors, the number of doses of medication given to those patients whose records were audited, the number of medication errors, and the error percentage for those patients who were reviewed. Monthly reports included this same information.</p> <p>"Medical Executive Committee Working Minutes," dated 12/04/12, included a report on the number of adverse patient events by month. The list included falls, skin tears, self injury, and others. The list did not include medication errors.</p> <p>No other data on the number of medication errors was documented.</p> <p>The pharmacist was interviewed on 3/19/13 beginning at 11:20 AM. He stated he reviewed a certain number of records each month and looked for medication errors and issues within those records. He stated he compiled statistics for those records. He stated the DNS tracked medication errors that were discovered and reported by nursing and other staff.</p> <p>The DNS was interviewed on 3/21/13 beginning</p>	A 266	<p>Corrective Action</p> <p>The Administrator and Director of Nursing will ensure that "self-reported" medication errors are recorded and presented in QAPI on a monthly basis along with the Quarterly Medical Executive Committee. The review of the "known medical" will include a discussion with the Medical Providers and Hospital Pharmacist to monitor performance and identify ways to improve such errors. This process will ensure the hospital accurately analyzes medication errors to help prevent them.</p> <p>Monitoring</p> <p>All medication errors will be presented to the QAPI meeting monthly and Medical Executive Committee on a quarterly basis to ensure compliance with this Federal regulation. The Pharmacist, Director of Nursing, and Administrator are responsible for compliance.</p>	

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A 266	Continued From page 7 at 10:00 AM. She stated she did not track medication errors because the pharmacist tracked them. The Administrator was interviewed on 3/21/13 beginning at 10:15 AM. He confirmed the number of medication errors was not tracked by the hospital's QAPI program. The hospital did not track medication errors through its QAPI program. This prevented the hospital from accurately analyzing medication errors in order to prevent them.	A 266			
A 273	482.21(a), (b) PROGRAM SCOPE, PROGRAM DATA (a) Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will improve health outcomes ... (2) The hospital must measure, analyze, and track quality indicators ... and other aspects of performance that assess processes of care, hospital service and operations. (b) Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of services and quality of care; and (3) The frequency and detail of data collection must be specified by the hospital's governing body.	A 273	<u>A273 482.21(a), (b) PROGRAM SCOPE, PROGRAM DATA</u> The hospital will make every effort to meet and comply with the Federal Statutes regarding program scope and program data for the quality review process. Corrective Action The Director of Nursing will present to the QAPI committee monthly and quarterly to the Medical Executive Committee on the following areas: relevant quality indicators, falls, adverse medication reactions, self reported medicine errors, spikes in adverse patient events, and restraint use. The presentation of the information will be followed by a discussion with the team to identify new trends, or problems along with solutions or ideas to prevent re-occurrences of the events that are presented. This will lead to a comprehensive review increasing the quality of patient care that the hospital provides.	6/7/13	

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A 273	Continued From page 8 This STANDARD is not met as evidenced by: Based on staff interview and review QAPI documents, it was determined the hospital failed to ensure its QAPI program analyzed and tracked relevant quality indicators. This resulted in a lack of feedback to staff which could prevent them from taking action to reduce adverse patient events. Findings include: The hospital's QAPI program was reviewed. It maintained data by month on incidents and accidents including falls, skin tears, self-injury, bruises, patient to patient contact, and "other." However, the hospital did not use the data to identify trends or analyze increases in the number of incidents. For example, the "Summary of Incidents" presented to the Medical Executive Committee at their 12/04/12 meeting, documented numbers of incidents for the first 9 months of 2012. The number of falls stayed at or below 2 per month for 7 of those months. The number of falls climbed to 10 in May 2012 and 7 in July 2012. The number of patients with bruises was 4 for February of 2012, then remained at 3 or below until August 2012, and climbed to 11 for September 2012. The Administrator was interviewed on 3/21/13 beginning at 10:15 AM. When asked if any causes for the rise in incidents had been identified for the affected months, he stated the QAPI program did not analyze causes for spikes in adverse patient events. He stated data was listed by month but staff did not look for trends in	A 273	Monitoring The Director of Nursing will present the information to the QAPI committee on a monthly basis and quarterly to the Medical Executive Committee to ensure compliance with this Federal regulation. The Administrator is responsible for compliance with this citation.		

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A 273	Continued From page 9 adverse patient events. In addition, he confirmed the QAPI program did not track restraint usage or all medication errors.	A 273		
A 493	<p>The hospital did not analyze and track adverse patient events in order to decrease their occurrence.</p> <p>482.25(a)(2) PHARMACY PERSONNEL</p> <p>The pharmaceutical service must have an adequate number of personnel to ensure quality pharmaceutical services, including emergency services.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of Idaho state rules for hospitals, it was determined the hospital failed to ensure there were an adequate number of pharmacists to ensure pharmaceutical services were provided to patients in accordance with accepted standards of practice. This resulted in the increased likelihood of drug interactions and medication errors. Findings include:</p> <p>Idaho state licensing rules for hospitals (IDAPA 16.03.14.330.06.a) require that "The pharmacist shall review the prescriber's original order or a direct copy thereof." This provides the opportunity for the pharmacist to maintain a medication profile necessary for the review of drug interactions and medication errors.</p> <p>The pharmacist was interviewed on 3/19/13 beginning at 11:20 AM. He stated he worked at the hospital for 8 hours on Tuesdays and for 4 hours on Fridays. He stated he did not review original medication orders or copies of those</p>	A 493	<p>A 493 482.25(a) (2) PHARMACY PERSONNEL</p> <p>The hospital will make every effort to meet and comply with the Federal Statutes to provide adequate pharmaceutical personnel.</p> <p>Corrective Action The Director of Nursing completed an in-service with Medical Staff, Pharmacist, and Nursing Staff about the new procedure for medication orders that are obtained. All new orders for patients will be sent or reviewed by the Pharmacist-in-charge on a daily basis for review. The means of review and the new process will be completed by fax, e-mail, or in-person by the Pharmacist-in-charge. This new process will ensure that medications prescribed to patients are reviewed on a daily basis enhancing the quality of care provided to patients in the hospital.</p>	6/7/13

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/21/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 493	Continued From page 10 orders, either when he was at the hospital or when he was not at the hospital. He stated nurses transcribed the orders and entered them on to the MAR. He stated he updated patients' medication profiles, including checking for drug interactions when he was at the hospital but acknowledged it could be as long as 4 days before this happened. He stated the hospital did not have enough pharmacists to review medication orders and evaluate them for correct dosages, medication interactions, and other issues in a timely manner. The hospital did not employ sufficient pharmacists to directly review medication orders.	A 493	Monitoring The Pharmacist will make a report to the Administrator on a monthly basis in QAPI and quarterly in the Medical Executive Committee about the numbers of medication orders that were reviewed. The Administrator is responsible for compliance.		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PS	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the Idaho state licensure survey of your hospital. Surveyors conducting the review were:</p> <p>Rebecca Lara, RN, BA, HFS Gary Guiles, RN, BS, HFS, Team Leader</p> <p>Acronyms used in this report include:</p> <p>P&T = pharmacy and therapeutics (committee)</p>	B 000	<p>RECEIVED APR 18 2013</p> <p>FACILITY STANDARDS</p> <p>BB223 16.03.14.330.03 Scope of Services</p> <p>The hospital will make every effort to meet and comply with the Idaho Statutes regarding a pharmacy and therapeutics (committee).</p>	6/7/13
BB223	<p>16.03.14.330.03 Scope of Services</p> <p>03. Scope of Services. (10-14-88)</p> <p>a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91)</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the hospital failed to ensure a P&T Committee met to discuss pharmacy issues and update the formulary. This resulted in a lack of oversight for pharmacy services. Findings include:</p>	BB223	<p>Corrective Action</p> <p>The hospital has an informal pharmacy and therapeutics (committee). The committee will now meet on at least a quarterly basis or as needed to discuss issues regarding the hospital formulary and issues concerning the pharmacy in the hospital.</p> <p>Monitoring</p> <p>All minutes from the Committee will be presented to the QAPI committee and Medical Executive Committee to ensure compliance. The Administrator is responsible for compliance.</p>	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
4/16/13

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BB223	Continued From page 1 No meeting minutes were present that documented the activities of a P&T Committee between 1/01/12 and 3/19/13. The pharmacist was interviewed on 3/19/13 beginning at 11:20 AM. He stated the hospital did not have a P&T Committee. He stated pharmacy issues were discussed informally with the medical staff but no record of this was kept. The hospital did not maintain a P&T Committee.	BB223		
BB226	16.03.14.330.06 Safe Handling of Drugs 06. Safe Handling of Drugs. In addition to the rules listed below, written policies and procedures which govern the safe dispensing and administration of drugs shall be developed by the pharmacy and therapeutics committee with the cooperation and the approval of the medical staff. (10-14-88) a. The pharmacist shall review the prescriber's original order or a direct copy thereof; and (10-14-88) b. The pharmacist shall develop a procedure for the safe mixture of parenteral products; and (10-14-88) c. All medications shall be administered by trained personnel in accordance with accepted professional practices and any laws and regulations governing such acts; and (10-14-88) d. Each dose of medication administered shall be properly recorded as soon as administered in the patient's medication record which is a separate and distinct part of the patient's medical record; and (10-14-88)	BB226	BB226 16.03.14.330.06 Safe Handling of Drugs The hospital will make every effort to meet and comply with the Idaho Statutes regarding a pharmacist reviewing all orders prescribed by a medical provider. Corrective Action See P.O.C. for A493 Monitoring See P.O.C. for A493	6/7/13

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BB226	Continued From page 2 e. Drug reactions and medication errors shall be reported to the attending physician and pharmacist in accordance with hospital policy. (10-14-88) This Rule is not met as evidenced by: Based on staff interview, it was determined the hospital failed to ensure a pharmacist reviewed prescribers' original medication orders or a direct copy of those orders. This resulted in the increased likelihood of drug interactions and medication errors. Findings include: The pharmacist was interviewed on 3/19/13 beginning at 11:20 AM. He stated he worked at the hospital for 8 hours on Tuesdays and for 4 hours on Fridays. He stated he did not review original medication orders or copies of those orders, either when he was at the hospital or when he was not at the hospital. He stated nurses transcribed the orders and entered them on to the MAR. He stated he updated the medication profiles when he was at the hospital but acknowledged it could be as long as 4 days before this happened. The pharmacist did not directly review medication orders.	BB226		