



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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Boise, ID 83720-0009
PHONE 208-334-6626
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April 4, 2013

Jeff Hill, Administrator
Steele Memorial Medical Center
203 South Daisy Street
Salmon, ID 83467

RE: Steele Memorial Medical Center, Provider #131305

Dear Mr. Hill:

This is to advise you of the findings of the complaint survey at Steele Memorial Medical Center, which was concluded on March 26, 2013.

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

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

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

Jeff Hill, Administrator
April 4, 2013
Page 2 of 2

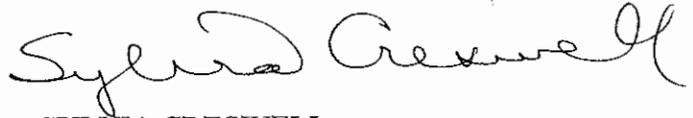
After you have completed your Plan of Correction, return the original to this office by **April 16, 2013**, and keep a copy for your records.

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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/
Enclosures

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

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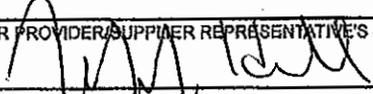
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131305	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2013
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NAME OF PROVIDER OR SUPPLIER STEELE MEMORIAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SOUTH DAISY STREET SALMON, ID 83467
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C 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation at your critical access hospital. Surveyors conducting the investigation were:</p> <p>Susan Costa RN, HFS, Team Lead Aimee Hastriter RN, BS, HFS</p> <p>Acronyms used in this report include:</p> <p>CAH - Critical Access Hospital CDC - Centers for Disease Control CNS - Central Nervous System COPD - Chronic Obstructive Pulmonary Disease Crash Cart - Cart containing supplies for Airway Management and Cardiac Resuscitation, including medications CRNA - Certified Registered Nurse Anesthetist ED - Emergency Department IV - Intravenous line gm - gram ml - milliliter OR - Operating Room PA - Physician Assistant PACU - Post Anesthesia Care Unit RN - Registered Nurse STFA - Surgical Technician First Assistant</p>	C 000		
C 241	<p>485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL</p> <p>The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.</p>	C 241		

RECEIVED
APR 15 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X5) DATE 4/12/13
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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 241	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation, review of personnel files, policies, log books and medical records and staff interview, it was determined the governing body failed to ensure policies were developed and implemented to promote the delivery of quality health care. This directly impacted 3 of 7 patients (#9, #12, and #13) whose surgical records were reviewed and 2 of 2 patients (#15 and #18) whose care was observed. This failure had the potential to result in a staff member performing tasks outside of the scope of practice, emergency equipment not being monitored for patient safety, and patients and staff exposed to potential cross contamination of infections. Findings include: 1. The personnel file was reviewed for the STFA. There was only one employee with this title. His personnel file contained a job description titled "Operating Room Technician." It did not include the duties the individual was approved to perform when serving as first assist to the surgeon. The file did not contain evidence the STFA had been privileged or credentialed to assist the surgeon. The credentialing file of a PA, who was also noted to be a first assist, was reviewed. His file contained documentation the PA was credentialed and privileged to perform specific tasks during orthopedic surgeries. His file contained documentation of supervisory oversight by a board certified orthopedic surgeon. Similar information was not found for the STFA. Patient #9 was a 55 year old male admitted to the	C 241	Responsible Person: Surgery Department Manager The following plan of action will ensure that staff members will perform within their scope of practice, assuring patient and staff safety. 1. Update job description of a surgical technologist first assistant that will include specific duties and tasks by 4/12/13. This will ensure that the STFA will know specific task and duties that can be expected of them. 2. The medical executive staff will address privileging and credentialing surgical technologist first assistants at the next medical executive staff meeting on 5/14/13. 3. The surgical services manager will develop a surgical technologist first assistant competency check off list and have a surgeon confirm competencies in six months and annually after that. 4. See attached Job Description: Operating Room Technician First Assistant. 5. CNO or designee will monitor compliance with regulatory requirements	4/12/13 5/14/13	

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C 241	<p>Continued From page 2</p> <p>facility on 1/07/13 for removal of lesions on his right temple and left forearm. His medical record contained an "INTRAOPERATIVE NURSING RECORD" form that indicated the surgeon was assisted by the STFA.</p> <p>The Surgical Services Nurse Manager was interviewed on 3/25/13 at 12:50 PM. He explained the STFA's role during surgery included assisting the surgeon with positioning the patient or instruments, dressing the surgery site at the completion of surgery, and possibly suturing the incision if the surgeon requested assistance. He confirmed the exact scope of practice for the STFA was not clear. The Surgical Services Nurse Manager confirmed the STFA was not privileged or credentialed to perform those activities during surgery. He stated that he was not aware of the issue being addressed by the Medical Staff.</p> <p>The governing body failed to ensure processes were developed and implemented for defining the duties and oversight of the STFA.</p> <p>2. According to the "Adult and Pediatric Crash Cart-Check" policy, dated 4/08/11, the crash cart in "PACU will be checked on days when there are patients being cared for" on the unit. Among other items, nursing staff were to ensure the crash cart seal was intact, the defibrillator was plugged into the wall and the batteries were charged, and the defibrillator passed the "charge test."</p> <p>The log for documenting crash cart assessments (such as checking to ensure machinery worked and supplies were current) was reviewed from</p>	C 241	<p>On an ongoing basis.</p> <p>Responsible person: Nursing Managers of each applicable department.</p> <p>1. Email policy to all nursing staff regarding updated policy on Adult and Pediatric Crash Cart-Check (120-156). See Attached. 2. Review policy at next nursing staff meeting. 3. Perform a daily checks on the PACU crash cart and perform PI study for one year and report study to Performance Improvement committee on a quarterly basis.</p> <p>How it will improve: It will ensure that the nursing staff is aware of the policy and checks will be performed to maintain patient safety.</p>	4/11/13 4/16/13	

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C 241	<p>Continued From page 3</p> <p>1/02/13 through 3/14/13. This log was compared to the OR log to ensure that the crash cart was checked each day that surgeries were performed. During the month of February it was noted that on 6 of 20 surgery days, 2/06/13, 2/13/13, 2/14/13, 2/18/13, 2/20/13, and 2/25/13, there was no documentation the crash cart had been checked.</p> <p>Medical records for 4 patients who had surgery in February of 2013 were reviewed. Patient #12 was cared for in PACU on 2/14/13 and Patient #13 was cared for in PACU on 2/20/13. Patient #12 and #13 were cared for in the PACU on days when the crash cart was not checked in accordance with the CAH's policy.</p> <p>The Surgical Services Nurse Manager was interviewed on 3/25/13 at 12:50 PM. He stated he was not aware that the crash cart had not been assessed on each day when surgical procedures were performed. He confirmed staff were expected to complete this task on days when surgeries were performed and was not sure why this was not accomplished.</p> <p>The governing body failed to ensure the CAH's policy was consistently implemented to ensure the resuscitation equipment in the PACU was checked daily.</p> <p>3. The CAH's "Handwashing Policy," dated 7/01/05 and revised 9/30/06, contained instructions for hand hygiene using soap and water and alcohol based hand rub. According to the policy, "If hands are not visibly soiled, or after having contact with inanimate objects or patient's intact skin, use an alcohol-based hand rub for routinely decontaminating hands. Decontaminate</p>	C 241	<p><i>CNO or designee will monitor compliance with regulatory requirements on an ongoing basis</i></p> <p>Responsible person: Infection Control Manager.</p> <p>The following plan of action will increase compliance with hand hygiene for protection of the patient and staff.</p> <p>1. The Department of Health and Human Services Centers for Medicare and Medicaid Services infection control deficiencies were reported to the Infection Control Committee on 4/11/13.</p> <p>2. E-mail hand washing policy to all employees on 4/11/13.</p>	

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C 241	<p>Continued From page 4</p> <p>hands by handwashing or alcohol-based rub: ...before and after each patient contact, after removing gloves or protective equipment."</p> <p>According to the CDC "Guidelines for Hand Hygiene in Health-Care Settings," dated 10/25/02, "Personnel should be informed that gloves do not provide complete protection against hand contamination. Bacterial flora colonizing patients may be recovered from the hands of [equal to or greater than] 30% of HCWs [Health Care Workers] who wear gloves during patient contact. Further, wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex virus. In such instances, pathogens presumably gain access to the caregiver's hands via small defects in gloves or by contamination of the hands during glove removal."</p> <p>The "Textbook of Basic Nursing, 9e [edition]," published by Lippincott, Williams, & Wilkins in 2008, explained the process of administering medication using IV ports. Instructions include wiping the port with alcohol wipes prior to access for medication administration.</p> <p>Infection control policies and standards of practice were not followed. Examples include:</p> <p>a. Patient #15 was a 36 year old female admitted to the facility on 3/20/13 for surgery on her right shoulder. Her care was observed from 9:10 AM until 11:45 AM. Infection control breaches were observed as follows:</p> <p>- At 9:45 AM the Pre-operative RN placed an IV in Patient #15's right hand. He placed the</p>	C 241	<p>3. The Infection control officer will meet with all departments in clinical areas to review hand washing policy by 6/30/13.</p> <p>4. Infection Control officer will meet with each department manager and discuss any areas that need additional alcohol-based hand rub dispensers by 4/17/13.</p> <p>5. Install one new alcohol based hand rub dispenser in each operating room by 4/19/13</p> <p>6. Implement a new hand hygiene audit/QI thought out the facility for one year.</p> <p>7. Hold inservice with CRNA's on asepsis emphasizing the importance of cleaning IV ports with alcohol prior to administering any medication by 4/19/13.</p> <p>8. Use single use IV start kits (they include a tourniquet and tape) for each patient starting 4/11/13. This will decrease the likelihood of any cross contamination from items such as a tourniquet or tape.</p> <p>9. Incorporate annual compliance for hand washing technique by Swank for all employees. (Compliance completed for this year.)</p> <p>10. See attached Handwashing policy# 135-008.</p> <p><i>CNO or designee will monitor compliance with regulatory requirements on an ongoing basis.</i></p>	<p>4/17/13</p> <p>4/19/13</p> <p>4/19/13</p> <p>4/1/2014</p>

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C 241	<p>Continued From page 5</p> <p>tourniquet and tape he had used back on the portable tray that held IV start supplies without wiping them down. The tray was placed on a cart in the hallway.</p> <p>- At 9:59 AM, the CRNA was observed to administer medication to Patient #15 using the IV on two occasions without wiping the port with alcohol prior to administration. In addition, hand hygiene was not performed prior to the medication administration.</p> <p>- At 10:00 AM, the CRNA was observed to pick up a 30 ml syringe that had fallen to the floor. The syringe was to be used to do a shoulder nerve block. The syringe was placed back on the bedside table and used during the block procedure.</p> <p>- At 10:02 AM the CRNA picked up a trash can and relocated it closer to his work area. Hand hygiene was not performed after handling the trash can.</p> <p>- In the OR, at 11:21 AM, the CRNA was observed to lift up the IV port of Patient #15's IV tubing that was resting on the operating table and administer medication. The port was not wiped with alcohol prior to administration.</p> <p>- At 11:28 AM a sensor on Patient #15's forehead was changed. The cable that attached to the sensor fell to the floor. The CRNA picked up the cable and connected the cable to the sensor without wiping the cable with disinfectant, and without changing his gloves.</p> <p>- At 11:41 AM, the Circulating RN, who had been</p>	C 241		

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C 241	<p>Continued From page 6</p> <p>assisting with patient positioning while wearing gloves, was observed to apply sterile gloves over the gloves that were already worn. She then proceeded to apply the skin prep to Patient #15's arm and shoulder prior to surgery.</p> <p>- At 11:43 AM, the Surgical Services Nurse Manager who was assisting in the OR, was observed positioning the patient and cleaning up the OR environment. He removed the gloves he was wearing and donned sterile gloves to assist the Circulating RN in completing the skin prep. Hand hygiene was not observed after the removal of one pair of gloves and prior to donning the sterile gloves.</p> <p>- At 11:47 AM, the Circulating RN was observed to remove her sterile gloves and dispose of them. She then proceeded to assist with equipment set up, including adjusting cords and pedals on the floor. Following this she was observed to document information in the computer and then exited the OR to get additional supplies. Hand hygiene was not performed after removing gloves or after touching the floor.</p> <p>b. Patient #18 was a 65 year old male admitted to the ED 3/19/13 with abdominal pain. His care was observed by two surveyors from 1:25 PM to 2:00 PM. Infection control breaches were noted as follows:</p> <p>- At 1:30 PM the RN was observed to start Patient #18's IV. Once the IV was in place, she removed the gloves she was wearing, reached into a supply cabinet to obtain a syringe pre-filled with normal saline, and administered a portion of the saline into the IV. She was not observed to</p>	C 241		

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C 241	<p>Continued From page 7</p> <p>complete hand hygiene after removing gloves and before moving to the next task.</p> <p>- At 1:55 PM the RN left Patient #18's room after placing a nasal cannula on Patient #18 and administering medication. She walked across the hall to a locked medication room. She operated the button lock on the door and went into the room. The RN unlocked a medication cabinet, placed a syringe into the cabinet, locked the cabinet and returned to Patient #18's room. Once in the room she handled the IV tubing and set up an IV pump for the infusion of fluids then charted on the computer. No hand hygiene was performed during that time.</p> <p>The Surgical Services Nurse Manager, who was also the Infection Control Officer, was interviewed on 3/21/13 at 3:30 PM. He confirmed that IV ports should be wiped with alcohol prior to access for medication administration. He confirmed it was his expectation that hand hygiene be completed in accordance with facility policy and standards of practice. He confirmed that picking up items off of the floor and using them for patient care was not appropriate infection prevention.</p> <p>The governing body failed to ensure its infection control policy was consistently implemented to promote the delivery of quality health care.</p>	C 241		
C 297	<p>485.635(d)(3) NURSING SERVICES</p> <p>All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted</p>	C 297		

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C 297	<p>Continued From page 8 standards of practice, and Federal and State laws.</p> <p>This STANDARD is not met as evidenced by: Based on record review, review of facility policies and interview, it was determined the CAH failed to ensure staff administered medications to patients in accordance with facility policies. Failure to follow policy and standards directly impacted 1 of 1 ED patients (#4), who received intravenous antibiotics and whose records were reviewed. The failure to follow facility policies and standards of practice had the potential to result in adverse patient outcome. Findings include:</p> <p>1. Patient #4 was a 52 year old male admitted to the ED on 3/17/13 for care related to diabetic foot ulcers. Patient #4's "Emergency Department Record", dated 3/17/13, included diagnoses of coronary atherosclerosis, COPD, and a history of kidney failure and documented an IV was started in Patient #4's left forearm at 3:16 PM. The RN who cared for Patient #4 documented the administration of Vancomycin 1.5 gm in 300 ml Normal Saline from 4:28 PM until 5:22 PM, an administration time of 54 minutes. In addition, Meropenem 2 gm in 100 ml of Normal Saline was administered from 4:28 until 5:13 PM. This indicated both medications were infusing simultaneously through the same IV. Patient #4 was discharged to home at 5:35, which was 13 minutes after the antibiotics were completed.</p> <p>According to "Nursing 2013 DRUG HANDBOOK," Vancomycin in dosage greater than 1 gram must be infused over 90 minutes. The handbook advised caution for patients with impaired kidney</p>	C 297	<p>Responsible person: Director of Pharmacy</p> <p>In order to ensure that all drugs, biologicals, and intravenous medications are administered in accordance with Standards of Practice, Federal and State laws, the following plan of actions for condition C297 will be adhered to.</p> <p>Post infusion monitoring:</p> <ol style="list-style-type: none"> Changes to Policy #120-074 / #160-060 (Medication Administration Policy and Procedure). See attached policy with highlighted changes. 4/11/13 Policy emailed to all nursing staff with updated changes. 4/11/13 Pharmacist to review policy at all nursing staff meetings for the next 3 months. 7/1/13 PI Study on post infusion monitoring for one year. Report Quarterly to Performance Improvement Committee. 5/30/14 <p>Antibiotic infusions:</p> <ol style="list-style-type: none"> Created new policy #030-066 Intravenous antibiotic infusion policy. See attached. 4/11/13 Email new policy to all nursing staff. 4/12/13 Pharmacist to review policy at all nursing staff meetings for the next 3 months. 7/1/13 PI Study on antibiotic infusion monitoring for one year. Report Quarterly to Performance Improvement Committee. 5/30/14 		

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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 297	<p>Continued From page 9</p> <p>function. The drug handbook listed Meropenem as incompatible with other intravenous drugs and should be used with caution for patients with impaired renal function which could also cause seizures or adverse CNS reactions. Patient #4's "Emergency Department Record", dated 3/17/13, documented Patient #4 had a history of kidney failure.</p> <p>The facility's policy "Medication Administration Policy and Procedure," dated 9/15/99 and reviewed 3/24/11, included "The nurse will monitor the patient's response to the first dose of a new medication."</p> <p>During an interview on 3/21/13 beginning at 8:55 AM, the Pharmacy Director stated the recommendation for Vancomycin and Meropenem would be to administer first one then the other, and not both together. He stated the first dose of an antibiotic the patient should be monitored for at least 20 minutes after infusion was complete. He was unable to provide a policy related to patient monitoring after antibiotics.</p> <p>The CAH failed to ensure that the policy for administration of medications was followed.</p>	C 297	<p>CNO or designee will monitor compliance with regulatory requirements on an ongoing basis.</p>		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID5F49	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/26/2013
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NAME OF PROVIDER OR SUPPLIER STEELE MEMORIAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SOUTH DAISY STREET SALMON, ID 83467
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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) COMPLETE DATE
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B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation at your critical access hospital. Surveyors conducting the investigation were: Susan Costa RN, HFS, Team Lead Aimee Hastriter RN, BS, HFS Acronyms used in this report include: CAH - Critical Access Hospital CDC - Centers for Disease Control CNS - Central Nervous System COPD - Chronic Obstructive Pulmonary Disease Crash Cart - Cart containing supplies for Airway Management and Cardiac Resuscitation, including medications CRNA - Certified Registered Nurse Anesthetist ED - Emergency Department IV - Intravenous line gm - gram ml - milliliter OR - Operating Room PACU - Post Anesthesia Care Unit RN - Registered Nurse STFA - Surgical Technician First Assistant	B 000		
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	BB226	Refer to action plan C297.	

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TITLE

CEO

(X6) DATE

4/12/13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID5F49	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/26/2013
NAME OF PROVIDER OR SUPPLIER STEELE MEMORIAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 SOUTH DAISY STREET SALMON, ID 83467		
(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) COMPLETE DATE
BB226	Continued From page 1 (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) 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: Refer to C 0297 as it relates to safe administration of drugs.	BB228		



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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May 6, 2013

Jeff Hill, Administrator
Steele Memorial Medical Center
203 South Daisy Street
Salmon, Idaho 83467

Provider #131305

Dear Mr. Hill:

On **March 26, 2013**, a complaint survey was conducted at Steele Memorial Medical Center. The complaint allegations, findings and conclusions are as follows:

Complaint #ID00005939

ALLEGATION #1: The facility staff did not ensure infection prevention practices as follows:

- IV supplies were used for multiple patients
- Nurse did not swab the port before injection of medication into the IV tubing
- Nurse started an IV without gloves
- Surgical masks were worn through multiple cases, were not changed after leaving the Operating Room (OR) and were worn through the Post Anesthesia Care Unit (PACU) and back into OR
- Staff was wearing jewelry in the OR.

FINDINGS #1: An unannounced survey was conducted from 3/18/13 to 3/26/13. Patient records and policy and procedures were reviewed, patient and staff interviews were conducted, and patient care was observed.

Observations of patient care in the Emergency Department (ED), Pre-Op, Operating Room, PACU, and post operative (Post-Op) areas were conducted.

Infection control policies and standards of practice were not followed.

Infection control breaches were observed as follows:

A 36 year old female admitted to the facility for surgery on her right shoulder. Her care was observed in the pre-op and operative areas.

A pre-operative RN placed an IV in the patient's right hand. Without wiping them down, he then placed the tourniquet and tape he had used on a portable tray that held IV start supplies. The RN confirmed the tourniquet and tape were left in the tray for use on other patients, and the tray and contents were not disinfected between patients.

The certified registered nurse anesthetist (CRNA) was observed to administer medication into the IV tubing on two occasions without wiping the port with alcohol prior to administration. In addition, hand hygiene was not performed prior to the medication administration.

The CRNA was observed to pick up a medication filled syringe that had fallen to the floor. He placed the syringe back on the bedside table and used it during a nerve block procedure.

The CRNA picked up a trash can and relocated it closer to his work area. Hand hygiene was not performed after handling the trash can.

When the patient was in the OR, the CRNA was observed to lift up the IV port of the patient's IV tubing that was resting on the operating table and administer medication. The port was not wiped with alcohol prior to administration.

A sensor on the patient's forehead was changed, and in the process the cable that attached to the sensor fell to the floor. The CRNA picked up the cable and connected the cable to the sensor without wiping the cable with disinfectant, and without changing his gloves.

The Circulating RN, who had been assisting with patient positioning while wearing gloves, was observed to apply sterile gloves over her soiled gloves. She then proceeded to apply the skin prep to the patient's arm and shoulder prior to surgery.

The Surgical Services Nurse Manager who was assisting in the OR, was observed positioning the patient and cleaning up the OR environment. He removed the soiled gloves he was wearing and donned sterile gloves to assist the Circulating RN in completing the skin prep. Hand hygiene was not observed after the removal of the soiled gloves and prior to donning the sterile gloves.

The Circulating RN was observed to remove her sterile gloves and dispose of them. She then proceeded to assist with equipment set up, including adjusting cords and pedals on the floor. Following this she was observed to document information in the computer and then exited the OR to get additional supplies. Hand hygiene was not performed after removing gloves or after

touching the floor.

A 65 year old male was admitted to the ED with abdominal pain. His care was observed and infection control breaches were noted as follows:

The RN was observed to start an IV, then removed the gloves she was wearing. She reached into a cabinet to obtain a syringe pre-filled with normal saline and administered a portion of the saline into the IV. She was not observed to complete hand hygiene after removing gloves and before moving to the next task.

The RN started oxygen through a nasal cannula for the patient and administered IV medication. She took the syringe with some remaining medication she had just administered and walked across the hall to a locked door. A push button combination lock on the door was used to enter the room. The RN unlocked a cabinet, placed the syringe into the cabinet, locked the cabinet and returned to the ED exam room. Once in the room she handled the IV tubing and set up an IV pump for the infusion of fluids then charted on the computer. No hand hygiene was performed during that time.

Staff were noted to take a mask from the scrub sink area before entry into the OR and remove their masks upon leaving the OR.

The OR staff was not noted to be wearing jewelry before, during, or after the procedures observed.

Deficiencies were cited at 42 CFR Part 485.627(a), related to the failure of the facility to ensure policies regarding infection control measures were practiced.

CONCLUSION #1: Substantiated. A Federal deficiency related to the allegation was cited.

ALLEGATION #2: The facility did not ensure an arm band with patient information was placed on patients before procedures and medications were administered. Patients did not receive pain medications as ordered. A patient exhibited atrial fibrillation in the ED, and when admitted to the general nursing floor did not have cardiac monitoring. A patient who received Lasix and multiple liters of IV fluid, yet was unable to void, and nursing staff was unable to insert a urinary catheter. After multiple attempts to insert a urinary catheter, a patient was bleeding from his urethra. The patient was transferred to a facility for a higher level of care, and a nurse accompanied the patient, holding pressure on his penis to halt the bleeding during the transport.

FINDINGS #2: Patient medical records were reviewed and patient care was observed in the ED, pre-operative area, and on the general medical-surgical floor. Multiple procedures were observed, which included medication administration, starting of IV's, a nerve block, X-rays and a

Jeff Hill, Administrator

May 6, 2013

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surgical procedure. All patients that were observed were noted to have an identification band in place on their wrist before the procedures were initiated. In addition, the nursing staff was noted to question the patients verbally for name identification before the procedure.

Six patients were interviewed regarding nursing staff response to pain and symptom management. Patients responded that pain medications and anti-nausea medications were administered as needed. Patients verbalized that staff confirmed their identity prior to performing tests or administering medication. The patients stated they were included in the development of their plan of care.

One medical record reviewed was that of a patient that was admitted to the ED with abdominal pain. The patient was admitted to the medical-surgical floor with diagnoses that included chronic renal failure. The patient was admitted in the afternoon, and was transferred to a referral facility the next day as his condition required a higher level of care that could not be provided at the CAH. The patient was at the CAH a total of 23 hours before his transfer.

The ED record indicated the patient received 750 ml of IV fluid while in the ED. The Intake and Output record for the patient after he was admitted to the medical-surgical floor indicated he had 1,696 ml of IV fluid, for a total of 2,446 ml IV fluid in the 23 hours. During that time, the patient record indicated he voided once in the ED, and once during the night. The medical record documented orders to place a urinary catheter were written at 9:25 AM, and attempted once by a nurse. At 11:30 AM, after a second attempt by the NP to place a urinary catheter, an order was written for the patient to be transferred to a referral facility. The record indicated the patient was bleeding heavily from his urethra after the catheter insertion attempts. The NP documented in the patient's progress notes he was to be transferred to the care of a urologist for renal failure secondary to obstruction from the prostate. He was transported by emergency vehicle, accompanied by a registered nurse who had to maintain pressure on the penis to halt the bleeding.

The ED record by the physician who examined the patient documented his heart rate was normal and the rhythm was regular. There was no documentation by the ED physician that he had atrial fibrillation that would require cardiac monitoring on the medical floor.

After the patient was admitted to the referral facility, he was examined and a history and physical was performed and dictated. The H&P documented the patient was in atrial fibrillation, but had no prior history of atrial fibrillation, arrhythmias, hypertension or other cardiovascular disease. The patient medical record from the CAH did not indicate he was in atrial fibrillation.

While injury occurred to the patient's penis, it could not be verified that the injury was related to lack of competence on the part of CAH staff. The patient was appropriately transported to

another hospital with greater capability to meet his medical needs.

CONCLUSION #2: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: Staff was unqualified and worked out of their scope of practice as follows:

- Registered Nurses were working in PACU without ACLS or PALS certification,
- CST (Certified Surgical Technician) was working as a First Assist which was outside his scope of practice as a CST.

FINDINGS #3: Nursing schedules and OR schedules for four 24 hour periods were randomly selected to review staffing and staff qualifications regarding ACLS (Advanced Cardiac Life Support) and PALS (Pediatric Advanced Life Support) certification. Each shift reviewed had at least one RN working that held current certification for ACLS and PALS. A job description for Registered Nurse noted ACLS and PALS certification was required within one year of employment. Of the personnel files that were reviewed, the staff who were not certified had been employed for less than 12 months.

Seven surgical patient records and personnel files for 17 patient care providers were reviewed. One file was that of a Surgical Technician who was documented in a surgical record as working as a First Assistant during a procedure. A job description titled "Operating Room Technician" was in the file. The individual's personnel file also contained documentation of completion of a training program for First Assistant. There was no defined policy, job description, or evidence of credentials or privileges to indicate he was functioning within his scope of practice when he worked as First Assistant.

Deficiencies were cited at 42 CFR Part 485.627(a), related to the failure of the facility to ensure policies which defined the role of the Surgical Technician/First Assistant.

CONCLUSION #3: Substantiated. Federal deficiencies related to the allegation are cited.

ALLEGATION #4: Patient care concerns in the peri-operative area are as follows:

- CRNA did not remain with intubated PACU patients
- CRNA did not write orders for post op care for patients
- CRNA refused to start IV's for difficult to start patients
- Patients arrived in PACU with unsecured and/or infiltrated IV's
- Emergency carts not checked on a routine basis
- Oxygen tanks are not full and available for use in the Post-Op area
- PACU not stocked with necessary oxygen supplies such as nasal cannula or face masks
- Narcotics were not stored appropriately in the OR and PACU
- Narcotics were wasted without a witness

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- Patients in PACU were disturbed with surrounding activities of staff
- Pregnancy results were not obtained before surgery

FINDINGS #4: Observations and staff interviews were conducted during patient care in the ED, OR, and peri-operative areas. Two patients were noted to be extubated before they were moved from the OR to the PACU area. Orders were written by the CRNA before he left the PACU after giving report to the bedside nurse. The peri-operative and PACU areas had adequate oxygen supplies at the head of bed, as well as, in a mobile cart in the room. The oxygen tanks in the peri-operative and PACU areas, and were noted to have be full. The PACU area was quiet, the bedside nurse, physician, and CRNA spoke quietly, and there was no non-patient related activities. IV's were noted to be secured on all patients observed. A female patient refused the pregnancy test, signed a waiver, and the physician was notified before she was taken to the OR. Narcotic storage was in a double locked drawer in the PACU, there was no opportunity for observation of narcotic administration. The manager for the OR was interviewed, and confirmed one CRNA did not want to be contacted for difficult IV starts. He stated another CRNA was available and requested after the second attempt by a nurse that he be notified to come and start the IV.

CONCLUSION #4: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5: Patient privacy was not protected in the following examples: PACU staff contacted patients by phone before surgery, allowing recovering patients in the PACU to overhear confidential information discussed during the phone calls. The ED Computer was left with open patient information on the screen visible to patients and family when in the room.

FINDINGS #5: Patient care was observed in the ED, OR, PACU, and peri-operative areas. A nurse was observed to use the computer in the patient care area. The computer screen changed to an automatic screen saver upon 60 seconds of no activity. A nurse was interviewed, and stated when she used the computer, she would click the screen to the screen saver mode before she left the room. The computer screen would not be locked, but an individual would have to go to the computer and start pushing buttons. The nurse stated the supervision in the ED would make that opportunity unlikely. Patient information was not visible on the computer screen during the observation period. During the observation in the PACU, the bedside nurse, physician, and CRNA spoke quietly, and there was no non-patient related activities noted.

CONCLUSION #5: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #6: Electric cords were laying on the floor and walkways in the operating room.

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FINDINGS #6: Two operating rooms were observed on 3/20/13 during procedures. There were numerous pieces of electrical equipment, however, the proper electrical cords were used and were arranged in such a way as to be least invasive for foot traffic during surgery.

CONCLUSION #6: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #7: Medication was not administered according to Nursing Standards of Practice.

FINDINGS #7: An unannounced survey was conducted. During the investigation, observations were made in the ED, Pre-Op, OR, and Post-Op areas. Reviews were conducted of current and closed medical records, as well as policies and procedures related to medication administration.

Eighteen medical records were reviewed, including 7 specifically related to antibiotic administration.

One record documented a 52 year old male who was treated in the ED for diabetic foot ulcers. His diagnoses also included a history of kidney failure. Record review documented the administration of Vancomycin 1.5 gm infused over 54 minutes. In addition, Meropenem 2 gm was infusing through the same site. The patient was discharged home 13 minutes after the antibiotics had completed.

According to "Nursing 2013 DRUG HANDBOOK," Vancomycin in dosage greater than 1 gram must be infused over 90 minutes. The handbook advised caution for patients with impaired kidney function. The drug handbook listed Meropenem as incompatible with other intravenous drugs and should be used with caution for patients with impaired renal function which could also cause seizures or adverse CNS reactions.

The facility's policy "Medication Administration Policy and Procedure," dated 9/15/99 and reviewed 3/24/11, included "The nurse will monitor the patient's response to the first dose of a new medication."

During an interview on 3/21/13 beginning at 8:55 AM, the Pharmacy Director stated the recommendation for Vancomycin and Meropenem would be to administer first one then the other, and not both together. He stated the first dose of an antibiotic the patient should be monitored for at least 20 minutes after infusion was complete.

Observations of medication administration in the ED, Pre-Op, and OR were conducted. On multiple occasions medications were observed to be administered by the nursing staff into patients' IV tubing ports without wiping first with disinfectant.

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Deficiencies were cited at 485.635(d)(3) related to the failure of the facility to follow Nursing Standards of Practice as it related to medication administration.

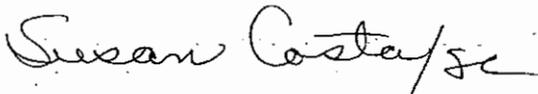
A related deficiency was cited at 42 CFR Part 485.627 (a), for the failure of the facility to ensure infection control policies related to medication administration were followed.

CONCLUSION #7: Substantiated. Federal 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,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/