

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 18, 2012

Michael Fenello, Administrator
St Luke's McCall
1000 State Street
Mc Call, ID 83638

RE: St Luke's McCall, Provider #131312

Dear Mr. Fenello:

This is to advise you of the findings of the Medicare/Licensure survey at St Luke's McCall, which was concluded on September 13, 2012.

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

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

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

Michael Fenello, Administrator
September 18, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **October 1, 2012**, and keep a copy for your records.

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

Sincerely,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures



RECEIVED
OCT 01 2012

Thursday, September 27, 2012

FACILITY STANDARDS

Idaho Department of Health and Welfare
3232 Elder St
PO Box 83720
Boise, ID 83720-0009

RE: St Luke's McCall, Provider ID # 131312

Dear Mr. Gary Guiles and Associates:

Enclosed is the Plan of Correction addressing the Medicare deficiencies discovered during the Medicare/Licensure survey conducted at St Luke's McCall on September 13, 2012.

Our facility greatly appreciated the professionalism and competency you demonstrated as you surveyed our organization and look forward to the opportunity to improve our processes creating a quality focused environment for our patients.

We also look forward to any feedback concerning our Plan of Correction. If you have any questions, please feel free to contact myself or our Quality Manager, Cindy Mosier (208-630-2255).

Sincerely,

A handwritten signature in black ink that reads "Mike Fenello".

Mike Fenello, CEO

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 9-13-12
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MCCALL	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 STATE STREET MC CALL, ID 83638
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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C 000 INITIAL COMMENTS

The following deficiencies were cited during the medicare recertification survey of your hospital. The surveyor conducting the recertification was Gary Gules, RN, HFS.

Acronyms used in this report include:

CAH = critical access hospital
CRNA = Certified Registered Nurse Anesthetist
RN = registered nurse

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 medical record review and staff interview, it was determined the facility failed to ensure compliance with Federal laws and regulations related to advanced directives for 2 of 13 adult inpatients (#19 and #30) 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:

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

FACILITY STANDARDS

CPT 4-1-2012

PRE-CORRECTIVE

C 000 C151 - 485.608(a)
Advance Directives

Action Plan Responsible Parties:
Lisa Looney, Chief Nursing Officer; Sandy Dryden, Director of Patient Financial Services; and Cindy Mosier, Manager of Patient Care Quality and Safety

Process Improvement & Action Plan Implementation:
Staff Education:

- ✓ Registration staff was immediately trained to provide all registered patients a copy of the pamphlet "Patient Rights and Responsibilities" which includes advance directive education. In addition, scripting was developed that included the key words "it is your right to make your wishes known about advance directives". Education was completed 9/28/12.
- ✓ Nursing staff was immediately educated to offer the patient an opportunity to formulate advance directives or to obtain additional information about advance directives and the requirement to assess and document whether or not the patient has executed an advance directive.. Education was completed 9/28/2012

Process Improvement:

- ✓ Monitoring was implemented to ensure that every patient had their advance directive status documented prominently in the record. For the inpatient population this documentation is included in the initial assessment / admission health history.

Continued on page 2

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michele Jewell</i>	TITLE CEO	(X6) DATE 9-27-12
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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 Continued From page 1

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.

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 non-medical health care institution, whether or not the individual has executed an advance directive." The hospital failed to comply with this Federal regulation as follows:

1. Patient #19's medical record documented an 81 year old female who was admitted as a swing patient on 7/22/12 following gall bladder surgery. She was discharged on 7/26/12. Her medical record did not state if she had developed an advance directive. The record did not state what her wishes for health care were should she not be able to make those wishes known. The record also did not state who could make medical decisions for her if she was unable to direct her care.

The Quality Manager reviewed Patient #19's medical record on 9/11/12 beginning at 4:15 PM. She stated documentation regarding an advance directive was not present in the record.

The CAH did not document whether Patient #19 had an advance directive or whether she was afforded the opportunity to develop one.

2. Patient #30's medical record documented a 48

C 151 Continued from page 1

C151 – 485.608(a)
Advance Directives
Process Improvement:

- ✓ If an advance directive has been formulated, nursing staff will request that a copy be provided to the hospital and document that request as well as create a plan of care for those wishes that are communicated to the care team, pending delivery of Advance Directive.
- ✓ The advance directive policy and procedure has been scheduled for priority review and revision. All aspects of providing patients the opportunity to be informed of their right to formulate advance directives and to have their wishes included in their plan of care as well as documentation and implementation standards will be contained within this review and revision per the process improvements noted above. Policy review and implementation will be completed by October 16, 2012.

QAPI Integration:

- ✓ Beginning October 1, 2012, St. Luke's McCall will audit 100% of inpatient records for compliance with assessment and documentation of advance directives. St. Luke's McCall will continue auditing pending sustained compliance as measured by 98% compliance rate x 3 continuous months.
- ✓ Ongoing compliance will be audited intermittently thereafter and reported to senior leadership.

Plan of Action continued on page 3

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C 151 Continued From page 2
year old female who was admitted on 9/12/12 where she had total knee surgery. She was currently a patient as of 9/13/12. The section labeled "Review-ADVANCE DIRECTIVE," dated 9/05/12 at 1:30 PM, stated "Yes/Location: on file at hospital." The medical record did not contain the referenced advance directive.

The RN who documented that the advance directive was on file was interviewed on 9/13/12 beginning at 11:50 AM. She was not able to locate the advance directive. She stated she did not know where advance directives were kept at the hospital. The RN stated she documented Patient #30 had an advance directive at the hospital because the patient had told her this during a pre-admission interview. The RN stated she had not seen the advance directive.

The Quality Manager also reviewed Patient #19's medical record on 9/13/12 at 11:50 AM. She stated she did not know where advance directives were kept.

The CAH did not ensure Patient #19's advance directive was available to staff.

C 271 485.635(a)(1) PATIENT CARE POLICIES

The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

This STANDARD is not met as evidenced by:
Based on staff interview and review of medical records and CAH policies, it was determined the facility failed to ensure appropriate policies for the provision of pain procedures had been

C 151 Continued from page 2
C151 - 485.608(a)
Advance Directives

QAPI Integration: (continued)

- ✓ Results will be reported to the CNO, CEO and Senior Leadership monthly until sustained compliance is achieved, then intermittently thereafter. A summary of the initial audits will be reported quarterly to the Quality Committee of the Board of Directors until sustained compliance is achieved, then intermittently thereafter.

C 271 C271 - 485.635(a)
Patient Care Policies
Appropriate Policies for the Provision of Pain Procedures

Action Plan Responsible Parties: Lisa Looney, Chief Nursing Officer; Pam Bush RN, Surgical Clinical Supervisor; Troy Britton CRNA; Cindy Mosier, Manager of Patient Care Quality and Safety

Continued page 4

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C 271 Continued From page 3
developed. This affected the care of 3 of 3 pain procedure patients (#35, #37, and #38) whose records were reviewed. This resulted in a lack of direction to staff and had the potential impact patient care. Findings include:

1. The policy "EPIDURAL STEROID: LUMBAR," dated 8/01, discussed the scheduling, equipment, and set up of the procedure. The policy did not specify what type of preoperative work up, such as a history and physical examination, the practitioner was required to perform.

The CRNA who performed epidural steroid injections for Patients #35 and #37 was interviewed on 9/13/12 beginning at 3:00 PM. He confirmed the policy. He stated primary care physicians examined patients in their offices. He stated pain procedures were then scheduled at the CAH. He stated the results of history and physical examinations were not typically sent to the hospital prior to the procedures. He said he did not normally conduct a physical examination of patients prior to the procedures.

The epidural steroid policy did not define the work up for pain procedure patients.

2. Patient #35's medical record documented a 70 year old male who had a lumbar epidural steroid injection performed on 9/06/12 beginning at approximately 1:25 PM. Patient #35 was discharged at 2:25 PM on 9/06/12. The "Outpatient Record-Nursing Department" form, dated 9/06/12, stated Patient #35 received Versed 2 mg IV during the procedure. Patient #35's medical history was not present in the medical record. In addition, a physical

C 271 Continued from page 3
C271 - 485.635(a)
Patient Care Policies
Appropriate Policies for the Provision of Pain Procedures

Process Improvement:

- ✓ St Luke's McCall began immediately requiring that a history and physical exam be present in the medical record prior to the initiation of any minor procedures including pain procedures. Completion date - 9/28/2012
- ✓ The Epidural Steroid Policy has been scheduled for priority review and revision. This revision will specify that a history and physical examination will be required. Completion date - 10/16/2012

QAPI Integration:

- ✓ Beginning October 1, 2012, St. Luke's McCall will audit 100% of inpatient records for compliance to ensure a history and physical examination is present in the medical record prior to the initiation of any minor procedure including pain procedures. St. Luke's McCall will continue auditing pending sustained compliance as measured by 100% compliance rate x 3 continuous months.
- ✓ Ongoing compliance will be audited intermittently thereafter and reported to senior leadership.
- ✓ Results will be reported to the CNO, CEO and Senior Leadership monthly until sustained compliance is achieved, then intermittently thereafter. A summary of the initial audits will be reported quarterly to the Quality Committee of the Board of Directors until sustained compliance is achieved, then intermittently thereafter

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C 271	<p>Continued From page 4</p> <p>examination was not documented by a practitioner prior to the procedure.</p> <p>The Quality Manager reviewed Patient #35's medical record on 9/13/12 beginning at 2:20 PM. She confirmed a medical history was not documented. She confirmed a physical examination of Patient #35 by the practitioner was not documented.</p> <p>The CAH did not document a medical history or physical examination of Patient #35 prior to epidural steroid injection.</p> <p>3. Patient #37's medical record documented a 75 year old female who had an epidural steroid injection performed on 8/20/12 beginning at approximately 9:00 AM. Patient #37 was discharged at 9:45 AM on 8/20/12. The "Outpatient Record-Nursing Department" form, dated 8/20/12, stated Patient #37 received Versed 2 mg IV during the procedure. Patient #37's medical history was not present in the medical record. In addition, a physical examination was not documented by a practitioner prior to the procedure.</p> <p>The Quality Manager reviewed Patient #37's medical record on 9/13/12 beginning at 2:20 PM. She confirmed a medical history was not documented. She confirmed a physical examination of Patient #37 by the practitioner was not documented.</p> <p>The CAH did not document a medical history or physical examination of Patient #37 prior to epidural steroid injection.</p>	C 271	See Prior Plan of Action

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

PRINTED: 09/18/2012
FORM APPROVED
OMB NO. 0938-0397

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09-13-12
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C 271 Continued From page 5
4. Patient #38's medical record documented a 36 year old male who had an epidural steroid injection performed on 8/15/12 beginning at approximately 1:40 PM. Patient #38 was discharged at 2:20 PM on 8/15/12. The "Outpatient Record-Nursing Department" form, dated 8/15/12, stated Patient #38 received Versed 4 mg IV during the procedure. Patient #38's medical history was not present in the medical record. In addition, a physical examination was not documented by a practitioner prior to the procedure.

The Quality Manager reviewed Patient #38's medical record on 9/13/12 beginning at 2:20 PM. She confirmed a medical history was not documented. She confirmed a physical examination of Patient #38 by the practitioner was not documented.

The CAH did not document a medical history or physical examination of Patient #38 prior to epidural steroid injection.

C 271 See Prior Plan of Action

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID1TKS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 9/13/12
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B 000 16.03.14 Initial Comments
The following deficiency was cited during the Idaho state licensure survey of your hospital. The surveyor conducting the review was Gary Guiles, RN, HFS.

B 000

See Subsequent Action Plans on next pages

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OCT 01 2012
FACILITY STANDARDS

BB443 16.03.14.460.03 Policies and Procedures
03. Policies and Procedures. There shall be written policies and procedures for at least the following:
(10-14-88)
a. Services offered, including types of surgeries performed; and (10-14-88)
b. Procedure for evaluation, treatment and referral of patients; and (10-14-88)
c. Responsibility and accountability to other hospital services or departments, and to the medical staff and administration. (10-14-88)
This Rule is not met as evidenced by:
Refer to C271 as it relates to the failure of the hospital to develop appropriate policies for the provision of pain procedures.

BB443

Bureau of Facility Standards LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Ferrell</i>	TITLE CEO	(X6) DATE 9-27-12
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