

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7007 3020 0001 4038 8423

September 17, 2012

John Olson, Administrator
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Olson:

Based on the survey completed at Walter Knox Memorial Hospital, on August 31, 2012, by our staff, we have determined Walter Knox Memorial Hospital, is out of compliance with the Medicare Hospital Provision of Services (42 CFR 485.635). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction

John Olson, Administrator
September 17, 2012
Page 2 of 2

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

Such corrections must be achieved and compliance verified by this office, before October 15, 2012. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than October 7, 2012.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 30, 2012.**

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

We urge you to begin correction immediately.

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

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm

cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office



The Emmett Hospital
1202 E. Locust • Emmett, Idaho 83617
Phone (208) 365-3561 • FAX (208) 365-1575

September 26, 2012 .

Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street .
P.O. Box 83720
Boise, ID 83720-0009

RECEIVED
SEP 26 2012
FACILITY STANDARDS

Attn: Gary Guiles, RN
Re: State Survey 8/31/2012

Dear Gary,

Thank you for assisting us in our efforts to implement changes that will elevate our standard of care at WKMH. Attached you will find our action plan that addresses the state and federal deficiencies that we were cited for. The plan includes the title of the person responsible for implementing specific parts of the plan, as well as a deadline. Additionally, we have attached specific documents to showcase how we will effectively track our compliance, along with the educational materials that will be provided to our staff. We look forward to speaking with you in the near future. We are confident that our action plan will bring us back into compliance and prevent further deficiencies in the future.

Sincerely,

John Olson, CEO

"Caring is what we do best"

Sep. 17. 2012 2:16PM

No. 2252

P. 4/20

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617
---	--

(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 complaint survey at your hospital. Surveyors conducting the investigation were: Gary Gules, RN, HFS, Team Leader Rebecca Lara, RN, BA, HFS Acronyms used in this report include: CAH = critical access hospital CPR = cardiopulmonary resuscitation ED = Emergency Department H&P = history and physical examination IV = intravenous LPN = Licensed Practical Nurse NPO = nothing by mouth, the patient may not eat or drink anything RN = Registered Nurse	C 000	Refer to attached POC for all deficiencies.	
C 259	485.631(b)(1)(iii) RESPONSIBILITIES OF MD OR DO [The doctor of medicine or osteopathy--] In conjunction with the physician assistant and/or nurse practitioner members, periodically reviews the CAH's patient records, provides medical orders, and provides medical care services to the patients of the CAH; [end] This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and medical staff bylaws, it was determined the CAH failed to ensure the physician provided medical care to 1 of 5 patients (#4) whose records were reviewed for care	C 259		

RECEIVED
SEP 26 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>John N. Olson</i>	TITLE CEO	(X6) DATE 9/26/12
---	--------------	----------------------

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.

Sep. 17. 2012 2:17PM

No. 2052 P. 5/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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 259	Continued From page 1 following a procedure. This resulted in a delay in providing medical treatment. Findings include: 1. Patient #4's medical record documented a 61 year old female who had upper gastrointestinal endoscopy with biopsy and colonoscopy with biopsy performed on 7/31/12. She suffered cardiopulmonary arrest at 4:10 AM on 8/01/12 and was transferred to an acute care hospital. An H&P, dated 8/19/12, did not include any cardiac or pulmonary diagnoses. The H&P stated Patient #4 experienced some wheezing and coughing at times. No other cardiopulmonary symptoms were mentioned. The "PRE-ANESTHESIA EVALUATION", dated 7/31/12 at 9:50 AM, did not document pulmonary symptoms or difficulty walking. The procedures ended on 7/31/12 at 12:35 PM and Patient #4 was taken to the recovery area. Recovery Room notes at 12:37 PM documented she complained of pain and nausea. At 12:45 PM on 7/31/12, the recovery nurse documented she attempted to assist Patient #4 to the bathroom but the patient could not move her legs to walk. At 2:10 PM on 7/31/12, the recovery nurse documented Patient #4 required oxygen at 10 liters per minute and said her abdominal discomfort made it difficult to breathe. A telephone order was obtained at 2:25 PM on 7/31/12 to admit Patient #4 to the medical floor for observation. A note by the day shift RN, at 3:00 PM on 7/31/12, stated Patient #4 rated her abdominal pain at 10 of 10, her abdomen was firm to touch, and she had no bowel sounds. Patient #4 was medicated with IV narcotic at 3:15 PM. A note by the day shift RN, at 3:15 PM on	C 259			

Sep. 17. 2012 2:17PM

No. 2252 P. 6/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617		ZIP CODE
(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) COMPLETE DATE	
C 259	Continued From page 2 7/31/12, stated Patient #4 took elps of water and vomited." A note by the day shift LPN, on 7/31/12 at 4:31 PM, documented Patient #4 did not have energy to ambulate. A note by the day shift RN, at 5:22 PM on 7/31/12, stated Patient #4 was medicated with Ativan 1 mg IV for abdominal pain rated 10 of 10. The final note by the day shift was an RN note at 7:45 PM on 7/31/12. It stated Patient #4's abdomen remained firm and it hurt for her to take a deep breath. A note by the LPN, on 7/31/12 at 8:15 PM, stated Patient #4 was assisted to stand but became dizzy and had to sit down. The note stated she was not able to ambulate to the bathroom and required a bedside commode. At 8:58 PM on 7/31/12, the LPN documented Patient #4 required assistance to ambulate. A note by the LPN, on 7/31/12 at 8:36 PM, stated Patient #4 removed her oxygen. Her oxygen saturation level at the time was 94% without the oxygen. (The American Lung Association's "A QUICK GLANCE GUIDE TO OXYGEN THERAPY," not dated, stated "The goal of oxygen therapy is to provide oxygen saturation of at least 90 % at all activity levels.") A note by the LPN, on 7/31/12 at 10:12 PM, stated Patient #4's oxygen saturation level dropped to 78%. Oxygen was restarted at 3 liters per minute. At 10:17 PM on 7/31/12, Patient #4 was medicated by the RN with IV Demerol for pain rated at 10 of 10. A note by the LPN, on 7/31/12 at 10:40 PM, stated Patient #4 "...states still having pain. Did not rate at this time. Complains mainly about upper abdomen area." A note by the LPN, on 8/01/12 at 12:10 AM, stated Patient #4 "...has emesis bag in hand, spitting into it. States still feels nauseated." A note by the LPN, on 8/01/12 at	C 259			

Sep. 17. 2012 2:17PM

No. 2252 P. 7/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617	
(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)
C 259	<p>Continued From page 3</p> <p>12:30 AM, stated Patient #4's abdominal girth appeared larger. The note stated the ED RN was called to start another IV. The note stated Patient #4 was on oxygen at 1.5 liters per minute.</p> <p>A note by the LPN, on 8/01/12 at 12:58 AM, stated "Call from [surgeon]. Informed of pt's current condition. Orders received for fluid bolus then increased rate. Clindamycin, radiology, and labs in morning. Pt is now NPO except for sips and ice chips. Page [surgeon] if change in fever or tachycardia." No parameters regarding when to notify the physician were included in the order, such as if Patient #4's pulse exceeded a certain rate or her blood pressure was too high or low.</p> <p>Patient #4's condition continued to decline. A note by the night RN, on 8/01/12 at 4:10 AM, stated patient #4 "...went into respiratory arrest and became pulseless. CPR Initiated." Patient #4's heart rate was restored and she was transferred to an acute care hospital.</p> <p>The medical record from the receiving hospital documented Patient #4 arrived at approximately 6:00 AM on 8/01/12. She was taken to surgery that morning to repair a perforated bowel. A nuclear medicine report, dated 8/01/12, stated a perfusion scan was performed at 1:44 PM. The report confirmed "brain death." The record stated Patient #4 was removed from life support on 8/03/12 and died.</p> <p>A "Progress Note" by the physician, dated 8/01/12 but not timed, stated Patient #4 was admitted to the CAH post procedure for persistent distention, nausea, and failure to progress. The note stated the physician discussed the patient with the LPN</p>	C 259	

Sep. 17. 2012 2:17PM

No. 2252 P. 8/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617		ZIP CODE
(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)	(X4) COMPLETION DATE	
C 259	Continued From page 4 at 1:00 AM (on 8/01/12). The note stated "The update at the time she was having persistent abdominal pain. The patient was able to walk on one occasion and pass a little bit of gas, however, was still distended. The patient was also having nausea and had an episode of emesis. She was also having intermittent tachycardia, however maintaining her blood pressure. At that morning I ordered morning laboratories, x-rays, started Clindamycin and ordered a fluid bolus." The note further stated that, at approximately 4:00 AM, Patient #4 required resuscitation. The physician was interviewed on 8/28/12 beginning at 1:55 PM. He stated he performed the scoping procedures on Patient #4 and then left the CAH. He confirmed giving orders to admit Patient #4 to the CAH. He stated he did not return to the CAH to examine Patient #4. He stated Patient #4 was brain dead when she arrived at the receiving hospital. The physician did not provide medical care services to Patient #4. He did not examine her when she was admitted to the CAH when she failed to recover from the scoping procedures. He did not examine Patient #4 after he talked to the LPN at 12:58 AM, on 8/01/12, and was informed she was experiencing significant complications. 2. Medical Staff Bylaws, amended 2/28/12, stated at 18.1.1(f), "Each Practitioner must assume timely adequate professional care for his patients in the Hospital by being available, or having available an alternative Practitioner with whom prior arrangements have been made. Each	C 259			

Sep. 17. 2012 2:17PM

No. 2252 P. 9/20

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED G 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617		ZIP CODE
(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 259	Continued From page 5 member of the medical staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area and who may attend the staff member's patients in an emergency or until the staff member arrives. The physician chairman of the Medical Staff Quality Committee was interviewed on 8/29/12 beginning at 10:00 AM. She stated Patient #4's physician lived in another town (approximately 20 miles from the CAH). She stated the attending physician did not return to the CAH to examine the patient or turn the care over to a physician who resided near the CAH. She stated she had recommended to the medical staff if a non-local physician admits a patient to the CAH that their care be followed by a local physician.	C 259			
C 270	485.635 PROVISION OF SERVICES Provision of Services This CONDITION is not met as evidenced by: Based on review of medical records and staff interview, it was determined the CAH failed to ensure services were provided to 2 of 9 patients whose records were reviewed. This failure resulted in a lack of safe and effective nursing care provided to patients. Findings include: 1. Refer to C-294 as it relates to the failure of the CAH to ensure nursing services met the needs patients.	C 270			

Sep. 17, 2012 2:18PM

No. 2252 P. 10/20

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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 270	Continued From page 6 2. Refer to C-295 as it relates the failure of the CAH to ensure an RN provided nursing care to patients. 3. Refer to C-298 as it relates to the failure of the CAH to ensure a nursing care plan was developed for in-patients. The cumulative effect of these negative systemic practices resulted in the inability of the CAH to provide basic nursing care services.	C 270			
C 294	485.635(d) NURSING SERVICES Nursing services must meet the needs of patients. 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 nursing services met the needs of 1 of 5 patients (#4) whose records were reviewed for care following a procedure. This resulted in a lack of monitoring of an unstable patient. Findings include: 1. Patient #4's medical record documented a 61 year old female who had upper gastrointestinal endoscopy with biopsy and colonoscopy with biopsy performed on 7/31/12. The procedures ended at 12:36 PM and she was taken to the recovery area. Patient #4 did not recover sufficiently to be discharged. A telephone order was obtained at 2:25 PM on 7/31/12 to admit Patient #4 to the medical floor for observation. Orders included an IV, water as requested, Demerol IV for pain, Ativan IV for anxiety, and Zofran IV for nausea. Orders for oxygen were not	C 294			

Sep. 17. 2012 2:18PM

No. 2252 P. 11/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617		ZIP CODE
(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)	(X6) COMPLETION DATE
C 294	<p>Continued From page 7 present</p> <p>Patient #4's Clinical Documentation Report, dated 7/31/12 at 2:30 PM, stated she was transferred to the medical floor. Nursing notes on 7/31/12, between 2:30 PM and 8:15 PM, did not document Patient #4 received oxygen. At 8:35 PM on 7/31/12, the LPN documented Patient #4 removed her oxygen because it was "bothering me" and the oxygen was discontinued. At 10:12 PM on 7/31/12, the LPN documented Patient #4's oxygen saturation level dropped to 79%. Patient #4 was placed on oxygen at 3 liters per minute. At 12:30 AM on 7/31/12, the LPN documented Patient #4 was receiving oxygen at 1.5 liters per minute. At 12:58 AM on 7/31/12, the LPN documented speaking to Patient #4's physician. Orders were obtained for an antibiotic and morning laboratory and X-ray tests. No orders for oxygen were obtained. At 1:38 AM on 7/31/12, the LPN documented Patient #4's oxygen saturation level was 87% on 3 liters of oxygen. The note stated Patient #4's oxygen was increased to 4 liters per minute. A nursing note by the LPN, on 8/01/12 at 2:30 AM, stated Patient #4's oxygen was increased to 4 liters per minute via nasal cannula. At 4:10 AM on 8/01/12, nursing notes stated Patient #4 suffered cardiopulmonary arrest.</p> <p>The Director of Quality reviewed Patient #4's medical record with the surveyors on 8/29/12 beginning at 2:05 PM. She confirmed orders for oxygen were not present in the medical record.</p> <p>Nursing staff applied and adjusted Patient #4's oxygen without a physician order.</p>	C 294		

Sep. 17. 2012 2:18PM

No. 2252 P. 12/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83817		
(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 294	<p>Continued From page 8</p> <p>2. As noted above, Patient #4's medical record documented she was transferred to the medical floor at 2:30 PM on 7/31/12. Nursing notes documented Patient #4 complained of pain rated 10 of 10 on 7/31/12 at 3:00 PM, 3:15 PM, 6:22 PM, and 10:17 PM. Nursing notes on 7/31/12 documented Patient #4 vomited at 3:45 PM, was dry heaving at 4:00 PM, and complained of nausea at 8:15 PM. Nursing notes on 8/01/12 documented Patient #4 was spitting into an emesis bag and complaining of nausea at 12:10 AM.</p> <p>Nursing notes, on 7/31/12 at 4:31 PM, documented Patient #4 did not have energy to ambulate. At 8:15 PM on 7/31/12, the LPN documented Patient #4 was assisted to stand but became dizzy and had to sit down. The note stated she was not able to ambulate to the bathroom and required a bedside commode. At 8:58 PM on 7/31/12, the LPN documented Patient #4 required assistance to ambulate.</p> <p>No documentation was present stating the physician was notified of Patient #4's continuing nausea or her difficulty ambulating. At 12:58 AM on 8/01/12, the LPN documented the physician called the hospital. The note stated the physician was "Informed of pte current condition" and orders were obtained. The note did not state specifically what symptoms the physician was informed of.</p> <p>At 2:30 AM on 8/01/12, the LPN documented Patient #4's oxygen saturation levels dropped to the low 80s. Again, the physician was not informed of Patient #4's change in condition.</p>	C 294		

Sep. 17. 2012 2:18PM

No. 2252 P. 13/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617	ZIP CODE
(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 294	Continued From page 9 The LPN who care for Patient #4 was interviewed on 8/28/12 beginning at 2:40 PM. She stated Patient #4's physician called the hospital at 12:58 AM on 8/01/12. She stated she was attempting to call the physician at the time. However, she stated a nurse did not contact the physician from 7:00 PM on 7/31/12 until 4:10 AM on 8/01/12 when Patient #4 arrested. She stated she did not request the physician to come and examine Patient #4. Patient #4's physician was interviewed on 8/28/12 beginning at 1:55 PM. He stated the LPN did not inform him of Patient #4's low oxygen saturation levels when he spoke to her by phone at 12:58 AM on 8/01/12. He stated the LPN sounded like Patient #4 was doing better. Nurses failed to notify the physician of Patient #4's deteriorating condition. 3. Patient #4's "Clinical Documentation Report," dated 7/31/12 from 2:30 PM through 8/01/12 at 12:30 AM, documented her abdomen was firm and/or distended 5 different times. No documentation was present that nursing staff measured her abdomen in order to determine whether it was increasing in size. The Director of Quality was interviewed on 8/30/12 beginning at 10:30 AM. She confirmed Patient #4's abdominal girth was not measured. Nurses failed to measure Patient #4's abdominal girth.	C 294		
C 295	485.635(d)(1) NURSING SERVICES A registered nurse must provide (or assign to	C 295		

Sep. 17. 2012 2:18PM

No. 2252 P. 14/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83817		
(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 295	Continued From page 10 other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. 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 an RN provided nursing care for 1 of 5 patients (#4) whose records were reviewed for care following a procedure. This resulted in a lack of assessment and oversight of patient care. Findings include: 1. Patient #4's medical record documented a 61 year old female who had upper gastrointestinal endoscopy with biopsy and colonoscopy with biopsy performed on 7/31/12. The procedures ended at 12:38 PM and she was taken to the recovery area. Patient #4 did not recover sufficiently to be discharged from same day surgery. A telephone order was obtained at 2:26 PM on 7/31/12 to admit Patient #4 to the medical floor for observation. Orders included an IV, water as requested, Demerol IV for pain, Ativan IV for anxiety, and Zofran IV for nausea. Patient #4's Clinical Documentation Report noted the day shift RN cared for Patient #4 during that shift. The final progress note by the day shift RN was documented at 7:45 PM on 7/31/12. Between 7:45 PM on 7/31/12 and 4:10 AM on 8/01/12, when Patient #4 suffered cardiopulmonary arrest, the RN documented 2	C 295			

Sep. 17. 2012 2:18PM

No. 2252 P. 15/20

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1702 EAST LOCUST STREET EMMETT, ID 83617		ZIP CODE
(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 295	<p>Continued From page 11</p> <p>progress notes. The first note was dated 7/31/12 at 8:58 AM. It documented diminished lung sounds bilaterally and noted bowel tones in all 4 quadrants. The note stated Patient #4 required assistance to ambulate. The other progress note by the RN was dated 7/31/12 at 10:17 PM. It documented medicating Patient #4 with Demerol for pain which was rated at 10 of 10. No assessment of Patient #4's condition was documented at this time. No further assessment of Patient #4's condition by the RN was documented until 4:10 AM on 8/01/12.</p> <p>At 10:12 PM on 7/31/12, the LPN documented Patient #4's oxygen saturation level dropped from 94% at 8:35 PM to 79%. Even though the RN medicated the patient 5 minutes later, no assessment of her condition by the RN was documented. The LPN documented speaking with the physician at 12:58 AM on 8/01/12. No documentation was present that the RN spoke to the physician or informed him of her opinion regarding Patient #4's condition. The LPN documented Patient #4's oxygen saturation level was 87% on 3 liters of oxygen at 1:38 AM and the level was in the low 80s at 2:30 AM on 8/01/12. No documentation of an assessment of Patient #4's condition or notification of the physician by the RN was present at these times.</p> <p>The night shift RN was interviewed on 8/28/12 beginning at 3:20 PM. She confirmed the lack of RN documentation and stated she did not speak with the physician prior to Patient #4's cardiopulmonary arrest.</p> <p>The RN failed to evaluate Patient #4 and to notify the physician of her condition.</p>	C 295			

Sep. 17. 2012 2:18PM

No. 2252

P. 16/20

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

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE 1202 EAST LOCUST STREET EMMETT, ID 83617	ZIP CODE
(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 298	<p>485.635(d)(4) NURSING SERVICES</p> <p>A nursing care plan must be developed and kept current for each inpatient.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the CAH failed to ensure a nursing care plan was developed for 1 of 5 in-patients (#9) whose records were reviewed. This resulted in a lack of direction to nursing staff caring for patients. Findings include:</p> <p>Patient #9's medical record documented a 36 year old female who was admitted to the facility on 7/31/12 at 6:57 PM. The "HISTORY AND PHYSICAL," dated 7/31/12, documented Patient #9 was admitted for an emergent Caesarean section (surgical procedure used to deliver a baby) secondary to severe pre-eclampsia (high blood pressure and excess protein in the urine after 20 weeks of pregnancy in a woman who previously had a normal blood pressure) and fetal distress. The "OPERATIVE CARE RECORD" documented Patient #9 underwent surgery on 7/31/12, from 6:03 PM to 7:26 PM, when Patient #9 was transferred to the post-anesthesia care unit. The infant was transferred to a neonatal intensive care unit in a nearby town. From the post-anesthesia care unit, Patient #9 was transferred to the medical/surgical floor at approximately 9:11 PM, where she remained until she was discharged on 8/03/12 at 11:54 AM. There was no nursing plan of care found in Patient #9's medical record to provide direction for nursing staff who cared for Patient #9 during her 3 day post-operative hospital stay.</p> <p>The Director of Quality reviewed Patient #4's</p>	C 298		

Sep. 17. 2012 2:19PM

No. 2252 P. 17/20

PRINTED: 09/17/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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 298	Continued From page 13 medical record with the surveyors on 8/30/12 beginning at 10:30 AM. She confirmed a nursing plan of care had not been developed for Patient #9. Nursing staff did not develop a plan of care for Patient #9.	C 298			

Sep. 17. 2012 2:19PM

No. 2252 P. 18/20

PRINTED: 09/17/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDH71J	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint survey at your hospital. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Rebecca Lara, RN, HFS	B 000		
BB144	16.03.14.250.01 Medical Staff Qualifications and Privileges 250. MEDICAL STAFF. The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88) 01. Medical Staff Qualifications and Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88) a. Privileges shall be granted only on the basis of individual training, competence, and experience. (10-14-88) b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88) c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88) This Rule is not met as evidenced by:	BB144		

RECEIVED
SEP 26 2012
FACILITY STANDARDS

Bureau of Facility Standards

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

John N. Olson

TITLE

CEO

(X8) DATE

9/26/12

STATE FORM

400

MPUP11

If continuation sheet 1 of 3

Sep. 17. 2012 2:19PM

No. 2252 P. 19/20

PRINTED: 09/17/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDH71J	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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)	(X6) COMPLETE DATE	
BB144	Continued From page 1 Based on staff interview and review of medical records and physician credentials files, it was determined the CAH failed to ensure complete privileges were granted to one physician whose files were reviewed. This resulted in the inability to ensure the physician was qualified to perform the procedure. Findings include: Patient #4's medical record documented a 61 year old female who had upper gastrointestinal endoscopy with biopsy and colonoscopy with biopsy performed on 7/31/12. She suffered cardiopulmonary arrest at 4:10 AM on 8/01/12 and was transferred to an acute care hospital. The credentials file of Patient #4's physician, who performed the colonoscopy procedure, was reviewed. The file stated he was last reappointed to the medical staff on 1/31/12. His privilege list included gastroscopy, proctoscopy and sigmoidoscopy. The list did not include colonoscopy. The Administrative Assistant in charge of medical staff credentialing was interviewed on 8/29/12 beginning at 9:00 AM. She confirmed the physician had not been granted privileges for colonoscopy. The CAH failed to grant complete privileges to a physician prior to allowing him to perform procedures.	BB144			
BB176	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)	BB175			

Sep. 17. 2012 2:19PM

No. 2252 P. 20/20

PRINTED: 09/17/2012
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDH71J	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/31/2012
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 EAST LOCUST STREET EMMETT, ID 83617		
(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) COMPLETE DATE
BB175	Continued From page 2 a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to C298 as it relates to the lack of patient care plans.	BB175		

Plan of Correction

RECEIVED
SEP 26 2012
FACILITY STANDARDS

C259- Responsibilities of MD or DO

1. Problem- Physician did not provide medical care services to the patient and did not examine the patient when she was admitted.

Corrective Action- We have hired a new General Surgeon, Dr. [REDACTED] lives in Emmett and has an established practice in town.

Improvements- [REDACTED]'s close proximity to the hospital significantly reduces the problems that arose with our previous surgeon who lived 25 miles from the hospital. [REDACTED] lives 5 minutes away and will be able to closely monitor difficult cases.

Implementation- [REDACTED] began practicing on 9/4/2012.

2. Problem- Physician did not follow medical staff bylaws by not naming a local member of the Medical Staff to attend to the patient's care.

Corrective Action- Medical staff was reminded on 9/11/12 in medical staff meeting that the bylaws state that, "Each Practitioner must assume timely adequate professional care for his patients in the Hospital by being available, or having available and alternative Practitioner with whom prior arrangements have been made. Each member of the medical staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area and who may attend the staff member's patients in an emergency or until the staff member arrives." We will reinforce this in the next medical staff meeting to be held on 10/9/12.

Improvements- Patient safety will increase and response time to critical/acute problems that may arise will decrease. Nursing staff will have the needed support to provide safe, timely care for their patients.

Implementation- [REDACTED] and [REDACTED] Chart Analysts, will perform a Medical Record Chart Audit (see attached) on a daily basis to track compliance. This report includes documenting who the admitting physician is and if there is an alternate, following physician. They will report compliance to [REDACTED] QI manager. [REDACTED] will document findings and report compliance on a monthly basis. This Medical Record Chart Audit will begin on 10/1/12.

C270 PROVISION OF SERVICES

1. C294- Nursing Services must meet the needs of the patients.

1. Problem- No complete orders. No oxygen orders. Nursing staff applied and adjusted patient's oxygen without physician orders.

Corrective Action- [REDACTED], [REDACTED], or acting CRNA will activate PACU orders on all patients for all surgical procedures performed in the OR (see attached PACU orders). The admitting physician will activate Post-Op Orders; Same Day Surgery (see attached Post-Op Orders). In addition to these measures, we will be conducting an inpatient chart audit every shift (12 hr) to monitor compliance with physician orders, as well as monitor that initial assessments and care plans have been initiated by an RN. This will be carried out each shift by the charge RN.

Improvements- Will improve continuity of care and add another step in the process of ensuring safety to the patient. Will increase level of care and safety while in the PACU and in Same Day Surgery. As it relates to the specific citing, the RN will be allowed to apply oxygen and titrate as necessary per standing orders. The policies implemented give consistent criteria and guidelines for RN or delegate staff to follow. The inpatient Chart Audit will ensure that compliance is met every shift for each inpatient.

Implementation- The PACU and Post-Op orders compliance will be implemented effective 10/1/12 and will be monitored by the OR manager, [REDACTED]. [REDACTED] will then report the daily compliance on a monthly basis to the QI manager, [REDACTED]. [REDACTED] will be responsible for reporting on our level of compliance in completing PACU and Post-Op orders on all patients. The inpatient Chart Audit is completed every shift by the charge nurse and will be reported to [REDACTED] RN, BSN, CNO on compliance. Jason will then report to the QI manager, [REDACTED] on a monthly basis to report compliance. (See inpatient Chart Audit).

2. Problem- Nursing failed to notify the physician of the patient's deteriorating condition.

Corrective Action- Education will be provided by [REDACTED] RN, BSN, CNO. Education will include discussion on ethics and review of patient advocacy as defined in the ANA code of ethics. Teaching will also include "Evaluating a Symptom" algorithm. This education will take place on 9/27/12 in the monthly nursing staff meeting.

Improvements- This education will empower nurses in their decision-making capacities. Nurses will have a clear algorithm to follow as an aid to ensure the correct nursing judgment is being made.

Implementation- This education will be presented to the nursing staff members on 9/27/12 at a monthly staff meeting. Minutes will be kept to document the teaching. In addition to this, role will be taken at the meeting and each nurse will sign that they received the presentation of material.

3. Problem- Nurses failed to measure patient's abdominal girth.

Corrective Action- Education will be provided by [REDACTED] RN, BSN, CNO. Education will include discussion on ethics and review of patient advocacy as defined in the ANA code of ethics. Teaching will also include "Evaluating a Symptom" algorithm. This algorithm has a specific example of measuring abdominal girth. This education will take place on 9/27/12 in the monthly nursing staff meeting. Monthly, staff participates in unit-specific education and skills seminar. All staff is required to be certified in BLS, ACLS, PALS, NRP, and STABLE. This was implemented on 6/8/12. Since this date, we have had ACLS, NRP, and STABLE classes. Three ER nurses have received their certifications in TNCC. We plan to have all ER RNs TNCC certified by June 2013. New staff will have these certifications completed by one-year anniversary of employment at WKMH.

Improvements- We believe that these educational certifications and ongoing monthly educational opportunities will give our nurses an increased ability to recognize acute change in patient status and intervene appropriately for all patients.

Implementation- This education will be presented to the nursing staff members on 9/27/12 at a monthly staff meeting. Minutes will be kept to document the teaching. In addition to this, role will be taken at the meeting and each nurse will sign that they received the presentation of material.

2. C295- A registered nurse must provide the nursing care of each patient. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.

1. Problem- RN failed to evaluate the patient and notify the physician of condition.

Corrective Action- Education will be provided by [REDACTED] RN, BSN, CNO. Education will include discussion on ethics and review of patient advocacy as defined in the ANA code of ethics. Teaching will also include "Evaluating a Symptom" algorithm, which includes steps to gather a rapid physical examination that will quickly determine a change in patient condition that indicates notifying the physician immediately. This education will take place on 9/27/12 in the monthly nursing staff meeting.

All staff is required to be certified in BLS, ACLS, PALS, NRP, and STABLE. This was implemented on 6/8/12. Since this date, we have had ACLS, NRP, and STABLE classes. Three ER nurses have received their certifications in TNCC. We plan to have all ER RNs TNCC certified by June 2013. New staff will have these certifications completed by one-year anniversary of employment at WKMH.

Monthly, staff participates in unit-specific education and skills seminar.

Additionally, we have changed the plan of care from total patient care to a traditional team approach, effective 10/1/12. Responsibilities will be divided between the RN, LPN, and CNA. The role of the RN and LPN can be found in the attached, "Standards of Nursing Practice with Role Differentiation". In addition to these measures, an inpatient chart audit will be performed every shift (12 hr) to monitor compliance with physician orders, as well as monitor that initial assessments and care plans have been initiated by an RN. This will be audited every shift by the charge nurse and reported to [REDACTED] RN, BSN, CNO. [REDACTED] will then report compliance to [REDACTED], QI manager. [REDACTED] will report compliance on a monthly basis in QI report. This implementation will commence on 10/1/12.

Implementation- This education will be presented to the nursing staff members on 9/27/12 at a monthly staff meeting. Minutes will be kept to document the teaching. In addition to this, role will be taken at the meeting and each nurse will sign that they received the presentation of material.

Walter Knox Memorial Hospital will also be transitioning to an all RN staff. We will have an RN and support staff in the ER, as well as an RN and support staff on the Medical/Surgical department. This will allow for WKMH to have an RN in the ER and an RN on the Medical/Surgical floor at all times. (See attached RN to LPN transition)

Improvements- These steps will improve continuity of care and patient safety. The education will empower nurses in their decision-making capacities. Nurses will have a clear algorithm to follow as an aid to ensure the correct nursing judgment is being made. The inpatient Chart Audit will ensure that compliance is met every shift for each inpatient. We believe that these educational certifications and ongoing monthly educational opportunities will give our nurses an increased ability to recognize acute change in patient status and intervene appropriately for all patients.

Our new model of care will bring us into compliance and allow for the RN to provide primary care to all patients. The RN will then delegate appropriate patient care to the LPN, and CNA.

3. C298- A nursing care plan must be developed and kept current for each inpatient.

1. Problem- Nursing staff did not develop a plan of care for patients

Corrective Action- We have changed the plan of care from total patient care to a traditional team approach, effective 10/1/12. Responsibilities will be divided between the RN, LPN, and CNA. The role of the RN and LPN can be found in the attached, "Standards of Nursing Practice with Role Differentiation". In addition to these measures, an inpatient chart audit will be performed every shift (12 hr) to monitor compliance with physician orders, as well as monitor that initial assessments and care plans have been initiated by an RN. This will be audited every shift by the charge nurse and reported to [REDACTED] RN, BSN, CNO. Jason will then report compliance to [REDACTED] QI manager. [REDACTED] will report compliance on a monthly basis in QI report. This implementation will commence on 10/1/12.

Implementation- Education will be provided at the monthly staff meeting on 9/27/12 by [REDACTED] LPN, and [REDACTED] RN, BSN, CNO regarding implementation and use of care plan in HMS system for all inpatients. [REDACTED] will present step-by-step instructions on how to use the HMS system for care plan implementation. A live demonstration will be used to educate staff on this process. Staff will sign off competency in creating care plans and using the care plan to document all nursing tasks.

Improvements- These changes will allow for the RN to supervise all patients and the care administered by staff. The RN will be empowered to delegate patient assignments as outlined in the Standards of Nursing Practice with Role Differentiation policy. An RN will perform all initial assessments and care plans on all inpatients.

Education on the HMS system care plan will allow nurses to effectively create a care plan and allow them to modify the care plan as needed throughout the duration of the patient's stay. Additionally, this education will train staff to use the care plan flow sheet to document all aspects of nursing care (vital signs, daily cares, neurological checks, etc.). This will increase the continuity of care and develop an even stronger resolve to meet goals and deadlines set in the care plan.

BB144- Medical Staff Qualifications and Privileges

1. Problem- The CAH failed to grant complete privileges to a physician prior to allowing him to perform procedures.

Corrective Action- 9-15-12 Until new delineation of privileges are developed, the colonoscopy procedure will be hand written, so appropriate privileges can be requested and approved. Current delineation of privileges are outdated.

Implementation- Immediately

Improvement- 11-13-12 New delineation of privileges will be reviewed and approved by the Medical Staff, which will include current surgical procedures.

BB175- Patient Care Plans

3. Problem- Nursing staff did not develop a plan of care for patients

Corrective Action- We have changed the plan of care from total patient care to a traditional team approach, effective 10/1/12. Responsibilities will be divided between the RN, LPN, and CNA. The role of the RN and LPN can be found in the attached, "Standards of Nursing Practice with Role Differentiation". In addition to these measures, an inpatient chart audit will be performed every shift (12 hr) to monitor compliance with physician orders, as well as monitor that initial assessments and care plans have been initiated by an RN. This will be audited every shift by the charge nurse and reported to [REDACTED] RN, BSN, CNO. [REDACTED] will then report compliance to [REDACTED] QI manager. [REDACTED] will report compliance on a monthly basis in QI report. This implementation will commence on 10/1/12.

Implementation- Education will be provided at the monthly staff meeting on 9/27/12 by [REDACTED] LPN, and [REDACTED] RN, BSN, CNO regarding implementation and use of care plan in HMS system for all inpatients. [REDACTED] will present step-by-step instructions on how to use the HMS system for care plan implementation. A live demonstration will be used to educate staff on this process. Staff will sign off competency in creating care plans and using the care plan to document all nursing tasks.

Improvements- These changes will allow for the RN to supervise all patients and the care administered by staff. The RN will be empowered to delegate patient assignments as outlined in the Standards of Nursing Practice with Role Differentiation policy. An RN will perform all initial assessments and care plans on all inpatients.

Education on the HMS system care plan will allow nurses to effectively create a care plan and allow them to modify the care plan as needed throughout the duration of the patient's stay. Additionally, this education will train staff to use the care plan flow sheet to document all aspects of nursing care (vital signs, daily cares, neurological checks, etc.). This will increase the continuity of care and develop an even stronger resolve to meet goals and deadlines set in the care plan.

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

September 25, 2012

John Olson, Administrator
Walter Knox Memorial Hospital
1202 East Locust Street
Emmett, ID 83617

RE: Walter Knox Memorial Hospital CCN #131318

Dear Mr. Olson:

On **August 31, 2012**, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005699

Alligation #1: A patient died following a routine colonoscopy.

Findings #1: An unannounced visit was made to the Critical Access Hospital (CAH) on 8/28/12 to 8/31/12. Staff were interviewed. Eight medical records were reviewed. CAH policies and administrative documents were reviewed. Medical Staff credentials files and meeting minutes were reviewed.

No unexpected deaths of inpatients were documented at the CAH in 2012. One medical record documented a patient whose condition deteriorated necessitating transfer to an acute care hospital.

The medical record documented a 61 year old female who had upper gastrointestinal endoscopy with biopsy and colonoscopy with biopsy performed on 7/31/12. She suffered cardiopulmonary arrest at 4:10 AM on 8/01/12 and was transferred to an acute care hospital.

A History and Physical (H&P) assessment of the patient, dated 6/19/12, did not include any cardiac or pulmonary diagnoses. The H&P stated the patient experienced some wheezing and coughing at times. No other cardiopulmonary symptoms were mentioned. The "PRE-ANESTHESIA EVALUATION", dated 7/31/12 at 9:50 PM, did not document pulmonary symptoms or difficulty walking.

The procedures ended at 12:36 PM and the patient was taken to the recovery area. She complained of pain and nausea after the procedure. At 12:45 PM on 7/31/12, the recovery nurse documented she

attempted to assist the patient to the bathroom but the patient was unable to move her legs to walk. At 2:10 PM on 7/31/12, the recovery nurse documented the patient required oxygen at 10 liters per minute and said her abdominal discomfort made it difficult to breathe. A telephone order was obtained at 2:25 PM on 7/31/12 to admit the patient to the medical floor for observation. A note by the day shift registered nurse (RN), at 3:00 PM on 7/31/12, stated the patient rated her abdominal pain at 10 of 10, her abdomen was firm to touch, and she had no bowel sounds. The patient was medicated with IV narcotic at 3:15 PM. A note by the day shift RN, at 3:15 PM on 7/31/12, stated the patient took sips of water and vomited." A note by the day shift RN, at 5:22 PM on 7/31/12, stated the patient was medicated with Ativan 1 mg IV for abdominal pain rated 10 of 10. The final note by the day shift was an RN note at 7:45 PM on 7/31/12. It stated the patient's abdomen remained firm and it hurt for her to take a deep breath.

Nursing shift change occurred at 7:00 PM on 7/31/12. A note by the licensed practical nurse (LPN), on 7/31/12 at 8:15 PM, stated the patient was not able to ambulate to the bathroom. A note by the LPN, on 7/31/12 at 8:35 PM, stated the patient removed her oxygen. Her oxygen saturation level at the time was 94%. (The American Lung Association's "A QUICK GLANCE GUIDE TO OXYGEN THERAPY," not dated, stated "The goal of oxygen therapy is to provide oxygen saturation of at least 90 % at all activity levels.") A note by the LPN, on 7/31/12 at 10:12 PM, stated the patient's oxygen saturation level dropped to 79%. Oxygen was restarted at 3 liters per minute. At 10:17 PM on 7/31/12, the patient was medicated by the RN with IV Demerol for pain rated at 10 of 10. A note by the LPN, on 7/31/12 at 10:40 PM, stated the patient "...states still having pain. Did not rate at this time. Complains mainly about upper abdomen area." A note by the LPN, on 8/01/12 at 12:10 AM, stated the patient "...has emesis bag in hand, spitting into it. States still feels nauseated." A note by the LPN, on 8/01/12 at 12:30 AM, stated the patient's abdominal girth appeared larger. The note stated the ED RN was called to start another IV. The note stated the patient was on oxygen at 1.5 liters per minute.

A note by the LPN, on 8/01/12 at 12:58 AM, stated "Call from surgeon. Informed of pt's current condition. Orders received for fluid bolus then increased rate. Clindamycin, radiology, and labs in morning. Pt is now NPO except for sips and ice chips. Page surgeon if change in fever or tachycardia."

The patient's condition continued to decline. The LPN documented the patient's oxygen saturation level was 87% on 3 liters of oxygen at 1:38 AM and the level was in the low 80s at 2:30 AM on 8/01/12. A note by the night RN, on 8/01/12 at 4:10 AM, stated the patient "...went into respiratory arrest and became pulseless. CPR initiated." The patient's heart rate was restored and she was transferred to an acute care hospital.

Nursing notes documented they administered oxygen to the patient and adjusted flow rates. However no orders for oxygen were present in the medical record.

The patient's "Clinical Documentation Report," dated 7/31/12 from 2:30 PM through 8/01/12 at 12:30 AM, documented her abdomen was firm and/or distended 5 different times. No documentation was present that nursing staff measured her abdomen in order to determine whether it was increasing in size.

Between 7:45 PM on 7/31/12 and 4:10 AM on 8/01/12, when the patient suffered cardiopulmonary arrest, the RN documented 2 progress notes. The first note was dated 7/31/12 at 8:58 AM. It

documented diminished lung sounds bilaterally and noted bowel tones in all 4 quadrants. The note stated the patient required assistance to ambulate. The other progress note by the RN was dated 7/31/12 at 10:17 PM. It documented medicating the patient with Demerol for pain which was rated at 10 of 10. No assessment of the patient's condition was documented at this time. No further assessment of the patient's condition by the RN was documented until 4:10 AM on 8/01/12. At 10:12 PM on 7/31/12, the LPN documented the patient's oxygen saturation level dropped from 94% at 8:35 PM to 79%. Even though the RN medicated the patient 5 minutes later, no assessment of the patient's condition by the RN was documented. The LPN documented speaking with the physician at 12:58 AM on 8/01/12. No documentation was present that the RN spoke to the physician or informed him of her opinion regarding the patient's condition. No documentation of an assessment of the patient's condition or notification of the physician by the RN was present at these times.

The medical record from the receiving hospital documented the patient arrived on the morning of 8/01/12 and was taken to surgery that morning to repair a perforated bowel. A nuclear medicine report, dated 8/01/12, stated a perfusion scan was performed at 1:44 PM. The report confirmed "brain death." The record stated the patient was removed from life support on 8/03/12 and died.

A "Progress Note" by the physician, dated 8/01/12 but not timed, stated the patient was admitted to the CAH post procedure for persistent distention, nausea, and failure to progress. The note stated the physician discussed the patient with the LPN at 1 AM (on 8/01/12). The note stated "The update at the time she was having persistent abdominal pain. The patient was able to walk on one occasion and pass a little bit of gas, however, was still distended. The patient was also having nausea and had an episode of emesis. She was also having intermittent tachycardia, however maintaining her blood pressure. At that morning I ordered morning laboratories, x-rays, started Clindamycin and ordered a fluid bolus." The note further stated that, at approximately 4:00 AM, the patient required resuscitation.

Medical Staff Bylaws, amended 2/28/12, stated at 18.1.1(f), "Each Practitioner must assume timely adequate professional care for his patients in the Hospital by being available, or having available an alternative Practitioner with whom prior arrangements have been made. Each member of the medical staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area and who may to attend the staff member's patients in an emergency or until the staff member arrives."

The above patient's physician stated he lived in a town approximately 25 miles from the hospital. He stated he did not return to the hospital to examine the patient after she exhibited signs of complications. Neither did a local physician examine the patient. Care of the patient was not turned over to a local physician.

Interviews with nursing staff revealed they did not request a physician to examine the above patient. Also, following shift change at approximately 7:45 PM on 7/31/12, the patient was primarily cared for by an LPN with minimal RN involvement. The LPN did speak with the physician at 12:58 AM on 8/01/12. An RN did not communicate with the physician after 2:30 PM on 7/31/12.

The complaint was substantiated. A deficiency was cited at 42 CFR Part 485.631(b,1,iii) for the failure of the physician to provide care to the patient.

John Olson, Administrator
September 25, 2012
Page 4 of 4

Also, deficiencies were cited at 42 CFR Part 485.635 for the failure of the nursing staff to adequately monitor the patient and report her deteriorating condition to the physician and for the lack of monitoring of the patient by a registered nurse.

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

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

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

Sincerely,



GARY GILES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm