COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7009 0820 0000 2807 2023

May 3, 2011

Rick Richards, Administrator
Northern Idaho Advanced Care Hospital
600 N Cecil Rd
Post Falls, ID 83854

RE: Northern Idaho Advanced Care Hospital, Provider # 132001

Dear Mr. Richards:

Based on the survey completed at Northern Idaho Advanced Care Hospital, on April 19, 2011, by our staff, we have determined Northern Idaho Advanced Care Hospital, is out of compliance with the Medicare Hospital **Infection Control (42 CFR 482.42)**. 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 deficiency, which caused this condition to be unmet, substantially limits the capacity of Northern Idaho Advanced Care Hospital, to furnish services of an adequate level or quality. The deficiency is described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed also, is a similar form describing State licensure deficiencies and your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected.

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 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 June 3, 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 26, 2011.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **May 17, 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
ec: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

Addendum to the Plan of Correction
Survey Completed 04/19/2011
Provider/Supplier/CLIA Identification Number 132001

Please note the effective dates for implementation of plans for correction for deficiencies identified in the CMS/State Licensure Survey completed on 04/19/2011.

Tag	***Effective Date***
A-168	4/15/2011
A-214	5/19/2011
A-396	5/16/2011
A-457	5/23/2011
A-620	5/05/2011
A-749	5/16/2011

I certify that I have reviewed the deficiency plan of correction and effective dates. I further certify that the effective dates are accurate.

Signed [signature] Title CEO Date 5/24/11

ARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	132001		04/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN IDAHO ADVANCED CARE HOSPITAL	600 NORTH CECIL ROAD POST FALLS, ID 83854

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS Team Leader Teresa Hamblin, RN, MSN, HFS Susan Costa, RN, HFS Aimee Hastriter, RN, BS, HFS Karen Robertson, RN, BS, HFS Acronyms used in this report include: AACN - American Association of Critical-Care Nurses BiPAP - Bi-level Positive Airway Pressure, a method of respiratory ventilation cc - cubic centimeter; equivalent to an mililiter CDC - Centers for Disease Control C. difficile - Clostridium difficile, a spore-producing bacterium CMS - Centers for Medicare and Medicaid Services COPD - Chronic Obstructive Pulmonary Disease CPR - Cardio-Pulmonary Resuscitation DC - Discontinue DNR - Do Not Resuscitate DON - Director of Nursing DOT - Director of Therapy DPO - Director of Plant Operations E. coli - Escherichia coli, a bacterium EKG - Electrocardiogram Hgb - Hemoglobin H/H - Hemoglobin and Hematocrit HICPAC - Healthcare Infection Control Practices Advisory Committee HIT - Heparin Induced Thrombocytopenia H&P - History and Physical ICP - Infection Control Practitioner	A 000	RECEIVED MAY 18 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/16/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ing 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 000	Continued From page 1 ICU - Intensive Care Unit IVF - Intravenous fluid MAP - Mean Arterial Pressure MAR - Medication Administration Record mcg - micrograms mEq - milliequivalent mg - milligrams ml - mililiter MRSA - Methicillin Resistant Staphylococcus Aureus NP - Nurse Practitioner PA - Physician's Assistant PCT - Patient Care Technician POC - Plan of Care PPE - Personal Protective Equipment PRBC - Packed Red Blood Cells PT - Physical Therapist PTA - Physical Therapy Assistant QC - Quality Control RN - Registered Nurse T&C - Type and Cross UTI - Urinary Tract Infection	A 000		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital bylaws, it was determined the Governing Body failed to ensure the medical staff was accountable to the Governing Body by failing to enforce Medical Staff Rules. This affected the care of 7 of 31 patients (#1, #4, #9, #11, #16, #19, and #27) whose records were reviewed and had the potential to affect all patients receiving care at the facility. This	A 049		

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A 049	Continued From page 2 resulted in a lack of consistent care being provided to patients. Findings include: 1. "GOVERNING BODY BYLAWS," dated June 2010, defined practitioner as "...a physician, psychologist, podiatrist, or dentist." Section 3.10(b) of the bylaws stated the Governing Body was responsible to assure patients were "under the care of a licensed practitioner." The bylaws did not define what the term "under the care" of a licensed practitioner meant. "MEDICAL STAFF BYLAWS," approved by the Governing Body on 7/23/10, stated "ALLIED HEALTH PRACTITIONERS," which consisted of NPs and PAs, could not be members of the medical staff but were eligible for "practice prerogatives." The "MEDICAL STAFF BYLAWS" defined a practitioner as "...a physician, dentist, podiatrist, or clinical psychologist." "MEDICAL STAFF RULES AND REGULATIONS," included in the "MEDICAL STAFF BYLAWS," stated "7A...A hospitalized patient must be seen by the attending physician, or appropriate covering physician, daily." Neither the "GOVERNING BODY BYLAWS" nor the "MEDICAL STAFF BYLAWS" outlined the role of "ALLIED HEALTH PRACTITIONERS" in relation to physicians. Neither set of bylaws stated how NPs or PAs would be supervised, when they should consult with the physician, or how this interaction should be documented. As noted above, the rules and regulations stated physicians would see patients daily. These rules were not enforced and PAs and NPs often saw patients in place of a physician. Examples include: a. Patient #11's medical record documented a 70	A 049	**A-049 Medical Staff: Accountability** • Effective 5/12/2011 via the Medical Executive Committee (MEC), revisions to policy MS 015 "*Medical Staff Clinical Privileges-Allied Health Practitioner*" and Medical Staff Bylaws/Rules and Regulations, a recommendation to accept the revisions was made to the Governing Body (GB)who met, reviewed, and approved the revisions on 5/13/2011. • The revisions provide clear and effective direction for all MD/DO/LIP staff members as well as hospital staff members related to the supervisory role physicians are responsible for which ultimately improves systems and process leading to higher quality patient care outcomes. • Active providers (MD/DO/LIP staff members) were invited to participate in the discussions held on 5/12/2011 and agreed to abide by the changes by mutual consensus. • All MD/DO/LIP staff members will receive a written summary of the changes no later than 5/20/2011 from the hospital Medical Director as the representative of MEC. The letter will contain a copy of the revised policy and bylaw verbiage and additional information regarding measurement and monitoring of compliance. Non-compliance will be managed as defined in the Medical Staff Rules and Regulations utilizing the Ongoing Professional Practice Evaluation model. • Measurement and monitoring measures were approved by MEC and GB. The review of compliance with twice weekly documented supervising physician visits to examine patients, and co-signature on all H&Ps and Discharge summaries will commence no later than 5/23/2011 via record review. Reviews will be conducted	

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A 049	Continued From page 3 year old female who was admitted to the hospital on 3/03/11 and discharged on 4/08/11. Her diagnoses included ovarian cancer and abdominal fistula. Patient #11 was followed daily by either a NP or a PA. Except for a "PHYSICIAN PROGRESS NOTE" on 3/20/11, no documentation was present that a physician had examined Patient #11 from 3/04/11 through 4/06/11, a period of 33 days. Patient #11 was seen exclusively by a PA on 17 of those days and she was seen by a NP on 16 of those days. The Director of Case Management was interviewed on 4/14/11 at 3:30 PM. She confirmed the absence of documentation regarding physician involvement in the care of Patient #11. b. Patient #9's medical record documented a 49 year old male who was admitted to the hospital on 2/19/11 and discharged on 2/26/11. His diagnoses included chronic kidney disease, diabetes, and coronary artery disease. His History and Physical, dated 2/18/11, was written by a PA. The History and Physical was cosigned on 2/19/11 by a Nephrologist, who was listed as Patient #9's primary physician. "PHYSICIAN PROGRESS NOTES" by another Nephrologist were also documented on 2/19/11 and 2/20/11. Daily progress notes by the NP for the Nephrology group were documented on 2/21/11, 2/22/11, 2/23/11, 2/24/11, and 2/25/11. No "PHYSICIAN PROGRESS NOTES" were documented during this time. On 2/26/11 at 1:05 PM, a progress note by a Pulmonary physician who was not associated with the Nephrology Group, documented he responded when Patient #9 suffered cardiac arrest to provide CPR. Patient #9 was resuscitated and transferred to an	A 049 Cont	three times weekly Admission Orders and Discharge Orders require documentation that the order was under the direction of the supervising physician. The NP/PA will communicate daily with the supervising physician regarding the status of patients under that physician's care. Documentation of this communication will be evident in the medical record. Monitoring by the Medical Director of compliance will be accomplished by review of data collected by hospital administrator/designee at a minimum three times weekly review of the medical record beginning no later than 5/23/2011. Results will be reported at a minimum quarterly to MEC and GB. Any corrective action steps will be under the direction of the MEC in collaboration with the GB. **Person(s) Responsible: Administrator, Medical Director, Director of Quality and Risk Management (DQRM).**	

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A 049	Continued From page 4 acute care hospital at that time. No physician involvement with Patient #9 was documented on 5 of the 7 days he was a patient before his cardiac arrest. The Case Manager was interviewed on 4/14/11 at 3:30 PM. She confirmed the absence of documentation regarding physician involvement in the care of Patient #9. c. Patient #27's medical record documented a 74 year old female who was admitted to the hospital on 3/30/11 and was a current patient as of 4/15/11. Her diagnoses included congestive heart failure and chronic renal failure. Her History and Physical, dated 3/31/11, was dictated by a NP and was cosigned by a physician on 4/02/11. The NP also documented progress notes on 3/31/11 and 4/01/11. A physician documented progress notes on 4/02/11 and 4/03/11. Subsequent daily progress notes from 4/04/11 through 4/15/11 were all written by the NP. No documentation that a physician had seen Patient #27 on those dates or had participated in her care was present in the record. No physician involvement with Patient #27 was documented on 12 of the 16 days he was a patient The NP for Patient #27 was interviewed on 4/12/11 at 9:55 AM. The NP stated she often saw patients in place of the physician. d. Patient #1's medical record documented a 79 year old male who was admitted to the hospital on 3/29/11 and was a current patient as of 4/15/11. His diagnoses included aspiration pneumonia and end stage kidney disease. His History and Physical, dated 3/30/11, was written by a NP and was cosigned by a physician on 4/02/11. The NP	A 049		

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A 049	Continued From page 5 also documented progress notes on 3/31/11 and 4/01/11. A physician documented progress notes on 4/02/11 and 4/03/11. Subsequent daily progress notes from 4/04/11 through 4/14/11 were all written by the NP. No documentation that a physician had seen Patient #1 on those dates or had participated in his care was present in the record. The NP for Patient #1 was interviewed on 4/12/11 at 9:55 AM. The NP stated she often saw Patient #1 in place of the physician. e. Patient #19's medical record documented a 43 year old male who was admitted to the hospital on 3/28/11 and was a current patient as of 4/15/11. His diagnoses included quadriplegia, pneumonia, and decubitus ulcers. Progress notes documented Patient #19 was seen exculsively by a NP on 3/30/11, 4/01/11, 4/02/11, 4/03/11, 4/06/11, 4/11/11, 4/12/11, 4/13/11, and 4/14/11. No documentation that a physician had seen Patient #19 on those dates or had participated in his care was present in the record. No physician involvement with Patient #19 was documented on 9 of the 17 days he was a patient. The DON reviewed the medical record on 4/15/11 at 10:30 AM. She confirmed the lack of documentation of physician involvement for the 9 days referenced above. The Medical Director was interviewed on 4/14/11 beginning at 4:55 PM. He confirmed the Medical Staff Rule that physicians would see patients daily had not been followed. He also stated rules defining how NPs and PAs would be supervised, including when they needed to consult with physicians, had not been developed.	A 049		

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A 049	Continued From page 6 The Administrator was interviewed on 4/19/11 at 10:30 AM. He confirmed the bylaws were inconsistent. The Medical Staff was not accountable to the Governing Body and did not follow Medical Staff Bylaws regarding patient care. 2. A hospital policy, "Do Not Resuscitate (DNR) - No Code," dated February 2006, stated that once the decision to forgo CPR has been made, the directive must be documented as a written order by the attending physician in the patient's medical record. The physician would then write a "Do Not Resuscitate" order. However, mid-level practitioners wrote DNR orders instead of the attending physician as follows: a. Patient #4 was an 81 year old female who was admitted to the ICU on 12/04/10 after transfer from another hospital. A "NO CODE/DNR" order, dated 12/21/10, was written by a NP rather than by a physician. During an interview on 4/13/11 beginning at 10:15 AM, the Director of Case Management reviewed Patient #4's record and confirmed the DNR order was written by a NP. b. Patient #16 was an 85 year old patient admitted to the hospital on 4/08/11. An undated, untimed "NO CODE/DNR" order was written by a PA. During an interview on 4/14/11 at 4:30 PM, the Director of Case Management reviewed Patient #16's record and confirmed the order was written by a PA.	A 049		

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A 049	Continued From page 7 DNR orders were written by non-physician staff. The Governing Body did not ensure mid-level practitioners functioned according to medical staff criteria as it related to DNR orders.	A 049		
A 064	482.12(c)(1) CARE OF PATIENTS - PRACTITIONERS [...the governing body must ensure that the following requirements are met:] Every Medicare patient is under the care of: (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform; (iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices; (v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated on x-ray to exist; or (vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.	A 064	**A-064 Care of Patients: Practitioners** • Effective 5/12/2011 via the Medical Executive Committee (MEC), revisions to policy MS 015 "*Medical Staff Clinical Privileges-Allied Health Practitioner*" and Medical Staff Bylaws/Rules and Regulations, a recommendation to accept the revisions was made to the Governing Body (GB)who met, reviewed, and approved the revisions on 5/13/2011. • The revisions provide clear and effective direction for all MD/DO/LIP staff members as well as hospital staff members related to the supervisory role physicians are responsible for which ultimately improves systems and process leading to higher quality patient care outcomes. • Active providers (MD/DO/LIP staff members) were invited to participate in the discussions held on 5/12/2011 and agreed to abide by the changes by mutual consensus. • All MD/DO/LIP staff members will receive a written summary of the changes no later than 5/20/2011 from	

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A 064	Continued From page 8 This STANDARD is not met as evidenced by: Based on staff and patient interview, and review of medical records and hospital policy, it was determined the hospital failed to ensure 4 of 30 Medicare patients (#1, #9, #11, and #27) were under the care of a physician. This resulted in a lack of supervision being provided to patients. Findings include: 1. Patient #11's medical record documented a 70 year old female who was admitted to the hospital on 3/03/11 and discharged on 4/08/11. Her diagnoses included ovarian cancer and abdominal fistula. Her History and Physical, dated 3/03/11, was written by a physician. Two physician progress notes were documented by the attending physician, on 3/20/11 and on 4/07/11. Patient #11 was followed daily by either a NP or a PA. Except for the 3/20/11 progress note, no documentation was present that the attending physician had examined Patient #11 from 3/04/11 through 4/06/11, a period of 33 days. Patient #11 was seen exclusively by a PA on 17 of those days and she was seen exclusively by a NP on 16 of those days. The Director of Case Managment was interviewed on 4/14/11 at 3:30 PM. She confirmed the absence of documentation regarding physician involvement in the care of Patient #11. The medical record did not contain documentation to show that Patient #11 was under the care of a physician. 2. Patient #9's medical record documented a 49 year old male who was admitted to the hospital on 2/19/11 and discharged on 2/26/11. His	A 064	the hospital Medical Director as the representative of MEC. The letter will contain a copy of the revised policy and bylaw verbiage and additional information regarding measurement and monitoring of compliance. Non-compliance will be managed as defined in the Medical Staff Rules and Regulations utilizing the Ongoing Professional Practice Evaluation model. • Measurement and monitoring measures were approved by MEC and GB. The review of compliance with twice weekly documented supervising physician visits to examine patients, and co-signature on all H&Ps and Discharge summaries will commence no later than 5/23/2011 via record review. Reviews will be conducted three times weekly Admission Orders and Discharge Orders require documentation that the order was under the direction of the supervising physician. The NP/PA will communicate daily with the supervising physician regarding the status of patients under that physician's care. Documentation of this communication will be evident in the medical record. Monitoring by the Medical Director of compliance will be accomplished by review of data collected by hospital administrator/designee at a minimum three times weekly review of the medical record beginning no later than 5/23/2011. Results will be reported at a minimum quarterly to MEC and GB. Any corrective action steps will be under the direction of the MEC in collaboration with the GB. **Person(s) Responsible: Administrator, Medical Director, Director of Quality and Risk Management (DQRM).**	

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A 064	Continued From page 9 diagnoses included chronic kidney disease, diabetes, and coronary artery disease. His History and Physical, dated 2/18/11, was written by a PA and cosigned by a Nephrologist, who was listed as Patient #9's primary physician, on 2/19/11. In addition, physician progress notes by another Nephrologist were also documented on 2/19/11 and 2/20/11. Daily progress notes by the NP for the Nephrology group were documented on 2/21/11, 2/22/11, 2/23/11, 2/24/11, and 2/25/11. No physician progress notes were documented during this time. On 2/26/11 at 1:05 PM, a progress note by a Pulmonary physician who was not associated with the Nephrology Group, documented he responded when Patient #9 suffered cardiac arrest to provide CPR. Patient #9 was resuscitated and transferred to an acute care hospital at that time. The Director of Case Managment was interviewed on 4/14/11 at 3:30 PM. She confirmed the absence of documentation regarding physician involvement in the care of Patient #9. The medical record did not contain documentation to show that Patient #9 was under the care of a physician. 3. Patient #27's medical record documented a 74 year old female who was admitted to the hospital on 3/30/11 and was a current patient as of 4/15/11. Her diagnoses included congestive heart failure and chronic renal failure. Her History and Physical, dated 3/31/11, was written by a NP and was cosigned by a physician on 4/02/11. The NP also documented a progress note on 3/31/11 and 4/01/11. A physician documented progress notes on 4/02/11 and 4/03/11. Subsequent daily	A 064		

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A 064	Continued From page 10 progress notes from 4/04/11 through 4/15/11 were all written by the NP. No documentation that a physician had seen Patient #27 on those dates or had participated in her care was present in the record. Also, her "ADMISSION ORDERS," dated 3/30/11 but not timed, were written by a PA but were not countersigned by the physician. The surveyor accompanied the NP when she examined Patient #27 on 4/12/11 at 9:55 AM. Patient #27 told the NP that her physician had not come to see her. The NP replied she was there to examine Patient #27. After the visit, the NP was asked if there was a scheduled time when the physician saw patients and cared for them. The NP stated there was no set pattern when the physician saw patients in place of the NP. The NP said the physician sometimes saw patients on weekends when she was off duty. She said she spoke with the physician frequently regarding patients but stated this communication was not documented. The medical record did not contain documentation to show that Patient #27 was under the care of a physician. 4. Patient #1's medical record documented a 79 year old male who was admitted to the hospital on 3/29/11 and was a current patient as of 4/15/11. His diagnoses included aspiration pneumonia and end stage kidney disease. His History and Physical, dated 3/30/11, was written by a NP and was cosigned by a physician on 4/02/11. The NP also documented a progress note on 3/31/11 and 4/01/11. A physician documented progress notes on 4/02/11 and 4/03/11. Subsequent daily progress notes from 4/04/11 through 4/14/11 were all written by the NP. No documentation	A 064		

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A 064	Continued From page 11 that a physician had seen Patient #1 on those dates or had participated in his care was present in the record. The NP who cared for Patient #1 was interviewed on 4/12/11 at 9:55 AM. She stated there was no set pattern when the physician saw patients. The NP said the physician saw patients if there was a problem the physician needed to address. The NP stated she was not aware if the hospital had developed a policy regarding how frequently the physician needed to see patients or under what circumstances mid-level providers such as NPs or PAs should consult with the physician. The medical record did not contain documentation to show that Patient #1 was under the care of a physician. The Medical Director was interviewed on 4/14/11 beginning at 4:55 PM. He confirmed patients were frequently seen by mid-level providers. He stated the hospital had not defined what it meant to be under the care of a physician. He said the hospital had not developed policies defining the role of physicians in relation to mid-level providers. The hospital failed to ensure patients were under the care of a physician.	A 064		
A 132	482.13(b)(3) PATIENT RIGHTS: ADVANCED DIRECTIVES The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §489.100 of this part (Definition), §489.102 of this part (Requirements for providers), and §489.104	A 132		

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A 132	Continued From page 12 of this part (Effective dates). This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure patients' code status was documented/communicated clearly and consistently in patient records to ensure patient wishes/advance directives would be honored. This impacted 2 of 31 patients (#4 and #18) whose records were reviewed. The lack of clarity had the potential to result in patients not having their advance directives honored. Findings include: 1. Patient #4 was an 81 year old female who was admitted to the ICU on 12/04/10 after transfer from another hospital. A "LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE" for Patient #4, dated 6/28/10, had a fax date of 12/03/10 at 12:07 PM, indicating the hospital received the document prior to her admission on 12/04/10. The living will stated "I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration. This directive shall be the final expression of my legal right to refuse or accept medical and surgical treatment, and I accept the consequences of such refusal or acceptance. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions." The living will was signed by Patient #4.	A 132	**A-132 Patient Rights: Advanced Directives** • The process for the documentation of the patient wishes related to advance directives, do not resuscitate, and other limited resuscitation desires was reviewed with education of staff regarding the differences between advanced directives and do not resuscitate (advance directives only take effect when patient in a terminal condition). The process finalized includes the admission order regarding code status, patient categorization orders, and documentation of code status changes. Effective 5/18/2011, at a minimum three times weekly for a minimum of 3 months, all inpatient records will be reviewed to determine the presence or absence of: 1. A MD/DO/LIP admission order documenting the patient's code status. 2. A MD/DO/LIP signed, dated, and timed "Patient Categorization Orders" which, as per PR 095 "Withholding/Withdrawing Life Sustaining Treatment (Advance Directives) which indicates the patient has discussed their wishes with the MD/DO/LIP and their order reflects those wishes 3. Any code status changes are reflected in the appropriate order forms. Code status changes will be noted and documented by Case Management. The nursing House Supervisor will be responsible to ensure the immediate need for all appropriate documentation to be complete and in the record if the change occurs during off hours such as nights and weekends. • **Person(s) Responsible: DQRM, DNO, Director of Case Management (DCS), Health Information Management Supervisor (HIMS).**	

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A 132	Continued From page 13 The Director of Case Management was interviewed on 4/13/11 beginning at 10:15 AM. She was asked to read Patient #4's advance directive, dated 6/28/10, and state how she understood it. She stated she interpreted it as a DNR. Physician "ADMISSION ORDERS," for Patient #4, dated 12/04/10 and untimed, did not list code status. There were boxes available to check, indicating full code, advanced directive, and DNR. None of these boxes were checked. There were no other physician orders designating code status present in Patient #4's record at admission. The physician's "HISTORY AND PHYSICAL," dated 12/04/10, documented Patient #4's code status as a "limited code." It stated Patient #4 did not want a ventilator, defibrillator, chest compressions or intubation. It stated the physician had discussed this with Patient #4's caregiver and family. Additionally, "PHYSICIAN PROGRESS NOTES" documented "limited code" status, without defining the limits of the code as in the H&P, from the time of admission, until code status documentation changed on 12/21/11 (17 days after admission). The Director of Case Management was interviewed on 4/13/11 beginning at 10:15 AM. She was asked to look at Patient #4's record and explain what the "limited code" entailed that was indicated in the physician's progress notes. She reviewed the record and stated she did not know what the limits of the code were. She stated there should have been a physician's order in Patient #4's record but she did not see one.	A 132		

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A 132	Continued From page 14 The hospital had a green form titled "PATIENT CATEGORIZATION ORDERS." The form was routinely placed in the front of patient records to communicate to staff patients' code status, such as full code, no code/DNR, or a limited code. If a patient was designated by the physician as a limited code, the boxes were checked to indicate the limits of the code, including the following: No intubation No ventilator No defibrillation No closed chest compressions Do not call a Code Blue No telemetry No other measures (specify) No chemical agents (Resuscitation drugs) This form was not in Patient #4's record. Staff would not have had access to the limits of the code unless they knew to search out information in the H&P. The physician who designated the "limited code" for Patient #4 was interviewed on 4/13/11 beginning at 3:30 PM. He stated he reviewed the wishes of Patient #4 and her family at the time of admission and documented the wishes in his H&P. He stated he thought he wrote an order for the limited code status on the green sheet and it should have been in the record. He stated he knew it was important and acknowledged the order form was not present in Patient #4's record. A hospital policy, "Do not Resuscitate (DNR) - No Code," dated February 2006, stated A Code Blue will be initiated on any patient in need of emergency resuscitation due to cardiac and/or respiratory arrest unless there is a written "Do Not	A 132		

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A 132	Continued From page 15 Resuscitate" (DNR) order OR the patient presents with a comfort ONE/DNR bracelet or form. In the absence of a DNR order, there is the presumption that patient wishes to be resuscitated. The policy did not address "limited code" status. Patient #4's record lacked clear and consistent information to ensure patient wishes (advance directives) would have been honored. 2. Patient #18 was a 49 year old female admitted to the hospital on 4/06/11. The record documented inconsistencies in information related to patient wishes and code status, as follows: > A "LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE," dated 10/10/05, stated "I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn." A handwritten note on another page of the document stated "wants to be kept alive artificially for at least 24 hours after doctors have stated there is no chance." It was unclear who wrote the additional note, whether it was Patient #18 or her legal representative. > A "PREADMISSION SCREEN," dated 3/28/11, documented Patient #18's code status as "DNR." > Untimed admission orders, dated 4/06/11, identified Patient #18 as full code status. > A speech therapy note, dated 4/07/11, documented Patient #18's code status as "DNR"	A 132		

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A 132	Continued From page 16 on a form titled "DYSPHAGIA ASSESSMENT & DISCHARGE." > "PHYSICIAN PROGRESS NOTES" documented full code status for Patient #18 on 4/09/11 at 12:49, 4/10/11 at 2:16 PM, and 4/11/11 at 5:48 PM. The Speech Therapist who documented "DNR" status was interviewed on 4/14/11 at 10:00 AM. When asked how she decided on a patient's code status, she stated she reviewed the Pre-Admission form, which indicated the patient's status at the previous hospital since all of their patients arrive as transfers from other facilities. She stated Patient #18's prior hospitalization indicated DNR status. The record lacked clarity and consistency related to code status to ensure Patient #18's wishes would be honored.	A 132		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the hospital failed to ensure the use of restraints was in accordance with physician orders for 3 of 5 restrained patients (#6, #12, and #29) whose records were reviewed. This resulted in unauthorized restraint use. Findings include:	A 168	**A-168 Patient Rights: Restraint or Seclusion** **1. Restraint Orders** • Effective April 12, 2011, Physician/LIP restraint orders were edited to include the provision for all restraint orders to be effective for a 24 hour period. These changes were approved by the Governing Body on March 15, 2011. On May 11, 2011, during a House Supervisor meeting, House Supervisor (HS) staff was reminded of their responsibility to participate in a nursing driven proeess to ensure no restraints are used past 24 hours from the order being written. The process involves both night and day shift HS. The night HS will identify all patients who, based upon a nursing assessment, will likely require restraints in the immediate future. Pre-printed orders will be pulled for each patient and provided to the day shift HS. The day shift HS will also complete a brief assessment in addition to the assessment completed by the LN assigned to that patient's care to ensure appropriate restraint use. The HS has the responsibility to inform the MD/DO/LIP of the patient assessment and facilitate their assessment of the patient to determine the continued medical necessity for restraints. This medical necessity will be documented on the restraint order form. The HS will oversee the process to ensure no restraints are used without a valid order and that renewal orders are provided by the MD/DO/LIP less than or equal to 24 hours from the previous order.	

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A 168	Continued From page 17 1. Patient #6 was a 37 year old female who was admitted to the hospital on 1/24/11. Restraint orders were written for "1 calendar day," (i.e. the restraint orders would expire at 11:59 PM on the day the orders were written). They included the following restraint orders: > 1/25/11 at 8:00 AM for a left wrist restraint > 1/26/11 at 8:00 AM for a left wrist restraint > 1/26/11 at 4:00 PM for a left wrist restraint > 1/27/11 at 8:00 AM for a left wrist restraint and 4 bed rails > 1/28/11 at 8:00 AM for a left wrist restraint and 4 bed rails > 1/29/11 at 8:00 AM for a left wrist restraint and 4 bed rails > 1/30/11 at 10:00 AM for a left wrist restraint Nursing documentation indicated restraints continued through the night and were not discontinued at 11:59 PM according to the physician's orders. The type of restraints applied and monitored were not documented on the "Restraint Flow Sheet" for the dates listed above. The ICP was interviewed on 4/13/11 at 10:15 AM. She reviewed Patient #6's record and confirmed nursing staff did not document the type of restraints applied, and the physician's orders were for 1 calendar day and should have been written for 24 hours. Restraint orders were not followed in accordance with physician orders. 2. Patient #12 was a 72 year old male admitted to the hospital on 4/09/11 and a current patient at the time of the survey. Restraint orders were	A 168 Cont	• Daily chart audits will be conducted for a minimum of 3 months and intermittently thereafter to determine compliance with the documentation requirements listed above. • Hospital policy PC 200 "*Restraint Use*" has been revised to reflect 24 hour time frame validity vs. one calendar day. The edits were approved at the March 15th GB meeting • Non-compliance will result in corrective action planning on the part of the LN or MD/DO/LIP via MEC and Ongoing Professional Practice Review. Restraint order compliance data will be analyzed and reported to CP, QC, MEC, and Governing Body to ensure all aspects of this process are integrated in to the hospital QA/PI program. **Person(s) Responsible: Medical Director, Director of Nursing (DON) and DQRM**	

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A 168	Continued From page 18 written for "1 calendar day," (i.e. the restraint orders would expire at 11:59 PM on the day the orders were written). They included the following restraint orders: > 4/09/11 at 4:15 PM for bilateral wrist restraints and 4 bed rails > 4/10/11 at 2:00 PM for bilateral wrist restraints and 4 bed rails > 4/11/11 at 9:00 AM for bilateral wrist restraints Nursing documentation indicated restraints continued through the night and were not discontinued at 11:59 PM according to the physician's orders. The types of restraints were not documented on the "Restraint Flow Sheet" on 4/09/11. Wrist restraints were documented on the "Restraint Flow Sheet" for 4/10/11 but there was no documentation of the 4 bed rails. The ICP was interviewed on 4/13/11 at 10:15 AM. She reviewed Patient #12's record and confirmed there was no documentation as to the type of restraints applied on 4/09/11 and 4/10/11. She also confirmed all physician orders were for 1 calendar day and stated they should have been written for 24 hours. Restraint orders were not followed in accordance with physician orders. 3. Patient #29 was a 60 year old female who was admitted to the hospital on 2/10/11. Restraint orders were written for "1 calendar day," (i.e. implying the restraint orders would expire at 11:59 PM on the day the orders were written). They included the following restraint orders: > 2/15/11 at 2:35 PM for bilateral wrist restraints,	A 168		

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A 168	Continued From page 19 > 2/16/11 at 10:00 AM for bilateral wrist restraints, > 2/17/11 at 10:00 AM for bilateral wrist restraints, > 2/18/11 at 10:00 AM for bilateral wrist restraints, > 2/19/11 at 10:00 AM for bilateral wrist restraints, > 2/20/11 at 10:00 AM for bilateral wrist restraints, > 2/21/11 at 9:30 AM for bilateral wrist restraints and 4 bed rails. Nursing documentation of restraint monitoring continued through the nights and were not discontinued at the end of each calendar day per physician's orders. During an interview on 4/14/11 at 12:05 PM, an ICP reviewed Patient #29's record and confirmed the physician orders were written for 1 calendar day rather than for a 24 hour period. Restraint orders were not followed in accordance with physician orders.	A 168		
A 214	482.13(g) PATIENT RIGHTS: SECLUSION OR RESTRAINT Death Reporting Requirements: Hospitals must report deaths associated with the use of seclusion or restraint. (1) The hospital must report the following information to CMS: Each death that occurs while a patient is in restraint or seclusion. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion. Each death known to the hospital that occurs within 1 week after restraint or seclusion where it	A 214		

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A 214	Continued From page 20 is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation. (2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient ' s death. (3) Staff must document in the patient's medical record the date and time the death was reported to CMS. This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of facility policy and procedures, it was determined the facility failed to ensure all deaths occurring within 24 hours after restraints had been removed were reported to CMS and/or the reporting to CMS was document in the medical record with the date and time the report was made for 2 of 4 deceased patients (#3 and #5) whose records were reviewed. Failure to report the incident had the potential to impede CMS statistics and failure to document the reporting had the potential to result in an incomplete medical record. Findings include: 1. The facility's policy titled "Restraint Use," revised 1/11, stated under the "Reporting" section that "The death of any patient while in restraints must be reported to the CMS Regional Office as follows: .....each death that occurs within 24 hours after	A 214	**A-214 Patient Rights: Seclusion or Restraint** • Effective 5/10/ 2011, the Senior Management team reviewed the *"CMS Patient Death while Restraints in Use"* process. The senior management group changed the process for reporting any death with any possibility of restraint use correlation which was communieated to the House Supervisor staff on 5/12/2011. Process changes included posting of sample and completed forms on the Senior Management share drive, review of policy PC 200 "*Restraint Use*", and review of the internal "Death of a Patient" form were completed on 5/13/2011. This form will be the document where notification of CMS will be completed in all future transactions. The senior management call log includes specific information related to questions to be asked any time a patient death is reported to the Administrator on Call to ensure 24 hour coverage. Any notices of patient deaths will be reviewed at a minimum weekly in senior management meetings. • Compliance review will be accomplished by 100% patient death review. Electronic and paper copies of all CMS notifications will be archived by the DQRM and reviewed at a minimum quarterly with MEC and GB. **Person(s) Responsible: DQRM, DON, DCS, DCM, Chief Financial Officer (CEO), Director of Pharmacy (DOP), Director of Therapy (DOP), Chief Financial Officer (CFO), Director of Marketing and Business Development (DMBD).**	

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A 214	Continued From page 21 the patient has been removed from restraint." The policy further stated "Staff must document in the medical record the date and time the death was reported to CMS." The policy was not implemented as follows: a. Patient #3 was an 80 year old female who was admitted to the facility on 10/15/10 for care related to an infection of her abdominal cavity following surgery. A "Restraint Orders" form was completed by the NP on 10/26/11 at 8:30 AM. The NP ordered bilateral wrist restraints. A "Restraint Flow Sheet," for 10/26/10 documented the restraint were used until they were discontinued at 11:15 AM on 10/27/10. Patient #3 expired at 3:09 PM, less than 4 hours after the restraints were removed. No documentation was found in Patient #3's record indicating CMS was notified of her death within the 24 hour time frame of restraint usage. In an interview on 4/14/11 at 4:40 PM, the Director of Quality and Risk Management stated CMS had not been notified of Patient #3's death within 24 hours of restraint use. The facility failed to report Patient #3's death which occurred within 24 hours of restraint use. b. Patient #5 was admitted on 1/04/11 for care primarily related to sepsis. Patient #5's medical record contained a "Restraint Orders" form signed by the physician on 1/25/11 at 8:00 AM. The physician ordered a soft left wrist restraint. A "Restraint Flow Sheet" form for 1/25/11, completed by nursing staff, documented restraint usage from 7:00 AM on 1/25/11 through 1/26/11	A 214		

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A 214	Continued From page 22 at 5:00 AM when the restraint was discontinued. The medical record documented Patient #5 passed away at 1/26/11 at 5:20 PM, 12 hours and 20 minutes from the time the restraint was discontinued. On 4/14/11 at 11:05 AM, the Director of Quality and Risk Management stated the required report to CMS was not kept in the medical record, but was filed in a separate location. He then provided a copy of the report. The hospital did not document the report to CMS in Patient #5's medical record. Deaths occurring within 24 hours of restraint usage were not reported and/or not documented in the medical record with the date and time of CMS notification of the death.	A 214		
A 396	482.23(b)(4) NURSING CARE PLAN 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, policies and procedures, and interviews with staff, it was determined the hospital failed to ensure POCs were developed and/or updated for 4 of 31 patients (#16, #23, #26 and #28) whose records were reviewed. This resulted in a lack of direction to interdisciplinary staff in the delivery of care to patients and had the potential to interfere with coordination of patient care. Findings include: 1. Patient #26 was a 58 year old female admitted to the facility on 4/11/11 for continued medical	A 396		

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A 396	Continued From page 23 management for congestive heart failure as well as spinal osteomyelitis (an infection of the bone). Additional diagnoses included lower extremity paralysis, COPD, pneumonia, pressure ulcers to her gluteal crease and buttocks, urinary tract infection, anemia, depression and anxiety. The POC for Patient #26 was initiated on 4/11/11 and contained several sections related to nursing diagnoses. The following examples indicated an incomplete POC: a. In the section related to "ALTERATION IN SKIN INTEGRITY," the care plan described the wound location as "spinal," and was not signed by a nurse. The pressure ulcers to her gluteal crease and buttocks were not included in the care plan, although they were documented on a "WOUND ADDENDUM/WEEKLY UPDATE" form initiated on 4/11/11 by the Wound Care RN. b. In the "ALTERATION IN PULMONARY STATUS" section, "COPD" was listed as a reason for altered pulmonary status. The care plan did not include MRSA pneumonia as described in the admission notes written by the NP. Interventions on the care plan included oxygen therapy, but did not specify the liter flow rate. The POC also included an intervention of oxygen monitoring, but the frequency for monitoring was not noted. The care plan did not include a goal, and was not signed or dated. c. A nursing diagnosis, titled "ALTERATION IN SWALLOWING FUNCTION" was included in the care plan, but was not addressed. However, the admission H&P dictated by the NP included dysphagia (difficulty swallowing) with a reference to speech therapy for a modified barium swallow procedure. This indicated Patient #26 had an	A 396	**A-396 Nursing Care Plan** • A new process was implemented on 1/3/11 with new forms for the documentation of care plans. During the period from 1/3/11 through present, audits have been done with education, training, and one to one inservice with nursing personnel regarding appropriate and complete patient plan of care. Data collected from 1/3/11 indicated improvements have occurred with continued improvement desired. Additional interventions have been implemented since 5/1/11 and include further review during case conferences conducted for all patients in the Med/Surg environment (weekly) and High Observations (three times weekly) with updates as indicated. Staff will directly interact with all disciplines to ensure plans, barriers, progress, and results of care efforts. For a minimum of 3 consecutive months via heads up meetings (both shifts), staff meetings, and 1:1 dialogue, feedback and education will be provided to staff members related to interdisciplinary care planning. In addition, review and as needed, update of the plan of care will become an integral part of the 12 hour chart checks on both shifts. Effective 5/2/2011, mandatory licensed nursing staff classes were repeated to review the key components of documentation of the plan for the provision of care to patients. All licensed nursing staff has completed the required education as of 5/13/2011.	

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A 396	Continued From page 24 alteration in swallowing function which should have been addressed in the care plan. d. The nursing diagnosis of "ALTERATION IN ACTIVITIES OF DAILY LIVING," was not addressed, although the "ADMISSION ASSESSMENT" on 4/11/11 at 2:35 PM documented Patient #26 required assistance with toileting, bathing, dressing, and mobility. e. The nursing diagnosis "ALTERATION IN COPING AND ADJUSTMENT" was addressed, although it was not initialed by a nurse. Interventions included "Provide access to support (clergy, support groups, counseling, etc.), and communicate with patient the POC and discharge plan a minimum of three times a week." The admission H&P dictated by the NP on 4/11/11 described Patient #26 as living alone, depressed, history of multiple substance abuse, an estranged relationship with her family, and an extensive psychiatric history. The same information was noted by the admitting nurse in the " ADMISSION ASSESSMENT" on 4/11/11 at 2:35 PM. The interventions on the care plan did not include interventions to meet Patient #26's psychological and social needs during her hospitalization and preparation for discharge. In an interview on 4/15/11 at 2:40 PM, the RN caring for Patient #26 reviewed the record and confirmed the care plan had not been completed and did not demonstrate a personalized nursing plan of care to meet the needs of Patient #26. 2. In an interview on 4/12/11 at 10:00 AM, the DON. She stated the facility utilized an interdisciplinary POC that covered a 5 week time span. She stated staff were to update the POC	A 396	• Nursing leadership including house supervisory staff will continue to provide 1:1 leadership and direction for licensed staff to include oversight, education, and coaching/counseling as necessary based on the results of the weekly reviews. • Results from the care plan reviews will be communicated to Clinical Process (CP) every two weeks and at a minimum quarterly to QC, MEC, and GB to ensure the information, process improvements, and educational opportunities are integrated in to the hospital QA/PI program. **Person(s) Responsible: DQRM, DON, DCM, DCS, DTO, DPO**	

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A 396	Continued From page 25 on a weekly basis. In the following examples the POC did not contain updated information: a. Patient #23 was a 68 year old female admitted to the facility on 3/18/11. She was admitted for continued medical management of respiratory failure. She had an abdominal wound subsequent to colon surgery and received antibiotics for sepsis. The following diagnoses were addressed in the initial POC, however were not updated on a weekly basis: > Patient #23's medical record contained an order from the NP on 3/29/11 at 2:10 PM for staff to apply ace wraps to both lower extremities to decrease edema. In addition, "PHYSICIAN PROGRESS NOTES" completed by the NP on 3/30/11, indicated Patient #23's lower extremities were to be elevated in addition to being wrapped with ace bandages. This POC was not updated with this information. > "PHYSICIAN PROGRESS NOTES," dated 4/06/11 indicated Patient #23 had a rectal tube in place (not present on admission) and had persistent diarrhea. However, the section related to "ALTERATION IN ELIMINATION" was not updated to reflect this change in status. > The section related to "ALTERATION IN SAFETY AND BEHAVIOR" was not updated for the weeks 4/05/11 or 4/12/11. > The section related to "ALTERATION IN SWALLOWING FUNCTION" was not updated for the weeks 4/05/11 or 4/12/11.	A 396		

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A 396	Continued From page 26 The ICP was interviewed on 4/14/11 at 11:45 AM. She reviewed Patient #23's POC. She stated the facility was working on staff education related to information to be placed on the care plans and updating the care plans. She confirmed the POC for Patient #23 was not current and complete. b. Patient #28 was a 49 year old male admitted to the facility on 4/01/11. Patient #28 was being treated for acute respiratory failure and was so weak he was unable to move his extremities. The following diagnoses were addressed in the initial POC but were not updated on a weekly basis: > The section related to "INFECTIOUS PROCESS" was not updated after 4/04/11. > The section related to "POTENTIAL FOR SKIN BREAKDOWN" was not updated after 4/04/11. > The section related to "ALTERATION IN SKIN INTEGRITY" was not updated after 4/02/11. The POC indicated his chest tube was discontinued on 4/02/11 and he received dressing changes directed by the Wound Care RN. > The section related to "ALTERATION IN PAIN/COMFORT" was not updated after 4/02/11. > The section related to "ALTERATION IN ELIMINATION" was not updated after 4/02/11. The POC contained documentation from 4/02/11 that Patient #28 had a rectal tube in place. The RN who took care of Patient #28 was interviewed on 4/14/11 at 8:10 AM. He stated Patient #28 no longer had a rectal tube and was unsure of when it was discontinued.	A 396		

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A 396	Continued From page 27 > The section related to "ALTERATION IN SAFETY AND BEHAVIOR" was not updated after 4/01/11. A staff RN reviewed Patient #28's medical record on 4/14/11 at 2:50 PM. She stated the sections noted above were not updated. She stated improvements had been made to the care plans and staff continued to receive education on appropriate documentation. Nursing care plans were not kept current. 3. Patient #16's admission assessment completed by nursing on 4/08/11 included a Braden Scale assessment of her potential for skin breakdown. The Braden Scale score for Patient #16 was 16. The Braden Scale assessment instruction included on the form stated "If score is 16 or less, patient is at high risk, incorporate into care plan." On Patient #16's POC, dated 4/08/11, no goals or interventions were checked as applicable to her under the category of "POTENTIAL FOR SKIN BREAKDOWN." The space on the POC to enter a patient's latest Braden Scale score was blank. None of the check boxes used to identify the reasons for potential skin breakdown or to indicate no care issues existed, were checked. Further, a nursing progress note in Patient #16's record, dated 4/10/11 at 8:45 AM, also included a Braden Scale assessment resulting in a score of 16. Patient #16's "POTENTIAL FOR SKIN BREAKDOWN" POC update for the week of 4/11/11 - 4/17/11, was similarly blank. The DON was interviewed, on 4/14/11 at 9:15 AM. When asked about the Braden Scale scores	A 396		

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A 396	Continued From page 28 and Patient #16's POC, she stated the expectation is that if a problem is identified when the patient is admitted, the nurse checks the boxes on the POC accordingly to identify goals and interventions. She confirmed the POC was incomplete.	A 396		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure all patient medical record entries were complete, dated, and timed for 6 of 31 patients (#5, #8, #7, #11, #13, and #25) whose records were reviewed. This interfered with clarity of the course of care and had the potential to interfere with coordination of patient care. Findings include: 1. Incomplete Medication Administration Record documentation. A hospital policy, "Medical Record Documentation & Content," dated August 2008, stated the medical record documentation would contain sufficient information to document the course and facilitate continuity of care. It would include documentation of any medication administered. The "Medication Administration Record," (MAR) for each patient had pre-populated times for regularly scheduled medications. According to	A 450	**A-450 Medical Records Services-Complete entries** • A review of the processes and requirements per policy and regulation was completed and found to be appropriate by the leadership of the hospital. • Beginning 4/25/2011 via Heads up meetings (both shifts), 1:1 dialogue, and other means of communication to be completed by 5/26/2011, all clinical	

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A 450	Continued From page 29 the ICP during an interview on 4/14/11 at 12:05 PM, when a medication was given, nursing staff was expected to write initials next to the time. When a medication was held, staff were expected to circle the time and write an explanation. Pre-populated medication times on MARs were not initialed or circled to indicate whether they had been given or held, as follows. a. Patient #5's MAR did not document medications had been given or held: > 1/07/11 Albuterol inhaler at 1:00 AM, > 1/24/11 Albuterol inhaler at 7:00 PM, > 1/25/11 Albuterol inhaler at 1:00 AM. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the MAR was incomplete. b. Patient #25's MAR did not document medications had been given or held: > 4/07/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM, > 4/08/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM and 2:00 PM, > 4/09/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM, > 4/10/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM and 2:00 PM, > 4/11/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM, > 4/12/11 Ipratropium 0.5 mg - Albuterol 3.0 mg at 6:00 AM. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the	A 450 Cont	staff were required to review IM 040 *"Medical Record Documentation & Content"*. Discussions ensued as to the need for complete medical reeord entries including documentation of medications administered or held and dating/timing of all entries. • 12 hour chart checks are completed once per shift and will now include a thorough review of the patient medical record to ensure all entries are complete including dating and timing. • Monthly quantitative and qualitative chart audits are completed on 5 closed records and 10 open records by all disciplines. Included in these audits will be a review of chart entries including dating and timing, documentation of medications given or held, and overall medical record completion. Results will be reported monthly via the Health Information Management (HIM) meeting. Action plans will be developed during the HIM meeting and implemented after the appropriate education of staff, coaching, counseling, and system/process review. This process will continue for, at a minimum, 3 months. Results including analysis of data and corrective action recommendations will be reported at a minimum quarterly to Quality Council (QC), MEC and GB. **Person(s) Responsible: DQRM, HIMS, DON, DCS, DPO, DCM, DOT, DMDB**	

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A 450	Continued From page 30 record and confirmed the medication administration times had not been initialed. c. Patient #7's MAR dated 3/18/11, did not document a medication had been given or held: > Gabapentin 300 mg at 6:00 AM. In an interview on 4/14/11 at 4:35 PM, the Director of Case Management (an RN) reviewed the record and confirmed the medication administration time had not been initialed. d. Patient #11's MAR dated 3/19/11,did not document a medication had been given or held: > Lovenox 40 mg at 4:00 PM. In an interview on 4/14/11 at 4:35 PM, the Director of Case Management reviewed the record and confirmed the medication administration times had not been initialed. e. Patient #13's MAR dated 4/01/11, did not document the medications (listed below) had been given or held: > Lovenox 40 mg subcutaneous at 9:00 AM, > KCL (Potassium Chloride) 20 mEq at 9:00 AM, > Lasix 40 mg every day at 9:00 AM, > Ipratropium 0.5 mg - Albuterol 3.0 mg solution 3 ml at 7:00 AM and 1:00 PM. In an interview on 4/14/11 at 11:10 AM, the RN providing care for Patient #13 reviewed the record and confirmed the medication administration times had not been initialed. f. Patient #8's MAR did not document medications	A 450		

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A 450	Continued From page 31 (listed below) had been given or held: > 3/30/11 Gabapentin Capsule, 100 mg at 6:00 AM, > 3/31/11 Biscadoyl, 10 mg Suppository at 6:00 AM, > 3/31/11 Sulfamethoxazole Trimethoprin Tablet, 800 mg at 6:00 AM, > 4/01/11 Beneprotein 2 scoops at 6:00 AM, > 4/01/11 Boost 1 box at 6:00 AM, > 4/01/11 Sulfamethoxazole Trimethoprin Tablet, 800 mg at 6:00 AM, > 4/04/11 Combivent Aerosol, 8 puffs at 1:00 AM, > 4/06/11 Combivent Aerosol, 8 puffs at 7:00 AM and 1:00 PM, > 4/06/11 Duoneb 3 ml every 6 hours at 7:00 AM and 1:00 PM, > 4/07/11 Combivent Aerosol, 8 puffs at 1:00 AM, > 4/07/11 Duoneb 3 ml at 1:00 AM, > 4/08/11 Combivent Aerosol, 8 puffs at 1:00 AM, > 4/08/11 Duoneb 3 ml at 1:00 AM, > 4/09/11 Beneprotein 2 scoops at 6:00 PM. In an interview on 4/14/11 at 3:15 AM, the RN providing care for Patient #8 reviewed the record and confirmed the medication administration times had not been initialed. The facility failed to ensure the patients' MARs were complete. 2. Documents that Were Not Signed, Not Dated, and/or Not Timed, or Incomplete a. Patient #5's "ADMISSION CLINICAL SUMMARY" was filled out by the attending physician and dated 1/05/11. It was untimed. In an interview on 4/14/11 at 4:25 PM, the	A 450		

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A 450	Continued From page 32 Director of Case Management reviewed the record and agreed the "ADMISSION CLINICAL SUMMARY" was untimed. b. Patient #25 "ADMISSION CLINICAL SUMMARY" was filled out by the attending physician and dated 2/08/11. It was untimed. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the "ADMISSION CLINICAL SUMMARY" was untimed. c. The hospital's policy, titled "Informed Consent" dated 2/06 and revised 6/10, contained a procedure for obtaining telephone/verbal consent which stated "the hospital staff members should complete the consent form, sign as witnesses, and date and time their signatures." The policy further stated "every effort will be made to obtain the original form as soon as possible to be placed on the chart." Patient #13, a 76 year old female was admitted to the hospital on 3/10/11. The admission consent form, titled "CONSENT TO HOSPITAL ADMISSION AND GENERAL MEDICAL TREATMENT," dated 3/10/11, was signed as witnessed by two individuals, one of whom did not provide a title or discipline. The consent indicated Patient #13's husband gave verbal consent. A signature from Patient #13's was not obtained and a signature from her husband was not obtained on his subsequent visits according to hospital policy. In an interview on 4/14/11 at 11:10 AM, the RN providing care for Patient #13 reviewed Patient #13's record and confirmed the findings. She	A 450		

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A 450	Continued From page 33 stated she did not know the facility policy required a signature by the guardian or spouse after the telephone or verbal consent was obtained. The admission consent form was incomplete. A form titled "AN IMPORTANT MESSAGE FROM MEDICARE ABOUT YOUR RIGHTS," dated 3/10/11, provided a section for the patient or representative signature and date, and read: "Sign and date here to show you received this notice and understand your rights." Patient #13's husband's name and date were documented on the form. The form was not signed by the husband as the person acknowledging receipt. In an interview on 4/13/11 at 11:30 AM, the husband of Patient #13 stated he lived far away, and came to visit his wife several days each week. He stated he had not been approached to sign any consent that had been obtained by telephone. All medical record entries were not complete, dated, and timed.	A 450		
A 454	482.24(c)(1) ORDERS DATED AND SIGNED (i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section. (ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to write orders by hospital policy in accordance with State law.	A 454	**A-454 Medical Records Services-Dating and Timing of Chart Entries** • A review of the processes and requirements per policy and regulation was completed and found to be appropriate by the leadership of the hospital. • The MEC along with those credentialed practitioners on the medical staff who are active at the hospital were educated in person regarding the date and time requirements. Additional practitioners will be re-educated regarding these requirements in a written communication that will be provided no later than 5/26/11. • All forms utilized were reviewed for the required elements (date and time) with updates to forms missing the time of the entry with implementation no	

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A 454	Continued From page 34 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the hospital failed to ensure all orders were dated, timed, and authenticated for 9 of 31 patients (#2, #5, #14, #15, #16, #18, #25, #27, and #28) whose records were reviewed. This resulted in a lack of clarity about the course of care. Findings include: 1. Patient #16 was an 85 year old patient admitted to the hospital on 4/08/11. A "NO CODE/DNR" order, written by a PA was not dated or timed. During an interview on 4/13/11 at 12:35 PM, an RN reviewed Patient #16's record and confirmed the PA's "NO CODE/DNR" order was not dated or timed. "ADMISSION ORDERS," dated 4/08/11, written by a PA, were not timed. During an interview on 4/14/11 at 4:30 PM, the Director of Case Management reviewed the record and confirmed the order was written by a PA and untimed. 2. Patient #18 was a 49 year old female admitted to the hospital on 4/06/11. A physician's order for a "FULL" code, documented on a form titled "PATIENT CATEGORIZATION ORDERS" was not dated or timed. During an interview on 4/13/11 at 11:35 AM, an RN reviewed Patient #18's record and confirmed the order was not dated or timed. 3. Patient #27's medical record documented a 74 year old female who was admitted to the hospital on 3/30/11 and was a current patient as of 4/15/11. Her diagnoses included congestive heart failure and chronic renal failure. Her "ADMISSION ORDERS" form was filled out by	A 454 cont	later than 5/20/11. • Beginning 4/25/2011 via Heads up meetings (both shifts), 1:1 dialogue, and staff meetings ending on 5/20/2011, all clinical staff were required to review IM 040 *"Medical Record Documentation & Content"*. Discussions ensued as to the need for complete medical record entries including documentation of medications administered or held and dating/timing of all entries. Based upon feedback from staff, the current systems, process and resources are adequate to ensure the hospital policy is followed • 12 hour chart checks are completed once every shift and will include a thorough review of the activities for the previous 12 hours such as execution of orders. • Monthly quantitative and qualitative chart audits are completed on 5 closed records and 10 open records by all disciplines. Included in these audits will be a review of chart entries including dating and timing, documentation of medications given or held, and overall medical record completion. Results will be reported monthly via the Health Information Management (HIM) meeting. Action plans will be developed during the HIM meeting and implemented after the appropriate education of staff, coaching, counseling, and system/process review. This process will continue for, at a minimum, 3 months. Results including analysis of data and corrective action recommendations will be reported at a minimum quarterly to Quality Council (QC), MEC and GB. **Person(s) Responsible: Medical Director, DQRM, DON, DCS, DTO, DPO, HIMS, DMBD**	

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A 454	Continued From page 35 the PA and dated 1/04/11. The orders were not timed. In an interview on 4/14/11 at 4:35 PM, the Director of Case Management reviewed the record and confirmed the "ADMISSION ORDERS" were not timed. 4. Patient #28 was a 49 year old male admitted to the facility on 4/01/11 and was a current patient at the time of the survey. According to the "HISTORY & PHYSICAL," dictated by the physician on 4/02/11, Patient #28 was being treated for acute respiratory failure and was so weak he was unable to move his extremities. His "ADMISSION ORDERS" were dated and signed, but not timed, by the physician on 4/01/11. A staff RN reviewed Patient #28's medical record on 4/14/00 at 2:50 PM. She verified the admission orders were not timed. 5. Patient #2 was a 73 year old female admitted to the facility on 2/22/11 and discharged on 4/01/11. She was treated for therapy related to a right hip fracture and multiple pressure ulcers. Two pages of "ADMISSION ORDERS" were signed and dated, but not timed, by the physician on 2/22/11. During an interview on 4/14/11 at 4:05 PM, the Director of Case Management reviewed the medical record. She confirmed the admission orders lacked a time of completion by the physician. 6. Patient #5 was admitted on 1/04/11 for care primarily related to sepsis. The "ADMISSION ORDERS" form was filled out by the physician	A 454		

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A 454	Continued From page 36 and dated 1/04/11. The orders were untimed. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the "ADMISSION ORDERS" were untimed. 7. Patient #14 was admitted on 3/25/11 for care primarily related to a deep back wound. The "ADMISSION ORDERS" form was filled out by the physician and dated 3/25/11. The orders were untimed. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the "ADMISSION ORDERS" were untimed. 8. Patient #15 was admitted on 3/30/11 for care primarily related to hemorrhagic stroke. The "ADMISSION ORDERS" form was filled out by the physician and dated 3/30/11. The orders were untimed. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the "ADMISSION ORDERS" were untimed. The "PATIENT CATEGORIZATION ORDERS" form (code status), was signed by the physician but was not dated or timed. Patient #15's code status was changed on the "PHYSICIAN'S ORDERS" on 4/04/11. The order was dated and signed by a physician, but not timed. In an interview on 4/13/11 at 4:00 PM, the DON agreed that the "PATIENT CATEGORIZATION ORDERS" form was not dated or timed. She	A 454		

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A 454	Continued From page 37 confirmed the "PHYSICIAN'S ORDERS," dated 4/04/11, were also untimed. 9. Patient #25 was admitted on 2/08/11 for care primarily related to acute respiratory failure requiring ventilation. The "ADMISSION ORDERS" form was filled out by the physician and dated 2/08/11. The orders were untimed. The "PATIENT CATEGORIZATION ORDERS" form, was signed by the physician and dated 3/09/11, but was not timed. In an interview on 4/14/11 at 4:25 PM, the Director of Case Management reviewed the record and agreed the "ADMISSION ORDERS" and the "PATIENT CATEGORIZATION ORDERS" were not timed. The hospital did not ensure all orders were timed.	A 454		
A 457	482.24(c)(1)(iii) VERBAL ORDERS AUTHENTICATED BASED ON LAW All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure verbal orders were authenticated within 48 hours for 4 of 31 patients (#2, #16, #23, and #27) whose records were reviewed. This impeded the ability of the facility to quickly identify potential errors in interpretation and transcription of orders which had the potential to impact patient care and safety. Findings include:	A 457	**A-457: Verbal Orders Authenticated Based On Law** • Processes related to limiting verbal orders and obtaining verbal order authentication were developed. • On April 20, 2011, memos were posted informing staff to avoid verbal orders if the ordering provider is present. • A process was developed that would identify all verbal or telephone orders by Health Unit Coordinator (HUC) staff to alert MD/DO/NP/PA staff to all verbal and/or telephone orders that need authentication utilizing a "flag" indicator for each order. Additional assistance in flagging the order would be provided through the qualified person that took the verbal or telephone order. MD/DO/NP/PA will review each medical record at the time of daily documentation authenticate the order including date, time, and signature. . • On 5/12/2011, the MEC approved the process with the notification of all medical staff practitioners of the process, requirements, and follow up through the written notification and summary of hospital policy, PC 195 *"Physician Orders"* and the Rules and Regulations of the Medical Staff. A copy of the requirements will be included in the correspondence to be distributed to the medical staff no later than 5/20/2011 and signed by the Medical Director or President of the Medical Staff.	

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A 457	Continued From page 38 1. A hospital policy, "Physician Orders," dated January 2009, stated verbal orders were expected to be countersigned as soon as possible but not to exceed 48 hours. In the examples that follow, orders were not authenticated within 48 hours: a. Patient #16 was an 85 year old patient admitted to the hospital on 4/08/11. A telephone order, dated 4/09/11 at 9:30 AM, to give ceftriaxone 1 gram daily was written by an RN on behalf of an NP. During an interview on 4/14/11 at 4:30 PM, the Director of Case Management reviewed the record and confirmed there was no counter signature for the telephone order. Verbal orders were not authenticated within 48 hours. b. Patient #27's medical record documented a 74 year old female who was admitted to the hospital on 3/30/11. She was currently a patient as of 4/15/11. A telephone order from the physician was documented on 4/06/11 at 5:50 PM. The order stated to give 15 units of Insulin for a blood glucose levels over 400. The order was taken by a RN and was later signed by a NP. The date and time the order was signed by the NP was not documented. Without the date and time documented it could not be established the verbal order was authenticated within 48 hours. In an interview on 4/14/11 at 4:35 PM, the Director of Case Management reviewed the record and confirmed the date and time for the counter signature were missing. It was not clear that the verbal order was authenticated within 48 hours.	A 457 cont	• The effectiveness of the process will be monitored through an at least twice weekly review to ensure orders have been authenticated within the 48 hour time frame. Results of this audit process are reported monthly via the HIMS, MEC, and GB meeting for a minimum of 3 months. Compliance issues will be managed via the Ongoing Professional Practice Evaluation as defined in the medical staff Rules and Regulations and tracked by credentialed provider. • Effective 4/18/2011, the HIM department became responsible for twice weekly record review to ensure orders have been authenticated within the 48 hour time frame. Results of this audit process are reported monthly via the HIMS meeting for a minimum of 3 months. At a minimum quarterly, audit results with recommendations for improvements, if needed, will be reported to MEC and GB. Compliance issues will be managed via the Ongoing Professional Practice Evaluation as defined in the medical staff Rules and Regulations. **Person Responsible: DQRM, HIMS, DON, DCS, DCM**	

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A 457	Continued From page 39 c. Patient #23 was a 68 year old female admitted to the facility on 3/18/11. She was admitted for continued medical management of respiratory failure. She had an abdominal wound subsequent to colon surgery and received antibiotics for sepsis. Patient #23's medical record contained a verbal order received by an RN on 4/02/11 at 7:35 AM. The order was to stop Acetazolamide 250 mg by mouth, to stop Furosemide 40 mg IV (intravenously) each morning, to stop Torsemide 10 mg IV each AM and to stop Potassium 30 mEq by mouth twice a day. Staff were to continue Patient #23 on BiPAP and give 500 ml normal saline as a bolus. The order was not authenticated by the physician as of 4/14/11. Patient #23's medical record also contained a verbal order received 3/21/11 at 11:55 PM by an RN. The order was for a normal saline bolus of 500 cc over 2 hours and then run the normal saline at 150 cc an hour. If after 2 hours, Patient #23's MAP was <60, staff were to initiate a Neo-Synephrine drip at 10 mcg-30 mcg per minute as need to keep the MAP >60. The order was not authenticated by the physician as of 4/14/11. During an interview on 4/14/11 at 11:45 AM, the ICP reviewed Patient #23's medical record. She verified the above verbal orders did not contain physician authentication within 48 hours. d. Patient #2 was a 73 year old female admitted to the facility on 2/22/11 and discharged on 4/01/11. She received therapy for a right hip fracture and nursing care for multiple pressure	A 457		

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A 457	Continued From page 40 ulcers. Her medical record contained documentation of verbal orders received by an RN on 3/04/11 at 6:30 PM. The orders were to transfer Patient #2 to the high observation unit as a result of rectal bleeding. Staff were to T&C 2 units of PRBC and hold. Staff were to check Patient #2's Hgb at the time of the order and every 4 hours. Patient #2 was to receive normal saline IVF at a rate of 125 cc an hour. Staff were to call the physician with the results of the Hgb. The physician authenticated the orders on 3/14/11, however the time of authentication was not noted. Patient #2's medical record also contained verbal orders were received by an RN on 3/05/11 at 5:00 AM. Staff were to transfuse 2 units PRBC now, cancel the H/H to be done at 7:00 AM and draw an H/H after completion of 2 units PRBC. Results were to be called to the physician. The physician authenticated the orders on 3/14/11, however the time of authentication was not noted. In addition, Patient #2's medical record contained three pages of medication reconciliation forms completed per a verbal order received by an RN on 3/06/11 at 3:20 PM. There was no physician authentication as of 4/14/11. The Director of Case Management reviewed the medical record on 4/14/11 at 4:05 PM. She verified the lack of physician authentication within 48 hours for verbal orders. Verbal orders were not authenticated within 48 hours.	A 457		
A 466	482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT	A 466		

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A 466	Continued From page 41 [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent. This STANDARD is not met as evidenced by: Based on review of records, policies and procedures, and staff interview, it was determined the hospital failed to ensure staff obtained properly informed consent for 2 of 31 patients (#13 and #23) whose records were reviewed. This resulted in an incapacitated individuals receiving blood and undergoing invasive procedures without the written consent of the patients or patients' representatives. Findings include: The hospital's policy, titled "Informed Consent" dated revised June 2010, contained a procedure for obtaining telephone/verbal consent. It read "the hospital staff members should complete the consent form, sign as witnesses, and date and time their signatures." The policy indicated "every effort will be made to obtain the original form as soon as possible to be placed on the chart." In the following examples, verbal consents were not followed up with a written consent in accordance with hospital policy: 1. Patient #23 was a 68 year old female admitted to the facility on 3/18/11 and was a current patient at the time of the survey. She was admitted for continued medical management of respiratory failure. She had an abdominal wound subsequent to colon surgery and received	A 466	**A-466 Content of Record-Informed Consent** • Effective 5/23/2011, NIACH form # 301 *"Consent for Invasive Procedure or Specialized Treatment"* was revised to include language clarifying how the consent was obtained including when verbal consents are obtained when the patient is unable to provide the consent themselves. Specifically, under the second witness signature linc it now states "Second witness signature required for verbal consent from the patient or authorized representative". This form will be utilized for a minimum of 90 days on a trial basis. • Effeetive 5/18/2011, HUC, Admissions staff, and House Supervisor staff were notified of the proposed change and were included in the implementation of the revised form no later than 5/23/2011. In additiou, staff was educated on the need to notify persons providing verbal consent to please inform admissions or nursing staff when they are in the building in order to make every effort to obtain an original signature thereby authenticating the verbal consent. This education was provided beginning 5/12/2011 via heads up meetings, 1:1 dialogue, and staff meetings to the remaining affected staff. • Effective 5/23/2011, HIM staff will include compliance audits on discharge charts. The audit will confirm compliance with complete documentation of verbal consents received vs. the number of verbal consents received with original signatures obtained. This audit will be conducted for a minimum of 3 months. Results will be reported at a minimum monthly via HIM Meetings and at a minimum quarterly to MEC and GB. **Person(s) responsible: DQRM, DMDB, HIMS, DON**	

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A 466	Continued From page 42 antibiotics for sepsis. Her medical record contained the following consents: a. A "CONSENT INVASIVE PROCEDURE OR SPECIALIZED TREATMENT" form, dated 4/03/11, indicated a specific physician would perform a left pleural thoracentesis (a procedure to drain fluid from the left lung). The form contained several lines at the bottom for signatures of the patient, patient's representative, and witnesses. This consent was signed by three RNs. An "X" was placed on the line for "Patient Signature/Mark" but did not contain a signature. Patient #23's spouse's name was written in on the line designated "Authorized Representative." There was no documatation to indicate the consent was obtained verbally and there was no documentation staff attempted to obtain a written consent for the thoracentesis after the verbal consent was obtained. b. A "CONSENT TO BLOOD OR BLOOD PRODUCT TRANSFUSION" form, dated 4/03/11 at 11:00 AM, indicated Patient #23 was to receive leukocyte reduced red cells. The consent was signed by two RNs. Patient #23's spouse's name was written in on the line designated "Authorized Representative." There was no documatation to indicate the consent was obtained verbally and there was no documentation staff attempted to obtain a written consent for the blood transfusion after the verbal consent was obtained. The ICP reviewed Patient #23's medical record during an interview on 4/14/11 at 11:45 AM. She stated Patient #23's spouses name was written on the "Authorized Representative" line because this was a verbal consent. She stated because the consent was signed by two RN's, it was	A 466		

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A 466	Continued From page 43 considered a valid and complete consent form. Verbal consents were not properly executed in accordance with facility policy. 2. Patient #13 was a 76 year old female admitted to the hospital on 3/10/11 for continued medical management of respiratory failure and sepsis. Patient #13 was documented on admission as being confused and was unable to communicate due to being on ventilator support. Her medical record contained the following consents: a. On 3/26/11 a "CONSENT TO BLOOD OR BLOOD PRODUCT TRANSFUSION" was obtained by phone consent. On the line for patient signature was a notation "Pt (patient) unable to sign." The line for an authorized representative had a notation "Phone consent spouse" (with the husband's name written in). The consent was signed by 2 RNs. There was no documentation staff had attempted to obtain a written consent for the blood transfusion after the verbal consent was obtained. b. On 4/11/11 a "CONSENT INVASIVE PROCEDURE OR SPECIALIZED TREATMENT" for a PICC (Peripherally Inserted Central Catheter) was obtained by phone consent. On the line for patient signature was a notation "phone verification by husband" (with the husband's name written in). The form was signed by 2 RNs. There was no documentation staff attempted to obtain a written consent for the PICC after the verbal consent was obtained. In an interview on 4/13/11 at 11:30 AM, Patient #13's husband stated he lived far away but came to visit his wife several days each week. He	A 466		

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A 466	Continued From page 44 stated he had not been approached to sign consents which were obtained by telephone. In an interview on 4/14/11 at 11:10 AM, the RN providing care for Patient #13 reviewed the record and confirmed the above documentation. She stated she did not know the facility policy required a signature by the guardian or spouse after obtaining a verbal consent. Verbal consents were not properly executed in accordance with facility policy.	A 466		
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 that hospital kitchen staff stored food properly in the facility's dietary department. This had the potential to compromise the safety and nutritional value of the food. Findings include: 1. A policy titled "Food Safety and Sanitation," dated 2/06, regarding food storage, listed "potentially hazardous frozen food that is removed from freezer storage to be thawed [e.g the cut pieces of chicken in the refrigerator], is	A 620	**A-620 Directory of Dietary Services** • Effective 5/05/2011, proposed changes to the process of ensuring all foods are stored and managed properly were reviewed with Bistro Staff. The efforts documented below will improve systems, processes, and reference material. The Food Services Manager also reviewed NIACH policy FN-010 with Bistro staff and requested feedback for revisions. In addition, a label gun was purchased on 05/06/2011 to assist with completing of labeling duties. In addition, the latest edition of the FDA Food Code, 2009 was purchased as a compliment to the Idaho Food Code. • Effective 5/16/2011 daily kitchen labeling compliance inspections will be conducted for 2 weeks then at a minimum of every other day for 4	

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A 620	Continued From page 45 labeled with the date of pull from the freezer for thawing." The policy also stated "food not in its original container is to be covered, labeled as to content and dated." For prepared foods (e.g. pasta salad and sandwich preparation items) the policy stated "Food that has been prepared for service is covered, dated and discarded after two days, if not used. Potentially hazardous food that is left over is labeled as such with the date, content and time it was removed from service and retained for no longer than two days." During a tour of the hospital's kitchen, on 4/13/11 starting at 3:00 PM and ending at 4:30 PM, the following food was observed to be uncovered, unlabeled, and/or kept beyond two days: a. Walk-In Freezer: chicken tenders, undated, cut pieces of chicken, undated. An open bag of waffles, undated. Part of a lemon cream pie, undated. b. Walk-In Refrigerator: a tray of cut pieces of frozen chicken was uncovered and unlabeled. A tray of pasta salad was dated 4/10/11, which was 3 days prior to the observation. c. Refrigerator designated for the Bistro (the employee and visitor dining room): containers of salsa, sour cream, and butter portions were not labeled to include the date of preparation and the content. d. Covered refrigerated cart with open containers of cheese, tomatoes, lettuce, and other sandwich preparation items, tomatoes dated 4/09/11, and cheese dated 4/10/11.	A 620 Cont	weeks. The Food Service Manager (FSM) and Bistro staff will share responsibility for the audits. Any errors will be corrected immediately upon discovery and a log completed to document activity. Bistro staff meetings will take place at a minimum monthly for a minimum of 3 months. Food safety issue discussions, audit results, and Q&A will take place at the staff meetings. Audit results will be reported at a minimum monthly to CP and at a minimum quarterly to the Safety Committee (SC), QC, MEC, and GB. **Person(s) Responsible: FSM, DCS, DQRM**	

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A 620	Continued From page 46 The Dietary Manager discarded the butter during the survey process, and confirmed the above listed items were unlabeled and or undated. She stated food that was prepared and stored in the refrigerator was good for three days and would be discarded on the fourth day. The Dietary Manager stated the tomatoes would be discarded at the end of that working day. The hospital did not ensure kitchen staff had covered and/or labeled all food products to prevent cross-contamination and/or spoilage.	A 620	**A-747 Infection Control** • Hand Hygiene, Isolation Precautions, and Management of MDRO policies and Hospital Environmental Cleaning products were reviewed, revised as appropriate, and approved for implementation. On 4/26/2011, pending final MEC/GB approval, C-diff approved equipment and room cleaning products were distributed to all areas potentially impacted by the need to adequately clean all patient care areas and equipment with a known C-diff infection. All clinical staff received education on the procurement and use of the cleaning products, proper PPE use, and hand hygiene via daily heads up meetings, 1:1 dialogue, and care conferences. Enhanced hand hygiene, proper PPE use, and proper cleaning product use audits were implemented on 05/02/2011. Housekeeping and Bistro staff was introduced to the cleaning products and systems/process changes via staff meetings on 4/26/2011.	
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, staff interview, and review of medical records, hospital policies, and professional references used by the hospital, it was determined the hospital failed to provide a sanitary environment to avoid sources and transmission of infections. The failure to provide a sanitary environment resulted in the potential for patients to develop infections that could have been prevented. Findings include: 1. The hospital failed to ensure policies related to controlling infections and communicable diseases were developed and implemented. Refer to A748 as it relates to the lack of comprehensive infection control policies.	A 747	• The staff education and product changes were important to ensure all patients were being cared for in an environment with adequate safeguards to ensure patient risk for nosocomial transmission of contagion was minimized. • An infection control practitioner consultant was obtained by the hospital. The expert reviewed all aspects of the infection control program and made recommendations for improvement which are documented below. • NIACH is working with our national	

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A 747	Continued From page 47 2. The hospital failed to ensure systems were developed for controlling infections and communicable diseases. Refer to A749 as it relates to practices that increased the likelihood patients would develop infections. The cumulative result of these systemic deficient practices resulted in increased opportunities for patients to acquire infections.	A 747	accounts vendor to implement their nationally recognized program, "ERASE CAUTI" (catheter associated urinary tract infection). Program roll out will be initiated on 5/18/2011. • No later than 5/26/2011, all staff with potential patient contact will have completed a fully comprehensive educational module to accomplish the NIACH Infection control goals. Included are modules on the reduction of Catheter Associated Urinary Tract Infections, Environmental Cleaning for C-dif rooms, and other topics important in the reduction of Hospital Acquired Infections. These modules will enhance the education provided to staff members in earlier staff meetings, heads up meetings, and 1:1 dialogue. Additional quick reference material has been made available to staff members who will also be reviewed with completion of all staff module presentations no later than 5/26/2011. Staff that have not completed the modules will not complete work until such time the education is completed. Competency will be assessed via quarterly safety rounds, quarterly infection control rounds. Weekly audits to ensure proper hand washing, PPE use and use of proper cleaning materials will be reviewed at a minimum every other week by the Infection Control Task Force. This activity will occur for a minimum of 6 weeks. Results will be reported at a minimum quarterly to P&T/Infection control committee, QC, MEC, and GB. **Person(s) Responsible: ICP, DQRM, DON, DOP, Director of Plant Operations (DPO), and the DCS.**	
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and review of medical records, policies, and professional references used by the hospital, it was determined the facility failed to ensure policies related to controlling infections and communicable diseases were developed and implemented. This failure directly impacted 3 of 31 sample patients (#23, #25 and #29) and had the potential to impact all patients receiving care at the facility. Failure to adequately develop and implement policies and procedures had the potential to place patients at increased risk for hospital acquired infections. Findings include: 1. In an interview on 4/14/11 at 9:00 AM, the ICP and Director of Quality and Risk Management stated they did not have a specific policy related to prevention of urinary tract infections in patients with urinary catheters. They stated they used the CDC guidelines, and the Director of Quality and Risk Management provided surveyors with the	A 748		

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A 748	Continued From page 48 CDC/HICPAC "Guideline For Prevention of Catheter-Associated Urinary Tract Infections 2009." The CDC/HICPAC guidelines stated, "It is suggested to change catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised." During the interview on 4/14/11 at 8:55 AM, the ICP stated changing the urinary catheter when a patient was diagnosed with a hospital acquired UTI was not a current part of the infection control education or treatment recommendations. After being informed of the CDC guidelines, the ICP stated she was not aware of the guidelines recommending changing a urinary catheter after a UTI has occurred. The following are examples of patients whose urinary catheters were not changed after a diagnosis of a hospital acquired UTI was determined: a. Patient #25 was admitted on 2/08/11 for care primarily related to acute respiratory failure requiring ventilation. Patient #25's urinary catheter was changed on 1/31/11 prior to admission according to the "PREADMISSION SCREEN" form dated 2/03/11. On the "Site Documentation Record" form the nurse's keep in their daily use binder, under the urinary catheters section, the space for "Date placed" had a question mark written in. On 2/20/11, an incident report was completed by the ICP based on the findings of E. coli bacteria	A 748	**A-748 Infection Control Officers** • In the NIACH policy IC 010, "*Infection Control Plan*", the designated ICP is referenced including a description of the roles, responsibilities, and leadership requirements. The plan has been reviewed in depth with the Infection Control Task Force and the ICP with understanding noted. Competency assessment of the ICP will be completed at a minimum annually. Continuing education in the ICP role has and will continue to be emphasized via twice annual review by the corporate infection control expert. • Education for clinical and medical staff will be completed no later than 5/26/11 regarding best practice recommendations based on CDC/HIPAC research, data, and practice recommendations. Compliance evaluation will be accomplished through the surveillance work of the ICP who will report to the Infection Control Task force at a minimum monthly for a minimum of 3 months. Results will be analyzed and reported to the Infection Control Committee at a minimum quarterly.	

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A 748	Continued From page 49 found in Patient #25's urine. According to the incident report, the ICP determined the urine infection was hospital acquired and associated with Patient #25's urinary catheter. The ICP indicated the UTI was treated with antibiotics for 10 days. There was no documentation in the incident report the urinary catheter was or should have been changed. A "PHYSICIAN PROGRESS NOTE," dated and signed on 3/18/11 at 1:06 PM indicated Patient #25 had E. coli bacteria in his urine. This was an infection from the same bacteria found responsible for the UTI on 2/20/11. In an interview on 4/13/11 at 4:40 PM, the House Supervisor RN reviewed Patient #25's medical record and confirmed evidence of two UTIs (on 2/20/11 and 3/18/11) since admission. She confirmed there was no order to change the urinary catheter or documentation of a urinary catheter change since Patient #25 was admitted on 2/08/11. She further stated the urinary catheter should be changed monthly and when a patient has a UTI. b. Patient #29 was a 60 year old female who was admitted to the hospital on 2/10/11. An Admission Nursing Assessment, dated 2/10/11, documented Patient #29 had a urinary catheter upon admission. The admitting diagnoses did not include a UTI. A urine culture laboratory result, dated 2/18/11, documented bacteria was present in the urine, indicating a UTI. There was no documentation Patient #29's urinary catheter was changed after identification of the UTI. The medical record contained a second urine culture obtained on 3/18/11. A bacteria, different	A 748	• Effective 5/4/2011, processes to identify patients with C. difficile that also eomply with HIPAA rules were initiated for placement on the doors of persons infected with C-difficile. All hand sanitizer dispensers have received signage regarding their use in C-diff rooms including permanent signage and an additional cover stating "Notice!! This sanitizer is not effective against C-diff. Please use only soap and water for hand washing" Sodium Hypochlorite 1:10 solution cleaning wipes and aerosols approved by EPA and intended for equipment and environmental cleaning have been distributed as appropriate with completion of staff education no later than 5/26/11. Patient/family educational materials regarding infection control are reviewed at weekly informational meetings conducted by the CEO and have been initiated in the admission materials provided to all patients. Review and family education to the material will take place during the initial Patient Care Conferences and during patient care treatments. Twice daily communication regarding patients requiring isolation (including C. difficile) has been initiated with care teams with an emphasis on cleaning the hospital environment, signage, hand sanitation, and proper PPE use. Effective 5/13/2011 the NIACH policy on management of MDRO was approved based on a recommendation from the MEC a day earlier. This policy eovers the definition of "containment" as it relates to patients with C-diff leaving their rooms. It will be included in the education that will be completed no later than 5/26/2011 and be reviewed once per shift in heads up meetings so staff are aware of which patients may or may not leave their room based on "containment". **Person(s) Responsible: ICP, DQRM, DOP, DON, DCS**	

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A 748	Continued From page 50 from the one found on 2/18/11, was identified, indicating Patient #29 had a second UTI. There was documentation of discontinuation of the urinary catheter on 3/17/11. The ICP was interviewed on 4/14/11 at 12:05 PM. She reviewed Patient #29's record and stated the urinary catheter was changed on 3/02/11 (12 days after confirmation of a UTI on 2/18/11) and again on 3/07/11 after Patient #29 accidentally pulled out the existing urinary catheter. The urinary catheter was discontinued on 3/17/11. She confirmed there was no physician's order to change the urinary catheter after identification of the first UTI on 2/18/11. The urinary catheter was not changed according to the CDC recommendations when a UTI occurred. 2. During an interview on 4/14/11 at 9:00 AM, the ICP and Director of Quality and Risk Management stated in addition to the hospital's policy and procedures regarding infection control they also referred to the Lippincott and AACN manuals for procedures and the CDC guidelines for policies. The CDC "2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings" defined C. difficile as a spore-forming bacteria which is a major cause of healthcare-associated diarrhea. The Guidelines stated, "Important factors that contribute to healthcare-associated outbreaks include environmental contamination, persistence of spores for prolonged periods of time, resistance of spores to routinely used disinfectants and antiseptics, hand carriage by	A 748		

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A 748	Continued From page 51 healthcare personnel to other patients, and exposure of patients to frequent courses of antimicrobial agents." In addition, "studies have shown that asymptomatic patients constitute an important reservoir within the health-care facility and that person-to-person transmission is the principle means of transmission between patients." The CDC guidelines recommend implementation of contact precautions for patients with diarrhea, accurate identification of patients, rigorous environmental cleaning, and consistent hand-hygiene with soap and water. The Guidelines specified, "Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment." The facility's policy, "Isolation Precautions," dated February 2006, described the procedures for contact precautions. The policy indicated movement or transportation of the patient from the room was to be limited and if movement was necessary for care, infectious material was to be contained. The policy did not define containment. The policy did not specify who was responsible to determine when infectious material was contained (such as diarrhea), or how this decision was to be communicated between staff. Beyond containment of the infectious material, the policy did not indicate what precautions were to be taken prior to a patient leaving an isolation room. For example, the expectation that patients with C. difficile wash their hands with soap and water prior to therapy sessions outside of the room. The policy also stated in addition to standard precautions, gloves were to be worn when entering the room. Additional PPE, such as	A 748		

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A 748	Continued From page 52 gowns and goggles were optional and could be used if "it is anticipated that clothing will have substantial contact with the patient, environmental surfaces or items in the patient's room, or if the patient is incontinent or has diarrhea..." The policy did not specify a patient with C. difficile was to utilize PPE when their clothing would come into contact with surfaces outside of their isolation room. The facility did not ensure contact precautions were consistently implemented as follows: a. Patient #23 was a 68 year old female admitted to the facility on 3/18/11. She was admitted for continued medical management of respiratory failure. She had an abdominal wound subsequent to colon surgery and received antibiotics for sepsis. The POC indicated Patient #23 was diagnosed positive with C. difficile and was subsequently placed on contact precautions. "PHYSICIAN'S PROGRESS NOTES," dated 4/05/11, indicated Patient #23 was C. difficile positive and a rectal tube was placed as a result of multiple loose stools. Patient #23 was interviewed on 4/14/11 at 9:00 AM. A sign on the outside of Patient #23's door read "CONTACT PRECAUTIONS" and directed visitors to report to the nurses' station before entering the room. The sign contained directions specific to maintaining contact precautions and directed individuals to wear gloves and gown when entering the room and wash hands with warm water and an antimicrobial agent after removing the above and prior to leaving the room. Information on the sign indicated the movement and transport of patients outside of the room was to be limited to medically necessary purposes	A 748		

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A 748	Continued From page 53 only. It read, "If transport is essential, ensure infected areas of the patient's body are contained and covered." On 4/14/11 at 10:20 AM, Patient #23 was observed being pushed in a wheelchair by a PTA (who was wearing only gloves) to the physical therapy room. Patient #23 was not wearing any personal protective equipment (such as gloves or gown). The Regional Director of Quality witnessed the transport of Patient #23. She stated if a patient's stool was controlled (i.e. with a rectal tube) the patient was allowed to complete a therapy session outside of their room. She stated PPE worn by the patient and/or staff depended on if the stool was contained. However, the facility policy failed to define what containment meant. Patient #23's RN was interviewed on 4/14/11 at 10:25 AM. She stated she was surprised to find Patient #23 was taken to therapy but speculated it may have been because Patient #23 had a rectal tube in place to contain the stool. She stated if Patient #23 did not have a rectal tube she would not have gone down to therapy. At this time the RN was observed to don a gown and gloves as she prepared to locate Patient #23 in the therapy room and administer her medications. In an interview on 4/14/11 at 10:50 AM, the ICP stated, for a patient on isolation precautions related to C. difficile to participate in physical therapy in the group room, the patients could not be incontinent or have loose stools. She further stated a rectal tube in place was considered a contained system if it was clean, intact, and not leaking. She stated she would also expect the patient to wear gloves if using physical therapy	A 748		

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	132001		04/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 748	Continued From page 54 equipment in the group room. In an interview on 4/14/11 at 10:55 AM, the Director of Therapy Services stated if the stool was contained, then a patient with C. difficile was permitted to use equipment in the group room. He stated they did not use any special precautions such as having the patient wear an isolation gown or gloves. He stated therapy staff generally communicate with a patient's RN regarding the appropriateness of removing a patient from an isolation room for group therapy. If there were additional questions or concerns staff were to speak with the ICP. In a second interview on 4/14/11 at 11:05 AM, the RN for Patient #23 stated therapy services did not speak with her prior to Patient #23's therapy session to confirm stool was indeed contained enough for therapy outside of the room. She stated she was somewhat concerned about the decision to perform therapy in a group setting. A staff RN was interviewed on 4/15/11 at 10:50 AM. She stated it was not typical for patients with C. difficile to leave their rooms for therapy sessions, except if the stool was contained (i.e., in a brief). She stated the decision regarding if a patient in contact isolation was appropriate for therapy outside their room was based on nursing judgement. She further stated once a patient was placed in isolation, even if they were found to no longer be infectious, they would remain in contact precaution isolation. The facility did not have a policy or procedure in place to ensure consistency among staff regarding guidelines for determining when a patient in isolation precautions was appropriate to	A 748		

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A 748	Continued From page 55 attend therapy sessions in a group setting. It was unclear what the expectations were regarding personal protective equipment or preparation (such as hand washing with soap and water) prior to the patient leaving their isolation room.	A 748		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop 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 observation, interview, and review of medical records and facility policies it was determined the facility failed to ensure systems were developed for controlling infections and communicable diseases. This directly impacted 3 of 31 sample patients (#19, #25 and #28) and had the potential to impact all patients receiving care at the facility. Failure to develop a system to control infections and spread of disease had the potential to negatively impact patient health and safety. Findings include: 1. The ICP provided a copy of the slide show used for the "Annual Nursing Refresher/Reorientation" from March 2011. The education was specific to cleaning and care of urinary catheters. Under the section titled "Urinary Collection Bag," it noted "Hang the collection bag below bladder level to prevent urine reflux into the bladder and to facilitate gravity drainage." A memo was sent to "All nursing and therapies staff" from the "Infection Control Team: UTI	A 749	**A-749 Infection Control Officer Responsibilities** • After education and additional training by the expert infection control beginning on 5/16/2011, the hospital ICP has begun the weekly monitoring of IC compliance including the positioning of urinary bladder collection bags with an emphasis on patient transfers using a Hoyer lift. Staff education has occurred regarding positioning of indwelling catheter bags and was completed by 5/13/11. During active surveillance for compliance, immediate staff education will be provided for any non-compliance with documented protocols and other resource/reference material from HIPAC/CDC guidelines provided to staff. • The ICP monitoring results will be reported at a minimum every other week for a minimum of 3 months to the Infection Control Task Force and at a minimum quarterly to the Infection Control Committee, QC, MEC, and GB. **Person(s) Responsible: ICP, DQRM, DON, DCS, DTO, DOP**	

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A 749	Continued From page 56 Taskforce" on March 21, 2011. The memo addressed caring for patients with urinary catheters, including "ensure that the level of the drainage bag and connected tubing is below the level of the patient's bladder." a. Patient #28 was a 49 year old male admitted to the facility on 4/01/11 and was a current patient at the time of the survey. According to the "HISTORY & PHYSICAL," dictated by the physician on 4/02/11, Patient #28 was being treated for acute respiratory failure and was so weak he was unable to move his extremities and required Hoyer assistance for transfers to and from his bed to his wheelchair. Beginning at 11:30 AM on 4/13/11, the surveyor observed staff entering and leaving Patient #28's room as he was made ready for a physical therapy session. Between 11:30 AM and 11:45 AM, a PCT, Patient #28's RN, and the DOT were observed to enter and exit Patient #28's room numerous times. At 11:45 AM, the DOT indicated Patient #28 was almost ready to begin therapy and allowed the surveyor to enter the room. Upon entry at 11:45 AM, Patient #28 was observed in a Hoyer sling in transition from the bed to his wheelchair. Patient #28 was in a slightly upright position, with his bottom lower than the level of his knees. Patient #28's urinary catheter bag was observed hooked near the top of the Hoyer lift, more than 12 inches above the level of his bladder. A PTA and student PT were observed to work together during this transfer. It was noted the position of the urinary catheter bag was not corrected by any additional staff entering or exiting Patient #28's room. Patient #28's RN was interviewed on 4/13/11 at	A 749		

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A 749	Continued From page 57 12:00 noon. He stated the urinary catheter bag was supposed to be below the level of the bladder and verified the bag was hooked to the Hoyer lift inappropriately. He stated this was not the first time he witnessed staff hang the urinary catheter bag on the hooks of the Hoyer lift and above the level of the bladder. The DOT was interviewed on 4/13/11 at 4:00 PM. He explained the urinary catheter bags were to be suspended on the sling portion of the Hoyer that supported a patient's legs, or it was to be placed on the patient's legs during the transfer. However, placement of a urinary catheter bag on a patient's legs had the potential to raise the bag above the level of the bladder. The student PT was interviewed on 4/14/11 at 4:50 PM. She stated she was instructing the PTA on how/what tasks to perform while preparing Patient #28 for his therapy session. She stated both she and the PTA were aware the urinary catheter bag was to be hung below the level of the bladder and stated she usually hung the bag at the base of the sling under the legs. She stated if the urinary bag was placed in a location other than this it was inadvertent and not noticed. b. Patient #25 was admitted on 2/08/11 for care primarily related to acute respiratory failure requiring ventilation. Patient #25 had a urinary catheter and required a Hoyer lift for transfers to and from the bed to a chair. During an observation on 4/14/11 from 2:05 to 2:25, two PCTs were observed providing care to Patient #25 in preparation for physical therapy. After cleaning and dressing Patient #25 the PCTs were observed to prepare him for transfer from the bed to his chair using the Hoyer lift. One PCT was	A 749		

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A 749	Continued From page 58 observed to hook the urinary catheter bag onto the hooks near the top of the Hoyer lift. As Patient #25 was elevated off of the bed, and the level of the urinary catheter bag was almost level with his bladder, the second PCT removed the bag from the hook and hooked it into a pocket on her pants (which lowered the bag below the level of Patient #25's bladder). The PCT who placed the urinary catheter bag onto the hooks of the Hoyer lift was interviewed on 4/14/11 at 3:20 PM. She confirmed it was her habit to place the urinary catheter bag on the hooks of the Hoyer lift and did not remember when this procedure became a habit. She stated she was not taught this and agreed having the urinary bag down low was preferred but stated she was unsure of where to place the bag so that it would not pull on the patient or be in the way during the transfer. She stated she was not the only PCT who did this. c. Patient #19's medical record documented a 43 year old male who was admitted to the hospital on 3/28/11. He was currently a patient as of 4/15/11. His diagnoses included quadriplegia, pneumonia, and decubitus ulcers. Patient #19 was observed on 4/14/11 at 2:00 PM during a Hoyer assisted transfer from his bed to his motorized wheelchair. A PCT and the Director of Operations managed and provided the transfer. As Patient #19 was on the sling apparatus and was being raised from the bed to a semi-reclining position, while still suspended over his bed, the PCT hooked his urinary catheter bag onto one of the straps of the Hoyer sling that supported the left leg. The bag was at the same level of Patient #19's bladder at that point, then as Patient #19 was raised to a higher position to be moved towards his	A 749		

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A 749	Continued From page 59 wheelchair, Patient #19 settled into a more upright position, with his bottom much lower than the urinary collection bag (about 10 inches). Patient #19 then was positioned over his wheelchair and lowered into it. The urinary bag and tubing were then placed onto the chair at a level below his bladder. The total transfer time was approximately 10 minutes. During an interview on 4/14/11 at 9:00 AM, the ICP, stated a memo was sent to staff to remind them to keep urinary catheter bag below the level of the bladder. She stated if a patient was in a wheelchair, the bag should generally be hung under the wheelchair, leaving it on the lap would not necessarily be below the level of the bladder. She stated for a Hoyer lift, staff generally hold the bag, keeping it below the level of the bladder During an interview on 4/15/11 at 12:00 PM, the Director of Quality and Risk Management was asked if there had been any formal monitoring of staff related to the appropriate hanging of urinary catheter bags. He stated there had been no formal monitoring, however, if senior staff noticed a bag hung inappropriately, they corrected staff on the spot. Urinary catheter bags were hung inappropriately and had the potential to increase patient risk for UTIs. The facility did not have a system in place to monitor this portion of UTI prevention. 2. During an interview on 4/14/11 at 9:00 AM, the ICP and Director of Quality and Risk Management stated in addition to the hospital's policy and procedures regarding infection control they referred to the Lippincott and AACN manuals for procedures and the CDC guidelines for	A 749		

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A 749	Continued From page 60 policies. The Lippincott Manual of Nursing Practice, 9th edition, indicated, "The use of sodium hypochlorite at 5000-ppm, bleach diluted 1:10, or buffered commercially prepared bleach solutions..." are to be used for outbreaks of C. difficile. On 4/14/11 at 10:45 AM, the isolation cart of a patient in contact precautions due to C. difficile was observed. The cart contained "Sani-wipes" (a disposable wipe) for use as needed to clean surfaces in the patient's room or for items removed from the patient's room. It was noted the "Sani-wipes" provided were not effective in cleaning surfaces exposed to C. difficile as they did not contain bleach and did not list C. difficile as a germ they were effective against. The facility's "Isolation Precautions" policy, dated February 2006, indicated when possible, noncritical patient-care equipment was to be dedicated to a single patient in isolation rather than shared between patients. If this was not possible, the object was to be cleaned and disinfected between patients. The policy did not specify what products were to be used for this process. In an interview on 4/14/11 at 3:20 PM, the DPO stated the "Sani-wipes" were ineffective against C. difficile. He further stated the only product he was aware of was effective against C. difficile was a 1:10 bleach to water solution. He then stated the hospital was working on having bleach wipes available for isolation carts of patients with C. difficile. However, they were not currently available for use in the facility.	A 749		

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A 749	Continued From page 61 In an interview on 4/14/11 at 10:50 AM, the ICP was asked if she was aware the "Sani-wipes" currently being used to clean the automatic blood pressure machines used for multiple patients were ineffective against C. difficile. She stated she was not aware the "Sani-wipes" were ineffective against C. difficile. On 4/14/11 at 3:40 PM, a PCT was observed coming out of an isolation room with a automatic blood pressure monitoring machine. The PCT was observed to clean the device with the "Sani-wipes" available on isolation carts. When asked, the PCT stated she used the same machine for all her assigned patients, even those in isolation. She stated she cleaned the blood pressure machine in between each patient using the "Sani-wipes." In an interview on 4/15/11 at 10:30 AM, the DON stated she was aware the Infection Control Committee was working on obtaining a new cleaning product for the isolation carts, but was unaware the current "Sani-wipes" did not kill C. difficile. The DON verified PCT staff used the "Sani-wipes" to clean the blood pressure machine between patients, including those under isolation precautions. A staff RN was interviewed on 4/15/11 at 10:50 AM. She stated each isolation patient had their own stethoscope which was left in the room. The equipment to monitor blood pressure and saturation level would be used for multiple patients (whether or not they were in isolation) and wiped down with the wipes provided on the isolation carts.	A 749		

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A 749	Continued From page 62 In a subsequent interview on 4/15/11 at 11:00 AM, the DPO stated Central Supply ordered the "Sani-wipes" and stocked the isolation carts with supplies. He stated he was unaware hospital staff (such as nurses and PCTs) were using the "Sani-wipes" for cleaning equipment used in multiple patient rooms. He further stated general hospital staff did not have easy access to bleach cleanser because it was a hazardous material. He confirmed there was a breakdown in communication between housekeeping, Central Supply, and nursing in regards to the disinfectant needed to effectively decontaminate for C. difficile. The facility did not ensure systems were thoroughly developed and in place for controlling infections.	A 749		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 132001	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/19/2011
NAME OF PROVIDER OR SUPPLIER NORTHERN IDAHO ADVANCED CARE HOSPIT	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH CECIL ROAD POST FALLS, ID 83854		

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the recertification survey of your hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS Team Leader Teresa Hamblin, RN, MSN, HFS Susan Costa, RN, HFS Aimee Hastriter, RN, BS, HFS Karen Robertson, RN, BS, HFS Acronyms used in this report include: AACN - American Association of Critical-Care Nurses BiPAP - Bi-level Positive Airway Pressure, a method of respiratory ventilation cc - cubic centimeter; equivalent to an mililiter CDC - Centers for Disease Control C. difficile - Clostridium difficile, a spore-producing bacterium COPD - Chronic Obstructive Pulmonary Disease DC - Discontinue DON - Director of Nursing DPO - Director of Plant Operations E. coli - Escherichia coli, a bacteria Hgb - Hemoglobin H/H - Hemoglobin and Hematocrit HICPAC - Healthcare Infection Control Practices Advisory Committee HIT - Heparin Induced Thrombocytopenia H&P - History and Physical ICP - Infection Control Practitioner MAP - Mean Arterial Pressure MAR - Medication Administration Record mcg - micrograms mEq - milliequivalent ml - mililiter MRSA - Methicillin Resistant Staphylococcus Aureus	B 000	RECEIVED MAY 18 2011 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/16/11

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B 000	Continued From page 1 NKA - No Known Allergies NP - Nurse Practitioner PCT - Patient Care Technician POC - Plan of Care PPE - Personal Protective Equipment PRBC - Packed Red Blood Cells PTA - Physical Therapy Assistant RN - Registered Nurse T&C - Type and Cross UTI - Urinary Tract Infection	B 000		
BB152	16.03.14.250.09 Medical Orders 09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospital¿s policy. (5-3-03) This Rule is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure verbal orders were authenticated in accordance with facility policy for 4 of 31 patients (#2, #16, #23, and #27) whose records were reviewed. This impeded the ability of the facility to quickly identify potential errors in interpretation and transcription of orders which had the potential to impact patient care and safety. Findings include:	BB152	**BB152 Medical Orders** • A process was developed that would identify all verbal or telephone orders by Health Unit Coordinator (HUC) staff to alert MD/DO/NP/PA staff to all verbal and/or telephone orders that need authentication utilizing a "flag" indicator for each order. Additional assistance in flagging the order would be provided through the qualified person that took the verbal or telephone order. MD/DO/NP/PA will review each medical record at the time of daily documentation authenticate the order including date, time, and signature. . • On 5/12/2011, the MEC approved the process with the notification of all medical staff practitioners of the process, requirements, and follow up through the written notification and summary of hospital policy, PC 195 *"Physician Orders"* and the Rules and Regulations of the Medical Staff. A copy of the requirements will be included in the correspondence to be distributed to the medical staff no later than 5/20/2011 and signed by the Medical Director or President of the Medical Staff. • The effeetivenss of the process will be monitored through an at least twiee weekly review to ensure orders have been authenticated within the 48 hour time frame. Results of this audit process are reported monthly via the HIMS, MEC, and GB meeting for a minimum of 3 months. Compliance issues will be managed via the Ongoing Professional Practice Evaluation as defined in the medical	

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BB152	Continued From page 2 Refer to A 457 as it relates to the facility's failure to ensure verbal orders were authenticated within 48 hours in accordance to facility policy.	BB152	staff Rules and Regulations and tracked by credentialed provider. **Person Responsible: Medical Director, President of Medical Staff, HIMS, Administrator**	
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Based on review of clinical records, policies and procedures, and interviews with staff, it was determined the hospital failed to ensure POCs were developed and/or updated for 4 of 31 patients (#16, #23, #26 and #28) whose records were reviewed. This resulted in a lack of direction to interdisciplinary staff in the delivery of care to patients and had the potential to interfere with coordination of patient care. Findings include: Refer to A 396 as it relates to the facility's failure	BB175	BB 175 • A new process was implemented on 1/3/11 with new forms for the documentation of care plans. During the period from 1/3/11 through present, audits have been done with education, training, and one to one inservice with nursing personnel regarding appropriate and complete patient plan of care. Data collected from 1/3/11 indicated improvements have occurred with continued improvement desired. Additional interventions have been implemented since 5/1/11 and include further review during case conferences conducted for all patients in the Med/Surg environment (weekly) and High Observations (three times weekly) with updates as indicated. Staff will directly interact with all disciplines to ensure plans, barriers, progress, and results of care efforts. For a minimum of 3 consecutive months via heads up meetings (both shifts), staff meetings, and 1:1 dialogue, feedback and education will be provided to staff members related to interdisciplinary care planning. In addition, review and as needed, update of the plan of care will become an integral part of the 12 hour chart checks on both shifts. Effective 5/2/2011, mandatory licensed nursing staff classes were repeated to review the key components of documentation of the plan for the provision of care to patients. All licensed nursing staff has completed the required education as of 5/13/2011.	

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	132001		04/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN IDAHO ADVANCED CARE HOSPIT	600 NORTH CECIL ROAD POST FALLS, ID 83854

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BB175	Continued From page 3 to ensure POCs were developed and kept current.	BB175	• Nursing leadership including house supervisory staff will continue to provide 1:1 leadership and direction for licensed staff to include oversight, education, and coaching/counseling as necessary based on the results of the weekly reviews. • Results from the care plan reviews will be communicated to Clinical Process (CP) every two weeks and at a minimum quarterly to QC, MEC, and GB to ensure the information, process improvements, and educational opportunities are integrated in to the hospital QA/PI program. **Person(s) Responsible: DQRM, DON, DCM, DCS, DTO, DPO**	
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: Based on observations and staff interview and review of policy and procedures, it was determined the hospital failed to ensure that hospital kitchen staff stored food properly in the facility's dietary department. This had the potential to compromise the safety and nutritional value of the food. Findings include: Refer to A 620 as it relates to the facility's failure to ensure food was stored properly.	BB208	**BB 208** • Effective 5/05/2011, proposed changes to the process of ensuring all foods are stored and managed properly were reviewed with Bistro Staff. The Food Services Manager also reviewed NIACH policy FN-010 with Bistro staff and requested feedback for revisions. In addition, a label gun was purchased on 05/06/2011 to assist with completing of labeling duties. In addition, the latest edition of the FDA Food Code, 2009 was purchased as a compliment to the Idaho Food Code. • Effective 5/16/2011 daily kitchen labeling compliance inspections will be conducted for 2 weeks then at a minimum of every other day for 4 weeks. The Food Service Manager (FSM) and Bistro staff will share responsibility for the audits. Any errors will be corrected immediately upon discovery and a log completed to document activity. Bistro staff meetings will take place at a minimum monthly for a minimum of 3 months. Food safety issue discussions, audit results, and Q&A will take place at the staff meetings. Audit results will be reported at a minimum monthly to CP and at a minimum quarterly to the Safety Committee (SC), QC, MEC, and GB. **Person(s) Responsible: FSM, DCS, DQRM**	
BB223	16.03.14.330.03 Scope of Services 03. Scope of Services. (10-14-88) a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical	BB223		

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BB223	Continued From page 4 services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91) This Rule is not met as evidenced by: Based on record review, policy review, staff interview, and observation, it was determined the hospital failed to ensure procedures were established related to allergy reconciliation for 3 of 31 patients (#12, #14, and #16) whose records were reviewed. This had the potential to interfere with coordination of patient care and patient safety. Findings include: 1. A hospital policy, "Medication Orders," dated August, 2008, stated allergies and patient diagnoses were communicated to the pharmacist via the medical record documentation prior to the dispensing of medications. It further stated that medication orders would be reviewed for real or potential allergies or sensitivities. The hospital policy did not address how the allergies would be documented to ensure consistency (on the outside of the chart, on the MAR, and on the patient's identification band) to prevent error. It did not state how medications that were reported as allergies by patients, but were not true allergies (rather side effects or adverse effects) should be handled, whether they should be treated as allergies and kept on the allergy list or instead removed. It did not say whether the pharmacist could or should remove medications listed on the allergy list or whether a physician's order was required to remove them. It did not address how information obtained from	BB223	**BB 223** **Scope of Services (Pharmacy)** • In a collaborative effort, multiple disciplines have identified processes which will be communicated to hospital staff and medical staff effective 5/23/2011. The pharmacy department has made changes to PS 070 and PC 080 regarding the process for the identification and reconciliation of allergies from the pre-admission screen, referring hospital documentation, assessments by nursing and physicians and will be implemented with the education on 5/23/2011. The MEC and GB approved these changes to process on 5/13/11. Process changes include how pharmacy will reconcile allergies from physician orders and previous facility records if available, preadmission screening tool, and nursing and dietary initial assessments. All allergies will be entered in to the Medication Administration Record (MAR) information management system so they will display on the MAR. Pharmacy will complete any needed clarifications via discussion with the patient/family members. Communicate with practitioners and nursing staff medication contraindications due to allergies. • Compliance will be measured by review of the frequency of medication errors related to allergy reactions for a minimum of 3 months, frequency of Adverse Drug Events (ADE) related to medication allergy reactions for a minimum of 3 months and the percentage of intercepted errors for a minimum of 3 months. Weekly audits of 5 inpatient records for a minimum of 2 months will be conducted to determine the accuracy of allergies listed on the MAR compared to the front of the patient chart and allergy band. **Person(s) Responsible: DPO, DNO, DQRM, HIMS**	

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BB223	Continued From page 5 the pre-admission screen, the nursing admission assessment, the physician's H&P, and the physician's orders would be reconciled to ensure consistency and accuracy for patient safety. It did not describe how coordination would occur among staff, such as unit clerks, nurses, physicians, and pharmacists. Inconsistencies in allergies were found in the following examples: a. Patient #16 was an 85 year old patient admitted to the hospital on 4/08/11. An H&P, dated 4/08/11, stated Patient #16 had no known diagnosed allergies. The outside of Patient #16's record was consistent with the information in the H&P. It had a sticker "NKA," indicating no known allergies. During an observation and patient interview on 4/13/11 at 12:35 PM, Patient #16's red allergy wrist band was viewed. It stated "Iodine allergy." Patient #16 told the surveyor she had a bad reaction several years prior to a test that had iodine in it. She stated she was not aware of any other allergies. A HUC was interviewed on 4/13/11 at 2:30 PM. When asked why the outside of the chart stated "NKA" and did not include Iodine as an allergy, she stated the information listed on the outside of the chart was based on physician orders. She stated the information on the patient's wrist band may have come from a nurse. The RN taking care of Patient #16 was interviewed on 4/13/11 at 3:15 PM. She stated she did not know why there was a discrepancy in the allergy information. She further stated she had not put the allergy band on the patient.	BB223		

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BB223	Continued From page 6 2. Patient #12 was a 72 year old male admitted to the hospital on 4/09/11 and a current patient at the time of the survey. The "PREADMISSION SCREEN, dated 4/06/11, documented "Allergies/Reactions" as follows: > ibuprofen caused nausea > ASA [aspirin] caused nausea > motrin caused gastrointestinal upset An H&P, dated 4/09/11, the MAR, dated 4/13/11, and the outside of Patient #12's record listed an allergy to ibuprofen. They did not list an allergy to ASA. There was no documentation that explained why ibuprofen was listed as an allergy while ASA was not listed as an allergy when the "PREADMISSION SCREEN" indicated Patient #12 reported that nausea was her reaction to both medications. An RN was interviewed on 4/13/11 at 10:15 PM. She reviewed Patient #12's record and confirmed the discrepancies. She said she did not know why they were different but stated the physician only wrote an order for ibuprofen so that is why it got on the outside of the chart as it did. 3. Patient #14 was admitted on 3/25/11 for care primarily related to a deep back wound. A "PREADMISSION SCREEN" form, dated 3/22/11, documented "Allergies/Reactions" as follows: > Heparin caused HIT on 2/15/11 > Iodine caused an unknown reaction > Morphine caused a rash > PCN (penicillin) caused respiratory distress > Promethazine caused respiratory distress	BB223		

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BB223	Continued From page 7 An H&P dictated and transcribed on 3/25/11 by the attending physician, listed allergies as Iodine, Penicillin, Morphine, and Promethazine. The H&P further documented, "The reactions to these medications are not known." The H&P did not list the allergy to Heparin. On the "HOME MEDICATION LIST/DISCHARGE MEDICATION LIST," allergies were written as HIT positive, iodine, morphine, penicillin, and phenergan (promethazine). A staff pharmacist dated and timed the form 3/26/11 at 3:00 AM as reviewed. A MAR, dated 3/26/11 7:00 AM to 3/27/11 6:59 AM, listed Patient #14's allergies as morphine, iodine, penicillins, and promethazine. It did not include the allergy to Heparin. On 3/27/11 at 12:20 PM, an order was written by an NP to "Add Heparin (HIT) and methadone to patient's allergy list." On 3/31/11 at 11:00 AM, an order was written by an NP to, "Please add Ambien to patient's list of allergies. DC Lisinopril and please add to allergy list." The outside of Patient #14's chart had a sticker with allergies listed. The allergy sticker listed Iodine, Penicillin, Morphine, Promethazine, Methadone, Heparin Agents, and Lisinopril. The allergy sticker did not list Ambien as an allergy. On 4/13/11 at 4:30 PM, Patient #14 was observed to be wearing an allergy wrist band, which listed Iodine, Penicillin, Morphine, Promethazine, and Heparin. The allergy band did not list Methadone, Lisinopril, or Ambien as allergies. In an interview on 4/13/11 at 3:50 PM, the RN	BB223		

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BB223	Continued From page 8 who was taking care of Patient #14 stated she was not sure why Heparin was not included as an allergy on the original orders. She also stated the chart allergy sticker did not include Ambien. She then looked at Patient #14's wrist band and agreed that the wrist band did not have Methadone, Lisinopril, or Ambien written on it. The RN immediately updated the chart allergy sticker and Patient #14's allergy wrist band. The hospital did not ensure Patient #14's allergies were consistently documented and updated throughout the medical record.	BB223	**BB 538** • The hospital obtained the expertise of an infection control practitioner to review the infection control plan, program and services provided related to infection control. In the NIACH policy IC 010, "*Infection Control Plan*", the designated ICP is referenced including a description of the roles, responsibilities, and leadership requirements. The plan has been reviewed in depth with the Infection Control Task Force and the ICP with understanding noted. Competency assessment of the ICP will be completed at a minimum annually. Continuing education in the ICP role has and will continue to be emphasized via twice annual review by the corporate infection control expert. • Education for clinical and medical staff will be completed by 5/26/11provided regarding best practice recommendations based on CDC/HIPAC research, data, and practice recommendations. Compliance evaluation will be accomplished through the surveillance work of the ICP who will report to the Infection Control Task force at a minimum monthly for a minimum of 3 months. Results will be analyzed and reported to the Infection Control Committee at a minimum quarterly.	
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 observation, interview, and review of medical records, policies, and professional references used by the hospital, it was determined the facility failed to ensure policies related to controlling infections and communicable diseases were developed and implemented. This failure directly impacted 3 of 31 sample patients (#23, #25 and #29) and had the potential to impact all patients receiving care	BB538		

BB 538 Continued

- Effective 5/4/2011, markers that respect HIPAA rules are placed on all C-diff room door jams. All hand sanitizer dispensers have received signage regarding their use in C-diff rooms including permanent signage and an additional cover stating "Notice!! This sanitizer is not effective against C-diff. Please use only soap and water for hand washing" Sodium Hypochlorite 1:10 solution cleaning wipes and aerosols intended for equipment and environmental cleaning have been distributed as appropriate and approved by MEC on 5/12/11 and GB on 5/13/11 . Patient/family educational materials regarding infection control including hand washing and isolation precautions are reviewed at weekly informational meetings eonducted by the CEO and are now also be added to the Memory Book all patients receive upon admission. Review of the material will take place during the initial Patient Care Conferences and in direct education by hospital staff with patients. Twice daily notification/reminders to staff regarding patients requiring isolation preeautions notices room discussions take place via heads up with an emphasis on cleaning the hospital environment, signage, hand sanitation, and proper PPE use. Effective 5/13/2011 the NIACH policy on management of MDRO was approved by GB based on a recommendation from the MEC a day earlier. This policy covers the definition of "containment" as it relates to patients with C-diff and other infections leaving their rooms. It will be ineluded in the education for staff that will be eompleted by 5/26/11 and be reviewed once per shift in heads up meetings so staff are aware of which patients may or may not leave their room based on "containment".
Person(s) Responsible: ICP, DQRM, DOP, DON, DCS

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BB538	Continued From page 9 at the facility. Failure to adequately develop and implement policies and procedures had the potential to place patients at increased risk for hospital acquired infections. Findings include: Refer to A 748 as it relates to the facility's failure to ensure a well developed plan was established for the prevention and control of hospital acquired infections.	BB538		
BB540	16.03.14.540.03 Infection Control & Prevention Procedures 03. Infection Control and Prevention Procedures. There shall be a written infection control procedure which shall include aseptic techniques, cleaning, sanitizing, and disinfection of all instruments, equipment and surfaces, for all departments and services of the hospital where patient care is rendered. (10-14-88) This Rule is not met as evidenced by: Based on observation, interview, and review of medical records and facility policies it was determined the facility failed to ensure systems were developed for controlling infections and communicable diseases. This had the potential to impact all patients receiving care at the facility. Failure to develop a system to control infections and spread of disease had the potential to negatively impact patient health and safety. Findings include: Refer to A 749 as it relates to the facility's failure to ensure systems were developed for proper disinfection techniques throughout the facility.	BB540	**BB540** • After education and additional training by the expert infection control beginning on 5/16/2011, the hospital ICP has begun the weekly monitoring of IC compliance including the positioning of urinary bladder collection bags with an emphasis on patient transfers using a Hoyer lift. Staff education has occurred regarding positioning of indwelling catheter bags and was completed by 5/13/11. During active surveillance for compliance, immediate staff education will be provided for any non-compliance with documented protocols and other resource/reference material from HIPAC/CDC guidelines provided to staff. • The ICP monitoring results will be reported at a minimum every other week for a minimum of 3 months to the Infection Control Task Force and at a minimum quarterly to the Infection Control Committee, QC, MEC, and GB. **Person(s) Responsible: ICP, DQRM, DON, DCS, DTO, DOP**	

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HEALTH & WELFARE

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

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

May 13, 2011

Rick Richards, Administrator
Northern Idaho Advanced Care Hospital
600 North Cecil Road
Post Falls, ID 83854

Provider #132001

Dear Mr. Richards:

On **April 19, 2011**, a complaint survey was conducted at Northern Idaho Advanced Care Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004953

Allegation #1: The hospital did not establish clear code orders at patient admission that reflected patient wishes.

Findings #1: An unannounced visit was made to the hospital on 4/11/11 through 4/15/11. During the complaint investigation and recertification survey, surveyors reviewed 31 patient records, interviewed staff and patients, and reviewed policies, procedures, and other administrative documents.

It was determined the hospital did not ensure patients' code status was documented/communicated clearly and consistently in patient records to ensure patient wishes/advance directives would be honored. This impacted 2 of 31 patients whose records were reviewed. The lack of clarity had the potential to result in patients not having their advance directives honored.

One record documented an 81 year old female who was admitted to the intensive care unit of the hospital on 12/04/10 after transfer from another hospital. Physician "ADMISSION ORDERS" for the patient, dated 12/04/10, did not list a code status. There were boxes available to check, indicating full code, advanced directive, and DNR (do not resuscitate). None of these boxes were checked. There were no other physician orders designating code status present in the record at admission.

The physician's "HISTORY AND PHYSICAL," dated 12/04/10, documented the patient's code status as a "limited code." It stated the patient did not want a ventilator, defibrillator, chest compressions or

intubation. It stated the physician had discussed this with the patient, caregiver, and family. Additionally, "PHYSICIAN PROGRESS NOTES" documented "limited code" status without defining the limits of the code as in the H&P, from the time of admission until the code status documentation changed on 12/21/11 (17 days after admission).

The Director of Case Management was interviewed on 4/13/11 beginning at 10:15 AM. She was asked to look at the record and explain what the "limited code" entailed that was indicated in the physician's progress notes. She reviewed the record and stated she did not know what the limits of the code were. She stated there should have been a physician's order in the record but she did not see one.

The hospital had a green form titled "PATIENT CATEGORIZATION ORDERS." The form was routinely placed in the front of patient records to communicate to staff patients' code status, such as full code, no code/DNR, or a limited code. If a patient was designated by the physician as a limited code, the boxes were checked to indicate the limits of the code, including the following:

No intubation
No ventilator
No defibrillation
No closed chest compressions
Do not call a Code Blue
No telemetry
No other measures (specify)
No chemical agents (Resuscitation drugs)

This form was not in the patient's record. Staff would not have had access to the limits of the code unless they knew to search out information in the H&P.

The physician who designated the "limited code" for the patient was interviewed on 4/13/11 beginning at 3:30 PM. He stated he reviewed the wishes of the patient and her family at the time of admission and documented the wishes in his H&P. He stated he thought he wrote an order for the limited code status on the green sheet and it should have been in the record. He stated he knew it was important and acknowledged the order form was not present in the patient's record.

A hospital policy, "Do not Resuscitate (DNR) - No Code," dated February 2006, stated a Code Blue will be initiated on any patient in need of emergency resuscitation due to cardiac and/or respiratory arrest unless there is a written "Do Not Resuscitate" (DNR) order OR the patient presents with a "comfort ONE/DNR" bracelet or form. In the absence of a DNR order, there is the presumption that the patient wishes to be resuscitated. The policy did not address "limited code" status.

This patient's record lacked clear and consistent information to ensure patient wishes (advance directives) would have been honored.

The hospital was cited at CFR 482.13(b(3) for the hospital's failure to ensure patients' code status was documented/communicated clearly and consistently in patient records to ensure patient wishes/advance

directives would be honored.

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: Hospital staff did not inform patient/family ahead of time that insurance would not pay if the patient's status changed to comfort care only.

Findings #2: It was found that hospital staff communicated information to patients and families regarding what an insurance was expected to pay. One record documented a delay in hospital staff receiving information from an insurance company and thus a delay in getting the information to a patient and her family. As a result of the delay, the hospital dismissed the charges.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Staff reduced a patient's pain medication without consulting with the patient or the legal representataives, such as POA (power of attorney).

Findings #3: It was found hospital staff communicated with patients, legal representatives, and families to ensure patient wishes were honored related to pain management.

One record documented a patient whose pain medication was reduced based on a request from the patient's POA. However, the dosage was increased the same day after the patient was able to express wishes that differed from that of the POA.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff did not obtain appropriate informed consent for a procedure that required informed consent.

Findings #4: Based on review of records, policies and procedures, and staff interview, it was determined the hospital failed to ensure staff obtained properly informed consent for 2 of 31 patients whose records were reviewed. This resulted in verbal consents not being properly executed in accordance with facility policy.

In the case of the patient whom a complaint was received on behalf of, the informed consent forms were determined to be properly signed by one of two designated POAs (power of attorneys). However, in two unrelated patient cases, informed consent was not properly executed.

The hospital was cited at CFR 482.24(c)(2)(v) for a failure to ensure staff obtained properly informed consent for 2 of 31 patients whose records were reviewed.

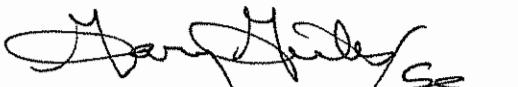
Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey

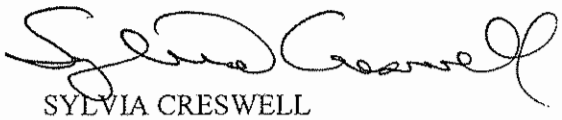
report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm