

COPY



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor  
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BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
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April 26, 2012

Brent Bryson, Administrator  
Intermountain Hospital  
303 North Allumbaugh Street  
Boise, ID 83704

RE: Intermountain Hospital, Provider #134002

Dear Mr. Bryson:

This is to advise you of the findings of the Medicare/Licensure survey at Intermountain Hospital, which was concluded on April 11, 2012.

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

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

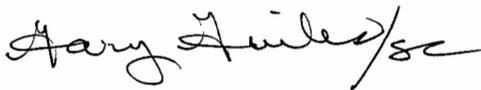
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Brent Bryson, Administrator  
April 26, 2012  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **May 9, 2012**, and keep a copy for your records.

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

Sincerely,



GARY GUILLES  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

GG/srm  
Enclosures

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 NORTH ALLUMBAUGH STREET BOISE, ID 83704</b>	
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A 000	INITIAL COMMENTS  The following deficiencies were cited during the Medicare health and LSC recertification survey of your hospital. Surveyors conducting the survey were:  Gary Guiles, HFS, Team Leader Rebecca Lara, RN, BA, HFS Karen Robertson, RN, BSN, HFS Susan Costa RN, HFS Mark Grimes, Supervisor, Facility Fire Safety and Construction Program  Acronyms used in this report include:  CNO- Chief Nursing Officer IC- Infection Control LPN - Licensed Practical Nurse POC-Plan of Care RN- Registered Nurse	A 000		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY  The patient has the right to personal privacy.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the hospital failed to ensure personal privacy was provided for patients residing in 10 of 11 rooms (Rooms 101-110) on the "Generations" nursing unit. This resulted in the inability of patients to toilet and shower with reasonable assurance that they would not be observed during these activities. Findings include:  The "Generations" nursing unit was a 21 bed psychiatric unit. It served older patients and patients with medical conditions that required	A 143	Patient Rights A 143 482.13 ( c ) ( 1 ) – Patient Rights – Personal Privacy  The CEO, CNO, Patient Safety Director, Medical Director and Director of Performance Improvement met on April 27, 2012 to review the current patient's rights policy ( Patient's Rights 1800.1 and 1800.2.)  The policy 1800.2 on patient's rights was revised to include protection and privacy of all patients admitted to Intermountain Hospital. Revision of the policy included evaluation of the bathroom doors for possible remodeling and refurbishing the doors to increase patient privacy. The administrative staff (CEO, CNO, Medical Director, PI Director and Safety Director) agreed to address this by installing a partial curtain between the door and the opening to allow for privacy. The partial curtain is attached using a Velcro attachment to reduce the risk for ligation.	4/27/2012

RECEIVED  
MAY 09 2012  
FACILITY STANDARDS

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

TITLE

(X6) DATE

*[Signature]* CNO

CNO

5/9/12

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

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A 143	Continued From page 1 nursing care. The unit was observed on 4/09/12 at 9:55 AM with the CNO. The census was 3 patients, ranging in age from 26 to 70. Rooms 101-110 were double occupancy rooms. A single bed "Observation Room" was located at the rear of the nursing station.  Rooms 101-110 each contained a bathroom with a toilet and a shower. The doors to each of these rooms was angled at the top from a height of approximately 75 inches to 66 inches (5 feet 6 inches) at the bottom. The surveyor, who was 6 feet 1 inch tall, walked by the door in room 108, which was empty at the time. The door was closed. The surveyor was able to see into the bathroom and observe the toilet and the area in front of the shower without any special effort, such as standing on tip toes or a step stool.  The DON was interviewed at the time of the observation. He conceded tall persons could easily see into the bathroom when patients were toileting or toweling off after a shower.  The hospital did not provide rooms where patients could toilet and shower without being observed.	A 143	The revised policy on patient's rights and privacy was submitted to the Patient Safety Committee. The revised policy was discussed during the MD Program directors meeting and approved by the MEC and Governing Board. See Attachment A  All housekeeping staff were educated on the revised policy to include routine cleaning of the partial curtains per cleaning schedules through the Housekeeping department.  Monitoring: The CNO/RN Managers and Supervisors will visually inspect all Gero/Medical Complex bathrooms during environmental rounds to assure curtain placement and compliance. Data will be reported to the Patient Safety Committee monthly. The Unit Charge Nurse Staff and Psych Tech staff will monitor bathroom safety per unit rounding and patient observations per policy. All deficiencies will be addressed immediately. Data will be reported to the PI Committee, MEC monthly and to the Governing Board quarterly	
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by: Based on review of clinical records and staff interviews, it was determined the hospital failed to ensure an RN supervised and evaluated the nursing care for 3 of 35 in-patients (#22, #35 and	A 395	A 395 - 482.23 (b)(3): RN Supervision of Nursing Care  Intermountain Hospital now ensures all LPN's are directly supervised by the Charge Nurse or designated RN. The LPN will have their responsibilities co-signed by the Charge/Designated RN after completion to assure RN reviews and maintains the scope of practice according to the State of Idaho Nurse Practice Act for nurses. The CNO reviewed the Nurse Practice Act which includes both RN's and LPN's. The nurse's (LPN) scope of practice is defined and allows for initial physical assessment coordination with the RN and completion of nursing related responsibilities. The RN is responsible for assuring a review of the LPN's patient care work-related requirements and to make a decision whether further assessment/treatment is warranted.	

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A 395	Continued From page 2 #36) whose records were reviewed. The failure of a RN to evaluate the care of patients had the potential for medication errors and deterioration in patients' medical conditions. Findings include:  1. Patient #22 was a 33 year old female admitted 4/01/12 at 4:00 PM. The admission assessment documented Patient #22 was a diabetic with a diagnosis of bipolar disorder, who had recently attempted suicide. The "NURSING ASSESSMENT," dated 4/01/12 was a seven page document that had printed instructions on the first page that included "(to be completed by an RN)." The last page of the assessment had an area for the RN completing the assessment, as well as, for the LPN collecting the data to sign and date/time the document. The form was signed, dated and timed by an LPN. There was no documentation an RN had reviewed or completed the form.  During an interview on 4/09/12 at 10:15 AM, the Adult Unit Charge Nurse, an RN, reviewed the record and confirmed the assessment had not been completed or signed by an RN. She stated she did not know why the form had not been signed by an RN. The Charge Nurse stated assessments are frequently initiated by an LPN, but the Charge Nurse is responsible for the completion of the form, as well as initiating the Plan of Care.  An RN did not complete and oversee the admission assessment for Patient #22.  2. Patient #36's medical record documented a 19 year old male who was admitted to the hospital	A 395	A 395 - 482.23 (b)(3): RN Supervision of Nursing Care (Continued)  Nursing Scope of Practice and Supervisory Requirements for LPN's will be reviewed, assessed and revised as required by a Registered Nurse as follows: See Attachment B  • Physical Assessment Coordination with RN • Admission/Discharge MD orders • Vital Signs parameters meeting RN notification and assessment • Detoxification (CIWA/COWS) parameters for RN Assessment • Medication orders • Progress note • Discharge Progress note  Secondly, the CNO, RN Managers/Supervisors addressed the required monitoring by RN's of change in patient condition. The policy was reviewed and required no changes as the policy did address how the RN will direct assessment and reassessment needs of the patient including any of the following: • Enhanced assessments by RN's after LPN physical assessment • Use of RN Supervisors for collateral assessments of patients. • Use of Attending MD/MD on-call for changes in patient condition including medical and psychiatric changes. • Use of medication and treatments • Evaluation for the requirement for patient transfer per emergency medical conditions.  Nursing staff will complete an educational program with a pre/post test to determine level of competency for patient change of conditions and the requirements for assessments and reassessments per existing policy and procedures. The pre-test will be completed by all licensed staff by available for a pre-test by May 18, 2012 and a post test be will complete on ALL licensed staff by June 1, 2012. The analysis of the pre/post test will be included in the follow-up for further license staff education and included annually in our skills lab.	5/18/2012 6/1/2012

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A 395	<p>Continued From page 3</p> <p>on 3/11/12 and discharged on 3/27/12. His diagnosis was bipolar disorder.</p> <p>A nursing narrative note, dated 3/16/12 at 11:00 PM, stated Patient #19's pulse had risen to 164 beats per minute. (The National Institutes for Health, queried on 4/13/12, defined a normal pulse rate for adults as 60-100.) The note stated the physician was called and Patient #19 was transferred to a local emergency department for evaluation. He returned to the hospital at 1:30 AM on 3/17/12. A physician order, dated 3/17/12 at 12:40 PM, stated Patient #19's vital signs were to be taken twice a day for 3 days. Patient #36's vital signs, including pulse, were documented 4 times on 3/17/12, at 1:48 AM, 6:00 AM, 11:05 AM, and 6:24 PM. His vital signs were documented at least twice on 3/18/12 through 3/26/12. After 1:48 AM on 3/17/12, the vital signs were all documented by psychiatric technicians. No documentation of the quality of Patient #36's pulse, such as whether or not it was regular, was documented following his return from the emergency department. No specific documentation of an assessment of Patient #36's cardiovascular status was documented following his return from the emergency department through his discharge on 3/27/12. At 6:24 PM on 3/17/12, Patient #36's pulse was documented as 119 beats per minute. No assessment by an RN was documented at this time.</p> <p>The RN Program Manager reviewed the medical record on 4/09/12 beginning at 2:55 PM. He confirmed no documentation of a specific assessment of Patient #36's cardiac status was documented following his return from the emergency department.</p>	A 395	<p>A 395 - 482.23 (b)(3): RN Supervision of Nursing Care (Continued)</p> <p>Monitoring:</p> <p>Delegated Responsibilities/ Change in Patient Condition: RN Managers/Supervisors will review a sample (50 open medical records/monthly x 3 months) of current inpatient medical records to affirm all LPN responsibilities are completed and authenticated by the RN. Responsibilities include physical assessments, medication orders (telephonic and MD written), vital signs (detox and routine), Progress Notes, and Discharge Notes are reviewed and authenticated by the RN completing the review. Patient care related follow-up requirements determined by the RN will be addressed and included within the medical record and completed by the designated RN.</p> <p>Aggregated data will be completed and analyzed including trending per unit/staff, staff opportunities for improvement and compliance with established guidelines. The aggregated and reported data will be forwarded to Quality/Performance Improvement Committee for discussion, review and trending. The analysis will be discussed in Unit Program Managers Meetings, MD Program Directors, Medical Executive Committee and the Board of Governors' meeting</p>	

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A 395	<p>Continued From page 4</p> <p>An RN did not monitor Patient #36's cardiovascular status.</p> <p>3. Patient #35's medical record documented a 41 year old male who was admitted to the hospital on 3/30/12 and discharged on 4/02/12. His diagnosis was schizoaffective disorder.</p> <p>A nursing narrative note, dated 4/01/12 at 5:00 AM, stated Patient #35 had developed a fever and respiratory symptoms in the night. The physician was notified and Patient #35 was sent to a local emergency room for evaluation. He was diagnosed with pneumonia. He returned to the hospital on 4/01/12 at 4:30 AM. A specific assessment of Patient #35's respiratory status by an RN was not documented following his return to the hospital. No documentation was present that an RN had listened to Patient #35's lungs or examined him. A nursing narrative note, dated 4/02/12 at 5:10 AM, stated Patient #35 was "...observed by nursing staff sitting on edge of bed @ approximately 0315. [Patient complained of shortness of breath] at this time." A nebulizer treatment was administered at this time with "...significant improvement" but no assessment of Patient #35's lung sounds was documented. The "Adult Vital Signs Flow Sheet" documented Patient #35's temperature was 97.7 on 4/01/12 at 4:30 AM and 97.3 on 4/01/12 at 3:35 PM. Vital signs were documented at 6:00 AM and 3:30 PM on 4/02/12, however, temperatures were not included.</p> <p>The RN Program Manager reviewed the medical record on 4/09/12 beginning at 2:55 PM. He confirmed no documentation of a specific</p>	A 395		

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A 395	Continued From page 5 assessment of Patient #35's respiratory status was documented following his return from the emergency department.	A 395		
A 396	An RN did not monitor Patient #35's respiratory status.  The facility did not ensure nursing care was supervised by a registered nurse. <b>482.23(b)(4) NURSING CARE PLAN</b>  The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient.  This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with staff and patients, it was determined the hospital failed to ensure that nursing staff developed and/or kept current nursing care plans for 4 of 35 in-patients (#13, #16, #39 and #44) whose records were reviewed. This resulted in 1) the failure to assist a patient through the grief process; 2) incomplete care planning for patients with wound care, diabetes and hepatitis. Findings include:  1. Patient #39 was a 20 year old male, admitted 4/03/12 with a diagnosis of suicidal ideation, severe bipolar disorder and mild mental retardation.  Three days after admission, Patient #39 was informed of his father's unexpected hospitalization and death. The nursing note, dated 4/06/12, included the following: "Patient was attending a group when his mother called to tell him his father passed away this morning. He	A 396	A 396 - 482.23(e)(4): Nursing Care Plan  The CNO, Nurse Managers, PI Director and Medical Director met on 4/27/2012 to review and revise the Nursing Care Plan Policy ( 1000.94) to include the formulation of a Problem list, Initial Treatment Plan for nursing related problems as well as updating the Treatment Plan when assessed needs require follow up. See Attachment C.  Nursing Care Plans are developed focusing on assessed needs which are required to be followed-up through both long/short-term goals, specific interventions and progress toward those goals per established individualized interventions.  A stand-alone treatment plan was developed to address patients who have acute medical problems which require a higher level of care (Emergency Department [E.D.] utilization) focusing on the reason for transfer, assessments and treatment provided through E.D. services and required follow-up recommendations at time of return to Intermountain Hospital via transfer. The stand-alone treatment plan (E.D. Transfer and Care) will be completed on all E.D. transfers whether or not the patient has an existing care plan addressing the same condition. The original nursing plan may be updated to reflect changes in condition however the returning E.D. Transfer and Care plan will guide the nursing staff toward follow-up on all E.D. recommendations. See Attachment D.	4/27/2012

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A 396	<p>Continued From page 6</p> <p>was tearful and stated he was sad and shocked about his fathers (incomplete sentence, or unfinished note)."</p> <p>The "MASTER TREATMENT PLAN," also referred to as the POC, contained diagnoses of "Depressed Affect," "Chronic Medical Condition, Asthma," and "Mood Instability," initiated from 4/04/12 to 4/06/12. The POC did not address the death of Patient #39's father.</p> <p>A "PROGRESS NOTE," dictated by the psychiatrist and dated 4/06/12, indicated Patient #39 was having anxiety and psychotic symptoms after the death of his father.</p> <p>As of 4/10/12, the medical record did not contain any further documentation by the nursing staff of acknowledgement of the loss and interventions to assist with the grief process for Patient #39.</p> <p>Nursing documentation on the forms "IMH NURSING FLOW SHEET," dated 4/07/12 and 4/08/12, and 4/09/12 did not mention the death of Patient #39's father, or of his increased anxiety as noted by the psychiatrist.</p> <p>During an interview on 4/09/12 at 10:00 AM, Patient #30 stated he was dealing with his father's death, and when asked if the nursing staff was helping with ways to help his anxiety, he stated he really had not talked with anyone about it.</p> <p>An interview on 4/10/12 at 11:15 AM, the Director of Social Services stated she had talked with Patient #30 shortly after his father passed away. She was unaware the POC had not been updated</p>	A 396	<p>A 396 - 482.23(e)(4): Nursing Care Plan (Continued)</p> <p>The E.D. transfer form was revised to reflect the requirements of using the E.D. Transfer and Care plan of care and a RN review check box was added to the E.D. Transfer Form to address the requirements of formulation of or updating the plan of care. See Attachment E.</p> <p>All licensed nursing staff will be trained on the revised policy regarding the formulation of the problem list, treatment plan and use of the E.D. Transfer and Care plan by May 31, 2012.</p> <p>Monitoring: RN Managers/Supervisors will review a sample (30 open medical records/monthly x 3 months) of inpatient, real-time medical records as well as 100% of all E.D. transfers to affirm all patients receive a nursing plan of care associated with their identified problems and when patients require a higher level of care (E.D. transfer.)</p> <p>The CNO/RN Management Team will aggregate and analyze data including trending per unit/staff. Staff opportunities for improvement and compliance with established guidelines will be determined. The aggregated and reported data will be forwarded to Quality/Performance Improvement Committee for discussion, review and trending. The analysis will be discussed in Unit Program Managers Meetings, MD Program Directors, Medical Executive Committee and the Board of Governors' meeting</p>	5/31/2012

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A 396	<p>Continued From page 7 to include grieving.</p> <p>The facility did not develop or update the POC related to anxiety and anticipated grief related to the death of an immediate family member.</p> <p>2. Patient #13 was a 40 year old female, admitted to New Start, a chemical dependency unit, on 4/05/12 for care related to alcohol detoxification. In addition, Patient #13 had diagnoses which included Hepatitis B and Hepatitis C.</p> <p>Nursing documentation on the forms "IMH NURSING FLOW SHEET," dated 4/05/12 at 11:23 PM, indicated Patient #13 had diarrhea and required medication. There was no POC, and the education sheet had not been initiated.</p> <p>During a tour with the Manager of New Start on 4/06/12 at 3:45 PM, it was discovered that Patient #13 had a room mate. There was an unmarked toothbrush on the sink in their bathroom, and the Manager of New Start was unable to determine who it belonged to.</p> <p>During an interview on 4/06/12 at 4:00 PM, the Charge Nurse for New Start reviewed Patient #13's record and confirmed the POC had not been initiated, and there was no documentation to address the diarrhea, Hepatitis B and C, and education on hygiene measures to reduce the possibility of cross infection with any potential room mates. The Charge Nurse indicated the toothbrush in Patient #13's bathroom would be discarded.</p> <p>The facility did not develop a nursing care plan for Patient #13.</p>	A 396		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>134002</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>INTERMOUNTAIN HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 NORTH ALLUMBAUGH STREET BOISE, ID 83704</b>		
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A 396	Continued From page 8  3. Patient #16 was a 49 year old female, admitted 3/25/12 for alcohol detoxification and history of seizures.  Patient #16 had a wound on her right knee with wound care orders written on 3/26/12 at 6:00 PM that included Bactroban ointment, telfa dressing and kerlix wrap. In addition, there was an order on 3/28/12 at 1:00 PM to evaluate healing. The "MASTER TREATMENT PLAN" for Patient #16 dated 3/25/12, also referred to as the POC, did not include wound care or interventions to assist in the healing process for Patient #16's wound.  In an interview on 4/10/12 at 8:20 AM, the Charge Nurse on the Adult Unit reviewed Patient #16's record and confirmed there was no POC that included wound care for the right knee wound.  The facility did not develop a nursing care plan that included wound care for Patient #16.  4. Patient #44 was a 25 year old female, admitted 4/09/12 for alcohol detoxification, suicidal ideation, and diabetes.  Patient #44 had a wound on her left arm upon admission, and the wound care orders written 4/09/12 at 8:20 PM included triple antibiotic ointment and dressing changes twice daily for five days. The "MASTER TREATMENT PLAN" for Patient #44 dated 4/09/12, also referred to as the POC, did not include wound care or interventions to assist in the healing process for Patient #44's wound.  In an interview on 4/10/12 at 8:15 AM, the Charge	A 396			

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

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A 396	Continued From page 9 Nurse on the Adult Unit reviewed Patient #44's record and confirmed there was no POC that included wound care for the left arm wound.  The facility did not develop a nursing care plan that included wound care for Patient #44.  The facility did not develop or modify POC's to include pertinent problems that could affect patient recovery.	A 396		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES  The hospital must have a full-time employee who-  (i) Serves as director of the food and dietetic services;  (ii) Is responsible for daily management of the dietary services; and  (iii) Is qualified by experience or training.  This STANDARD is not met as evidenced by: Based on observations and staff interview and review of policy and procedures, it was determined the hospital failed to ensure the director of dietary services 1) ensured hospital kitchen staff stored food properly in the facility's dietary department, and 2) ensured infection control measures were enforced. This had the potential to compromise patient health and food safety. Findings include:  1. A policy titled "Food Products/Storage," dated 3/00, regarding food storage, included foods must always be properly dated, labeled, and wrapped. The policy did not include instructions for opened	A 620	A 620 – 482.28 (a) (1) Director of Dietary  Intermountain Hospital now ensures that the Director of Dietary directly supervises the daily management of the dietary services department. The ICP, Dietary Manager and Performance Improvement Director met on May 3, 2012 to review the current monitoring schedule for Dietary Infection Control. Although general guidelines were present, a specific log with environmental rounds of the Dietary Department was not utilized. The Dietary Policy(s) 1900.61, 1900.48, 1900.78, 1900.80 and 1900.81 were all specific to Infection Control practices for the department. As a single-source document, 1900.80 Sanitary Controls - Dietary was revised to reflect a systematic reporting and monitoring schedule for the dietary department and will include the areas identified below (#1-4) – See Attachment F.  Daily supervision encompasses the following: 1. Hospital staff store food properly – Correct Temperatures, Time and Dated (expiration), properly wrapped and sealed and rotated per schedules. 2. Hospital staff will complete sanitation of the department per cleaning guidelines. This will include cooking areas, food prep areas, storage and dishwashing areas. • Sanitizing solutions will conform to established concentration (see policy) and will be tested by staff prior to use. Established guidelines for solution concentration will be posted in the department as well as kept in the departmental policy and procedure manual. For easy reference guide, the concentration will be readily available next to the cleaning solutions and cleaning containers.	5/3/2012



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A 620	<p>Continued From page 11</p> <p>According to the FDA (Food and Drug Administration) 2009 food safety standards, the quaternary ammonia sanitizer solution is to be 200 ppm.</p> <p>According to the tolerance exemptions in the Code of Federal Regulations, (40 CFR 180.940) large concentrations of sanitizer can be considered toxic or poisonous because residues of the materials remain.</p> <p>b. A red bucket, identified as a sanitizing solution, was on the counter filled with presoak solution for dishes and utensils. The Dietary Manager stated the presoak solution should not be in that kind of bucket, that the container for the presoak was a large grey shallow plastic container, and requested a worker to change the container. The use of buckets of incorrect color may result in misuse of the solution in the bucket.</p> <p>c. A personal drink container was observed in the dry storage area on a metal rack that held patient food items.</p> <p>d. Filters above the cooking area were noted to have dust and grease accumulation. The Dietary Manager stated the filters were cleaned once weekly, but could not provide a schedule or documentation of when they had last been cleaned.</p> <p>The Dietary Manager did not ensure that kitchen staff practiced and enforced infection control interventions to prevent the possible spread of infections.</p>	A 620	<p>A 620 – 482.28 (a) (1) Director of Dietary (Continued)</p> <p>6. Dietary Manager will complete a department-wide pre/post test for all department staff. Analysis and trending of information will occur and staff specific education will be completed prior to 5/31/12.</p> <p>The Dietary Manager will aggregate and analyze the data including trending per staff. Staff opportunities for improvement and compliance with established guidelines will be determined. Aggregation of data from criteria 1-6 above will be completed including analysis and trending which will be reported through Patient Safety/Quality. Outlier information will be addressed including staff responsibility for completion and compliance with established guidelines. The aggregated and reported data will be forwarded to Quality/Performance Improvement Committee for discussion, review and trending. The analysis will be discussed in Departmental Meetings, MD Program Directors, Medical Executive Committee and the Board of Governors' meeting</p>	5/31/2012

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B 000	16.03.14 Initial Comments  The following deficiencies were cited during the State licensure survey of your hospital. Surveyors conducting the survey include:  Gary Guiles, HFS, Team Leader Rebecca Lara, RN, BA, HFS Karen Dewey, RN, BSN, HFS Susan Costa RN, HFS Mark Grimes, Supervisor of Facility Fire Safety and Construction Program  Acronyms used in this report include:  IC- Infection Control LPN - Licensed Practical Nurse POC-Plan of Care RN- Registered Nurse	B 000		
BB175	16.03.14.310.03 Patient Care Plans  03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)  a. Nursing care treatments required by the patient; and (10-14-88)  b. Medical treatment ordered for the patient; and (10-14-88)  c. A plan devised to include both short-term and long-term goals; and (10-14-88)  d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)  e. A description of socio-psychological needs of the patient and a plan to meet those needs.	BB175	BB175 16.03.14.310.03 Patient Care Plans  The CNO, Nurse Managers, PI Director and Medical Director met on 4/27/2012 to review and revise the Nursing Care Plan Policy ( 1000.94) to include the formulation of a Problem list, Initial Treatment Plan for nursing related problems as well as updating the Treatment Plan when assessed needs require follow up. See Attachment C.  Nursing Care Plans are developed focusing on assessed needs which are required to be followed-up through both long/short-term goals, specific interventions and progress toward those goals per established individualized interventions.  A stand-alone treatment plan was developed to address patients who have acute medical problems which require a higher level of care (Emergency Department [E.D.] utilization) focusing on the reason for transfer, assessments and treatment provided through E.D. services and required follow-up recommendations at time of return to Intermountain Hospital via transfer.	4/27/2012



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B 000	<p><b>16.03.14 Initial Comments</b></p> <p>The following deficiencies were cited during the State licensure survey of your hospital. Surveyors conducting the survey include:</p> <p><b>Gary Guiles, HFS, Team Leader</b> <b>Rebecca Lara, RN, BA, HFS</b> <b>Karen Dewey, RN, BSN, HFS</b> <b>Susan Costa RN, HFS</b> <b>Mark Grimes, Supervisor of Facility Fire Safety and Construction Program</b></p> <p>Acronyms used in this report include:</p> <p>IC- Infection Control LPN - Licensed Practial Nurse POC-Plan of Care RN- Registered Nurse</p>	B 000	<p>BB175 16.03.14.310.03 Patient Care Plans (Continued)</p> <p>The stand-alone treatment plan (E.D. Transfer and Care) will be completed on all E.D. transfers whether or not the patient has an existing care plan addressing the same condition. The original nursing plan may be updated to reflect changes in condition however the returning E.D. Transfer and Care plan will guide the nursing staff toward follow-up on all E.D. recommendations. See Attachment D.</p> <p>The E.D. transfer form was revised to reflect the requirements of using the E.D. Transfer and Care plan of care and a RN review check box was added to the E.D. Transfer Form to address the requirements of formulation of or updating the plan of care. See Attachment E.</p> <p>All licensed nursing staff will be trained on the revised policy regarding the formulation of the problem list, treatment plan and use of the E.D. Transfer and Care plan by May 31, 2012.</p>	5/31/2012
BB175	<p><b>16.03.14.310.03 Patient Care Plans</b></p> <p>03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)</p> <p>a. Nursing care treatments required by the patient; and (10-14-88)</p> <p>b. Medical treatment ordered for the patient; and (10-14-88)</p> <p>c. A plan devised to include both short-term and long-term goals; and (10-14-88)</p> <p>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)</p> <p>e. A description of socio-psychological needs of the patient and a plan to meet those needs.</p>	BB175	<p>Monitoring: RN Managers/Supervisors will review a sample (30 open medical records/monthly x 3 months) of inpatient, real-time medical records as well as 100% of all E.D. transfers to affirm all patients receive a nursing plan of care associated with their identified problems and when patients require a higher level of care (E.D. transfer.)</p> <p>The CNO/RN Management Team will aggregate and analyze data including trending per unit/staff. Staff opportunities for improvement and compliance with established guidelines will be determined. The aggregated and reported data will be forwarded to Quality/Performance Improvement Committee for discussion, review and trending. The analysis will be discussed in Unit Program Managers Meetings, MD Program Directors, Medical Executive Committee and the Board of Governors' meeting</p>	

Bureau of Facility Standards

TITLE

(X6) DATE

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

Bureau of Facility Standards

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BB175	Continued From page 1 (10-14-88)  This Rule is not met as evidenced by: Refer to A396 as it relates to the failure of the facility to ensure the patients' care plans were individualized and/or kept current in order to meet their needs.	BB175		
BB208	16.03.14.320.07 Food Preparation and Service  07. Food Preparation and Service. (10-14-88)  a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. (10-14-88)  b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value. (10-14-88)  This Rule is not met as evidenced by: Refer to A-620 as it relates to the failure of the facility to ensure proper food storage and disposal.	BB208	BB208 16.03.14.320.07 Food Preparation and Service  Intermountain Hospital now ensures that the Director of Dietary directly supervises the daily management of the dietary services department. The ICP, Dietary Manager and Performance Improvement Director met on May 3, 2012 to review the current monitoring schedule for Dietary Infection Control. Although general guidelines were present, a specific log with environmental rounds of the Dietary Department was not utilized. The Dietary Policy(s) 1900.61, 1900.48, 1900.78, 1900.80 and 1900.81 were all specific to Infection Control practices for the department. As a single-source document, 1900.80 Sanitary Controls - Dietary was revised to reflect a systematic reporting and monitoring schedule for the dietary department and will include the areas identified below (#1-4) – See Attachment F.  Daily supervision encompasses the following: 1. Hospital staff store food properly – Correct Temperatures, Time and Dated (expiration), properly wrapped and sealed and rotated per schedules. 2. Hospital staff will complete sanitation of the department per cleaning guidelines. This will include cooking areas, food prep areas, storage and dishwashing areas. • Sanitizing solutions will conform to established concentration (see policy) and will be tested by staff prior to use. Established guidelines for solution concentration will be posted in the department as well as kept in the departmental policy and procedure manual.	5/3/2012

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BB175	Continued From page 1 (10-14-88)  This Rule is not met as evidenced by: Refer to A396 as it relates to the failure of the facility to ensure the patients' care plans were individualized and/or kept current in order to meet their needs.	BB175	BB208 16.03.14.320.07 Food Preparation and Service (Continued)  For easy reference guide, the concentration will be readily available next to the cleaning solutions and cleaning containers • Pre-soak containers will be marked accordingly and utilized by staff per procedural guidelines. 3. The Dietary Manager will visually inspect the department daily to assure that there are no personal items including drink cups, beverage containers, unwrapped food, or other personal items in the department or stored in/around food, storage areas or other food-stuff areas. A daily inspection log form was completed to address departmental review criteria on May 7, 2012. 4. The cooking area will be cleaned per scheduled cleaning (See policy 1900.48, 1900.80.) Overhead filters will be cleaned according to cleaning guidelines ( See Policy 1900.81) and documented on the cleaning log. 5. Dietary staff will complete a pre/post test to evaluate their current knowledge level focusing on items (1-4) above on or before May 20, 2012. Trending of the pre/post test will be completed by the Dietary Manager and any required educational deficits will be identified and a specific educational program will be developed for each staff member not achieving a satisfactory test score.  Monitoring: The Dietary Manager (during their assigned work week) and the Lead Dietary Staff when the Dietary Manager is not present will assure compliance with the following departmental criteria on a daily basis: 1. All stored foods are properly labeled, timed/dated, at approved temperatures and are wrapped appropriately. 2. All solutions utilized in the department are identified through a tag in/out system that properly identifies the proper concentration in the container including solutions used, concentration, date/time and staff initials. 3. Presoak containers will be marked/labeled with "Pre-Soak only" 4. A daily inspection log form will be completed daily by either the Dietary manager or Lead Dietary Staff.	
BB208	16.03.14.320.07 Food Preparation and Service  07. Food Preparation and Service. (10-14-88)  a. The dietary department shall have adequate space, equipment and utensils for the preparation, storage and serving of food and drink to the patient. (10-14-88)  b. Foods shall be stored, prepared and served following procedures which shall ensure the retention of their nutritive value. (10-14-88)  This Rule is not met as evidenced by: Refer to A-620 as it relates to the failure of the facility to ensure proper food storage and disposal.	BB208		5/7/2012  5/20/2012