



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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August 22, 2012

Casey Meza, CEO
Clearwater Valley Hospital and Clinics
301 Cedar Street
Orofino, Idaho 83544

RE: Clearwater Valley Hospital and Clinics, CCN #13-1320

Dear Ms. Meza:

This is to advise you of the findings of the Medicare/Licensure survey, which was concluded at your facility on August 10, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies identified during the survey. A similar form lists State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

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 Mountain View 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 of the Form 2567s.

Casey Meza
August 22, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by September 5, 2012, and keep a copy of your records.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

Enclosures

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

PRINTED: 11/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/10/2012
NAME OF PROVIDER OR SUPPLIER CLEARWATER VALLEY HOSPITAL & CLINICS			STREET ADDRESS, CITY, STATE, ZIP CODE 301 CEDAR STREET OROFINO, ID 83544	
(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 Critical Access Hospital. Surveyors conducting the recertification were: Gary Guiles, RN, HFS, Team Leader Rebecca Lara, RN, HFS Acronyms used in this report include: CAH = Critical Access Hospital CFR = Code of Federal Regulations CLIA = Clinical Laboratory Improvement Amendments COPD = Chronic Obstructive Pulmonary Disease CT = Computed Tomography Scan DNS = Director of Nursing Services POC = plan of care P&T = Pharmacy and Therapeutics PT = Physical Therapy PVT = Pharmacy Verification Technician PYXIS = Automated Medication Management System RN = Registered Nurse	C 000	<i>see attached</i>	
C 151	485.608(a) COMPLIANCE WITH FEDERAL LAWS & REGULATIONS The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients. This STANDARD is not met as evidenced by: Based on record review, patient interview, and staff interview, it was determined the facility failed to ensure compliance with Federal laws and regulations related to advanced directives for 7 of	C 151	<i>see attached</i>	10/1/12

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

TITLE

(X6) DATE

Sharon A. Bonar

Chokam CEO

11/27/12

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

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C 151	<p>Continued From page 1</p> <p>13 adult patients (#1, #7, #18, #19, #28, #30 and #31) whose records were reviewed for advanced directives. This resulted in a lack of documentation in patients' records that they were informed of their right to formulate advanced directives, such as a living will or durable power of attorney. Findings include:</p> <p>An advanced directive is defined at 42 CFR 489.100 as "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." In accordance with the provisions of 42 CFR 489.102(a), the advanced directives regulations apply to CAHs. 42 CFR 489.102(b)(1) requires that notice of the CAH's advanced directives policy be provided at the time an individual is admitted as an inpatient.</p> <p>42 CFR 489.102(b)(2), states the CAH is required to "Document in a prominent part of the individual's current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive." The hospital failed to comply with this Federal regulation as follows:</p> <p>1. Documentation that patients were informed of their options for advanced directives could not be found. Examples include:</p> <p>a. Patient #1's medical record documented a 66 year old female who was admitted to swing bed status at the hospital on 8/01/12. She was currently a patient as of 8/10/12. Her right leg</p>	C 151	<i>see attached</i>	

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C 151	<p>Continued From page 2 had been surgically repaired following a fracture.</p> <p>Documentation whether or not Patient #1 had completed an advance directive was not present in her medical record. Also, no documentation was present whether or not Patient #1 was given the opportunity to develop an advance directive.</p> <p>Patient #1 was interviewed on 8/07/12 beginning at 11:10 AM. She stated she did not have an advance directive. She stated the CAH staff had not discussed an advance directive with her.</p> <p>The Admissions Coordinator reviewed Patient #1's medical record on 8/09/12 beginning at 2:15 PM. She confirmed the documentation.</p> <p>The CAH did not provide information to Patient #1 to assist her to complete an advance directive.</p> <p>b. Patient #7's medical record documented a 65 year old male, who was admitted to the hospital on 8/04/12 at 7:45 PM for care related to atrial fibrillation (irregular and often rapid heart rate that causes poor blood flow to the body) and sepsis (presence of infectious organisms or toxins created by infectious organisms in the blood) from a urinary origin. Documentation that Patient #7 was provided the option to prepare and advanced directive could not be found in the medical record.</p> <p>c. Patient #18's medical record documented a 47 year old male who was admitted to the hospital on 8/06/12 at 5:30 PM for care related to chest pain. He also had a history of insulin dependent diabetes and occurrence of a heart attack in 1998. Documentation that Patient #18 was provided the</p>	C 151	<i>see attached</i>	

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C 151	<p>Continued From page 3</p> <p>option to prepare an advanced directive could not be found in the medical record.</p> <p>d. Patient #19's medical record documented an 83 year old female who was admitted to the hospital on 8/07/12 at 3:00 AM for care related to upper abdominal discomfort. She also had a documented history of COPD. Documentation that Patient #19 was provided the option to prepare an advanced directive could not be found in the medical record.</p> <p>e. Patient #28's medical record documented a 79 year old male who was admitted to the hospital, on 8/08/12 at approximately 7:30 AM, for surgical repair of a right inguinal hernia (a portion of the intestine protrudes through a weak point or tear in the lower abdominal wall.) Patient #28 was discharged the afternoon of 8/08/12 at 2:10 PM according to the "RECOVERY ROOM FLOW SHEET." Documentation that Patient #28 was provided the option to prepare an advanced directive could not be found in the medical record.</p> <p>f. Patient #30's medical record documented an 84 year old female admitted to the hospital, on 8/09/12 at 9:45 AM, for care related to generalized weakness/fatigue. Her medical history included hypertension and diabetes. Documentation that Patient #30 was provided the option to prepare an advanced directive could not be found in the medical record.</p> <p>g. Patient #31's medical record documented a 74 year old female who was admitted to the hospital on 8/08/12 at 9:50 PM for care related to a large hematoma on the left leg with a history of deep vein thrombosis. She also had a documented</p>	C 151	<i>see attached</i>	

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C 151	Continued From page 4 history urinary bladder cancer. Documentation that Patient #31 was provided the option to prepare an advanced directive could not be found in the medical record. 2. The Admissions Coordinator was interviewed on 8/09/12 at 2:15 PM. She confirmed it was not the hospital's practice to document whether patients opted to participate in advanced directives. The Admissions Coordinator also said documentation was not consistent to support the existence of a living will or durable power of attorney that patients may have brought with them when admitted to the facility. Documentation that patients were provided the right to participate in advanced directives was not consistently found in patients' medical records.	C 151	<i>see attached</i>	
C 241	485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on staff interview and policy review, it was determined the CAH's governing board failed to ensure complete policies were developed and implemented and staff were trained to access policies. This resulted in a lack of guidance to staff to enable them to provide care in a	C 241	<i>see attached</i>	10/31/12

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C 241	Continued From page 5 consistent manner. Findings include: 1. On 8/10/12 at 8:30 AM, the surveyor attempted to review facility policies. He went to the Administrative Receptionist and asked her to about policies. She stated policies were stored electronically on a program called "Policy Tech." She attempted to access the policies via her computer but was not able to do so. She asked the Clinic Receptionist next to her to retrieve the policies. The Clinic Receptionist was not able to access the policies. The surveyor then went directly to the nursing unit where he asked the staff RN to access the CAH's policies. She attempted to access them but was not able to do so. The surveyor then asked the Nursing Assistant to access the CAH's policies. She attempted to access them but was not able to do so. The surveyor then asked the Charge Nurse to access the CAH's policies. She attempted to retrieve them but also was not able to locate them. The Charge Nurse stated the policies could not be easily accessed for review. CAH staff were unable to retrieve hospital policies for review. 2. Refer to C276 as it relates to the failure of the hospital to ensure a) the hospital had a legal relationship with all pharmacy staff that provided services and b) the hospital developed policies and procedures which defined and directed the provision of pharmacy services.	C 241	<i>see attached</i>		
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.	C 271	<i>see attached</i>	9/20/12	

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C 271	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of facility policies, it was determined the hospital failed to ensure health care services were provided consistent with appropriate written hospital policies. This directly impacted 3 of 3 patients (#7, #18 and #19) who were observed while care was being provided by nursing and laboratory staff, and had the potential to impact all patients. These failures had the potential to result in cross contamination and interfere with infection prevention. Findings include: 1. The hospital's policy, titled "Hand Hygiene," and approved on 4/13/11, documented indications for hand washing. Included in this section was direction to the staff to wash hands before having direct contact with patients, with a "non-bacterial or bacterial soap" if hands were visibly soiled. The policy also documented indications for use of alcohol hand cleaner, which stated staff could use an alcohol-based cleaner (instead of handwashing) before direct contact with a patient when hands were not visibly soiled. Nursing staff failed to practice hand hygiene in accordance with hospital policy as follows: a. Patient #7's medical record documented a 65 year old male, who was admitted to the hospital on 8/04/12 at 7:45 PM for care related to atrial fibrillation (irregular and often rapid heart rate that causes poor blood flow to the body) and sepsis (presence of infectious organisms or toxins created by infectious organisms in the blood) from a urinary origin.	C 271	<i>see attached</i>		

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NAME OF PROVIDER OR SUPPLIER CLEARWATER VALLEY HOSPITAL & CLINICS	STREET ADDRESS, CITY, STATE, ZIP CODE 301 CEDAR STREET OROFINO, ID 83644
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C 271	<p>Continued From page 7</p> <p>A RN was observed while administering medications to Patient #7 on 8/07/12, beginning at 8:45 AM. The RN was not observed to wash her hands or use hand sanitizer before entering Patient #7's room.</p> <p>b. Patient #18's medical record documented a 47 year old male who was admitted to the hospital on 8/06/12 at 5:30 PM for care related to chest pain. He also had a history of insulin dependent diabetes and occurrence of a heat attack in 1996.</p> <p>A RN was observed while administering medications to Patient #18 on 8/07/12, beginning at 9:00 AM. The RN was not observed to wash her hands or use hand sanitizer before entering Patient #18's room.</p> <p>c. Patient #19's medical record documented an 83 year old female who was admitted to the hospital on 8/07/12 at 3:00 AM, for care related to upper abdominal discomfort. She also had a documented history of COPD.</p> <p>A RN was observed while administering medications to Patient #19 on 8/07/12, beginning at 9:15 AM. The RN was not observed to wash her hands or use hand sanitizer before entering Patient #19's room.</p> <p>The DNS was interviewed on 8/08/13, beginning at 1:30 PM. The hospital's policy and practice related to hand hygiene was discussed. The DNS stated the staff is expected to wash their hands or use hand sanitizer prior to entering and before leaving patients' rooms. She also said the hospital was in the process of installing touchless</p>	C 271	<i>see attached</i>	
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C 271	<p>Continued From page 8</p> <p>hand sanitizer dispensers outside each patient room to allow for efficiency and to serve as a reminder to perform hand hygiene.</p> <p>Hand hygiene was not performed before nursing staff entered patients' rooms as stated in the hospital's policy.</p> <p>2. The hospital's policy, titled "ROUTINE VENIPUNCTURE PROCEDURE," signed by the Laboratory Director on 5/04/11, included information from a CLIA approved manual, titled "An Introduction to Phlebotomy." The policy included "You must change your gloves immediately if the gloves are visibly contaminated with blood or if they show evidence of perforation, tears, or leaks.</p> <p>Laboratory staff failed to follow infection prevention guidelines included in the policy as follows:</p> <p>Patient #19's medical record documented an 83 year old female who was admitted to the hospital on 8/07/12 at 3:00 AM for care related to upper abdominal discomfort. She also had a documented history of COPD.</p> <p>A laboratory assistant was observed while attempting to draw Patient #19's blood from her left arm on 8/07/12, beginning at 9:16 AM. The lab assistant stated she had unsuccessfully attempted to draw Patient #19's blood before the surveyor entered the room. She said Patient #19's skin and veins were fragile and difficult to access. The lab assistant stopped the procedure and stated she wanted to call another staff member to perform the blood draw. The</p>	C 271	<i>see attached</i>		

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C 271	Continued From page 9 laboratory assistant was observed wearing gloves when the surveyor entered the room. However, the index finger of the right glove was cut and folded back to reveal the finger. The Laboratory Manager was interviewed on 8/09/12, beginning at 10:15 AM. The hospital's infection control practices were discussed. The Lab Manager said laboratory assistants should wear fully intact gloves when drawing blood from patients. She confirmed that using gloves with holes or open areas in them was a breach in infection control and prevention.	C 271	<i>see attached</i>	
C 276	Gloves were not worn in accordance with hospital policy. 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 hospital policies and contracts, it was determined the facility failed to ensure systems for the provision of pharmacy services were developed and implemented. This resulted in a lack of direction	C 276	<i>see attached</i>	9/5/12

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C 276	<p>Continued From page 10</p> <p>to pharmacy personnel and had the potential to negatively impact patient care. Findings include:</p> <p>1. The DNS was interviewed on 8/07/12, beginning at 8:00 AM. When the surveyor requested to tour the pharmacy and meet with the Director of Pharmacy, the DNS stated the facility was transitioning to a new Director of Pharmacy. She stated the current Director of Pharmacy was a contract employee and was not on site at that time. She said the current Director of Pharmacy was employed by a retail pharmacy and was only available for emergencies. The DNS also stated the Incoming Director of Pharmacy was an employee of the hospital, but was away from the facility for a planned vacation, scheduled for the week of survey and the following week. When asked who was overseeing pharmacy services, the DNS stated the hospital had 2 pharmacy technicians who were filling the PYXIS (automated medication management system) machine. The DNS stated they were part of a program that was approved by the Idaho Board of Pharmacy, called a "tech check tech program." The DNS also said the hospital had an agreement with a tele-pharmacy company based in another state to review medication orders and monitor medication administration records.</p> <p>The DNS then contacted the current Director of Pharmacy by phone and inquired about her availability to meet with surveyors. According to the DNS, the current Director of Pharmacy stated she was available for medication emergencies only, such as the need to fill a medication order for a medication that could not be found in the hospital pharmacy. Another pharmacist, who was the business partner of the current Director of</p>	C 276	<i>see attached</i>	

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NAME OF PROVIDER OR SUPPLIER CLEARWATER VALLEY HOSPITAL & CLINICS			STREET ADDRESS, CITY, STATE, ZIP CODE 301 CEDAR STREET OROFINO, ID 83544	
(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 276	<p>Continued From page 11</p> <p>Pharmacy, also worked at the hospital on occasion. The DNS then made arrangements with the business partner to meet with surveyors the following morning.</p> <p>Surveyors requested copies of contractual agreements for the current Director of Pharmacy and the Director of Pharmacy's business partner. At approximately 4:00 PM of the same day (8/07/12), the DNS informed surveyors that contracts for the current Director of Pharmacy, and Director's business partner, could not be found.</p> <p>On 8/08/12, beginning at 10:03 AM, the Pharmacist, who was the partner of the current Director of Pharmacy, was interviewed. The Pharmacist stated he last provided coverage for the hospital in October of 2011. He said when he provided pharmacist coverage at the hospital his practice was to process and verify physician orders and fill the PYXIS. When asked to explain the current pharmacy process, he said his understanding was that the hand written physician orders were scanned to the tele-pharmacy, via a specific soft-ware system. He said the tele-pharmacy processed the orders and created the electronic medication administration record. He said PVTs stocked the PYXIS.</p> <p>The PVT who was also present during the above interview, stated the new/incoming Director of Pharmacy, who was on vacation at the time of the survey, came to the hospital once a week. She said medications were packaged by the PVTs and held from the PYXIS until they were verified weekly by the pharmacist. Additionally, the PVT</p>	C 276	<i>see attached</i>	

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C 276	<p>Continued From page 12</p> <p>stated if the technicians were filling the PYXIS with unit dose medications, the technicians checked one another's work. She said the Director of Pharmacy did not directly oversee the process of filling the PYXIS with unit dose medications. The PVT said the new Director of Pharmacy, who was currently on vacation, was monitoring PYXIS reports electronically from a lap top, while on vacation.</p> <p>A pharmacist was not present in the hospital to direct pharmacy operations and oversee the activities of the PVTs. Two pharmacists who provided services at the hospital did not have a legal/contractual relationship with the hospital.</p> <p>2. When pharmacy/pharmacist related policies were requested, one pharmacy policy, job descriptions for the pharmacist and PVTs, and a description of the "VERIFICATION TECHNICIAN PROGRAM" were provided. No other pharmacy related policies were provided.</p> <p>The policy "Pharmacist and support staff, responsibilities of," dated 02/05/2009, did not address the use of PVTs, including the procedure used for the packaging and labeling of medications by the PVTs. Additionally, the pharmacy policy failed to address the supervision of PVTs by the pharmacist, the duties the PVTs were allowed to perform at the hospital, or the ability of PVTs to access the pharmacy when there was no pharmacist on site.</p> <p>The document titled "VERIFICATION TECHNICIAN PROGRAM" did not state it was an official policy and did not include an approval date. This document discussed packaging and</p>	C 276	<i>see attached</i>		

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C 276	Continued From page 13 repackaging medications by the pharmacy technicians. The Acting Administrator and the DNS were interviewed on 8/17/12 beginning at 3:00 PM. They confirmed there were no other policies that specifically described supervision of the PVTs. They also stated the document titled "VERIFICATION TECHNICIAN PROGRAM" had not been approved by the medical staff. The pharmacy policy failed to define current pharmacy processes. 3. P&T Committee meeting minutes were reviewed. Minutes documented the committee met quarterly in 2011. The documentation for 2012 showed the committee had not met since 1/03/12. The Quality Assurance Assistant was interviewed on 8/14/12 beginning at 10:20 AM. She stated no P&T Committee minutes were present after 1/03/12. The Acting Administrator and the DNS were interviewed on 8/17/12 beginning at 3:00 PM. They stated a policy which defined the P&T Committee's duties was not present at the hospital.	C 276	<i>see attached</i>		
C 336	485.641(b) QUALITY ASSURANCE The CAH did not provide guidance to the P&T committee. The CAH has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment	C 336	<i>see attached</i>	9/15/12	

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C 336	Continued From page 14 furnished in the CAH and of the treatment outcomes. The program requires that -- This STANDARD is not met as evidenced by: Based on staff interview and review of quality assurance documents, it was determined the CAH failed to ensure the quality and appropriateness of treatment was evaluated including the investigation of 9 of 9 reported adverse patient events reviewed. Additionally, the CAH failed to ensure all adverse patient events were reported to hospital's adverse event reporting system. This directly impacted 1 of 1 patient (Patient #27) reviewed whose record documented adverse events. This prevented the CAH from identifying processes which could be improved in order to decrease the number of adverse patient events that occurred. Findings include: 1. "OCCURRENCE REPORTS" identified 9 adverse patient events, such as falls, medication errors, and other incidents that occurred between 5/01/12 and 8/01/12. None of these reports documented an investigation of the occurrence or actions that were taken to prevent future occurrences. The DNS reviewed the "OCCURRENCE REPORTS" with the surveyor on 8/08/12 beginning at 4:20 PM. She stated the occurrences had been investigated but confirmed the investigations were not documented for the 9 "OCCURRENCE REPORTS." She also confirmed actions taken to prevent future recurrences of incidents were not documented.	C 336	<i>see attached</i>		

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C 336	Continued From page 15 She stated the hospital was changing software programs which monitored adverse patient events. She confirmed the current system did not include documentation that such events were investigated and actions taken to prevent future events. The CAH did not document the investigation of adverse patient events and actions taken to prevent future events. 2. Not all adverse patient events were reported through "OCCURRENCE REPORTS." Patient #27's medical record contained a physician "Progress Note," dated 6/15/12 but not timed, which documented the patient fell on 6/14/12 and required a CT scan to rule out a head injury. An "OCCURRENCE REPORT" documenting the fall for administrative records was not present. Also, on 6/20/12 at 9:50 PM, Patient #27's "Patient Notes: Nursing" documented he was "...VERY COMBATIVE CUSSING AT NURSING STAFF AND PULLING, SCRATCHING, PINCHING, AND TWISTING FINGERS AND ARMS OF NURSING STAFF." An "OCCURRENCE REPORT" documenting this incident was not present. The DNS reviewed the "OCCURRENCE REPORTS" with the surveyor on 8/08/12 beginning at 4:20 PM. She confirmed these incidents were not included in the "OCCURRENCE REPORTS." The CAH did not complete occurrence reports for all adverse patient events.	C 336	<i>See attached</i>	
C 402	485.645(d)(7) SPECIALIZED REHAB SERVICES	C 402	<i>See attached</i>	9/21/12

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C 402	Continued From page 16 [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Specialized rehabilitative services (§483.45 of this chapter): "(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) Obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services." This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure rehabilitative services were provided in accordance with the therapy plans for 2 of 3 swing bed patients (#1 and #27) whose records were reviewed. This resulted in the potential for unmet patient rehabilitative needs. Findings include: 1. Patient #1's medical record documented a 66 year old female who was admitted to swing bed status at the hospital on 8/01/12. She was	C 402	<i>see attached</i>	

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C 402	<p>Continued From page 17</p> <p>currently a patient as of 8/10/12. Her right leg had been surgically repaired following a fracture.</p> <p>A PT evaluation was documented on 8/01/12 at 3:12 PM. The evaluation included a plan for therapy services. The plan stated Patient #1 was to receive therapy 2 times a day for 4 weeks. PT progress notes documented Patient #1 received therapy 1 time on 8/02/12, 1 time on 8/03/12, 2 times on 8/08/12, 1 time on 8/07/12, and 1 time on 8/08/12. No other therapy notes were documented.</p> <p>The Admissions Coordinator reviewed the medical record with the surveyor on 8/09/12 beginning at 2:15 PM. She confirmed the lack of documented therapy visits and stated the number of PT visits provided did not match the number of visits ordered.</p> <p>Patient #1 did not receive PT services at the frequency specified in her therapy plan.</p> <p>2. Patient #27's medical record documented an 82 year old male who was admitted to swing bed status at the hospital on 6/04/12. He was discharged on 7/06/12. His diagnosis was stroke.</p> <p>A PT evaluation was documented on 6/12/12 at 1:42 PM. The evaluation included a plan for therapy services. The plan stated Patient #27 was to receive therapy 2 times a day for 4 weeks. PT progress notes documented Patient #27 received therapy 2 times on 6/13/12, 1 time on 6/14/12, 2 times on 6/15/12, no visits on 6/16/12 and 6/17/12, 1 time on 6/18/12, 1 time on 6/19/12, and 2 times on 6/20/12. No other therapy notes were documented.</p>	C 402	<i>see attached</i>	

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C 402	Continued From page 18 The Admissions Coordinator reviewed the medical record with the surveyor on 8/09/12 beginning at 2:15 PM. She confirmed the lack of documented therapy visits and stated the number of PT visits provided did not match the number of visits ordered. Patient #27 did not receive PT services at the frequency specified in the therapy plan.	C 402	<i>see attached</i>	

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B 000	16.03.14 Initial Comments The following deficiencies were cited during the Idaho state licensure survey of your Critical Access Hospital. Surveyors conducting the review were: Gary Gules, RN, HFS, Team Leader Rebecca Lara, RN, HFS	B 000	<i>see attached</i>	
BB117	16.03.14.200.03 Chief Executive Officer or Administrator 03. Chief Executive Officer or Administrator. The governing body through the chief executive officer shall establish the following policies, procedures or plans: (10-14-88) a. The hospital shall adopt a written personnel policy concerning qualification, responsibility, and condition of employment for each category of personnel. The policy and/or procedures shall contain the following elements: (10-14-88) I. Documentation of orientation of all employees to policies, procedures and objectives of the hospital. (10-14-88) II. Job descriptions for all categories of personnel. (10-14-88) III. Documentation of continuing education (inservice) for all patient care personnel. (10-14-88) b. There shall be a personnel record for each employee, which shall contain at least the following: (10-14-88) i. Current licensure and/or certification status.	BB117	<i>see attached</i>	

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Annex J Bonner

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

TITLE *Interim CEO*

(X6) DATE *11/27/12*

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BB117	Continued From page 1 (10-14-88) ii. The results of a Tuberculin Skin Test which shall be determined either by history of a prior positive, or by the application of a skin test prior to or within thirty (30) days of employment. If the skin test is positive, either by history or by current test, a chest X-ray shall be taken, or a report of the result of a chest X-ray taken within three (3) months preceding employment, shall be accepted. The Tuberculin Skin Test status shall be known and recorded and a chest X-ray alone is not a substitute. No subsequent annual chest X-ray or skin test is required for routine surveillance. (10-14-88) c. There shall be regularly scheduled departmental and interdepartmental meetings, appropriate to the needs of the hospital, and documentation of such meetings shall be available. (10-14-88) d. The chief executive officer shall serve as liaison between the governing body, medical staff and the nursing staff, and all other departments of the hospital. (10-14-88) e. Written policies and procedures shall be reviewed as needed. (10-14-88) This Rule is not met as evidenced by: Refer to C241 as it relates to the governing body's failure to ensure complete policies were developed and implemented and staff were trained to access policies.	BB117	<i>see attached</i>	
BB224	16.03.14.330.04 Policies and Procedures 04. Policies and Procedures. Written policies and procedures shall be developed by the pharmacy	BB224	<i>see attached</i>	

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BB224	Continued From page 2 and therapeutics committee or its equivalent to govern the pharmaceutical services provided by the hospital. (10-14-88) a. Policies and procedures shall be reviewed revised and amended as necessary, and dated to indicate the time of last review. (10-14-88) b. Written policies and procedures that are essential for patient safety, and for the control and accountability of drugs, shall be in 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	BB224	<i>see attached</i>	

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BB224	Continued From page 3 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 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	BB224	<i>see attached</i>	

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BB224	Continued From page 4 approved drugs shall be maintained in the hospital. (10-14-88) This Rule is not met as evidenced by: Refer to C276 as it relates to the lack of policies directing pharmacy services.	BB224	<i>see attached</i>	
BB417	16.03.14.440.06 Services and Records 06. Services and Records. There shall be a written plan of treatment and record for each inpatient or outpatient which includes at least the following information relating to rehabilitation potential: (10-14-88) a. Type, amount, frequency, and duration of treatments and response; and (10-14-88) b. Contraindications; and (10-14-88) c. Discharge planning; and (10-14-88) d. Patient progress by all personnel involved in care. (10-14-88) This Rule is not met as evidenced by: Refer to C402 as it relates to the failure of the hospital to provide therapy services in accordance with the plan of care.	BB417	<i>see attached</i>	

Providers Plan of Correction

Revision Submitted: November 27, 2012

ID Tag #	Deficiency summary	Action to Correct Deficiency	Action will improve process by	Date Completed	Plan to Monitor POC effective	Person Responsible
BB224 C276	<p>04. Written Policies & Procedures by Pharmacy & Therapeutics Committee to govern pharmaceutical services.</p> <p>a. P & P reviewed, revised, amended with dates</p> <p>b. Written P & P essential for for patient safety, control /accountability for drugs</p> <p>c. P & P shall include:</p> <p>i. Drug recall procedure</p> <p>ii. Medication auto stop orders</p> <p>iii. Drugs dispense/admin on written or verbal order of med staff member. Verbal to be signed by prescriber within 24 hours</p> <p>iv. Patient own drugs shall not be administered unless identified by pharmacist and physician orders. If not, shall be packaged, sealed , stored and returned to patient at the time of discharge</p>	<p>1. PIC – Director of Pharmacy Change Form was filed with Idaho State Board of Pharmacy (Attachment C.)</p> <p>2. “Verification Technician Program” approved by Idaho Board of Pharmacy on 01/24/12 (see Attachment C-1) will be presented for review and approval of CVHC Medical Staff at Monthly Medical Staff Meeting. Upon approval this document will be placed in Policy Tech in Pharmacy Policy section.</p> <p>Verification Technician Training Log documents duties PVT trained to perform. (see Attachment C-2.)</p>	<p>1. Provides CAH with Director of Pharmacy who is in charge of CAH Pharmacy services and responsible for all pharmacy related matters.</p> <p>2. Establishes Verification Program as approved Policy & Procedure.</p>	<p>08/22/12</p> <p>09/05/12</p>	<p>CAH will ensure Pharmacy Licenses remain active and current with the Idaho Board of Pharmacy</p> <p>DNS will conduct review random audits pharmacy service and staff to ensure compliance with regulatory standards over the next 12 months. These audits will be reviewed at P&T Committee and Quality Committee on a Quarterly basis.</p>	<p>Director of Pharmacy and Director of Nursing Services</p>
BB224 C276	<p>v. Self-administration of meds by patient not permitted unless ordered by physician</p>	<p>3. P & T Meeting schedule for 2012 is January, April, August, and November. April, 2012 meeting time was deferred and three meetings to review</p>	<p>CAH will establish and define P & T</p>	<p>09/05/12</p>		

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	<p>vi. Investigational drugs only under supervision of principal investigator and approved by P & T Committee</p> <p>vii. Compounding, packaging, label & dispensing, restrict to pharmacist or designee under supervision</p> <p>viii. Pharmacist or authorized pharmacy personnel under supervision shall make labeling changes</p> <p>ix. Discontinued drugs, outdates illegible or missing labels shall be returned to the pharmacy for proper disposition.</p> <p>x. a list or Formulary of approved drugs shall be maintained in hospital</p> <p>Rule is not met as evidenced by: Refer to C276 as it related to the lack of policies directing pharmacy services.</p>	<p>demonstrations by two different finalists in our review of telepharmacy services. Medical staff, Nurses, Pharmacy staff, IT staff and administrative staff convened to evaluate and select Envision Telepharmacy, our current provider.</p> <p>Implementation involved multiple hours of staff time, therefore we opted to defer P & T until our 3rd Quarter meeting which was scheduled and held on 08/21/2012. Minutes from 3rd Quarter P & T Meeting minutes on 08/21/12 will be Approved on 09/05/12.</p> <p>4. Medical Staff Bylaws Rule 3.1 Standing Committees shall be Amended to include P & T as a Medical Staff Committee which defines composition, duties, and meetings. P & T Committee will continue to meet Quarterly and maintain minutes.</p>	<p>Committee to provide oversight for Pharmacy service, meet regularly and maintain minutes.</p> <p>Medical Staff will review and approve P & T Committee Amendment to Bylaws.</p>	<p>10/16/12</p>		<p>MD Chief of Staff / Chair of P & T and Chief Executive Officer</p>
<p>BB417 C402</p>	<p>06. Services & Records. Shall be written plan of treatment</p>	<p>1. Develop quality indicator to track compliance with Physical</p>	<p>1. Provides mechanism to</p>	<p>09/21/12</p>	<p>1. Implement tracking system to</p>	<p>Physical Therapy/</p>

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BB417 C402	and record for inpatient & outpatient relating to rehabilitation potential a. type, amount frequency and duration of treatments & response b. Contraindications c. Discharge Planning d. patient progress by all personnel involved in care Rule not met: Refer to C402 as it related to the failure of the hospital to provide therapy services in accordance with the plan of care	Therapy Plan of Care. 2. Meet with MediTech design team to modify EMR (electronic medical record) format for initial Physical Therapy Plan of Care to accurately reflect the Physical Therapists needs assessment for frequency of Physical Therapy intervention.	identify potential discrepancies related to compliance with Physical Therapy Plan of Care. 2. Clarifies frequency of Physical Therapy intervention in the established Physical Therapy Plan of Care.	09/05/12	assess and measure provider compliance with established Physical Therapy Plan of Care on a monthly basis. 2. MediTech design team will create new parameter for Physical Therapy Plan of Care in EMR and Physical Therapy staff will be trained to utilize revised documentation process.	Rehabilitation Director Physical Therapy/ Rehabilitation Director and Informatics Registered Nurse
C151	Standard not met related to Advanced Directives for 7 of 13 patients a. Patient #1 - 66 yr F b. Patient #7 - 65 yr M c. Patient #18 - 74 yr M d. Patient #19 - 83 yr M e. Patient # 28 - 79 yr M f. Patient # 30 - 84 yr F g. Patient #31 - 74 yr F	Effective December, 2012 a monthly Audit will be conducted to verify Admission EMR Advanced Directive documentation is correct based upon interview of 10 random patients 24 hours after admission, each month for 12 months. Advanced Directive	Monthly Audit will verifying EMR Advanced Directive Documentation is consistent with patient interview. Inaccuracies will be corrected in EMR as needed.	12/30/12	Advanced Directive Monthly Audit will be reported to Joint Quality Committee meetings on a quarterly basis.	Director of Nursing Services

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		<p>Documentation as it appeared on the date of Survey for patient's # 1,7,18,19, 28,30 and 31 is attached. Please note EMR Question regarding if a patient has and Advanced Directive response of "No, information provided" actually means they do not have an Advanced Directive and a packet of information was provided to the patient on that day. Referr to Attachments section D-a through D-h.</p> <p>D-i New Advanced Directive verbiage to clarify "No – Info Packet Provided"</p> <p>D-j Advanced Directive Information packet given to all patients who do not have Advanced Directive documented.</p> <p>D-k Patient History policy with Advanced Directives covered.</p> <p>D-l Patient Right's Policy which includes Advanced Directives</p> <p>D -2 Welcome to our Hospital booklet with Advanced Directive</p>	<p>D-3 to conserve resource of booklets given to Inpatients these pamphlets will</p>	<p>10/01/12</p>	<p>Admitting staff will provide resource booklet to patients upon admission.</p>	<p>Admissions Supervisor</p>

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		notice highlighted D-3 Patient Rights and Responsibilities from Essentia Health which will be given to Outpatients when copies are received from printer.	be given to outpatients.			
C241 C241	CAH Governing Body responsible for total operation policies are administered to provide quality health care in a safe environment Standard not met evidenced by staff not trained to access policies	Policy Tech is a Policy and Procedure Management software program, which includes all policies. All staff has access to Policy Tech from the hospital's intranet home page (see Attachment E.) In addition, all hospital clinical staff has access directly from their MediTech status boards (patient information board see Attachment E.a.) the EMR (electronic medical record.) All staff has received education in the past on accessing policies and procedures, however, an educational training will again be scheduled to be completed by the end of October 2012. This training will also include a	Having all hospital staff able to access policies will enable them to provide care in a consistent manner.	10/31/12	A verbal survey will be conducted each week asking and/or observing 5 random staff members from all departments how to access policies. A log will be kept of these inquiries. This will be done until results show that 100% of staff surveyed can successfully access the policies.	Joint Director of Quality

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		<p>review of the "search" function for allowing easy access to policies. In the interim, a memo with instructions on accessing policies will be developed and distributed to all departments.</p> <p>The access log-in and password requirement has been eliminated as of 8/30/2012. Staff no longer needs to sign-in to access policies.</p>	<p>No longer require log-in and password to access Policy Tech will ease and streamline access to hospital policies.</p>	<p>08/30/12</p>		<p>Joint Director of Quality</p>
<p>C271</p>	<p>Patient Care Policies: Hand Hygiene approved 04/13/2011. Nurse failed to practice approved policy when administered medication to Patient #7, #18, and #19</p> <p>Lab staff Finger torn from glove when drawing patient blood sample.</p>	<p>All Clinical Employees will review Hand Hygiene Policy and Procedure (Attachment F-1) and Infection Control Bloodborne Pathogen Precaution Standards (Attachment F-2.)</p> <p>Installation complete of new hands free Sanitizer Dispensing Units in Patient Care Hallways (Attachment F-3)</p> <p>Infection control nurse will review and discuss both policies with all Laboratory Staff at next</p>	<p>Clinical staff will be aware of and practice proper Hand Hygiene and Bloodborne Safety Precautions at all times. Hands free hand Sanitizer Dispensing units have been installed in all Patient Care Hallways.</p> <p>Lab employee made</p>	<p>09/15/12</p> <p>08/28/12</p> <p>09/01/12</p>	<p>Observation Audits will be conducted on a Quarterly Basis and results will be reported at Clinical Department meetings and Quality Committee</p>	<p>Lab Manager, Infection Control Nurse, Director of Nursing Services</p>

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		Department Meeting. DNS will present both policies at next Nursing Department Meetings.	aware of proper glove protocol.	9/20/12		
C276	<p>Patient Care Policies Standard not met resulted in lack of direction to pharmacy personnel.</p> <p>1. Facility had no Director of Pharmacy contract</p> <p>2. "Pharmacist and support staff responsibilities dated 02/05/2009 did not address use of Pharmacy Verification Technicians.</p> <p>"Verification Technician Program did not state it was an official policy and did not include an approval date by Medical Staff</p>	<p>1. PIC – Director of Pharmacy Change Form was filed with Idaho State Board of Pharmacy (Attachment C.)</p> <p>2. "Verification Technician Program" approved by Idaho Board of Pharmacy on 01/24/12 (see Attachment C-1) will be presented for review and approval of CVHC Medical Staff at Monthly Medical Staff Meeting. Upon approval this document will be placed in Policy Tech in Pharmacy Policy section.</p> <p>Verification Technician Training Log documents duties PVT trained to perform. (see Attachment C-2.)</p>	<p>1. Provides CAH with Director of Pharmacy who is in charge of CAH Pharmacy services and responsible for all pharmacy related matters.</p> <p>2. Establishes Verification Program as approved Policy & Procedure.</p>	<p>08/22/12</p> <p>09/05/12</p>	<p>CAH will ensure Pharmacy Licenses remain active and current with the Idaho Board of Pharmacy</p> <p>DNS will conduct review random audits pharmacy service and staff to ensure compliance with regulatory standards over the next 12 months. These audits will be reviewed at P&T Committee and Quality Committee on a Quarterly basis.</p>	<p>Pharmacist in Charge and Director of Nursing Services</p> <p>Director of Nursing Services</p>

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	<p>3. P & T Committee meeting minutes were reviewed & met quarterly in 2011. Documentation for 2012 showed committee had not met since 01/03/2012.</p> <p>CAH did not provide guidance to the P & T Committee.</p>	<p>3. P & T Meeting schedule for 2012 is January, April, August, and November. April, 2012 meeting time was deferred and three meetings to review demonstrations by two different finalists in our review of telepharmacy services. Medical staff, Nurses, Pharmacy staff, IT staff and administrative staff convened to evaluate and select Envision Telepharmacy, our current provider. Implementation involved multiple hours of staff time, therefore we opted to defer P & T until our 3rd Quarter meeting which was scheduled and held on 08/21/2012. Minutes from 3rd Quarter P & T Meeting minutes on 08/21/12 will be Approved on 10/16/12.</p> <p>4. Medical Staff Bylaws Rule 3.1 Standing Committees shall be Amended to include P & T as a Medical Staff Committee which defines composition, duties, and</p>	<p>3. CAH will established a defined P & T Committee to provide oversight for Pharmacy service, meet regularly and maintain minutes.</p>	<p>10/16/12</p>		

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		meetings. P & T Committee will continue to meet Quarterly and maintain minutes.				
C336	<p>CAH has an effective quality assurance program to evaluate appropriateness of care and treatment</p> <p>1.occurrence reports were investigated but did not document action taken or prevent future recurrences of incidents not documented</p> <p>CHA did not complete occurrence reports for all adverse patient events.</p>	<p>At the time of this Survey we had partially implemented an electronic On-line Occurrence Reporting and Investigation documentation system. See Attachments section H:</p> <p>H-1 Employee Intranet Screen shows access to file an Occurrence Report</p> <p>H-2 On-Line Occurrence Reporting Training sessions and staff attendance sign-in sheets.</p> <p>H-3 Risk Management/Patient Relations Event Database Guide Doc 1 and Doc 2 Codes</p>	<p>Occurrence Reporting will be completed electronically, tracked and monitored.</p>	09/15/12	<p>Plan is to ensure the On-Line Occurrence Reporting and Investigation program is fully operational.</p>	Join Quality Director
C402	<p>Standard not met for Specialized rehabilitative service such as physical therapy, speech-language pathology are required in residents comprehensive plan of care</p> <p>Standard not met for two patients:</p>	<p>1. Develop quality indicator to track compliance with Physical Therapy Plan of Care.</p> <p>2. Meet with MediTech design team to modify EMR (electronic</p>	<p>1. Provides mechanism to identify potential discrepancies related to compliance with Physical Therapy Plan of Care.</p> <p>2. Clarifies frequency of Physical Therapy</p>	<p>09/21/12</p> <p>09/05/12</p>	<p>1. Implement tracking system to assess and measure provider compliance with established Physical Therapy Plan of Care on a monthly basis.</p> <p>2.MediTech design team will create new</p>	<p>Physical Therapy/ Rehabilitation Director</p> <p>Physical Therapy/</p>

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	<p>#1 – 66 yr F was to received therapy 2 times per day for 4 weeks. PT progress notes documented 1 time on multiple days.</p> <p>#27 – 82 yr M was to received therapy 2 times per day for 4 weeks. PT progress notes documented 1 time on multiple days.</p>	<p>medical record) format for initial Physical Therapy Plan of Care to accurately reflect the Physical Therapists needs assessment for frequency of Physical Therapy intervention.</p>	<p>intervention in the established Physical Therapy Plan of Care.</p>		<p>parameter for Physical Therapy Plan of Care in EMR and Physical Therapy staff will be trained to utilize revised documentation process.</p>	<p>Rehabilitation Director and Informatics RN</p>