



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

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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CERTIFIED MAIL: 7009 0820 0000 2807 2108

April 11, 2011

William Behnke, Administrator
Cascade Medical Center
PO Box 1330
Cascade, ID 83611

RE: Cascade Medical Center, Provider #131308

Dear Mr. Behnke:

Based on the survey completed at Cascade Medical Center, on March 31, 2011, by our staff, we have determined Cascade Medical Center, is out of compliance with the Medicare Hospital **Periodic Evaluation & QA Review (42 CFR 485.641)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused these conditions to be unmet, substantially limit the capacity of Cascade Medical Center, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

An acceptable Plan of Correction 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

William Behnke, Administrator

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for each deficiency cited;

- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of each form.

Such corrections must be achieved and compliance verified by this office, before May 15, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than May 7, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **April 21, 2011.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

SC/srm

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief

Kate Mitchell, CMS Region X Office

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131308	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/31/2011
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NAME OF PROVIDER OR SUPPLIER CASCADE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 402 OLD STATE HIGHWAY CASCADE, ID 83611
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B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the state licensure survey of your hospital. The surveyor conducting the licensure review was Gary Guiles, RN, HFS.</p> <p>Acronyms used in this report include:</p> <p>DON = Director of Nursing PA = Physician Assistant</p>	B 000	<p style="text-align: center;">RECEIVED APR 21 2011 FACILITY STANDARDS</p>	
BB115	<p>16.03.14.200.01 Governing Body and Administration</p> <p>200. GOVERNING BODY AND ADMINISTRATION.</p> <p>There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88)</p> <p>01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88)</p> <p>a. Membership of Governing Body, which consist of: (12-31-91)</p> <p>i. Basis of selecting members, term of office, and duties; and. (10-14-88)</p> <p>ii. Designation of officers, terms of office, and duties. (10-14-88)</p> <p>b. Meetings, (12-31-91)</p> <p>i. Specify frequency of meetings. (10-14-88)</p>	BB115	<p>BB115 – CMC’s Administration Policy for Medical Oversight regarding Midlevel Admissions (attachment R) states that patients admitted by midlevel providers will be provided medical oversight and chart review. All future inpatient admissions to CMC by a midlevel will be seen by a physician to ensure medical oversight. The CMC Medical Staff was updated and trained on the policy at the Medical Staff meeting on 04/20/11. The DON and Medical Records clerk will monitor inpatient charts to ensure that appropriate medical oversight has occurred for all inpatients.</p>	<p>04/20/11</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *CEO*

(X6) DATE: 04/20/2011

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BB115	Continued From page 1 ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants,	BB115		

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BB115	<p>Continued From page 2</p> <p>appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88)</p> <p>v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88)</p> <p>vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88)</p> <p>e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88)</p> <p>f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88)</p> <p>g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88)</p> <p>h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88)</p> <p>i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88)</p> <p>j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88)</p>	BB115		

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BB115	<p>Continued From page 3</p> <p>k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88)</p> <p>i. Bylaws shall be dated and signed by the current governing body. (10-14-88)</p> <p>m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure 2 of 10 inpatients (#2 and #9), whose records were reviewed, were under the care of a physician. This resulted in a lack of physician oversight for patient care. Findings include:</p> <p>1. Patient #9's medical record documented a 56 year old male who was admitted to the CAH on 2/08/11 for "unfortunate social situation" and congestive heart failure. He was transferred to swing bed status on 2/09/11. He was discharged to home on 2/10/11. The admitting History and Physical, dated 2/08/11, was written by the PA. Past medical history included quadriplegia and bilateral below the knee amputations. The History and Physical stated "the patient, most recently, was Air-evacuated to [a regional hospital] where he was treated for severe decubitus ulcers with overlying pseudomonas infection. It should be noted that the patient's wife informed nursing on his arrival this afternoon that she stopped the Levaquin [an antibiotic] after discharge from [the regional hospital] which was supposed to continue for two more weeks</p>	BB115		

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BB115	<p>Continued From page 4</p> <p>because she 'felt that it caused urinary retention...' The patient also, at that time, had a Klebsiella and e-coli urinary infection." The History and Physical stated Patient #9 had "...large decubitus primarily in the left lateral thigh and buttock area." No specific description of the ulcers was documented. The PA wrote orders to treat the decubitus ulcers on 2/09/11 at 11:26 AM. Again there was no note that he had examined the ulcers. Progress notes on 2/08/11 and on 2/09/11 were written by the PA. The Discharge Summary, dated 3/07/11, was written by the PA. All orders were written by the PA. A physician completed an "INPATIENT QUALITY & UTILIZATION WORKSHEET" which was dated 3/15/11. In addition, all of the orders were co-signed by a physician on 3/15/11. No evidence was present in the medical record to demonstrate Patient #9, a medically complex patient, was under the care of a physician.</p> <p>The PA who cared for Patient #9 was interviewed on 3/30/11 at 9:10 AM. He stated he did not examine Patient #9's decubitus ulcers. He also stated a physician was not involved with the care of patient #9.</p> <p>Patient #9 was not under the care of a physician.</p> <p>2. Patient #2's medical record documented a 51 year old male who was admitted to the CAH on 2/02/11 for pneumonia. He was discharged on 2/04/11. The admitting History and Physical, dated 2/02/11, was written by a PA. The Discharge Summary, dated 2/04/11, was written by the PA. All orders were written by a PA. A physician completed an "INPATIENT QUALITY & UTILIZATION WORKSHEET," which was dated 3/01/11. In addition, all of the orders were co-signed by a physician, but the date of the</p>	BB115		

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BB115	Continued From page 5 co-signatures was not documented. No evidence was present in the medical record to demonstrate Patient #2 was under the care of a physician. The Chief of Staff was interviewed on 3/29/11. He stated he was the only physician practicing at the hospital in 2011, except for a physician who covered the emergency room 1 weekend a month. He stated he had not been involved in the care of Patient #2. Patient #2 was not under the care of a physician.	BB115		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of policies and administrative documents, it was determined the hospital failed to ensure a quality improvement program had been developed and maintained. This resulted in the inability of the CAH to identify and correct care related issues. Findings include: Refer to C330 as it relates to the lack an ongoing quality improvement program.	BB124	BB124 – The PI Policy (attachment H) was completed and presented to the CEO on 04/01/11, approved by the CMC Board on 04/18/11, and approved by the CMC Medical Staff on 04/20/11. The Annual Review of Departments and Services Report (attachment I) was completed on 04/04/11 and approved by the Board on 04/18/11. The Annual Review will be completed by all departments by 12/15/11 to reflect the PI projects that each department is currently engaged in. The DON will present quarterly reports to the Medical Staff and CMC Board and the annual report to each entity by March of every year to reflect the quality of the CAH's total program.	04/20/11
BB261	16.03.14.350.09 Blood and Blood Products	BB261	The PI Policy states that the Board of Trustees has ultimate responsibility for	

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BB261	Continued From page 6 09. Blood and Blood Products. Facilities for procurement, proper storage, and transfusion of blood and products shall be readily available. The blood program shall include at least the following: (10-14-88) a. A means of acquiring blood for emergencies; and (10-14-88) b. Written agreement on blood supply by outside resource; and (10-14-88) c. A written procedure for prompt typing and crossmatching, and transfusion reaction investigation; and (10-14-88) d. Blood storage shall be in a refrigerator with a recording thermometer and audible and visual alarms for temperature variance. There shall also be a mercury thermometer inside, and temperatures recorded daily; and (10-14-88) e. Records shall be kept of receipt and disposition of all blood; and (10-14-88) f. Samples of each unit of blood shall be kept seven (7) days in the event of a reaction; and (10-14-88) g. The medical staff or an appropriate committee shall review all transfusions, all reactions, and is responsible for establishing policies and procedures for the blood service. (10-14-88) This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the hospital failed to ensure a procedure for typing and crossmatching of blood had been implemented. This resulted in the	BB261 BB124 CONT.	the quality of patient care and will evaluate the effectiveness of the total quality program. The new Plan/Do/Study/Act (PDSA) worksheet (attachment J) was completed on 04/06/11 and distributed to patient care departments for initial review by the CMC Board on 04/18/11. Performance Measurement Quality Indicators (attachment K) were distributed and discussed with department heads the same week. The patient activities will include a sample of both active and closed clinical records as stated in the objectives and goals of the PI Plan (attachment H). Records may be randomly or specifically selected for review. The PDSA worksheets will assist departments in improving the quality of patient care delivery and assist the DON in comprehensively reporting outcomes to the Medical Staff and CMC Board at least quarterly. The DON will use the worksheets to monitor quality improvements and report to the Medical Staff and CMC Board at least quarterly. The PI Plan states that an annual review/revision of policies and procedures will be conducted. On the		

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BB261	Continued From page 7 inability of the hospital to type and crossmatch blood for patients. Findings include: On 3/31/11 at 1:30 PM, a tour of the laboratory was conducted with the Laboratory Manager. She pointed out a refrigerator used to store blood. The refrigerator contained 4 units of O negative blood. The Manager stated the hospital only stored O negative blood because the laboratory did not have the capability to type and crossmatch blood. She stated the hospital only performed emergency blood transfusions with O negative blood and then transferred patients to hospitals with more complex laboratories for further care. The hospital did not have a procedure in place to type and crossmatch blood.	BB261 BB 124 CONT. BB261	Annual Review of Departments and Services report form, each department or patient care area will include any new policy additions and whether or not all of the department policies are current (#8 on page 3 of the report form, Attachment I). This will be reported to the Medical Staff and CMC Board by March of each year to reflect the previous calendar year improvements. BB261 – CMC is currently requesting quotes for Type and Cross Match capability for our laboratory. The Lab Manager will implement Policies and Procedures to reflect the usage of the machine that CMC purchases. The CEO is responsible for approving the purchase of new equipment following Board approval of budgetary spending.	10/2011
BB316	16.03.14.380.03 Policies and Procedures 03. Policies and Procedures. Written policies and procedures concerning surgical service shall be approved by the medical staff, appropriate nursing staff and the administration. They shall include, but not be limited to, the following: (10-14-88) a. Specific delineation of surgical privileges shall be made for each physician or practitioner performing surgery. Privileges for each physician shall be available to the operating room supervisor; and (10-14-88) b. A policy and procedure for all persons admitted for surgery, and shall include the following: (10-14-88) i. Verification of patient identity; and (10-14-88)	BB316		

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BB316	Continued From page 8 ii. Site and side of body to be operated upon; and (10-14-88) c. Written procedures for infection control including aseptic techniques for patients and personnel during preoperative, operative and postoperative periods in the surgery suite; and (10-14-88) d. When appropriate, a procedure for accountability of all instruments, sponges, needles used in surgery; and (10-14-88) e. A procedure for the safe handling and transportation of patients. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records and credentials files, it was determined the hospital failed to ensure surgical privileges were delineated for 3 of 5 practitioners (Staff A, B, and C), who performed surgical procedures. This prevented the hospital from ensuring the practitioners were qualified to perform those procedures. Findings include: Refer to C321 as it relates to the lack of privileges granted to providers.	BB316	BB316 – The “Procedures Request for Privileges” form (attachment G) has been updated to include Toenail Removal and Endoscopy Procedures. Following consultation with our Medical Director, SI Joint Injections will not be added to the privileges. Therefore, providers will not be permitted to perform the procedure. The updated privilege form was presented to and approved by the CMC Board on 04/18/11 and approved by the CMC Medical Staff on 04/20/11. Following the meetings, Jamey McNally’s file now contains an updated privilege form. Dr. Bedell’s privilege form will be updated upon his return from sabbatical July 1 st , 2011. Credentialing and Privileging are maintained by our Medical Records clerk.	04/20/11
BB317	16.03.14.380.04 Records 04. Records. Prior to surgery patient records shall contain the following: (10-14-88) a. A properly executed informed consent; and (10-14-88) b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight	BB317		

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BB317	Continued From page 9 (48) hours after admission; and (5-3-03) c. Appropriate screening tests, based on patient needs, completed and recorded prior to surgery. (10-14-88) d. Record requirements may be modified in emergency surgery cases to the extent necessary under the circumstances. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure medical history and physical examinations were performed prior to surgery for 3 of 3 patients (#12, #13, and #14) who had colonoscopies performed and whose medical records were reviewed. This prevented staff from ruling out a medical condition that could interfere with the procedure or patients' recovery. Findings include: 1. Patient #12's medical record documented a 60 year old male who had a colonoscopy performed on 11/15/10. A history and physical examination was not documented in his medical record. The DON reviewed Patient #12's medical record on 3/30/11 at 11:45 AM. She confirmed a history and physical examination was not present in the record. A history and physical examination was not performed prior to the procedure. 2. Patient #13's medical record documented a 66 year old male who had a colonoscopy performed on 12/21/10. A history and physical examination was not documented in his medical record.	BB317	BB317 – CMC has one provider who performs endoscopy procedures. [REDACTED] is currently on a six month sabbatical in [REDACTED] working as a physician. His contract resumes upon his return on July 1 st , 2011. At that time, [REDACTED] will be updated and trained on the necessity to have a medical history and record of physical examination performed and recorded no more than seven days before the endoscopy procedure. The DON is responsible for ensuring that [REDACTED] is trained and updated on the procedure.	07/20/11

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BB317	Continued From page 10 The DON reviewed Patient #13's medical record on 3/30/11 at 11:45 AM. She confirmed a history and physical examination was not present in the record. A history and physical examination was not performed prior to the procedure. 3. Patient #14's medical record documented a 58 year old female who had a colonoscopy performed on 12/16/10. A history and physical examination was not documented in her medical record. The DON reviewed Patient #14's medical record on 3/30/11 at 11:45 AM. She confirmed a history and physical examination was not present in the record. A history and physical examination was not performed prior to the procedure.	BB317		
BB538	16.03.14.540.01 Infection Control Committee 540. INFECTION CONTROL. The hospital shall develop a plan for the prevention and control of infection with special emphasis on hospital acquired infection. (10-14-88) 01. Infection Control Committee. The hospital shall establish an infection control committee composed of representatives of the medical staff, administration, nursing service, pharmacy services and laboratory. Other appropriate department heads shall be members as needed. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of policies, it	BB538	BB538 and BB539 – (attachment A Infection Control Policies and Procedures Table of Contents) The Infection Control (IC) Program Policy (attachment B) was updated to include an IC Surveillance Plan performed by the IC Committee and reported monthly to the CMC Medical Staff including a yearly report in January of each year. The DON is responsible for the IC reporting process. The procedure also defined the IC Committee's goals for the surveillance	04/20/11

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BB538	Continued From page 11 was determined the hospital failed to ensure an Infection Control Committee had been established. This resulted in a lack of guidance to staff in the control of infections. Findings include: Refer to C278 as it relates to the lack of an Infection Control committee.	BB538	and prevention of Hospital Acquired Conditions (HAC's), education, monitoring the environment to prevent HAC's, reviewing existing policies and implementing new policies and procedures. The IC Committee is composed of a physician, the Director of Nursing (DON), the Infection Control Officer (ICO), the Pharmacist, the Lab Supervisor, the CEO and members of the Medical Staff.	
BB539	16.03.14.540.02 Infection Control Program 02. Infection Control Program. The program shall include at least the following elements: (10-14-88) a. Definition of nosocomial infection, as opposed to community acquired infections; and (10-14-88) b. A procedure for hospital surveillance of and for nosocomial infections; and (10-14-88) c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: (10-14-88) i. Level or rate of nosocomial infections; and (10-14-88) ii. Site of infection; and (10-14-88) iii. Microorganism involved. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of policies, it was determined the hospital failed to ensure nosocomial infections had been defined. The hospital also failed to develop a procedure for surveillance of infections. This resulted in a lack of guidance to staff in the control of infections.	BB539	The Surveillance Program Policy (Attachment C) addresses the surveillance, education and consultation pieces of the IC Program and defines the process for reporting HAC's. All inpatient charts contain a Patient Nosocomial/Community Acquired Report Form (Attachment D) for tracking HAC's and Community Acquired Conditions. Following the survey the form was revised to include the "Microorganism involved in infection" to aid in identifying specific microorganism recurrences. A monthly Facility IC Report is filed by the ICO (attachment E). The CDC definition of Nosocomial Infections (attachment F) is present in the IC Policy and Procedure manual as well as in the Nosocomial reporting file folder.	

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BB539	Continued From page 12 Findings include: Refer to C278 as it relates to the lack of definition of nosocomial infection and the lack of surveillance procedures.	BB539	04/20/11 – Please also refer to the Medical Staff Agenda for the meeting held at 0800. The Performance Improvement Committee met and reviewed new PDSA initiatives for all patient care departments and gave final approval of the new PI Policy. The Infection Control Committee met to review the IC policy and monthly IC report. ██████████ privileges were approved, signed and are present in his credentialing file.	

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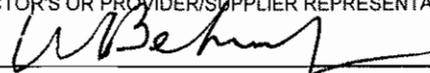
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C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your critical access hospital. The surveyor conducting the recertification was Gary Guiles, RN, HFS. Acronyms used in this report include: CAH = Critical Access Hospital DON = Director of Nursing IC = Infection Control mg = milligram PA = Physician Assistant	C 000		
C 241	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL 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. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, CAH policies, and credentials files, it was determined the CAH's governing body failed to ensure systems vital to the operation of the CAH had been developed, implemented, and monitored. This resulted in a lack of guidance and oversight of the CAH's operation. Findings include: 1. The governing body did not ensure medical services would be provided to Swing bed patients in accordance with the CAH's policy.	C 241	C241 – Cascade Medical Center (CMC) currently has one Intermediate Swing Bed (Private Pay) patient. She is scheduled for monthly visits with our physician during the first week of every month. The DON is responsible for ensuring that monthly visits occur for all Intermediate Swing Bed patients, as well as bi-weekly visits for Skilled Swing Bed patients. The nursing staff will be trained and updated on the policy during the April Nursing Staff meeting.	04/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CEO	(X6) DATE 04/20/2011
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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 The policy "SWING BEDS," not dated, stated "The patient will be visited by a medical provider at least twice weekly while in skilled swing bed status, and at least once a month, or as condition necessitates, while in unskilled swing bed status." This policy had not been followed. The plan to provide routine medical supervision of swing bed patients had not been implemented. Patient #1's medical record documented a 92 year old female who was admitted to the CAH as a swing bed patient on 5/21/10. She was currently a patient as of 3/30/11. Her primary diagnosis was breast cancer with metastasis. The medical record did not specify if Patient #1 was in skilled or unskilled swing bed status. Her history and physical examination was performed by the PA on 5/21/11. A physician documented a general examination of Patient #1 on 5/25/11, 8/04/11, and 10/04/10. The record documented she was seen again on 3/06/10 and 3/08/10 by a PA because of complaints of ear pain. No other examinations were documented. No general examinations were documented over a 5 month period, from 10/04/10 through 3/29/11. The Chief of Staff was interviewed on 3/29/11 at 4:05 PM. He stated, if the nurses asked a practitioner to see Patient #1 for a medical problem, she would be seen promptly. However, he said there was no plan to see Patient #1 on a routine basis The hospital did not implement a system to ensure swing bed patients were examined by a practitioner on a routine basis. 2. The CAH failed to ensure systems to identify	C 241			

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C 241	Continued From page 2 and investigate infections had been clearly defined and implemented. Refer to C278 as it relates to the lack of a comprehensive program to identify and investigate infections. 3. The CAH failed to ensure practitioners who performed surgical procedures had been granted privileges by the hospital board for those procedures. Refer to C321 as it relates to the lack of complete privileges granted to practitioners. 4. The CAH failed to ensure a comprehensive quality assurance program had been developed and implemented. Refer to C330 as it relates to the lack of a program to measure the CAH's performance.	C 241			
C 278	The governing body did not ensure critical systems had been developed and implemented. 485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on staff interview and review of policies, it was determined the CAH failed to ensure systems to identify and investigate infections had been clearly defined and implemented. This resulted in a lack of guidance to staff directing them as to how to control infections. Findings include: The "INFECTION CONTROL PLAN," not dated,	C 278	C278 – (attachment A Infection Control Policies and Procedures Table of Contents) The Infection Control (IC) Program Policy (attachment B) was updated to include an IC Surveillance Plan performed by the IC Committee and reported monthly to the CMC Medical Staff including a yearly report in January of each year. The DON is responsible for the IC reporting process. The procedure also defined the IC Committee's goals for the surveillance and prevention of Hospital Acquired Conditions (HAC's), education,	04/20/11	

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C 278	Continued From page 3 did not specify a committee or other group who was responsible for controlling infections at the CAH. The plan did not specify a method for surveillance of infections. Also, the plan did not include a definition of nosocomial or hospital acquired infections. The IC Officer was interviewed on 3/31/11 beginning at 12:55 PM. She stated the CAH did not have an IC committee or other designated group to provide guidance for the IC program. She stated the Medical Staff reviewed IC data but she said they did not provide policy direction for staff. She stated no group approved things like procedures to clean surfaces and equipment or procedures to maintain a sanitary environment. She stated she and another Registered Nurse provided surveillance activities for the CAH but she said an official procedure for surveillance of infections had not been developed. Finally, she stated the hospital had not adopted an official definition of nosocomial (hospital acquired) infections. The hospital had not developed a complete IC program.	C 278	monitoring the environment to prevent HAC's, reviewing existing policies and implementing new policies and procedures. The IC Committee is composed of a physician, the Director of Nursing (DON), the Infection Control Officer (ICO), the Pharmacist, the Lab Supervisor, the CEO and members of the Medical Staff. The Surveillance Program Policy (Attachment C) addresses the surveillance, education and consultation pieces of the IC Program and defines the process for reporting HAC's. All inpatient charts contain a Patient Nosocomial/Community Acquired Report Form (Attachment D) for tracking HAC's and Community Acquired Conditions. Following the survey the form was revised to include the "Microorganism involved in infection" to aid in identifying specific microorganism recurrences. A monthly Facility IC Report is filed by the ICO (attachment E). The CDC definition of Nosocomial Infections (attachment F) is present in the IC Policy and Procedure manual as well as in the Nosocomial reporting file folder.		
C 321	485.639(a) DESIGNATION OF QUALIFIED PRACTITIONERS The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by (1) a doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act;	C 321			

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C 321	<p>Continued From page 4</p> <p>(2) a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine; or</p> <p>(3) a doctor of podiatric medicine.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and credentials files, it was determined the CAH failed to ensure 3 of 5 practitioners (Staff A, B, and C), who performed surgical procedures, had been granted privileges by the hospital board for those procedures. This prevented the CAH from ensuring the practitioners were qualified to perform those procedures. Findings include:</p> <p>1. The CAH allowed Practitioner A to perform colonoscopies without current privileges.</p> <p>Medical records documented Patient #12, a 60 year old male, had a colonoscopy performed by Staff A on 11/15/10. Medical records documented Patient #13, a 66 year old male, had a colonoscopy performed by Staff A on 12/21/10. Medical records also documented Patient #14, a 58 year old female, had a colonoscopy with polypectomy performed by Staff A on 12/16/10.</p> <p>Staff A's privilege list, approved by the hospital board on 2/17/10, did not include colonoscopy in his list of privileges. Hospital board meeting minutes, dated 8/09/06, stated Staff A was granted temporary privileges at that time for "endoscopy procedures." A specific list of those procedures was not included. No privileges to perform endoscopic procedures were granted to Staff A when he was reappointed to the Medical Staff in 2008 and 2010.</p>	C 321	<p>C321 – The "Procedures Request for Privileges" form (attachment G) has been updated to include Toenail Removal and Endoscopy Procedures. Following consultation with our Medical Director, SI Joint Injections will not be added to the privileges. Therefore, providers will not be permitted to perform the procedure. The updated privilege form was presented to and approved by the CMC Board on 04/18/11 and approved by the CMC Medical Staff on 04/20/11. Following the meetings, [REDACTED] file now contains an updated privilege form. [REDACTED] privilege form will be updated upon his return from sabbatical July 1st, 2011. Credentialing and Privileging are maintained by our Medical Records clerk.</p>	04/20/11	

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C 321	<p>Continued From page 5</p> <p>The Director of Medical Records, who also maintained the practitioner credentials files, was interviewed on 3/29/11 at 3:10 PM. She confirmed privileges for colonoscopy had not been granted to Staff A.</p> <p>Staff A performed colonoscopies without privileges.</p> <p>2. Patient #11's medical record documented a 53 year old female who had a sacroiliac joint injection, a pain procedure, on 3/19/11. This was performed by Staff B.</p> <p>Staff B's privilege list, approved by the hospital board on 2/17/10, did not include sacroiliac joint injections in his list of privileges.</p> <p>The Director of Medical Records was interviewed on 3/29/11 at 3:10 PM. She confirmed privileges for sacroiliac joint injections had not been granted to Staff B.</p> <p>Staff B performed a sacroiliac joint injection without privileges.</p> <p>3. Patient #1's medical record documented a 92 year old female who had the toe nail removed from the big toe of her left foot on 12/29/10. This was performed by Staff C.</p> <p>Staff C's privilege list, approved by the hospital board on 9/15/10, did not include toe nail removal in his list of privileges.</p> <p>The Director of Medical Records was interviewed on 3/29/11 at 3:10 PM. She confirmed privileges for toe nail removal had not been granted to Staff C.</p>	C 321		

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C 321	Continued From page 6	C 321		
C 330	<p>Staff C performed performed a toenail removal without privileges.</p> <p>485.641 PERIODIC EVALUATION & QA REVIEW</p> <p>Periodic Evaluation and Quality Assurance Review</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of hospital policies, administrative documents, and governing body meeting minutes, it was determined the CAH failed to ensure a periodic evaluation and quality assurance program had been developed and implemented. This resulted in the inability of the CAH to identify and correct care related issues. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to C331 as it relates to the failure of the CAH to ensure a periodic evaluation of its total program was carried out. 2. Refer to C332 as it relates to the failure of the CAH to ensure a periodic evaluation of its total program, including the utilization of CAH services, was carried out. 3. Refer to C333 as it relates to the failure of the CAH to ensure a periodic evaluation of its total program, including a sample of both active and closed clinical records, was carried out. 4. Refer to C334 as it relates to the failure of the CAH to ensure a periodic evaluation of its total program, including the CAH's health care policies, 	C 330	C330 – See C331 through C337 addressing each deficiency	04/20/11

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C 330	Continued From page 7 was carried out.	C 330		
C 331	<p>5. Refer to C336 as it relates to the failure of the CAH to ensure an effective quality assurance program had been developed and implemented.</p> <p>6. Refer to C337 as it relates to the failure of the CAH to ensure an effective quality assurance program to evaluate the quality and appropriateness of treatment furnished in the CAH, including all patient care services and other services affecting patient health and safety, were evaluated.</p> <p>The cumulative effect of these negative systemic practices resulted in the inability of the CAH to evaluate the care provided.</p> <p>485.641(a)(1) PERIODIC EVALUATION</p> <p>The CAH carries out or arranges for a periodic evaluation of its total program. The evaluation is done at least once a year and includes review of--</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and Governing Body Meeting minutes, it was determined the CAH failed to ensure a periodic evaluation of its total program was carried out. This prevented the CAH from assessing its programs and services in order to make improvements. Findings include:</p> <p>An evaluation of the CAH's total program was not documented in Governing Body Meeting minutes between 4/01/10 and 3/30/11.</p> <p>The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the</p>	C 331	<p>C331 – The PI Policy (attachment H) was completed and presented to the CEO on 04/01/11, approved by the CMC Board on 04/18/11, and approved by the CMC Medical Staff on 04/20/11. The Annual Review of Departments and Services Report (attachment I) was completed on 04/04/11 and approved by the Board on 04/18/11. The Annual Review will be completed by all departments by 12/15/11 to reflect the PI projects that each department is currently engaged in. The DON will present quarterly reports to the Medical Staff and CMC Board and the annual report to each entity by March of every year to reflect the quality of the CAH's total program. The PI Policy states that the Board of Trustees has ultimate responsibility for the quality of patient care and will evaluate the effectiveness of the total quality program.</p>	04/20/11

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C 331	Continued From page 8 quality assurance program at the CAH. She stated an evaluation of the CAH's total program had not been completed in the past year. She also said a policy outlining how such an evaluation would be performed, including what items would be measured, had not been developed.	C 331		
C 332	<p>The CAH did not conduct an evaluation of its total program.</p> <p>485.641(a)(1)(i) PERIODIC EVALUATION</p> <p>[The evaluation is done at least once a year and includes review of--]</p> <p>the utilization of CAH services, including at least the number of patients served and the volume of services.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure a periodic evaluation of its total program, including the utilization of CAH services, was carried out. This prevented the CAH from assessing its programs and services in order to make improvements. Findings include:</p> <p>An evaluation of the CAH's total program, including the utilization of CAH services, was not documented between 4/01/10 and 3/30/11.</p> <p>The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the quality assurance program at the CAH. She stated an evaluation of the CAH's total program,</p>	C 332	<p>C332 – The new Plan/Do/Study/Act (PDSA) worksheet (attachment J) was completed on 04/06/11 and distributed to patient care departments for initial review by the CMC Board on 04/18/11. Performance Measurement Quality Indicators (attachment K) were distributed and discussed with department heads the same week and may serve as examples for each department. The DON will use the worksheets to monitor quality improvements and report to the Medical Staff and CMC Board at least quarterly.</p>	04/20/11

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C 332	Continued From page 9 including the utilization of CAH services, had not been completed in the past year. She also said a policy outlining how such an evaluation would be performed, including a method to evaluate the utilization of CAH services, had not been developed.	C 332			
C 333	485.641(a)(1)(ii) PERIODIC EVALUATION [The evaluation is done at least once a year and includes review of--] a representative sample of both active and closed clinical records. This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure a periodic evaluation of its total program, including a sample of both active and closed clinical records, was carried out. This prevented the CAH from assessing its programs and services in order to make improvements. Findings include: An evaluation of the CAH's total program, including a sample of both active and closed clinical records, was not documented between 4/01/10 and 3/30/11. The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the quality assurance program at the CAH. She stated an evaluation of the CAH's total program, including a sample of both active and closed	C 333	C333 – The DON will participate with departments in education and development of the PDSA worksheets (attachment J). The patient activities will include a sample of both active and closed clinical records as stated in the objective sand goals of the PI Plan (attachment H). Records may be randomly or specifically selected for review. The PDSA worksheets will assist departments in improving the quality of patient care delivery and assist the DON in comprehensively reporting outcomes to the Medical Staff and CMC Board at least quarterly.	04/20/11	

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C 333	Continued From page 10 clinical records, had not been completed in the past year. She also said a policy outlining how such an evaluation would be performed, including a method to review both active and closed clinical records, had not been developed. The CAH did not conduct an evaluation of its total program, including a sample of both active and closed clinical records.	C 333			
C 334	485.641(a)(1)(iii) PERIODIC EVALUATION [The evaluation is done at least once a year and includes review of--] the CAH's health care policies. This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure a periodic evaluation of its total program, including the CAH's health care policies, was carried out. This prevented the CAH from assessing its programs and services in order to make improvements. Findings include: An evaluation of the CAH's total program, including the CAH's health care policies, was not documented between 4/01/10 and 3/30/11. The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the quality assurance program at the CAH. She stated an evaluation of the CAH's total program, including the CAH's health care policies, had not been completed in the past year. She also said a	C 334	C334 – The PI Plan states that an annual review/revision of policies and procedures will be conducted. On the Annual Review of Departments and Services report form, each department or patient care area will include any new policy additions and whether or not all of the department policies are current (#8 on page 3 of the report form, Attachment I). This will be reported to the Medical Staff and CMC Board by March of each year to reflect the previous calendar year improvements.	04/20/11	

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C 334	Continued From page 11 policy outlining how such an evaluation would be performed, including a method to review the CAH's health care policies, had not been developed.	C 334			
C 336	The CAH did not conduct an evaluation of its total program, including the CAH's health care policies. 485.641(b) QUALITY ASSURANCE The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure a quality assurance program to evaluate the quality and appropriateness of treatment furnished in the CAH had been developed and implemented. This prevented the CAH from assessing its services in order to make improvements. Findings include: Evidence of a quality assurance program to evaluate the quality and appropriateness of treatment furnished in the CAH was not documented between 4/01/10 and 3/30/11. The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the quality assurance program at the CAH. She stated a quality assurance program to evaluate the quality and appropriateness of treatment furnished in the CAH had not been conducted in the past year. She also said a policy outlining a	C 336	C336 – The PI Policy (attachment H) was completed and presented to the CEO on 04/01/11, approved by the CMC Board on 04/18/11, and approved by the CMC Medical Staff on 04/20/11. The Annual Review of Departments and Services Report (attachment I) was completed on 04/04/11 and approved by the Board on 04/18/11. The Annual Review will be completed by all departments by 12/15/11 to reflect their PI projects that each department is currently engaged in. The DON will present the annual report to the Medical Staff and CMC Board by March of each year to reflect the quality of the CAH's total program. The PI Policy states that the Board of Trustees has ultimate responsibility for the quality of patient care and will evaluate the effectiveness of the total quality program.	04/20/11	

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C 336	Continued From page 12 quality assurance program had not been developed.	C 336			
C 337	<p>The CAH did not develop and implement a quality assurance program.</p> <p>485.641(b)(1) QUALITY ASSURANCE</p> <p>The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that-</p> <p>all patient care services and other services affecting patient health and safety are evaluated.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of CAH policies and administrative documents, it was determined the CAH failed to ensure an effective quality assurance program to evaluate the quality and appropriateness of treatment furnished in the CAH, including all patient care services and other services affecting patient health and safety, were evaluated. This prevented the CAH from assessing its services in order to make improvements. Findings include:</p> <p>Evidence of a quality assurance program, including quality indicators to assess all patient care services and other services affecting patient health and safety, was not documented between 4/01/10 and 3/30/11.</p> <p>The DON was interviewed on 3/31/11 at 12:55 PM. She stated she was responsible for the quality assurance program at the CAH. She</p>	C 337	<p>C337 – The DON will participate with departments in education and development of the PDSA worksheets (attachment J). The patient activities will include a sample of both active and closed clinical records as stated in the objectives and goals of the PI Plan (attachment H). Records may be randomly or specifically selected for review. The PDSA worksheets will assist departments in improving the quality of patient care delivery and assist the DON in comprehensively reporting outcomes to the Medical Staff and CMC Board at least quarterly.</p>	04/20/11	

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C 337	Continued From page 13 stated a quality assurance program, including quality indicators to assess all patient care services and other services affecting patient health and safety, had not been developed and implemented in the past year. She also said a policy outlining how such a quality assurance program would be implemented had not been developed. The CAH did not develop a quality assurance program, including quality indicators to assess all patient care services and other services affecting patient health and safety.	C 337		
C 385	485.645(d)(4) PATIENT ACTIVITIES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. Quality of Life - activities (§483.15(f)) "(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who-	C 385	C385 – The Swing Bed residents Activities Program Policy (attachment L) was reviewed. A C.N.A. with seven years experience as an Activities Director was identified and a new Activities Plan was implemented. The C.N.A. and the DON will work in conjunction with our Physical Therapist to provide an appropriate activity plan for all Swing Bed admissions. The Activity Plan of Care (attachment M) will be present in all Swing Bed charts upon admission and the Swing Bed Activity Progress Notes (attachment N) will be updated at a minimum of every week. R.N.'s, C.N.A.'s and the Physical Therapy Department have been trained to update the progress notes with any changes in activity or as the Swing Bed patient's health improves or declines to affect their activity. Also attached is the current Swing Bed patient's initial activity plan (attachment O) after implementation to improve documentation of her plan for activities.	04/20/11

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C 385	<p>Continued From page 14</p> <p>(i) Is a qualified therapeutic recreation specialist or an activities professional who-</p> <p>(A) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or</p> <p>(iii) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(iv) Has completed a training course approved by the State."</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure a program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being for 1 of 1 current swing bed patient (#1). This resulted in a lack of direction to staff to assist them to provide activities. Findings include:</p> <p>The CAH had 1 swing bed patient in residence during the survey. Patient #1's medical record documented a 92 year old female who was</p>	C 385		

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C 385	Continued From page 15 admitted to the CAH as a swing bed patient on 5/21/10 and was currently a patient as of 3/30/11. Her primary diagnosis was breast cancer with metastasis. An activities assessment and a plan for activities was not documented in her medical record. The DON, who also served as the Activities Director, was interviewed on 3/29/11 at 1:10 PM. She reviewed the medical record. She confirmed an activities assessment had not been conducted and a plan for activities had not been developed. The CAH did not provide an activities program for Patient #1.	C 385			
C 388	485.645(d)(6) RESIDENT ASSESSMENT [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Comprehensive assessment, comprehensive care plan, and discharge planning (§483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Comprehensive Assessments (§483.20(b)(1)) "A facility must make a comprehensive assessment of a resident's needs ...The assessment must include at least the following: (i) Identification and demographic information. (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	C 388	C388 – This deficiency was reviewed with our M.S.W. She agrees that the psychosocial assessment was not completed for our current Swing Bed patient. She has implemented her PI PDSA worksheet and plans to monitor current, future and closed Swing Bed charts to ensure the completion of a psychosocial evaluation and to improve the quality of our patient's stay. Please see attachment P and Q for Swing Bed Social Services.	04/20/11	

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C 388	<p>Continued From page 16</p> <ul style="list-style-type: none"> (vi) Mood and behavior patterns. (vii) Psychosocial well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge potential. (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols. (xviii) Documentation of participation in assessment. <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts."</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure assessments of psychosocial well-being and activity pursuit had been conducted for 1 of 1 current swing bed patient (#1). This prevented the staff from developing a plan to address psychosocial and activity needs. Findings include:</p> <p>The CAH had 1 swing bed patient in residence during the survey. Patient #1's medical record documented a 92 year old female who was admitted to the CAH as a swing bed patient on 5/21/10 and was currently a patient as of 3/30/11.</p>	C 388		

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C 388	<p>Continued From page 17</p> <p>Her primary diagnosis was breast cancer with metastasis. A psychosocial assessment and an activities assessment were not documented in her medical record. In addition, her plan of care, dated 5/22/10, did not include plans to address activities or psychosocial areas of care.</p> <p>The DON was interviewed on 3/29/11 at 1:10 PM. She reviewed the medical record. She confirmed a psychosocial and activities assessment had not been conducted.</p> <p>The CAH did not provide complete assessments for Patient #1.</p>	C 388		