



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 25, 2012

Rod Barton, Administrator
Cassia Regional Medical Center
1501 Hiland Ave.
Burley, ID 83318

RECEIVED

JUL 30 2012

FACILITY STANDARDS

CMS Certification Number: 13-1326

Re: Restore “deemed” status through Joint Commission accreditation

Dear Mr. Barton:

The Idaho Bureau of Facility Standards (State survey agency) conducted a recertification survey concluded on June 22, 2012. Based on the finding of your survey and the accepted plan of correction (PoC), the State survey agency determined that Cassia Regional Medical Center has met all the Medicare Hospital Conditions of Participation.

As a result of Cassia Regional Medical Center compliance with federal requirements, the Centers for Medicare and Medicaid Services (CMS) will reinstate the hospital’s Medicare “deemed” status through the Joint Commission and remove the hospital from the State survey agency’s survey jurisdiction. Copies of this letter are being provided to the State survey agency and the Joint Commission (JC).

If you have any questions, please contact me by telephone at (206) 615-2432 or by email linda.bedker@cms.hhs.gov.

Sincerely,

Linda Bedker, RN, MN, MPH
Health Insurance Specialist
Survey, Certification and Enforcement Branch

cc: Idaho Bureau of Facility Standards
Joint Commission

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

July 3, 2012

Rod Barton, Administrator
Cassia Regional Medical Center
1501 Hiland Avenue
Burley, ID 83318

RE: Cassia Regional Medical Center, Provider #131326

Dear Mr. Barton:

This is to advise you of the findings of the Medicare/Licensure survey at Cassia Regional Medical Center, which was concluded on June 22, 2012.

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

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

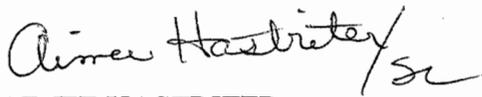
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

Rod Barton, Administrator
July 3, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **July 15, 2012**, and keep a copy for your records.

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

Sincerely,



AIMEE HASTRITER
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/srm
Enclosures



**Intermountain
Cassia Regional
Medical Center**

1501 Highland Avenue
Burley, ID 83318
208.678.4444

July 13, 2012

RECEIVED
JUL 16 2012
FACILITY STANDARDS

Bureau of Facility Standards

Attn: Sylvia Creswell

PO Box 83270

Boise, Idaho 83720-0009

RE: Medicare/Licensure Critical Access Hospital Survey

Ms. Creswell,

Enclosed you will find a copy of the corrective action plan for the Medicare/Licensure Critical Access Hospital Survey, which concluded at Cassia Regional Medical Center, on June 22, 2012. A copy was faxed to your office earlier today (Friday, July 13th). Please feel free to contact me if you have any questions or concerns regarding the submitted information.

Sincerely,

A handwritten signature in blue ink that reads "Jeanette Wheeler".

Jeanette Wheeler RN, BSN

Quality Director

Cassia Regional Medical Center

1501 Hiland Ave

Burley, Idaho 83318

208-677-6585

208-431-0474 (Cell)

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

PRINTED: 06/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/22/2012
NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your CAH, Surveyors conducting the recertification were: Aimee Hastriter RN, HFS, Team Lead Gary Guiles RN, HFS Rebecca Lara RN, HFS Acronyms used in this report include: CAH - Critical Access Hospital CRNA - Certified Registered Nurse Anesthetist ED - Emergency Department EMR - Electronic Medical Record HCL - Hydrochloride H&P - History and Physical IV - Intravenously MG - Milligram CT - Occupational Therapy PRN - As Needed. PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse	C 000	 C271 Patient Care Policies Policies and Procedures for the governing of Cassia Regional Medical Center (CRMC) Rehab Services will be written and updated for our facility. Policies and procedures will be written and submitted to the Rehab Services Medical Director for approval by July 31, 2012. Policies and procedures will be written to address the following elements: Patient assessment and plan of care for therapy services. This will include who will evaluate, when evaluations will occur, how re-evaluations will be completed, and what is included the development of a plan of care along with the scope of practice for Physical Therapists, Occupational Therapist, Speech Therapist, PT assistants, PT aides and PT students. Therapy will include active involvement in multidisciplinary patient care rounds on a consistent basis. Policies and procedures will be submitted for approval to the Medical Executive Committee on August 15, 2012 and the Governing Board on August 22, 2012. Staff education to new policies and procedures will occur by September 15, 2012. Additional 1:1 education will occur as audits take place. Therapy services will integrate with the multi-disciplinary patient care team by attending patient care rounds.	9/15/2012 and ongoing
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on staff Interview and review of medical records and policies, it was determined the CAH faked to ensure 4 of 5 therapy patients (#20, 429, #30, and #37), whose records were reviewed, contained complete therapy evaluations and plans of care. In addition, the CAH failed to	C 271		

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] Administrator

TITLE

(X6) DATE

7-13-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions..) Except for nursing homes, the findings stated above are disclosable 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
C 271	Continued From page 1 ensure policies defining and governing therapy services had been developed. This resulted in a lack of guidance for therapy staff. Findings include: 1, Patient #30's medical record documented a 35 year old female who was admitted to the CAH on 6/02/12 and was discharged on 6/08/12. She was admitted for a fractured left leg, She had a previous fracture of her right leg on 5/20/12 The left leg was surgically repaired on 6/02/12, Patient #30's "DISCHARGE SUMMARY," dated 6/12/12, stated We had physical therapy work with her to teach her transfers. In the process of doing that, a student therapist had her up and had her walking with walking contrary to physician's orders. When corrected, we worked on transfers only,,," Patient #30's "Post-Op Orders," dated 6/02/12 but not timed, stated "Up with Physical Therapy tomorrow." Patient #30's hand written PT evaluation by Physical Therapist C, dated 6/10/12 at 11:58 AM, was difficult to read. The objective section of the evaluation stated in its entirety, "Boot on R + stood for my care [approximately] 3 minutes then sat then stood for 2 minutes-into bed feet elevated." The evaluation included a plan for therapy which stated "[illegible word, patient 2 times a day] for there [therapeutic] activity as able, [illegible word] i stand i" No further PT plan of care was documented. The plan did not state if Patient #30 could bear weight or not. A PT progress note by Physical Therapist C,	C 271	C 271 continued The policies and procedures will be in place and implemented by the staff by September 15, 2012. Following training, from September 15 through November 15, 2012 a review of 100% of inpatient rehab visits will be conducted by the Rehab Services Manager and department physical therapists for two months to ensure understanding and compliance with documentation requirements. Medical records of patients seen will be reviewed on a weekly basis by Tom Nilsen, Rehab Services Manager. An audit sheet will be completed on 100% of inpatient rehab visits to determine compliance with documentation of date and time, evaluation of legibility, documentation of patient assessment and comprehensive plan of care, care plan updates with new orders or patient status changes, and appropriate employee scope of practice. Compliance with these areas of review will be shared on a weekly basis during team meetings with a report given to Keri Perrigot, the administrative lead. Individual counseling and ongoing education will occur as needed. The Rehab Services manager or staff designee will perform random record review monthly through end of 2012 to determine continued compliance and then quarterly through 2013 to sustain improvements. Information will be reported to staff during team meetings and through monthly Quality Council reports. Personal accountable for action plans and monitoring include: Tom Nilsen MS, PT, Mathew Kemp MS, PT, ATC, Troy Anderson DPT, OCS, Greg Hepworth OTR/L and Keri Perrigot Administrative Lead, PHR.	9/15/2012 and ongoing	

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NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83375		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 271	<p>Continued From page 2</p> <p>dated 6/04/12 at 8:00 AM, stated Patient #30 stood at the bedside. A progress note by Physical Therapist D, dated 6/04/12 at 1:20 PM, stated Patient #30 stood in the walker and took 4 steps. Another progress note by Physical Therapist D, dated 6/05/12 at 7:50 AM, stated Patient #30 stood and ambulated "a few steps to [a wheelchair with moderate assistance]. A progress note by Physical Therapist ID, dated 6/05/12 at 1:00 PM, stated Patient #30 ambulated 6 feet with a front wheeled walker and was "...putting a little weight on her [left] leg,"</p> <p>Patient #30's record contained a physician order, dated 6/05/12 at 7:40 PM, which called for physical therapy to "...transfer only-bed, wheelchair, commode-no ambulation."</p> <p>A progress note by PTA E, dated 6/06/12 at 8:30 AM, stated Patient #30 completed leg exercises times 10 repetitions and ambulated 6 to 8 feet with a front wheeled walker, The note stated Patient #30 was putting some weight on her leg. The next progress note, also by PTA E in conjunction with a PTA student, was dated 6/03/12 at 1:15 PM, It stated Patient #30 ambulated 10 feet with a front wheeled walker and put some weight on her foot.</p> <p>A physician progress note, dated 6/06/12, not timed, stated Patient #3C was up walking. The note stated the physician had requested no ambulation secondary to Patient #30's weight and her inability to cooperate"</p> <p>Patient #30's PT plan of care was not clear and it was riot updated to direct staff not to ambulate her.</p>	C 271		

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C 271	<p>Continued From page 3</p> <p>The Rehabilitation Manager was interviewed on 6/21/12 beginning at 9:50 AM. He reviewed Patient #30's medical record. He confirmed time therapy plan of care was not clear, He also confirmed the plan of care was not clarified when the physician ordered no weight bearing.</p> <p>The Rehabilitation Manager stated the CAH had not developed therapy policies, He stated policies defining evaluations, plans of care including updates, and supervision of therapy personnel, including PTAs and students, had not been developed,</p> <p>The CAH failed to provide Patient #30 with a complete therapy evaluation and plan of care and failed to provide direction to therapy personnel.</p> <p>2. Patient #20's medical record documented a 55 year old male who was admitted to the CAH on 5/26/12 and was discharged on 5/30/12, He was admitted for a fractured left hip. The hip was surgically repaired on 5/27/12.</p> <p>Patient #20's "POST-OP TOTAL HIP ORDERS," dated 5/27/12 at 9:00 AM, directed PT to initiate a total hip protocol with weight bearing as tolerated.</p> <p>A PT evaluation, dated 5/28/12 at 8:20 AM, stated it was not clear what Patient #20's level of function was prior to admission. The evaluation stated Patient #20 sat at the bedside with maximum assistance and was not able to stand. The plan stated "See [patient 2 times per] day-6 days per week for rehab, Will get further clarification on prior level of function."</p>	C 271			

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NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83316		
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C 271	<p>Continued From page 4</p> <p>Patient #20 was seen 4 more times by PT between the evaluation and 5/30/12 at 8:00 AM including once by a PTA on 5/29/12 at 8:30 AM. The 5/29/12 PTA note, under the "Plan" section, called for the patient to go from a supine position to sit on the edge of the bed with maximum assistance of 2 persons. The plan also stated to raise the bed to attempt standing times 2 and stand pivot transfer with maximum assistance of 2.</p> <p>The Rehabilitation Manager was interviewed on 6/21/12 beginning at 9:50 AM, He reviewed Patient #20's medical record. He confirmed the therapy evaluation and plan of care were not clear.</p> <p>The CAH failed to provide Patient #20 with a complete therapy evaluation and plan of care. Since the CAH did not have PT policies, it was not clear if the PTA was allowed to modify the plan of care,</p> <p>3, Patient #29's medical record documented a 37 year old male who was admitted to the CAH on 6/02/12 and was discharged on 6/06/12. He was admitted for a stroke.</p> <p>Patient #29's "GENERAL MEDICAL ADMISSION ORDERS," dated 6/02/12 at 11:40 PM, directed PT and OT were to evaluate and treat the patient. Another order, dated 6/04/12 at 4:15 PM stated to transfer Patient #29 to the medical floor and have PT and OT evaluate and treat the patient,</p> <p>A PT evaluation, dated 6/05/12 at 8:25 AM, stated PT would see Patient #29 2 times a day for strengthening and gait, He was seen by PT 2</p>	C 271		

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C 271	<p>Continued From page 5</p> <p>times on 6/05/12 and once on 6/06/12, An OT evaluation was not documented.</p> <p>The Rehabilitation Manager was interviewed on 6/21/12 beginning at 9:50 AM. He reviewed Patient #20's medical record. He confirmed the OT evaluation had not been completed. He stated he did not know why the evaluation had not been done.</p> <p>The CAH failed to conduct an OT evaluation for Patient #29.</p> <p>4. Patient #37's medical record documented a 77 year old male who was admitted to the CAH on 4/22/12 and was discharged on 4/27/12. He had gall bladder surgery on 4/23/12. He also had a diagnosis of lung disease and received 3 units of red blood cells during his stay.</p> <p>Patient #37's physician orders, dated 4/22/12 at 8:05 PM, stated to administer oxygen as needed, using at least 2 liters per minute when in bed. Another order, dated 4/24/12 at 9:05 AM, called for PT to evaluate and treat him.</p> <p>A PT evaluation, dated 4/24/12 at 1:40 PM, stated he was using oxygen at 3 liters per minute, The plan was to see him 2 times a day "...for strengthening in gait & transfers," A specific plan was not documented. The plan did not address the use of oxygen.</p> <p>A PT note, dated 4/25/12 at 7:50 AM, stated the therapist ambulated Patient #37 with 5 liters of oxygen and his oxygen saturation rate dropped to 77%. APT note, dated 4/25/12 at 1:00 PM,</p>	C 271		

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C 271	Continued From page 3 stated the therapist ambulated him with 8 liters of oxygen and his oxygen saturation rate dropped to 82%, A PT note, dated 4/26/12 at 8:15 AM, stated the therapist ambulated him with 8 liters of oxygen and his oxygen saturation rate dropped to 84%. A PT note, dated 4/27/12 at 7:35 AM, stated the therapist ambulated him with 4 liters of oxygen but did not document his oxygen saturation rates. A PT note, dated 4/27/12 at 1:30 PM, stated the therapist ambulated him with 8 liters of oxygen but did not document his oxygen saturation rates. The Rehabilitation Manager was interviewed on 6/21/12 beginning at 9:50 AM. He reviewed Patient #37's medical record, He confirmed the plan of care was not clear.	C 271		
C 276	The CAH failed to provide Patient #37 with a complete therapy plan of care, 485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered In accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on staff interview and review of medical	C 276	C 276 Patient Care Policies Allergy verification of each individual patient will occur by the admitting nurse upon admission. The nurse will follow up with the pharmacist when an allergy discrepancy is noted. The pharmacist will verify and communicate the identified discrepancy to the ordering physician. The determination and updated orders will be entered by the pharmacist in the Tandem HELP system.	7/15/2012 and ongoing

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C 276	<p>Continued From page 7 records and hospital policies, it was determined the CAH failed to ensure the rules for dispensation and administration of drugs and biologicals included a system to reconcile documented allergies for 1 of 20 patients (#4) whose records were reviewed, This failure had the potential to result in administration of medications that patients' were allergic to. Findings include:</p> <p>Patient #4's medical record documented an 89 year old female who presented to the ED on 6/15/12 at 5:51 PM, with a complaint of weakness. The "ED Physician Worksheet" documented Patient #4's past medical history included type 2 diabetes, hypertension, asthma, glaucoma, low back pain and degenerative arthritis, The "ED Physician Worksheet" also documented Patient #4 was allergic to the following: "Codeine , Sulfanilamide , Meperidine HCL, Amitriptyline Hcl, Minocycline Hcl, Aspirin, Morphine and Soma (Carisoprodol.)"</p> <p>The "GENERAL MEDICAL ADMISSION ORDERS," signed by the admitting physician, and dated 6/15/12 at 5:51 PM, documented Patient #4 was allergic only to "Sulfa." The admission orders also included an order for "Morphine Injection 1-2 mg 1V every 15 minutes PRN severe pain. Limit 10 mg per 4 hours."</p> <p>A computer-generated "MEDICAL PROGRESS NOTE," dated 6/18/12 at 7:00 AM to 6/19/12 at 6:59 AM, differed from the allergy list on the "GENERAL MEDICAL ADMISSION ORDERS" and documented Patient #4 was allergic to "Morphine; Minocycline Hcl; Amitriptyline Hcl; Meperidine Hcl; Sulfanilamide;</p>	C 276	<p>C276 continued</p> <p>Beginning July 15th, pharmacy will reconcile allergy medication conflicts on 100% of all new admissions prior to entry into the medication profile. Any discrepancies will be clarified by the pharmacist with the patient and clarified with the ordering physician. This process will be ongoing. Results and action plans will be reported at monthly pharmacy staff meetings, Pharmacy & Therapeutics Committee and Medical Executive Committee.</p> <p>At the upcoming Medical Surgical staff meeting, the medication reconciliation and allergy policies and procedures will be reviewed with all personnel.</p>	7/15/2012 and ongoing

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NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318
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C 276	<p>Continued From page 8</p> <p>Sulfamethoxazole; Aspirin; Codeine; Meperidine; Minocycline; Amltriptlyline; Carisoprodol." The characteristics of allergy symptoms related to these medications were not documented. The same "MEDICAL PROGRESS NOTE" also documented a PRN list of medications and include Injectable Morphine Sulfate, 2 mg IV, PRN, every 5 minutes.</p> <p>A "MEDICATIONS GIVEN REPORT," dated 6/16/12 at 6:01 AM to 6/20/12 at 6:00 AM, documented Morphine Sulfate, 2 mg, was administered to Patient #4 at 3:30 AM and 4:46 AM on 6/17/12. On 6/19/12, the report documented Morphine Sulfate was administered on 2 occasions; 2 mg at 3:08 PM and 1 mg at 4:31 PM, However, no documented allergic reaction to Morphine Sulfate was found in the medical record.</p> <p>An RN caring for Patient #4 was interviewed on 6/19/12 at 9:00 AM, The RN reviewed Patient #4's EMR and confirmed morphine was listed as an allergy and ordered as a PRN medication for pain control. The medication administration record in the EMR documented morphine was last administered to Patient #4 on 6/18/12 at 4:30 PM. The RN was unable to explain the discrepancies in the medical record related to documented allergies.</p> <p>The Director of Pharmacy was interviewed on 6/20/12 at 2:44 PM. He reviewed Patient #4's medication record and confirmed the discrepancies related to documentation of allergies. He stated CAH staff were very familiar with Patient #4 as she had been a patient in the facility many times over the past several years.</p>	C 276		

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NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318		
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C 276	Continued From page 9 The Director of Pharmacy explained that he believed many of the medications on Patient #4's medication list were not true allergies, rather they upset her digestive system. He confirmed there was no documented procedure in place to efficiently reconcile various allergy lists that potentially exist in patients' records. There was no documentation in Patient #4's medical record to indicate the pharmacist alerted the physician to the morphine allergy prior to dispensing the medication, Patient #4 was administered a medication she was identified as being allergic to, potentially placing her health at risk.	C 276			
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined the facility failed to ensure hand hygiene was completed in accordance with nationally recognized standards of practice, This directly impacted 1 of 1 patient (#36) whose surgery was observed and had the potential to impact all surgery patients. Failure to appropriately perform hand hygiene between glove changes had the potential to result in cross contamination and impede infection prevention. Findings include:	C 278	C 278 Patient Care Policies Patient #36's surgery was noted to have a lack of hand hygiene during the O.R. case on 06/20/12 as observed by two surveyors. RN A did not use hand hygiene in between gloves exchanges for the surgical abdominal prep, Foley insertion, moving equipment and cords on the floor before assuming her next task. The "Hand Hygiene Policy" regarding the instructions for hand hygiene was not followed. The "Hand Hygiene Policy" dated 10/2009 will be reviewed with the Surgical Services staff at their upcoming meeting on July 26 th at 6:30am. The content will be presented in a power point followed by questions and answer session.	7/26/2012 and ongoing	

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C 278	<p>Continued From page 10</p> <p>1. Patient #36 was a 68 year old female admitted to the facility on 6/20/12 for surgery to remove her uterus and ovaries. Her medical record contained an H&P completed by the surgeon on 6/18/12. The surgeon indicated Patient #36 had a history of pelvic pain, asthma, hypertension, genital herpes, and sleep apnea,</p> <p>Patient #36's surgery was observed by two surveyors on 6/20/12, from her arrival in the operating room at 8:55 AM through 9:40 AM. RN A and RN B were both present in the operating room and functioning as circulating nurses. At 9:10 AM, RN A was observed to use an electric razor to partially shave Patient #35's abdominal/pelvic region. RN A was then observed to open a package containing a pair of sterile gloves, Betadine solution, and sponges, including at least two sponges mounted on wands. RN A donned the sterile gloves and began to use the sponges to clean Patient #36's inner thighs and genital region. RN A used the sponges on the wands to clean the vaginal region. Once the entire pelvic area was thoroughly cleaned using the Betadine, RN A removed her gloves and immediately donned a second pair of sterile gloves, RN A then inserted a Foley catheter in Patient #33. At 9:25 AM, RN A put the supplies used in the trash, removed her gloves, and donned a pair of clean gloves, At 9:29 AM, RN A was observed to manipulate various equipment cords and position foot pedals on the floor under the operating table. Once equipment was arranged, RN A stood back to wait for the next task. RN A was not observed to perform hand hygiene after shaving Patient #36 and before donning gloves to use the Betadine solution to prepare the pelvic area for surgery.</p>	C 278	<p>C278 continued</p> <p>Surgical Services Staff education will also include review of the drafted "Cassia Regional Medical Center Surgical Hand Scrub Procedure." Review will include the Association of Operating Room Nurses (AORN) Standards, Recommended Practices, and Guidelines, 2011 Edition.</p> <p>Following Staff Education on July 26th, Hand hygiene monitoring will be performed by delegated individuals in the Surgical Area utilizing the "CRMC Hand Hygiene Compliance Monitoring Form." This document includes observation and documentation for who was observed, if the fingernail policy was followed, the number of times hand hygiene was actually performed, number of hand hygiene opportunities during the observation, whether the staff wears gloves as appropriate and whether hand hygiene occurred between glove changes. This report will be reviewed by the Surgical Services Manager, Tyler Moore and then referred to Infection Control, Rebecca Harper for follow up review and documentation. For the Surgical Areas, auditing will continue after the July 26th education by designated personnel on three different days of the week for a total of 6 cases per week thru August 31st. The data will be reviewed by the Surgical Services Manager, Tyler Moore; the Nurse Administrator, Michele Pond-Bell; and the Quality Manager, Jeanette Wheeler. The report will be forwarded to the Infection Control Committee, the Surgical Services Committee meeting and Medical Executive Committee for review. A plan for continued monitoring for compliance will be adapted after August 31st in conjunction with Infection Control for continued monitoring and surveillance.</p>	7/26/2012 and ongoing

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C 278	<p>Continued From page 11</p> <p>RN A was not observed to perform hand hygiene before donning sterile gloves to insert the Foley catheter or after removing the sterile gloves and before donning clean gloves to handle equipment. RN A was not observed to remove her gloves after manipulating equipment on the floor or apply clean gloves in preparation for the next task.</p> <p>The CAH's "Hand Hygiene Policy," dated 10/2009, contained instructions for hand hygiene using soap and water and alcohol based hand rub. According to the policy, "If hands are not visibly soiled, hand hygiene can be performed by either washing with soap-and-water or by using an alcohol-based hand rub in the following instances:...Before' inserting Invasive devices such as Foley [urinary] catheters and peripheral Intravascular catheters...When moving from a contaminated body site to a clean body site during patient care...After removing gloves," The policy indicated one of the primary sources of information was the "Centers for Disease Control (CDC) Guideline for Hand Hygiene in Health-Care Settings, 2002."</p> <p>According to the CDC "Guidelines for Hand Hygiene in Health-Care Settings," dated 10/25/02, "Personnel should be Informed that gloves do not provide complete protection against hand contamination, Bacterial flora colonizing patients may be recovered from the hands of [equal to or greater than] 30% of HCW [Health Care Workers] who wear gloves during patient contact. Further, wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex virus. In such instances, pathogens</p>	C 278			

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C 278	<p>Continued From page 12</p> <p>presumably gain access to the caregiver's hands via small defects in gloves or by contamination of the hands during glove removal." The document also included data comparing the barrier integrity of various gloves, "In published studies, vinyl gloves have had defects more frequently than latex gloves, the difference in defect frequency being greatest after use...Limited studies indicate that nitrile gloves have leakage rates that approximate those of latex gloves...Although recent studies indicate that improvements have been made In the quality of gloves, hands should be decontaminated or washed after removing gloves."</p> <p>RN B was interviewed on 6/20/12 at 2:00 PM. The topic of hand hygiene during the procedure, especially related to preparing the skin for surgery, was discussed. RN B stated that when the vaginal area was cleaned using the Betadine and sponges on the wands, then the gloves remained sterile and did not necessarily need to be changed prior to placing the Foley catheter. She confirmed that if the regular sponges were used in addition to the sponges or the wands, the gloves needed to be changed prior to inserting the Foley catheter. She stated she was not aware that staff had been educated to perform hand hygiene between glove changes.</p> <p>The Infection Preventionist and the Nursing Administrator were interviewed together on 6/21/12 at 1:50 PM, Both confirmed that staff were expected to perform hand hygiene between glove changes. In addition, the Nurse Administrator stated she would expect that gloves always be changed (and hand hygiene performed) between the process of preparing the</p>	C 278			

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C 278	Continued From page 13 vaginal area for surgery and placing the Foley catheter.	C 278			
C 302	The facility failed to ensure hand hygiene was performed in accordance with the established policy. 485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized, This STANDARD is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined the CAH failed to ensure records were accurate for 1 of 1 patient (#36) whose surgery was observed, Failure to ensure accurate documentation had the potential to interfere with quality, safety, and coordination of patient care, Findings include: Patient #36 was a 68 year old female admitted to the facility on 6/20/12 for surgery to remove her uterus and ovaries/ Her medical record contained an H&P completed by the surgeon on 6/18/12. The surgeon indicated Patient #36 had a history of pelvic pain, asthma, hypertension, and sleep apnea. Patient #36's record contained a form titled, "History and Physical Update." A pre-printed note on the form read, "The History and Physical was reviewed, the patient was examined, and no change has occurred in the patient's condition since the History and Physical was completed." The surgeon signed this form on 6/20/12 at 8:20 AM.	C 302	C302 Record Systems The History and Physical update form for Cassia Regional Medical Center will be revised.	7/24/2012	

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C 302	<p>Continued From page 14</p> <p>Patient #36's record also contained a form titled, "ANESTHESIA PROGRESS NOTES." On this form the CRNA documented a pre-surgical assessment which included a review of Patient #36's medical history, allergies, medications, and a physical exam. The CRNA documented that Patient #36's lungs were "CTAB [clear to auscultation (listening with a stethoscope) bilaterally]" and that her heart rate was in "NSR [normal sinus rhythm]," The CRNA Indicated general anesthesia was planned for Patient #36. The CRNA documented the assessment was completed on 6/20/12 at 8:25 AM.</p> <p>On 6/20/12, from 7:45 AM to 9:35 AM, two surveyors observed the pre-operative and intraoperative care for Patient #36. At 8:10 AM, the surgeon arrived to speak with Patient #36 and her family. The surgeon asked if there had been any changes. in Patient #36's medical history or medications, He reviewed the plan for surgery and the risks and benefits of the proposed plan, The surgeon was not observed to physically examine Patient #36, such as listening to her heart and lungs with a stethoscope.</p> <p>At 8:24 AM, the CRNA was observed to introduce himself to Patient #36. He asked Patient #36 if she had any prior issues with anesthesia and Patient #36 told him that during a previous surgery she was paralyzed but still able to hear conversations around her and felt the incision being initiated. The CRNA asked Patient #36 if her blood pressure and asthma were controlled by medications. Patient #36 reported she had been hospitalized twice in the last two years for asthma related issues but that her blood pressure and asthma seemed to be managed by the</p>	C 302			

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C 302	<p>Continued From page 15</p> <p>current medication regimen, The CRNA was not observed to complete a physical examination on Patient #36, such as listening to her heart and lungs.</p> <p>Patient #36's surgeon was interviewed on 6/20/12 at 2:25 PM. He reviewed his process for assessing a patient prior to surgery. He stated he typically saw a patient In his office within a week prior to surgery. While In the office he obtained a thorough history (such as medical, family, and social history) and completed a detailed physical examination, He stated the day of surgery he visited with patients and asked if there had been any changes in medical history or medications since the office visit. He stated if the patient relayed that anything had changed he would adjust his pre-operative assessment to include listening to heart and lungs if necessary or even canceling surgery if he deemed it unsafe. He confirmed that he had completed a full H&P on Patient #36 two days prior to surgery and that Patient #36 stated there were no changes in those two days.</p> <p>Patient #36's CRNA was interviewed on 6/20/12 at 2:30 PM. He explained his pre-operative patient assessment. He stated he reviewed the patient's medical information, physician orders, consent, labs, and diagnostic testing prior to actually speaking with the patient. He stated he routinely asked patients if they had any issues with prior anesthesia, explained his plan for sedation, and explained what the patient could expect on waking up from anesthesia, He stated he would usually listen to a patient's heart and lungs if any concern was noted, He confirmed he did not listen to Patient #36's heart and lungs</p>	C 302			

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C 302	Continued From page 16 because Patient #36 said she was not having any problems. The CRNA explained that he listened to the lungs after he intubated a patient to ensure adequate ventilation. The Quality Coordinator was interviewed on 6/22/12 at 8:40 AM. She reviewed Patient #36's medical record. She confirmed that based on the CRNA documentation on the "ANESTHESIA PROGRESS NOTES," It appeared the CRNA completed a physical examination which included listening to Patient #36's heart and lungs prior to surgery.	C 302		
C 322	The facility failed to ensure accurate documentation of a preoperative assessment for Patient #36. 485.639(b) ANESTHETIC RISK & EVALUATION (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined the facility failed to ensure that, prior to surgery or a procedure, patients were examined to evaluate	C 322	C322 Anesthetic Risk & Evaluation Rod Barton, Facility Administrator and Dr. Fred Wood, Facility Medical Director will complete discussions with specified Certified Registered Nurse Anesthetist (CRNA) regarding requirements for pre-anesthesia assessment. This includes identification of any anesthesia risk and patient's condition prior to induction of anesthesia as outlined in the <i>Anesthesia Services Policy</i> . This pre anesthesia assessment is to include a physical examination including lung and cardiac status. The conversation will stress that the exam must physically take place prior to documenting that it occurred and that an audit will be completed to ensure that updated physical exam is observed prior to the patient receiving anesthesia. Discussion with the CRNA will be completed by July 17, 2012.	7/24/2012 and ongoing

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C 322	<p>Continued From page 17</p> <p>the potential risks. This impacted 1 of 1 patient (#36) whose surgery was observed, and 3 of 3 sample patients (#9, #34, and #39) who had pain procedures. Failure to ensure an adequate pre-procedure examination had the potential to result in negative patient outcome. Findings include:</p> <p>1. Patient #36 was a 68 year old female admitted to the facility on 6/20/12 for surgery to remove her uterus and ovaries. Her medical record contained an H&P completed by the surgeon on 6/18/12. The surgeon indicated Patient #36 had a history of pelvic pain, asthma, hypertension, and sleep apnea.</p> <p>On 6/20/12, from 7:45 AM to 9:35 AM, two surveyors observed the preoperative and intraoperative care for Patient #36. At 8:10 AM, the surgeon arrived to speak with Patient #36 and her family. The surgeon asked if there had been any changes in Patient #36's medical history or medications, He reviewed the plan for surgery and the risks and benefits of the proposed plan. The surgeon was not observed to perform a physician examination on Patient #36 such as listening to her heart and lungs with a stethoscope.</p> <p>At 8:24 AM, the CRNA was observed to introduce himself to Patient #36. He asked Patient #36 if she had any prior issues with anesthesia and Patient #36 told him that during a previous surgery she was paralyzed but still able to hear conversations around her and felt the incision being initiated. The CRNA asked if Patient #36 if her blood pressure and asthma were controlled by medications, Patient #36 stated she had been</p>	C 322	<p>C322 continued</p> <p>The conversation will be reported to the Medical Executive Committee on July 18, 2012 and a follow up letter will be sent to the CRNA regarding the conversation and the ongoing audit to determine CRNA compliance by observation. Observations will be completed to ensure that the necessary physical exam actually took place prior to the patient being taken to the Operating Room for anesthesia. The discussion and individual findings will be reviewed at Governing Board scheduled for August 22, 2012.</p> <p>The discussion regarding the need for physician exam prior to documentation will be taken to General Medical Staff Meeting scheduled July 24, 2012 by Dr. Fred Wood.</p> <p>Following the discussion with the Medical Executive Committee and the issuance of the follow up letter to the CRNA, the Same Day Surgery Staff and OR Circulator, under the direction of the OR Manager Tyler Moore, will conduct 100% audit of the specified CRNA's case load for two months to ensure compliance. Observations will be sent to Quality for calculation and reported to Surgical Case scheduled August 16, 2012 and monthly to the Medical Executive Committee. Additional discussions for improved compliance will be held with the CRNA based on the outcome of the observations. Additional random audits for the specified CRNA will be conducted monthly through end of 2012 to determine continued compliance and then quarterly through 2013 to sustain improvements.</p>		

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C 322	<p>Continued From page 18</p> <p>hospitalized twice In the last two years for asthma related issues but that her blood pressure and asthma seemed to be managed by the current medication regimen. The CRNA was not observed to complete a physical examination on Patient #36, such as listening to her heart and lungs.</p> <p>Patient #36's surgeon was interviewed on 6/20/12 at 2:26 PM. He reviewed his process for assessing a patient prior to surgery. He stated he typically saw a patient in his office within a week prior to surgery. While in the office he obtained a thorough history (such as medical, family, and social history) and completed a detailed physical examination. He stated the day of surgery he visited with patients and asked if there had been any changes In medical history or medications since the office visit. He stated if the patient relayed that anything had changed he would adjust his pre-operative assessment to include listening to heart and lungs if necessary. or even canceling surgery if he deemed it unsafe. He confirmed that he had completed a full H&P on Patient #36 two days prior to surgery and that Patient #36 stated there were no changes in those two days,</p> <p>Patient #36`s CRNA was interviewed on 6/20/12 at 2:30 PM. He explained his pre-operative patient assessment. He stated he reviewed the patient's medical information, physician orders, consent, labs, and diagnostic testing prior to actually speaking with the patient. He stated he routinely asked patients if they had any issues with prior anesthesia, explained his plan for sedation, and explained what the patient can expect on waking up from anesthesia. He stated</p>	C 322		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 322	<p>Continued From page 19.</p> <p>he would usually listen to a patient's heart and lungs if any concern was noted. He confirmed he did not listen to Patient #36's heart and lungs because Patient #36 said she was not having any problems. The CRNA explained that he listened to the lungs after he intubated a patient to ensure adequate ventilation.</p> <p>The facility failed to ensure Patient #36 was examined prior to her surgery to evaluate the risk of anesthesia and the procedure.</p> <p>2. Patient #39 was admitted on 6/04/12 for a right lumbar transforaminal steroid injection. The "PROCEDURE SEDATION RECORD" indicated an RN administered Versed 1 mg IV at 2:20 PM, and that Patient #34 was placed on Oxygen at 2 liters per minute via a nasal cannula from 2:18 PM to 2:23 PM.</p> <p>Patient #39's record contained an H&P completed by the physician on 5/21/12. The physician's documentation included Patient #39's past medical and surgical history, a review of systems, and a physical examination. Under the section regarding "Review of Systems," the physician noted Patient #39 denied fevers, chills, night sweats, and unintentional weight loss or gain. The physician also noted Patient #39 denied loss of ability to control bowel and bladder. In the section for "Physical Exam," the physician noted Patient #39 was a "Pleasant gentleman in no acute distress," was "Normocephalic," and "He can sit, stand and ambulate independently. Lumbar range of motion is reduced and he has Increased pain with flexion." The physician did not document an assessment that included evaluating Patient #39's heart and lungs with a</p>	C 322	<p>C 322: History and Physical/Exam updates (Patients #39, #9, and #34)</p> <p>Rod Barton, Facility Administrator and Dr. Fred Wood, Facility Medical Director will complete discussions with identified surgeon regarding requirements for History and Physical Exams prior to procedures. Discussion will include the required components of a History and Physical as outlined in the CRMC Medical Staff Rules and Regulations. For outpatient surgery or procedures this includes (but is not limited to) the following elements: chief complaint, history and physical, past medical / surgical (if pertinent) history, allergies, present medications, pertinent diagnostic finding, review of symptoms, physical exam, assessment, diagnosis, and plan. All elements of the physical exam must be completed to ensure adequate review for risk of surgery and anesthesia. The conversation will stress that the history and physical must be completed in all elements to determine adequate review for risk of surgery and anesthesia. Discussion with the surgeon will be completed by July 31, 2012.</p> <p>The history and physical template will be revised to meet the required rules and regulations. The form will be revised by July 31, 2012.</p> <p>An audit of ten cases by the identified surgeon will be conducted to ensure appropriate utilization of the revised form. This audit will be conducted by August 31, 2012.</p>	<p>7/31/2012</p> <p>7/31/2012</p> <p>8/31/2012</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2012
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C 322	<p>Continued From page 20 stethoscope.</p> <p>Patient #39's record contained a form titled, "History and Physical Update." A pre-printed note on the form read, "The History and Physical was reviewed, the patient was examined, and no change has occurred in the patient's condition since the History and Physical was completed," The physician signed this form on 6/04/12 at 2:15 PM, The medical record did not contain evidence of an examination immediately prior to the procedure to evaluate the potential risks.</p> <p>3. Patient #9 was a 91 year old male admitted on 6/18/12 for a lumbar epidural steroid injection, The "PROCEDURE SEDATION RECORD" indicated an RN administered Versed 1 mg IV at 1:57 PM, and that Patient #9 was on 3 liters per minute of Oxygen via nasal cannula from 2:00 PM to 2:05 PM and again at 2:20 PM.</p> <p>Patient #9's medical record contained an H&P completed by the physician on 6/04/12, The physician documented Patient #9 had a history of a kidney tumor and diabetes. Under the "Physical Exam" section, the physician documented, "Pleasant 91-year-old man in no acute distress," and "He can sit, stand, and ambulate. Palpation of his lower back is negative. He complains of pain in the left gluteal region and somewhat over the great trochanter area." The physical examination did not include listening to Patient #9's heart and lungs with a stethoscope, or address body systems such as the neurological system, or the genitourinary, or gastrointestinal system.</p> <p>Patient #9's record contained a form titled,</p>	C 322			

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

PRINTED 6/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X9) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) PATE SURVEY COMPLETED 06/22/2012
NAME OF PROVIDER OR SUPPLIER CASSIA REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1501 HILAND AVENUE BURLEY, ID 83318		
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C 322	<p>Continued From page 21</p> <p>"History and Physical Update," A pre-printed note on the form read, "The History and Physical was reviewed, the patient was examined, and no change has occurred in the patient's condition since the History and Physical was completed," The physician signed this form on 6/18/12 at 1:50 PM. The medical record did not contain evidence of an examination immediately prior to the procedure to evaluate the potential risks.</p> <p>4. Patient #34 was a 53 year old female admitted on 6/04/12 for a lumbar epidural steroid injection. The "PROCEDURE SEDATION RECORD" indicated an RN administered Versed 2 mg IV at 1:15 PM, and that Patient #34 was on 2 liters per minute of Oxygen via nasal cannula from 1:14 PM to 1:19 PM.</p> <p>Patient #34's medical record contained an H&P completed by the physician on 5/21/12, The physician documented Patient #34's medical history included obesity, right-sided paralysis, seizure disorder, asthma, hypertension and stage III chronic kidney disease. Under the section regarding "Review of Systems," the physician noted Patient #34 denied fevers, chills, night sweats, and unintentional weight loss or gain, The physician also noted Patient #34 denied less of ability to control bowel and bladder. Under the "Physical Exam" section, the physician documented "Pleasant severely morbidly obese female..." and noted Patient #34 could, "sit, stand and ambulate Independently," The physical examination did not include listening to Patient #34's heart and lungs with a stethoscope or addressing other body systems such as the neurological system,</p>	C 322			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X11) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2012
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C 322	<p>Continued From page 22</p> <p>Patient #34's record contained a form titled, "History and Physical Update," A pre-printed note on the form read, "The History and Physical was reviewed, the patient was examined, and no change has occurred in the patient's condition since the History and Physical was completed," The physician signed this form on 6/04/12 at 1:12 PM. The medical record did not contain evidence of an examination Immediately prior to the procedure to evaluate the potential risks,</p> <p>The Medical Director was interviewed on 6/21/12 at 3:00 PM. He reviewed the records for Patients #9, #34, and #39 and confirmed the lack of a documented examination prior to the procedure to evaluate the risk of the procedures that were performed and the administration of the sedative medication, He stated he would have expected to see documentation of a pre-procedure assessment.</p> <p>The facility failed to ensure patients were adequately examined to evaluate the risks of the procedures to be performed.</p>	C 322			

Bureau of Facility Standards

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B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the Medicare recertification survey of your CAH. Surveyors conducting the recertification were: Aimee Hastriter RN, HFS, Team Lead Gary Guiles RN, HFS Rebecca Lara RN, HFS</p> <p>Acronyms used in this report Include:</p> <p>CAH - Critical Access Hospital CRNA Certified Registered Nurse Anesthetist ED - Emergency Department EMR - Electronic Medical Record HCL - Hydrochloride H&P - History and Physical IV - Intravenously MG - Milligram OT - Occupational Therapy PRN - As Needed PT - Physical Therapy PTA - Physical Therapy Assistant RN - Registered Nurse</p>	B 000	<p style="text-align: center;">RECEIVED JUL 16 2012 FACILITY STANDARDS</p> <p>BB224 Policies and Procedures Allergy verification of each individual patient will occur by the admitting nurse upon admission. The nurse will follow up with the pharmacist when an allergy discrepancy is noted. The pharmacist will verify and communicate the identified discrepancy to the ordering physician. The determination and updated orders will be entered by the pharmacist in the Tandem HELP system.</p> <p>Beginning July 15th, pharmacy will reconcile allergy medication conflicts on 100% of all new admissions prior to entry into the medication profile. Any discrepancies will be clarified by the pharmacist with the patient and clarified with the ordering physician. This process will be ongoing. Results and action plans will be reported at monthly pharmacy staff meetings, Pharmacy & Therapeutics Committee and Medical Executive Committee.</p> <p>At the upcoming Medical Surgical staff meeting, the medication reconciliation and allergy policies and procedures will be reviewed with all personnel.</p>	7/15/2012 and ongoing
BB224	<p>16.03.14.330.04 Policies and Procedures</p> <p>04. Policies and Procedures. Written policies and procedures shall be developed by the pharmacy and therapeutics committee or its equivalent to govern the pharmaceutical services provided by the hospital. (10-14-88)</p> <p>a. Policies and procedures shall be reviewed revised and amended as necessary, and dated to indicate= the time of last review. (10-14-88)</p> <p>b. Written policies and procedures that are essential for patient safety, and for the control and accountability of drugs, shall be in</p>	BB224		

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6899 5UM411

TITLE

Administrator

(X6) DATE

7-13-2012

Bureau of Facility Standards

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BB224	Continued From page 1 accordance with acceptable professional practices and applicable federal, state and local laws. (10-14-88) c, Policies and procedures shall include, but are not limited to the following: (10-14-88) i. There shall be a drug recall procedure that can be readily implemented; and (10-14-88) ii. All medications not specifically prescribed as to time or number of doses shall be controlled by automatic stop orders or other methods; and (10-14-88) iii. Drugs shall be dispensed and administered only upon written or verbal order of a member of the medical staff authorized to prescribe, Verbal orders for drugs shall be given only to those health care practitioners empowered to accept orders under Idaho law and written hospital policies and procedures. Verbal or telephone orders shall be signed by the prescriber within twenty-four (24) hours. The person accepting the verbal or telephone orders shall meet the procedures set forth in Subsection 250.10; and (12-31-91) iv. If patients bring their own drugs into the hospital, these drugs shall not be administered unless they are identified by the pharmacist and a physician's order is written to administer these specific drugs. If the drug(s) that the patient brought to the hospital is (are) not to be used while he is hospitalized, it (they) shall be packaged, sealed, stored, and returned to the patient at the time of discharge; and (10-14-88) v. Self-administration of medications by patients shall not be permitted unless specifically ordered	BB224		

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BB224	Continued From page 2 by the physician; and (10-14-88) vi. Investigational drugs shall be used only under the supervision of the principal investigator and after approval for use by the pharmacy and therapeutics committee; and (10-14-88) vii. Acts of drug compounding, packaging, labeling, and dispensing, shall be restricted to the pharmacist or to his designee under supervision; and (10-14-88) viii. The labeling of drugs and biologicals shall be based on currently accepted professional principles, applicable federal, state, and local laws, and include the appropriate accessory and cautionary instructions, as well as the expiration date when applicable. Only the pharmacist or authorized pharmacy personnel under the supervision of the pharmacist shall make labeling changes; and (10-14-88) ix. Discontinued drugs, outdated drugs, or containers with worn, illegible, 'or missing labels shall be returned to the pharmacy for proper disposition; and (10-14-88) x. Only approved drugs and biologicals shall be used, (See definition.) A list or formulary of approved drugs shall be maintained in the hospital. (10-14-88) This Rule is not met as evidenced by: Refer to C 276 as it relates to the facility's failure to ensure the rules for dispensation and administration of drugs and biologicals included a system to reconcile documented allergies,	BB224		
BB272	16.03.14.360.01 Medical Records Service, Facilities	BB272	BB 272 Medical Records	

Bureau of Facility Standards

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BB272	Continued From page 3	BB272	BB 272 continued..	
BB332	<p>360. MEDICAL RECORDS SERVICE. The hospital shall maintain medical records that are documented accurately and timely, and that are readily accessible and retrievable, (12-31-91)</p> <p>01. Facilities. The hospital shall provide a medical record room, equipment, and facilities for the retention of medical records. Provision shall be made for the safe storage of medical records, (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C 320 as it relates to the facility's failure to ensure records were accurate,</p> <p>16.03.14.390.01 Anesthesia Services, Policies and Procedures</p> <p>390. ANESTHESIA SERVICES. These services shall be available when the hospital provides surgery or obstetrical services with C-section capacity and shall be integrated with other services of the hospital and shall include at least the following: (10-14-88)</p> <p>01. Policies and Procedures. Policies and procedures shall be approved by the medical staff and the administration of the hospital. These written policies and procedures shall include at least the following: (10-14-88)</p> <p>a. Designation of persons permitted to give anesthesia, types of anesthetics, preanesthesia, and post anesthesia responsibilities; and (10-14-88)</p> <p>b. Preanesthesia physical evaluation of a patient by an anesthesiologist, with the recording of pertinent information prior to surgery together with the</p>	BB332	The History and Physical update form for Cassia Regional Medical Center will be revised.	7/24/2012

Bureau of Facility Standards

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DB332	Continued From page 4 history and physical and preoperative diagnosis of a physician; and (10-14-88) c. Review of patient condition immediately prior to induction; and (10-14-88) d. Safety of the patient during anesthetic period; and (10-14-88) e. Record of events during induction, maintenance, and emergence from anesthesia including; (10-14-88) i. Amount and duration of agents; and (10-14-88) ii. Drugs and IV fluids; and (10-14-88) iii. Blood and blood products. (10-14-88) f. Record of post-anesthetic visits and any complications shall be made within three (3) to forty-eight (48) hours following recovery; and (10-14-88) g. There shall be a written infection control procedure including aseptic techniques, and disinfection or sterilizing methods. (10-14-88) This Rule Is not met as evidenced by: Refer to C 322 as it relates to the facility's failure to ensure that, prior to surgery or a procedure, patients were examined to evaluate the potential risks,	BB332	BB 332 Anesthesia Services Rod Barton, Facility Administrator and Dr. Fred Wood, Facility Medical Director will complete discussions with specified Certified Registered Nurse Anesthetist (CRNA) regarding requirements for pre-anesthesia assessment. This includes identification of any anesthesia risk and patient's condition prior to induction of anesthesia as outlined in the <i>Anesthesia Services Policy</i> . This pre anesthesia assessment is to include a physical examination including lung and cardiac status. The conversation will stress that the exam must physically take place prior to documenting that it occurred and that an audit will be completed to ensure that updated physical exam is observed prior to the patient receiving anesthesia. Discussion with the CRNA will be completed by July 17, 2012. The conversation will be reported to the Medical Executive Committee on July 18, 2012 and a follow up letter will be sent to the CRNA regarding the conversation and the ongoing audit to determine CRNA compliance by observation. Observations will be completed to ensure that the necessary physical exam actually took place prior to the patient being taken to the Operating Room for anesthesia. The discussion and individual findings will be reviewed at Governing Board scheduled for August 22, 2012. The discussion regarding the need for physician exam prior to documentation will be taken to General Medical Staff Meeting scheduled July 24, 2012 by Dr. Fred Wood. Following the discussion with the Medical Executive Committee and the issuance of the follow up letter to the CRNA, the Same Day Surgery Staff and OR Circulator, under the direction of the OR Manager Tyler Moore, will conduct 100% audit of the specified CRNA's case load for two months to ensure compliance. Observations will be sent to Quality for calculation and reported to Surgical Case scheduled August 16, 2012 and monthly to the Medical Executive Committee. Additional discussions for improved compliance will be held with the CRNA based on the outcome of the observations. Additional random audits for the specified CRNA will be conducted monthly through end of 2012 to determine continued compliance and then quarterly through 2013 to sustain improvements.	7/24/2012 and ongoing	
BB416	16.03.14.440.05 Policies and Procedures 05. Policies and Procedures. Policies and procedures shall be developed by the physician director, nursing service, administration, and other personnel representing each service	BB416			

Bureau of Facility Standards

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BB418	Continued From page 5 offered, (10-14-88) This Rule is not met as evidenced by: Refer to C 271 as it relates to the facility's failure to medical records for therapy patients contained complete therapy evaluations and plans of care. In addition, the CAH failed to ensure policies defining and governing therapy services had been developed.	BB416	BB 416 Patient Care Policies Policies and Procedures for the governing of Cassia Regional Medical Center (CRMC) Rehab Services will be written and updated for our facility. Policies and procedures will be written and submitted to the Rehab Services Medical Director for approval by July 31, 2012. Policies and procedures will be written to address the following elements: Patient assessment and plan of care for therapy services. This will include who will evaluate, when evaluations will occur, how re-evaluations will be completed, and what is included the development of a plan of care along with the scope of practice for Physical Therapists, Occupational Therapist, Speech Therapist, PT assistants, PT aides and PT students. Therapy will include active involvement in multidisciplinary patient care rounds on a consistent basis. Policies and procedures will be submitted for approval to the Medical Executive Committee on August 15, 2012 and the Governing Board on August 22, 2012. Staff education to new policies and procedures will occur by September 15, 2012. Additional 1:1 education will occur as audits take place. Therapy services will integrate with the multi-disciplinary patient care team by attending patient care rounds. The policies and procedures will be in place and implemented by the staff by September 15, 2012. Following training, from September 15 through November 15, 2012 a review of 100% of inpatient rehab visits will be conducted by the Rehab Services Manager and department physical therapists for two months to ensure understanding and compliance with documentation requirements. Medical records of patients seen will be reviewed on a weekly basis by Tom Nilsen, Rehab Services Manager. An audit sheet will be completed on 100% of inpatient rehab visits to determine compliance with documentation of date and time, evaluation of legibility, documentation of patient assessment and comprehensive plan of care, care plan updates with new orders or patient status changes, and appropriate employee scope of practice. Compliance with these areas of review will be shared on a weekly basis during team meetings with a report given to Keri Perrigot, the administrative lead. Individual counseling and ongoing education will occur as needed. The Rehab Services manager or staff designee will perform random record review monthly through end of 2012 to determined continued compliance and then quarterly through 2013 to sustain improvements and then annually thereafter. Information will be reported to staff during team meetings and through monthly Quality Council reports. Personal accountable for action plans and monitoring include: Tom Nilsen MS, PT, Mathew Kemp MS, PT, ATC, Troy Anderson DPT, OCS, Greg Hepworth OTR/L and Keri Perrigot Administrative Lead, PHR.	7/15/2012 and ongoing	

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JUL 20 2012

FACILITY STANDARDS

Cassia Regional Medical Center
Addendum Submission for Plan of Correction
Medicare/Licensure Survey concluded 6/22/2012
Submitted: 7/20/2012

Addendum C 276 PATIENT CARE POLICIES:

The Pharmacy Director has been assigned direct responsibility and oversight for the determined audit of medication reconciliation for allergies. The Pharmacy Director will be responsible for reporting information to the pharmacy staff, and Pharmacy & Therapeutics Committee. The Pharmacy & Therapeutics Committee Chairman will report results to the Medical Executive Committee.

Addendum C 302 RECORD SYSTEMS:

Plan of Correction: The Facility Administrator and the Facility Medical Director will complete discussions with GYN Surgeon regarding requirements for History and Physical updates. Discussion will include the required components of a History and Physical and the need for a physical exam prior to surgery as outlined in the Intermountain *Patient History Physical Exam Policy*.

An update was discussed at Medical Executive Committee on July 18th. Further discussion will be held at the General Medical Staff Meeting scheduled July 24, 2012 and the Governing Board meeting scheduled for August 22, 2012.

Following the discussion with the Medical Executive Committee:

A. Same Day Surgery (SDS) staff, under the direction of the OR Manager, will perform audits to determine specific physician compliance with the policy as follows:

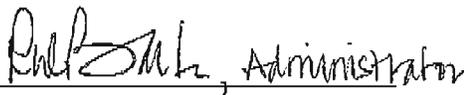
1. 100% review of all GYN cases for specific practitioner for 100% compliance with the History Physical Exam Policy for three consecutive months or until 3 consecutive months have been reported
2. Ongoing audits for compliance will be conducted monthly for specific practitioner for 50% of practitioner's cases per month for the next 12 months following the completion of number 1 listed above
3. At any point in the ongoing audits, should the audit results for the specified surgeon fall below 100% compliance, the 100% compliance audits will be resumed in the same manner as described above

B. SDS staff, under the direction of the OR Manager will perform audits to determine the remaining surgeon population compliance with the policy as follows:

Following general education to all physicians performing surgical cases

1. Audit 30 random cases per month for 100% compliance of the Patients History Physical Exam Policy for 3 months
2. If non-compliance with the policy is discovered, in the above audit for the remaining surgeon population, the following will occur:
 - a) Audit 30 random cases per month for 100% compliance for 3 consecutive months or until 3 consecutive months have been reported with 100% compliance

Representative Signature/Title:

 Administrator

Date: 7-20-2012

- b) *Ongoing audits for compliance will be conducted monthly for all surgeons for 15 cases/month for 100% compliance*
- c) *At any point in the ongoing audits, should they fall below 100% compliance, the 30 random case audits will be resumed in the same manner as described above in 2 and 3*

Audit results will be presented to the Surgical Case Committee by the OR manager and the Medical Executive Committee by the Surgical Case Committee Chairman.