



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

November 7, 2012

Marie Godley, Administrator  
Northern Idaho Advanced Care Hospital  
600 North Cecil Road  
Post Falls, ID 83854

RE: Northern Idaho Advanced Care Hospital, CCN #132001

Dear Ms. Godley:

This is to advise you of the findings of the Medicare/Licensure survey at Northern Idaho Advanced Care Hospital, which was concluded on October 19, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction, listing State licensure deficiencies. The Patient Identifier List is also included. The Form CMS-2567 listing federal deficiencies was forwarded to you by the CMS Region X Office, in Seattle, Washington, on November 6, 2012. In the spaces provided on the right side of each sheet, please provide a Plan of Correction for the state licensing deficiencies.

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 facility into compliance, and that the facility 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 State Form 2567.

Marie Godley, Administrator  
November 7, 2012  
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **November 20, 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,



SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

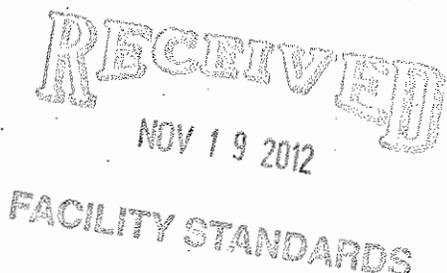
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Enclosures

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

PRINTED: 11/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>132001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTHERN IDAHO ADVANCED CARE HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH CECIL ROAD POST FALLS, ID 83854</b>
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A 000	<p><b>INITIAL COMMENTS</b></p> <p>The following deficiencies were cited during the validation survey of your hospital. Immediate jeopardy was identified. Surveyors conducting the review were:</p> <p>Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Gary Guiles, RN, HFS Libby Doane, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>AAPN = Advanced Practice Professional Nurse ABD = absorbent wound dressing BID = twice daily CAD = Coronary Artery Disease cc = cubic centimeter CEO = Chief Executive Officer CHF = Congestive Heart Failure CT scan = Computerized Axial Tomography DC = discontinue DON = Director of Nursing DRG = Diagnostic Related Group ED = Emergency Department EMS = Emergency Medical System Foley = a type of urinary catheter H&amp;P = History and Physical L = left LIP = Licensed Independent Practitioner LPN = Licensed Practical Nurse MWF = Monday Wednesday Friday NIACH = Northern Idaho Advanced Care Hospital NP = Nurse Practitioner NS = Normal Saline PA = Physician Assistant PEG tube = percutaneous endoscopic gastrostomy tube, a feeding tube into the stomach</p>	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maual Jolley</i>	TITLE <i>Chief Executive Officer</i>	(X6) DATE <i>11/16/12</i>
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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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A 000	Continued From page 1 PICC = percutaneous inserted central catheter POA = Power of Attorney POC = plan of care PRN = as needed pt = patient q = every QAPI = Quality Assessment Performance Improvement R = right RN = registered nurse RUE = Right Upper Extremity VAC = Negative Pressure Therapy for wound care  Immediate Jeopardy was identified at A 144 and the facility was notified on 10/18/12 at 1:30 PM. The facility submitted an immediate Plan of Correction on 10/18/12 at 4:30 PM and the Immediate Jeopardy was abated.	A 000		
A 064	482.12(c)(1) CARE OF PATIENTS - PRACTITIONERS  [ ...the governing body must ensure that the following requirements are met:] Every Medicare patient is under the care of: (i) A doctor of medicine or osteopathy (This provision is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to other qualified health care personnel to the extent recognized under State law or a State's regulatory mechanism); (ii) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State and who is acting within the scope of his or her license; (iii) A doctor of podiatric medicine, but only with respect to functions which he or she is legally authorized by the State to perform;	A 064	The President of the Medical Staff is responsible for enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted. The President of the Medical Staff reports to the Medical Executive Committee (MEC).  CEO reviewed findings with Medical Director on 11/8/2012. CEO reviewed findings with President of MEC on 11/13/2012. The MEC met on 11/15/2012 and discussed findings. MEC revised policy MS 015, "Medical Staff	11/21/12

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A 064	<p>Continued From page 2</p> <p>(iv) A doctor of optometry who is legally authorized to practice optometry by the State in which he or she practices;</p> <p>(v) A chiropractor who is licensed by the State or legally authorized to perform the services of a chiropractor, but only with respect to treatment by means of manual manipulation of the spine to correct a subluxation demonstrated on x-ray to exist; or</p> <p>(vi) A clinical psychologist as defined in §410.71 of this chapter, but only with respect to clinical psychologist services as defined in §410.71 of this chapter and only to the extent permitted by State law.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on staff interview and review of facility policies and medical records, it was determined the hospital failed to ensure 1 of 20 patients (#16) whose records were reviewed was under the care of a physician. The lack of physician involvement also had the potential to affect all patients admitted to the hospital. The failure of a physician to supervise and manage patient care had the potential to result in substandard care provided to patients. Findings include:</p> <p>1. Patient #16's medical record documented an 85 year old male who was initially admitted to the facility on 6/12/12, at 1:06 PM, for care related to clostridium difficile colitis (a contagious infection of the colon that is typically associated with the use of antibiotics resulting in symptoms such as fever, abdominal pain, and severe diarrhea.) Additional diagnoses included cancer of the prostate with recent prostatectomy (surgical removal of the prostate) and radiation therapy, mixed urinary tract infection, severe protein</p>	A 064	<p>Clinical Privileges Allied Health Practitioner (AHP) to reflect that H&amp;Ps may be dictated by the AHP only if the patient has been seen by a physician at NIACH. On 11/16/2012, The President of MEC and the Medical Director sent a letter to all providers on staff who utilize AHPs stating that physician collaboration must take place each day the patient is seen by an AHP and be documented in the medical record. This letter also stated that the MEC will enforce compliance for oversight of all AHPs by a qualified physician. This letter was accompanied by policy MS 015. MEC to enforce compliance by monitoring ongoing focused professional practice evaluation for interim note documentation. Data regarding compliance with this new policy will be collected on 100% of patients admitted starting 11/20/12 and presented to the MEC and Governing Body (GB) quarterly for at least one quarter. If compliance is obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB. The MEC met on 11/15/2012 and approved the letter and policy change. The GB met on 11/16/2012 and approved MEC letter and policy change.</p>	

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A 064	<p>Continued From page 3</p> <p>calorie malnutrition, urinary outlet obstruction with Foley catheter in place, CHF, CAD, hypertension, and chronic pain. He was transferred to an acute care hospital and discharged on 6/15/12.</p> <p>"ADMISSION ORDERS" for Patient #16 were signed by an NP on 6/12/12 at 3:00 PM. On 6/12/12 at 6:00 PM, the NP ordered Heparin, an anticoagulant. The "HISTORY &amp; PHYSICAL" was dictated by an NP on 6/13/12 at 12:18 PM and co-signed by the physician on 7/01/12 at 11:30 AM. The H&amp;P stated Patient #16 had a history of anemia and required transfusion prior to admission to NIACH. The examination did not mention if the patient was bleeding from his bladder or not, but it did state "He will continue with bladder irrigation." No order for bladder irrigation was documented. "PHYSICIAN PROGRESS NOTES" included 4 entries by mid-level providers (NPs and PAs). The entries included documentation by the NP on 6/13/12 at 11:00 AM, that indicated the NP had dictated the history and physical. Another progress note by the NP, dated 6/14/12 at 1:30 PM, stated Patient #16 had anemia and ordered 2 units of red blood cells transfused the following morning. The progress note stated Patient #16 had bleeding post bladder radiation. No progress notes by a physician were documented.</p> <p>"NURSING PROGRESS NOTES" documented problems with the urinary catheter and documented it required manual irrigation to remove clots on 6/14/12 at 12:30 AM, 6:30 AM, and 11:45 AM. The progress note by the NP, dated 6/14/12 at 1:30 PM, did not mention problems with the catheter. No further progress notes by the NP, PA, or physician were</p>	A 064		

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A 064	<p>Continued From page 4 documented.</p> <p>A "NURSING PROGRESS NOTE," dated 6/14/12 at 5:00 PM, stated "call placed to [NP's name] re: [regarding] continued inability to aspirate clots, foley not draining and patient's c/o [complaint of] severe pain."</p> <p>A telephone order by the NP, dated 6/14/12 at 6:00 PM, stated to replace the urinary catheter and continue to irrigate it as needed for clots. The order stated to transfer Patient #16 to a nearby ED if there was no resolution.</p> <p>A "NURSING PROGRESS NOTE," dated 6/14/12 at 7:15 PM, stated "patient transported to [the ED], report called to [ED]." A "NURSING PROGRESS NOTE," dated 6/14/12 at 11:50 PM, stated "pt back from [the ED] via EMS transport. Foley in place draining red urine. Monitoring Foley irrigated 10 cc."</p> <p>A telephone order by the PA, dated 6/14/12 at 11:30 PM, stated to irrigate Patient #16's catheter as needed if it was not draining. The continuous irrigation was not restarted. A "NURSING PROGRESS NOTE," dated 6/15/12 at 3:00 AM, stated staff were not able to irrigate the catheter. A telephone order by the PA, dated 6/15/12 at 4:20 AM, stated to increase Patient #16's Morphine but did not mention the catheter. A telephone order by the physician, dated 6/15/12 at 5:35 AM, stated to transfer Patient #16 to a nearby hospital. A "NURSING PROGRESS NOTE," dated 6/15/12 at 5:35 AM, stated one unit of blood had been transfused and Patient #16 was being transferred to another hospital.</p>	A 064		
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A 064	<p>Continued From page 5</p> <p>Patient #16's "DISCHARGE SUMMARY," dated 7/14/12, was written by the NP. It did not recap the problems with the catheter or Patient #16's course of treatment.</p> <p>The NP was interviewed on 10/19/12 beginning at 10:30 AM. She stated she admitted Patient #16 and followed him. She stated she dictated the H&amp;P and the Discharge Summary. She reviewed the medical record and stated Patient #16 was not seen by a physician while at the hospital. She stated physicians rounded on patients on Tuesdays and either Saturdays or Sundays. She stated patients were followed by mid-level providers the rest of the time.</p> <p>Patient #16 was not under the care of a physician.</p> <p>2. The policy "Medical Staff Clinical privileges-Allied Health Practitioner," revised 5/12, stated "...Activities performed by the allied health practitioner will be performed under the supervising physician's direction." The policy stated the NP or PA "...will communicate daily with the supervising physician regarding the status of patients under that physician's care. Documentation of this communication will be evident in the medical record." The policy also said "...Admission orders and orders for discharge and/or transfer may be completed by the AAPN or PA but with evidence that the supervising physician was involved in the decisions."</p> <p>The NP was interviewed on 10/19/12 beginning at 10:30 AM. She stated there was no documentation of communication between the</p>	A 064		

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A 064	Continued From page 6 physician and the mid-level providers caring for Patient #16.  The President of the Medical Executive Committee, a physician, and the CEO were interviewed on 10/18/12 beginning at 3:35 PM. They confirmed Patient #16 was not examined by a physician during his hospital stay. They stated the nephrologists saw their patients on Tuesdays and either Saturdays or Sundays. They stated patients were followed by mid-level providers the rest of the time. They confirmed that a patient could be admitted on a Tuesday afternoon and be discharged as many as 5 days later without seeing a physician.  The hospital had not developed policies to ensure all patients were under the care of a physician.	A 064			
A 093	482.12(f)(2) EMERGENCY SERVICES  If emergency services are not provided at the hospital, the governing body must assure that the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral when appropriate.  This STANDARD is not met as evidenced by: Based on staff interview and review of facility policies and medical records, it was determined the hospital failed to ensure 1) the medical staff enforced written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients and 2) that hospital policies related to emergencies matched the expectations of hospital management and medical staff. This affected the care for 1 of 3 patients (#16) who were transferred to acute care hospitals for emergency care. The absence of direction to	A 093	The President of the Medical Staff is responsible for enforcing the Medical Staff Bylaws, Rules and Regulations, implementing sanctions when indicated, and ensuring compliance with procedural safeguards where corrective action has been warranted. The President of the Medical Staff reports to the Medical Executive Committee (MEC).  The Medical Staff Bylaws state that a hospitalized patient must be seen by the attending physician, or appropriate covering physician, and/or allied health practitioner daily. It further states that a progress note shall be written on each patient for each visit in sufficient detail to	11/21/12	

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A 093	<p>Continued From page 7</p> <p>staff created the potential for delays in emergency care or in unnecessary transfers. Findings include:</p> <p>1. Patient #16's medical record documented an 85 year old male who was initially admitted to the facility on 6/12/12 at 1:06 PM for care related to clostridium difficile colitis (a contagious infection of the colon that is typically associated with the use of antibiotics resulting in symptoms such as fever, abdominal pain and severe diarrhea.) Additional diagnoses included cancer of the prostate with recent prostatectomy (surgical removal of the prostate) and radiation therapy, mixed urinary tract infection, severe protein calorie malnutrition, urinary outlet obstruction with Foley catheter in place, CHF, CAD, hypertension, and chronic pain. He was transferred to an acute care hospital and discharged on 6/15/12.</p> <p>"ADMISSION ORDERS" for Patient #16 were signed by an NP on 6/12/12 at 3:00 PM. On 6/12/12 at 6:00 PM, the NP ordered Heparin, an anticoagulant. The "HISTORY &amp; PHYSICAL" was dictated by an NP on 6/13/12 at 12:18 PM and co-signed by the physician on 7/01/12 at 11:30 AM. The H&amp;P stated Patient #16 had a history of anemia and required transfusion prior to admission to NIACH. A progress note by the NP, dated 6/14/12 at 1:30 PM, stated Patient #16 had anemia and ordered 2 units of red blood cells transfused the following morning. The progress note stated Patient #16 had bleeding post bladder radiation. No progress notes by a physician were documented during his stay.</p> <p>"NURSING PROGRESS NOTES" documented problems with the urinary catheter and</p>	A 093	<p>allow the formulation of a reasonable picture of the patient's clinical status at the time of observation. The Medical Staff Bylaws further state that orders for ancillary and diagnostic services must include the diagnosis and other appropriate information about the patient's diagnosis, or the signs or symptoms providing the justification for the service/treatment. For treatment orders, provide explanation as appropriate.</p> <p>CEO reviewed findings with Medical Director on 11/8/2012. CEO reviewed findings with President of MEC on 11/13/2012. The MEC met on 11/15/2012 and discussed findings. On 11/16/2012, The President of MEC and the Medical Director sent a letter regarding complete documentation to allow the formulation of a reasonable picture of the patient's clinical status at the time of observation. Letter was accompanied by Policy MS 040 "Medical Staff Availability and Consultations". MEC to enforce compliance by monitoring ongoing focused professional practice evaluation for interim note documentation and acute care transfers. Data regarding compliance will be collected on 100% of patients admitted starting 11/20/12 and presented to the MEC and Governing Body (GB) quarterly for at least one quarter. If compliance is</p>	

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A 093	<p>Continued From page 8</p> <p>documented it required manual irrigation to remove clots on 6/14/12 at 12:30 AM, 6:30 AM, and 11:45 AM. The progress note by the NP, dated 6/14/12 at 1:30 PM, did not mention problems with the catheter. No further progress notes by the NP, PA, or physician were documented.</p> <p>A "NURSING PROGRESS NOTE," dated 6/14/12 at 5:00 PM, stated "call placed to [NP's name] re: [regarding] continued inability to aspirate clots, foley not draining and patient's c/o [complaint of] severe pain."</p> <p>A telephone order by the NP, dated 6/14/12 at 6:00 PM, stated to replace the urinary catheter and continue to irrigate it as needed for clots. The order stated to transfer Patient #16 to a nearby ED if there was no resolution.</p> <p>A "NURSING PROGRESS NOTE," dated 6/14/12 at 7:15 PM, stated "patient transported to [the ED], report called to [the ED]." A "NURSING PROGRESS NOTE," dated 6/14/12 at 11:50 PM, stated "pt back from [the ED] via EMS transport. Foley in place draining red urine. Monitoring Foley irrigated 10 cc."</p> <p>A telephone order by the PA, dated 6/14/12 at 11:30 PM, stated to irrigate Patient #16's catheter as needed if it was not draining. The continuous irrigation was not restarted. A "NURSING PROGRESS NOTE," dated 6/15/12 at 3:00 AM, stated staff were not able to irrigate the catheter. A telephone order by the PA, dated 6/15/12 at 4:20 AM, stated to increase Patient #16's Morphine but did not mention the catheter. A telephone order by the physician, dated 6/15/12</p>	A 093	<p>obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB. The MEC met on 11/15/2012 and approved the letter. The GB met on 11/16/2012 and approved MEC letter.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>132001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>	
NAME OF PROVIDER OR SUPPLIER  <b>NORTHERN IDAHO ADVANCED CARE HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH CECIL ROAD POST FALLS, ID 83854</b>		
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A 093	<p>Continued From page 9</p> <p>at 5:35 AM, stated to transfer Patient #16 to a nearby hospital. A "NURSING PROGRESS NOTE," dated 6/15/12 at 5:35 AM, stated one unit of blood had been transfused and Patient #16 was being transferred to another hospital.</p> <p>Documentation that Patient #16 had been examined by a practioner to determine whether he required transfer or if the hospital could effectively meet his needs, was not found in his medical record.</p> <p>The NP was interviewed on 10/19/12 beginning at 10:30 AM. She stated she admitted Patient #16 and followed him. She stated she dictated the H&amp;P and the Discharge Summary. She reviewed the medical record and stated Patient #16 was not seen by a practitioner prior to transferring him to the ED.</p> <p>The President of the Medical Executive Committee, interviewed on 10/18/12 beginning at 3:35 PM; stated Patient #16's medical record had been reviewed following discharge but the lack of assessment of the patient prior to transfer had not been identified.</p> <p>Patient #16 was not examined by a practitioner prior to transferring him to the ED.</p> <p>2. The policy "Medical Staff Availability &amp; Consultations," dated 2/06, stated "Changes in patient condition or patient need will be communicated to the physician utilizing the physician contact mechanism provided by the medical staff member. The physician will respond to calls within 30 minutes." The policy continued, "Should the patient require urgent or</p>	A 093		

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A 093	Continued From page 10 emergent assessment and treatment, the attending physician (or on call designee) will respond to the hospital within 45 minutes of the communication of the urgent/emergent patient care need." The policy allowed a practitioners to wait up to 1 hour and 15 minutes prior to presenting to the hospital to evaluate emergencies.  The President of the Medical Executive Committee and the CEO were interviewed on 10/18/12 beginning at 3:35 PM. They stated practitioners on call were expected to present to the hospital within 20 minutes to evaluate emergencies.  The hospital's policy for the emergency assessment and evaluation of patients did not match the expectations of the hospital.	A 093			
A 115	482.13 PATIENT RIGHTS  A hospital must protect and promote each patient's rights.  This CONDITION is not met as evidenced by: Based on review of medical records, observation, and staff interview, it was determined the hospital failed to ensure patients' were protected from self harm. This resulted in a patient experiencing 24 self-decannulations without aggressive intervention to prevent further incidents. This placed the health and safety of the patient in immediate jeopardy. Findings include:  1. Refer to A 144 as it relates to the facility's failure to ensure patients' right to receive care in a safe setting was upheld by protecting them from	A 115	The Director of Nursing Services (DNO) is responsible for managing nursing operations. The Clinical Compliance Specialist (CCS) is responsible for following-up on incident reports and analysis, participating in the root cause analysis, and assisting in coordinating the Quality Council (QC), Medical Executive Committee (MEC), and Governing Body (GB) committees. The Clinical Process Committee is responsible for monitoring patient restraints and decannulations.  Plan for correction included assigning a staff member to monitor a patient on a 1 to 1 basis in order to protect him from	11/21/12	

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A 115	Continued From page 11 self injury.  The cumulative effect of these negative systemic practices resulted in the inability of the hospital to keep patients safe from harm.  On Thursday 10/18/12 at 1:30 PM, the CEO was notified in person of the immediate jeopardy related to the facility's failure to ensure a patient, who repeatedly decannulated himself, was assessed and measures were taken to protect him from injury.  A plan of correction was received, reviewed, and accepted on 10/18/12 at 4:30 PM. The plan included assigning a staff member to monitor a patient on a 1 to 1 basis in order to protect him from harm. The staffing schedule was adjusted for the following week, with provisions for sick calls, etc. Education for the entire clinical staff was initiated regarding incident reporting of unplanned events, i.e., pulling out tubes, catheters, tracheostomy tubes, etc. The facility planned to provide staff inservices until all clinical staff had been educated. An interdisciplinary team meeting was held on 10/18/12 at 2:00 PM to discuss interventions to ensure the safety of the patient. A root cause analysis was initiated in order to identify ways to protect this and other patients from harm.  Implementation of the above plan was verified and the CEO was notified in person on 10/18/12 at 4:30 PM, that the immediate jeopardy was abated.	A 115	harm. The staffing schedule was adjusted for the following week, with provisions for sick calls, etc. Education for the entire clinical staff was initiated on 10/18/2012 regarding incident reporting and unplanned events, i.e., pulling out tubes, catheters, tracheostomy tubes, etc. Clinical staff education completed on 11/16/2012. The interdisciplinary team (IDT) met on 10/18/2012 to discuss interventions to ensure the patient's safety. A Root Cause Analysis (RCA) was completed on 10/18/2012. DNO educated house supervisors to document all incidents occurring on his/her shift on the house supervisor report on 11/7/2012. CCS to review the house supervisor's report daily and compare incidents reported into the incident report system. CCS to notify appropriate department managers if incident report not completed on incident noted in house supervisor report. DNO to add decannulations to the house supervisor level of care tool to monitor for number of decannulations per patient. CCS to report all decannulations to Clinical Process Committee for analysis. Trends and analysis of incident reports to be reported to QC, MEC, and GB. Data regarding compliance will be collected on 100% of patients admitted starting 11/20/12 and presented to the QC, MEC,	
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING	A 144		

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A 144	<p>Continued From page 12</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, observation, and staff interview, it was determined the hospital failed to ensure 1 of 6 patients with tracheostomy tubes (Patient #3) received care in a safe setting. The hospital failed to ensure measures were taken to prevent Patient #3 from pulling out his tracheostomy tube and Foley catheter. These failures left Patient #3 vulnerable to decannulation and placed him in immediate jeopardy of serious harm, impairment, or death. Findings include:</p> <p>Patient #3's medical record documented a 75 year old male who was admitted to the hospital on 9/05/12 with diagnoses of acute respiratory failure, myocardial infarction, post resection of laryngeal cancer, severe end-stage Parkinson's Disease, and a drug resistant lung infection. He was currently a patient as of 10/19/12. At time of admission, Patient #3 had a tracheostomy tube and a PEG tube.</p> <p>Nursing notes documented incidents where Patient #3 had decannulated (accidentally or purposely pulled out a tube) 24 times between 9/12/12 and 10/15/12. These included:</p> <p>9/12/12-Foley catheter 9/15/12-tracheostomy tube 9/16/12-tracheostomy tube 9/18/12-tracheostomy tube 9/19/12-tracheostomy tube 9/21/12-PICC 9/22/12-tracheostomy tube</p>	A 144	<p>and GB quarterly for at least one quarter. If compliance is obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB.</p> <p>Starting on 11/12/2012 during morning huddle, DNO now discusses all decannulations and other reported incidents the past 24 hours. During this morning huddle discussion, staff analyze the root cause for decannulation and discuss preventative strategies to keep the patient safe. If trends of frequent decannulations identified for a single patient, the IDT will meet and focus on preventative strategies to keep the patient from decannulating and causing harm to him/herself. Documentation of the IDT huddle will be evident in the medical record.</p>	

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A 144	<p>Continued From page 13</p> <p>9/24/12-tracheostomy tube 9/24/12-tracheostomy tube 9/26/12-tracheostomy tube 9/26/12-tracheostomy tube 9/29/12-tracheostomy tube 9/29/12-tracheostomy tube 9/29/12-tracheostomy tube 9/30/12-tracheostomy tube 10/02/12-tracheostomy tube 10/02/12-tracheostomy tube 10/03/12-tracheostomy tube 10/07/12-tracheostomy tube 10/11/12-Foley catheter 10/12/12-tracheostomy tube 10/13/12-Foley catheter 10/14/12-tracheostomy tube 10/15/12-Foley catheter</p> <p>Patient #3's "INTERDISCIPLINARY PHYSICIAN LED PLAN OF CARE," page 6, dated 10/10/12-10/16/12, stated "ALTERATION IN PULMONARY STATUS...Pt [patient] pulled out trach X2 today." The same POC, page 15, stated "ALTERATION IN SAFETY AND BEHAVIOR" instructed staff to "Supervise pt for safety while restraints off, bilateral soft wrist restraints, confused pulling at lines, up with assistance, bed alarm, call light within reach, reinforce compliance with compensatory safety strategies, side rails X2, [bilateral wrist restraints with mittens]."</p> <p>Patient #3 was observed on 10/16/12 beginning at 9:05 AM. He was alone when the surveyor and his RN entered the room. He was laying on his left side. His left wrist was restrained and he had a protective mitten on his left hand. However, the wrist was restrained with his elbow bent leaving his left hand inches from his face. He was</p>	A 144		

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A 144	<p>Continued From page 14</p> <p>observed to reach up and scratch his forehead with his mittened hand. Even with the restraint and mitten, he was able to reach and could have dislodged his tracheostomy tube. Patient #3 did not have any kind of monitor or alarm that would alert staff if he pulled his tracheostomy tube or if his oxygen level dropped.</p> <p>The CEO, the Director of Respiratory Therapy, and the Clinical Compliance Specialist were interviewed together on 10/18/12 beginning at 10:05 AM. They confirmed the number of times Patient #3 had decannulated himself. They stated the hospital could not prevent Patient #3 from pulling out his tracheostomy tube. They stated he had pulled his tracheostomy tube out when his wife was in the room and again when the physical therapist was in the room. They stated Patient #3 had not had a one to one staff member assigned to prevent him from decannulating. They stated Patient #3 was restrained with his hand close to his face for comfort. The CEO stated she had observed Patient #3 without mittens two times on 10/17/12.</p> <p>Patient #3's physician was interviewed on 10/18/12 beginning at 10:25 AM. He stated Patient #3 required the tracheostomy tube. He stated Patient #3 had consistently shown acute respiratory failure without the airway (tracheostomy tube) present. He also stated Patient #3's surgeon was very adamant that the tracheostomy tube remain in place.</p> <p>The hospital had not taken steps to prevent Patient #3 from decannulating himself. This placed Patient #3's health and safety at risk of serious harm or death from respiratory failure if</p>	A 144		

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A 144 A 286	<p>Continued From page 15 the decannulation events continued.</p> <p>482.21(a), (c)(2), (e) PATIENT SAFETY</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on review of medical records and incident reports and staff interview, it was determined the facility failed to track and analyze adverse patient events for 2 of 2 current patients (#3 and #6) who were identified to have experienced self-decannulations. Failure to track and analyze adverse events impeded the facility's ability to</p>	A 144 A 286	<p>The Director of Nursing Services (DNO) is responsible for managing nursing operations. The Clinical Compliance Specialist (CCS) is responsible for following-up on incident reports and analysis, participating in the root cause analysis, and assisting in coordinating the Quality Council, Medical Executive Committee, and Governing Body committees. The Clinical Process Committee is responsible for monitoring patient restraints and decannulations.</p> <p>Education for the entire clinical staff was initiated on 10/18/2012 regarding incident reporting and unplanned events, i.e., pulling out tubes, catheters, tracheostomy tubes, etc. Clinical staff education completed on 11/16/2012. DNO to educate house supervisors to document all incidents occurring on his/her shift on the house supervisor report. CCS to review the house supervisor's report daily and compare incidents reported into the incident report system. CCS to notify appropriate department managers if incident report not completed on incident noted in house supervisor report. DNO to add decannulations to the house supervisor level of care tool to monitor for number</p>	11/21/12

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A 286	<p>Continued From page 16 improve patient care and safety. Findings include:</p> <p>1. The facility failed to track adverse events as follows:</p> <p>a. Patient #3's medical record documented a 75 year old male who was admitted to the hospital on 9/05/12 with diagnoses of acute respiratory failure, myocardial infarction, post resection of laryngeal cancer, severe end-stage Parkinson's Disease, and a drug resistant lung infection. He was currently a patient as of 10/19/12.</p> <p>Nursing notes documented incidents where Patient #3 had self-decannulated 24 times between 9/12/12 and 10/15/12. These included:</p> <p>9/12/12-Foley catheter 9/15/12-tracheostomy tube 9/16/12-tracheostomy tube 9/18/12-tracheostomy tube 9/19/12-tracheostomy tube 9/21/12-PICC 9/22/12-tracheostomy tube 9/24/12-tracheostomy tube 9/24/12-tracheostomy tube 9/26/12-tracheostomy tube 9/26/12-tracheostomy tube 9/29/12-tracheostomy tube 9/29/12-tracheostomy tube 9/29/12-tracheostomy tube 9/30/12-tracheostomy tube 10/02/12-tracheostomy tube 10/02/12-tracheostomy tube 10/03/12-tracheostomy tube 10/07/12-tracheostomy tube 10/11/12-Foley catheter</p>	A 286	<p>of decannulations per patient. CCS to report all decannulations to Clinical Process Committee for analysis. Trends and analysis of incident reports to be reported to Quality Council, Medical Executive Committee, and Governing Body.</p>	

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A 286	<p>Continued From page 17</p> <p>10/12/12-tracheostomy tube 10/13/12-Foley catheter 10/14/12-tracheostomy tube 10/15/12-Foley catheter</p> <p>Only 8 incident reports were documented that noted Patient #3 had decannulated. These included:</p> <p>9/21/12-PICC 9/24/12-tracheostomy tube 9/24/12-tracheostomy tube 10/02/12-tracheostomy tube 10/03/12-PEG tube 10/03/12-tracheostomy tube 10/04/12-tracheostomy tube 10/13/12-Foley catheter</p> <p>The Clinical Compliance Specialist was interviewed on 10/17/12 beginning at 3:35 PM. She stated she collected and compiled incident reports at the hospital. When asked why incident reports were not completed for all episodes of decannulation for Patient #3, she stated nurses did not always complete incident reports when patients decannulated.</p> <p>b. Patient #6's medical record documented a 67 year old male who was admitted to the hospital on 10/01/12 with diagnoses of respiratory failure and renal failure. He was currently a patient as of 10/19/12.</p> <p>Nursing notes documented incidents where Patient #6 had decannulated 2 times. These included:</p> <p>10/13/12-keofeed tube (a small feeding tube,</p>	A 286		

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A 286	<p>Continued From page 18</p> <p>weighted at the end, inserted via the nostril through the stomach, and may be advanced into the small intestine) 10/14/12-PICC</p> <p>No incident reports were documented that Patient #6 had decannulated.</p> <p>The Clinical Compliance Specialist was interviewed on 10/17/12 beginning at 3:35 PM. She stated no incident reports had been completed documenting decannulation events for Patient #6. She stated incident reports were tracked and trended through the QAPI program. She acknowledged the numbers of decannulations for the QAPI program were not accurate.</p> <p>The facility failed to accurately track adverse patient events.</p> <p>2. The facility failed to ensure adverse events were analyzed as follows:</p> <p>a. Only 8 incident reports were documented that noted Patient #3 had decannulated. These included:</p> <p>9/21/12-PICC 9/24/12-tracheostomy tube 9/24/12-tracheostomy tube 10/02/12-tracheostomy tube 10/03/12-PEG tube 10/03/12-tracheostomy tube 10/04/12-tracheostomy tube 10/13/12-Foley catheter</p> <p>The incident reports were reviewed and</p>	A 286		

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A 286	<p>Continued From page 19</p> <p>documented the following related to analysis and implementation of steps to prevent further decannulations:</p> <p>i. On 9/24/12 at 8:15 PM, the author of the incident report documented that Patient #3 was unrestrained at the time of decannulation and restraints were applied to "prevent him from decannulating himself again."</p> <p>ii. On 9/24/12 at 9:50 PM, the author of the incident report documented initiation of mitten to Patient #3's hands in addition to wrist restraints to "keep him from pulling out his trach again." The DON documented on the form, on 9/25/12, that Patient #3 was placed in a chair as a diversionary tactic.</p> <p>iii. On 10/02/12 the Director of Respiratory Therapy reviewed the incident and evaluated the size of tracheostomy tube in place and the mechanism by which it was easily removed when Patient #3 lifted his chin. There was documentation of discussion with the physician and a change in the tracheostomy tube was initiated.</p> <p>iv. In response to the tracheostomy decannulation on 10/03/12, the Director of Respiratory Therapy documented, on 10/04/12, "Will let staff know to keep an eye out for this and help to prevent decannulations."</p> <p>The incident reports did not include documentation the medical record was reviewed for the events surrounding each decannulation, such as ensuring staff were checking in on Patient #3 frequently or that reasons for potential</p>	A 286		

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PRINTED: 11/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>132001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NORTHERN IDAHO ADVANCED CARE HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>600 NORTH CECIL ROAD POST FALLS, ID 83854</b>
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A 286 Continued From page 20  
agitation (such as pain, positioning, toileting, etc.) had been addressed. There was no indication that staff were routinely interviewed to determine that restraints or the mittens were applied appropriately.

The CEO, the Director of Respiratory Therapy, and the Clinical Compliance Specialist were interviewed together on 10/18/12 beginning at 10:05 AM. They confirmed the number of times Patient #3 had decannulated himself. They stated the hospital could not prevent Patient #3 from pulling out his tracheostomy tube. They stated he had pulled his tracheostomy tube out when his wife was in the room and again when the physical therapist was in the room. They stated Patient #3 had not had a one to one staff member assigned to prevent him from decannulating. They explained that several interventions had been implemented to deter him from decannulating, such as placing him close to the nursing station for improved observation, involving him in therapy activities, and attempting to wean him from the need of the tracheostomy tube and Foley catheter.

The Clinical Compliance Specialist was interviewed on 10/19/12 at 11:15 AM. She confirmed that components of an investigation of adverse events were not thoroughly documented, and were not routinely completed in order to implement preventative actions to keep patients safe.

The facility failed to ensure decannulations were tracked and analyzed.

A 286

A 406 482.23(c)(2) WRITTEN MEDICAL ORDERS FOR DRUGS

A 406 The Director of Nursing Services (DNO) is responsible for managing nursing

11/21/12

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A 406	<p>Continued From page 21</p> <p>With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under §482.12(c).</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on review of medical records and facility policies and staff interview it was determined the facility failed to ensure wound care orders were signed by a physician for 3 of 11 patients with orders written by the wound care nurse (#2, #5 and #17) whose records were reviewed. This failure resulted in implementation of medications for wound care without a physician order. Findings include:</p> <ol style="list-style-type: none"> <li>1. Patient #2 was a 63 year old male admitted to the facility on 10/11/12 for treatment of chronic respiratory failure and pneumonia. The wound care nurse examined Patient #2 and recommended "Miconazole powder to perianal and scrotal skin twice a day and as needed after stools. Calazine barrier cream to perianal skin after powder." The recommendations were written on a "PHYSICIAN'S ORDERS" form and dated 10/11/12 at 3:20 PM. The recommendations were not signed by a physician. The recommendations were noted by the RN on 10/11/12 at 4:30 PM. The Unit Clerk indicated the order was processed on 10/11/12 at 3:25 PM. Patient #2's medication administration</li> </ol>	A 406	<p>operations. The DNO reports to the Clinical Process Committee.</p> <p>Policy PC 195 "Physician Orders" states that physician orders are required for the treatment and care of patients. CEO reviewed findings with Medical Director on 11/8/2012. CEO reviewed findings with President of MEC on 11/13/2012. The MEC met on 11/15/2012 and discussed findings and provided a letter to Medical Staff on the process for order authentication per policy PC 195. Education provided to nursing staff and wound care nurse on verbal/telephone orders to contain the name of the person giving the order and the first initial and last name of the professional designation of the health care practitioner receiving the order. Education will also include clarification of the order prior to initiating the order if received incorrectly. DNO to monitor physicians' orders for completeness and report trends to Clinical Process Committee, Quality Council, Medical Executive Committee, and Governing Body. Physician authentication of orders will be tracked through HIM and reported into MEC and GB quarterly. Data regarding compliance will be collected on 100% of patients admitted starting 11/20/12 and presented to the QC, MEC, and GB quarterly for at least one quarter. If</p>	

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A 406	<p>Continued From page 22</p> <p>record indicated the order for Miconazole powder was added to his medication list on 10/11/12 at 4:00 PM.</p> <p>The DRG Coordinator was interviewed on 10/18/12 at 2:35 PM. She reviewed Patient #2's medical record and confirmed the wound care order should have been cosigned by the physician prior to implementation.</p> <p>The facility failed to ensure wound care orders were signed by a physician.</p> <p>2. Patient #17 was a 62 year old female admitted to the facility on 8/01/12, 8/14/12 and 8/21/12 for treatment related to an infected hernia repair and renal failure. The wound care nurse completed an examination of Patient #17 and entered the following recommendations on the "PHYSICIAN'S ORDERS:"</p> <p>a. 8/07/12 at 7:20 AM: "Skin/Wound Care Recommendation: 1. Please change silvadene order to BID to buttock and ischial [lower back portion of the hip] wound q shift after cleansing [with] NS gauze. Use minimal amount to cover wound beds. Place Interdry Ag+ over sites. No tape. 2. Turn patient q 2 hours. 3. Stat 3 low air loss mattress. 4. Xenaderm to L abdominal wound [with] VAC dressing (change) MWF. Cover [with] foam dressing [after] 3M No Sting Spray to peri wound skin."</p> <p>b. 8/07/12 at 10:00 AM: "Skin/Wound Care Recommendation: 1. Xenaderm to R back lesion daily after gently cleansing. Skin prep to peri wound skin gauze drsg [dressing] [with] minimal tape to secure."</p>	A 406	<p>compliance is obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB.</p>	

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A 406	<p>Continued From page 23</p> <p>c. 8/08/12 at 3:45 PM: "Skin/Wound Care Recommendation: 1. Change dressing on L abdomen daily instead of MWF. DC foam dressing. Apply Xenoderm then cover [with] Interdry Ag+."</p> <p>d. 8/27/12 at 12:45 PM: "Skin/Wound Care Recommendation: 1. Bacitracin ointment to old L picc site and RUE lesion daily [after] cleansing [with] NS."</p> <p>e. 9/03/12 at 3:30 PM: "Skin/Wound Care Recommendation: 1. DC Hydrocolloid dressings to buttocks &amp; ischials [lower, back part of pelvis], Begin Xeroform gauze to open lesions, 3M No Sting Spray to peri wound skin then cover [with] non bordered Optifoam. Minimal Medipore tape to secure. Change Optifoam daily and Xeroform every other day if it is intact."</p> <p>f. 9/11/12 at 10:30 AM: "Skin/Wound Care Recommendation: 1. DC foam dressings to ischial &amp; buttock wounds. Begin Stoma powder, 3M No Sting Spray then Calazine barrier cream q shift and PRN. 2. Continue to turn patient q 2 hours. 3. Begin white foam to undermined areas at 3:00 and 9:00 on abdominal wound."</p> <p>g. 9/15/12 at 10:25 AM: "Skin/Wound Care Recommendation: 1. Do not send VAC [with] patient to [name of transfer facility] on Monday. Clamp tubing [with] a glove on the end of the tubing. DC VAC."</p> <p>The wound care recommendations were noted by an RN for each entry by the wound care nurse, but the recommendations were not signed by a</p>	A 406		
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A 406	<p>Continued From page 24 physician.</p> <p>During an interview on 10/18/12 beginning at 3:40 PM, the Clinical Compliance Specialist reviewed Patient #17's medical record and confirmed the wound care recommendations were not signed by a physician. She stated they were considered to be orders and should have been cosigned by the physician prior to implementation.</p> <p>The facility failed to ensure wound care orders were signed by a physician.</p> <p>3. Patient #5 was a 57 year old male admitted to the facility on 10/08/12 for treatment related to respiratory failure and paraplegia resulting from a motor vehicle accident. The wound care nurse completed an examination of Patient #5 and entered the following recommendations on the "PHYSICIAN'S ORDERS," dated 10/12/12 at 12:45 PM: "Skin/Wound Care Recommendations: 1. Please change gauze and ABD dressing to posterior neck incision q shift and PRN."</p> <p>The wound care recommendations were noted by an RN 10/12/12 at 3:30 PM. The recommendations were not signed by a physician.</p> <p>During an interview on 10/19/12 beginning at 10:12 AM, the DRG Coordinator reviewed Patient #5's medical record and confirmed the wound care recommendations were not signed by a physician. She stated they were considered to be orders and should have been cosigned by the physician prior to implementation.</p> <p>The facility's policy titled, "Medication</p>	A 406		

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A 406	Continued From page 25 Administration," revised 8/12, was reviewed. According to the policy, medication orders must include the physician's signature.	A 406		
A 466	The facility failed to ensure wound care orders were signed by a physician.  482.24(c)(2)(v) CONTENT OF RECORD - INFORMED CONSENT  [All records must document the following, as appropriate:] Properly executed informed consent forms for procedures and treatments specified by the medical staff, or by Federal or State law if applicable, to require written patient consent.  This STANDARD is not met as evidenced by:  Based on record review, staff interview and review of policies, it was determined the facility failed to obtain patient or POA consent for treatments and transfers to another facility for 3 of 20 (#4, #11 and #18) patients whose records were reviewed. The failure to obtain patient or patient designee consent before the transfer or treatment was provided had the potential for procedures or transfers to occur without the patients' or designees' approval. Findings include:  A policy, "Informed Consent," revised 02/2012, stated: "A general authorization and consent, such as that obtained at the time of admission is sufficient under those circumstances in which the proposed treatment or examination and its inherent risks and hazards are commonly known." The policy also stated: "In all other instances, a procedure specific consent should be obtained and documented." The policy	A 466	The Director of Nursing Services (DNO) is responsible for managing nursing operations. The DNO reports to the Clinical Process Committee.  Education provided to nurses and respiratory therapists on proper completion of consents for invasive procedures, blood product administration, and transfers per policy PR 070 "Informed Consent". DNO to monitor consents for transfers, blood product administration, and invasive procedures for appropriate completion. DNO to report trends and analysis to Clinical Process Committee, Quality Council, Medical Executive Committee, and Governing Body. Data regarding compliance will be collected on 100% of patients admitted starting 11/20/12 and presented to the QC, MEC, and GB quarterly for at least one quarter. If compliance is obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB.	11/21/12

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A 466	<p>Continued From page 26</p> <p>included such procedures as venous access catheter insertion and blood administration, as examples of procedures needing specific consents. The policy also stated the consent form should be completed by a professional hospital staff member with the content of the discussion documented in detail in the medical record. In the case of an incapacitated patient, the consent would be given by a guardian, or person designated in writing to make decisions for the patient. The patient's reason for incapacity should be listed in the appropriate section.</p> <p>A policy, "Transfer of Patients," revised 08/12, stated: "The patient will be informed of the risks and benefits of any transfer. The patient's physician/LIP will provide this information and will document this informed consent. The patient will be asked to sign a document indicating his/her understanding."</p> <p>1. Patients were transferred to facilities without completed consents. Examples include:</p> <p>a. Patient #11 was a 26 year old female, admitted to the facility on 9/11/12 for care related to respiratory failure and injuries from a motor vehicle accident. Patient #11 was transferred to an acute care hospital on 9/19/12 for a surgical procedure. A "TRANSFER FORM," dated 9/19/12 contained a statement "The above risks and benefits indicated above have been explained to me and I understand my right to refuse transfer and/or tests." The statement was followed with a line under which was "Signature Patient/Representative and Date." There was no signature or date.</p>	A 466		

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A 466	<p>Continued From page 27</p> <p>Patient #11 was transferred to an acute care hospital for a surgical procedure on 9/28/12. A "TRANSFER FORM," signed by the physician and dated 9/27/12, contained a statement "The above risks and benefits indicated above have been explained to me and I understand my right to refuse transfer and/or tests." The statement was followed with a line under which was "Signature Patient/Representative and Date." There was no signature or date.</p> <p>During an interview on 10/18/12 beginning at 4:40 PM, the DRG Coordinator reviewed Patient #11's medical record and confirmed the transfer form was not signed by the patient.</p> <p>Twice Patient #11 was transferred to another facility without his written consent.</p> <p>b. Patient #4 was a 66 year old male, admitted to the facility on 9/12/12 for care related to respiratory failure. Patient #4 was transferred to an acute care hospital for a CT scan. A "TRANSFER FORM," signed as a verbal order by an RN and dated 10/12/12, contained a statement "The above risks and benefits indicated above have been explained to me and I understand my right to refuse transfer and/or tests." The statement was followed with a line under which was "Signature Patient/Representative and Date." There was no signature or date.</p> <p>During an interview on 10/19/12 beginning at 9:35 AM, the DRG Coordinator reviewed Patient #4's medical record and confirmed the transfer form was not signed by the patient.</p>	A 466		

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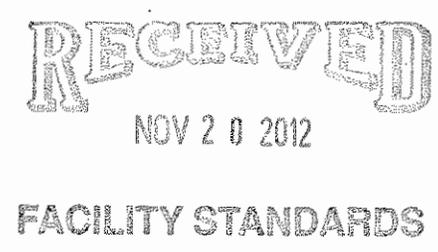
A 466	<p>Continued From page 28</p> <p>Patient #4 was transferred to another facility without his written consent.</p> <p>2. A blood transfusion was initiated without a properly executed consent:</p> <p>a. Patient #18 was a 74 year old male admitted to the facility on 10/13/12 for care related to respiratory failure and heart disease. Patient #18 had a tracheostomy, was on a ventilator and was non-verbal. The general admission consent had been signed by Patient #18's wife on the day of admission. A consent for blood transfusion dated 10/15/12, at 10:45 AM, contained a physician's signature at 10:30 AM, and two RN's signatures. The "Patient Signature" section was blank, the "Authorized Representative" section contained the written statement "verbal consent" and the "Relationship to Patient" section was blank. The consent did not indicate who had given a verbal consent. The progress notes for 10/15/12, as well as the nursing notes, were reviewed and there was no documentation of discussion of the need for administration of blood with Patient #18 or his wife. A "NURSING PROGRESS NOTE," dated 10/15/12, at 12:00 PM, described Patient #18 as confused with his legs out of bed, and the bed alarm was activated.</p> <p>During an interview on 10/18/12 at 2:45 PM, the RN providing care to Patient #18 reviewed his medical record. The RN stated she had not provided care for Patient #18 on 10/15/12, and was not sure who the consent had been obtained from. She confirmed there was no documentation in the nursing notes to validate who the consent had been discussed with.</p>	A 466		
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A 466	Continued From page 29  The facility did not ensure patient consents were fully executed before procedures and transfers occurred.	A 466		

Bureau of Facility Standards

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B 000	16.03.14 Initial Comments  The following deficiencies were cited during the state licensure survey of your hospital. Surveyors conducting the review were:  Susan Costa, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Gary Guiles, RN, HFS Libby Doane, RN, HFS  Acronyms used in this report include:  P&T = Pharmacy and Therapeutics	B 000			
BB124	16.03.14.200.10 Quality Assurance  10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88)  This Rule is not met as evidenced by: Refer to A 286 as it relates to the hospital's failure to ensure the Quality Assurance program fully identify internal systematic problems.	BB124		The Director of Nursing Services (DNO) is responsible for managing nursing operations. The Clinical Compliance Specialist (CCS) is responsible for following-up on incident reports and analysis, participating in the root cause analysis, and assisting in coordinating the Quality Council, Medical Executive Committee, and Governing Body committees. The Clinical Process Committee is responsible for monitoring patient restraints and decannulations.  Continued on Continuation page A	11/21/12
BB152	16.03.14.250.09 Medical Orders  09. Medical Orders. Written, verbal and telephone orders from persons authorized to give medical orders under Idaho law shall be accepted by those health care practitioners empowered to do so under Idaho law and written hospital policies and procedures. Verbal and telephone orders shall contain the name of the person	BB152		The Director of Nursing Services (DNO) is responsible for managing nursing operations. The DNO reports to the Clinical Process Committee.  Policy PC 195 "Physician Orders" states that physician orders are required for the	11/21/12

Bureau of Facility Standards

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

*Maria Jolly*

TITLE  
*CEO*

(X6) DATE  
11/19/12

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  132001	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/19/2012
NAME OF PROVIDER OR SUPPLIER  NORTHERN IDAHO ADVANCED CARE HOSPIT.		STREET ADDRESS, CITY, STATE, ZIP CODE 600 NORTH CECIL ROAD POST FALLS, ID 83854		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB152	Continued From page 1  giving the order, the first initial and last name and professional designation of the health care practitioners receiving the order. The order(s) shall be promptly signed or otherwise authenticated by the prescribing practitioner in a timely manner in accordance with the hospital's policy. (5-3-03)  This Rule is not met as evidenced by: Refer to A 406 as it relates to the failure of the facility to ensure wound care orders were signed by a physician before implementation.	BB152	Continued from page 1  treatment and care of patients. CEO reviewed findings with Medical Director on 11/8/2012. CEO reviewed findings with President of MEC on 11/13/2012. The MEC met on 11/15/2012 and discussed findings and provided a letter to Medical Staff on the process for order authentication per policy PC 195.  Continued on Continuation page B	
BB223	16.03.14.330.03 Scope of Services  03. Scope of Services. (10-14-88)  a. The scope of pharmaceutical service shall be consistent with the needs of the patients and include a program for the control and accountability of drug products throughout the hospital. A pharmacy and therapeutics committee or its equivalent composed of members of the medical staff, the director of pharmaceutical services, the director of nursing services, hospital administration and other health disciplines as necessary, shall develop written policies and procedures for drug selection, preparation, dispensing, distribution, administration, control, and safe and effective use. Refer to Subsections 250.03 and 250.04. (12-31-91)  This Rule is not met as evidenced by: Based on staff interview and review of P&T committee meeting minutes, it was determined the hospital failed to ensure the medical staff participated in P&T Committee meetings to oversee pharmacy services at the hospital. This lack of participation by the medical staff had the potential to negatively impact pharmacy services	BB223	The Governing Body maintains overall responsibility for the implementation and maintenance of the Performance Improvement Plan with the daily responsibility for implementation afforded to the administrator. Policy HP 030, "Performance Improvement Plan", states members of the Pharmacy & Therapeutics (P&T)/Infection Control Committee include: physician, pharmacy, infection control practitioner, nursing, quality/risk manager, and clinical services. On 11/15/2012, the P&T committee met and reviewed the standing agenda. Attendees included the Director of Pharmacy, CEO, Director of Plant Operations, DNO, Clinical Compliance Specialist, the President of Medical Executive Committee (MEC) and the Medical Director. Future compliance to include having a physician at each P&T	11/15/12

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BB223	<p>Continued From page 2 at the hospital. Findings include:</p> <p>Minutes from the "Pharmacy and Therapeutics/Infection Control" committee meetings were reviewed. Four meetings were documented between October 10/01/11 and 10/17/12. These occurred on 10/27/11, 1/19/12, 4/12/12, and 7/24/12.</p> <p>The only P&amp;T meeting that documented medical staff involvement and oversight occurred on 10/27/11. Minutes documented the Medical Director attended this meeting and participated in the committee's oversight of the service. No documentation of involvement by the medical staff was documented following the 10/27/11 meeting.</p> <p>The Director of Pharmacy Services confirmed no member of the medical staff had participated in the P&amp;T Committee since 11/11.</p> <p>Medical staff did not participate in the P&amp;T Committee.</p>	BB223	Continued from page 2 committee meeting. The MEC and Governing Body will monitor the compliance through review of attendance at these meetings during quarter reports from the P&T Committee. The Medical Director and/or the President of the MEC will attend all future P&T Committee meetings. The next P&T committee meeting is scheduled in January 2013.	

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		BB124	Continued from page 1 Education for the entire clinical staff was initiated on 10/18/2012 regarding incident reporting and unplanned events, i.e., pulling out tubes, catheters, tracheostomy tubes, etc. Clinical staff education completed on 11/16/2012. DNO to educate house supervisors to document all incidents occurring on his/her shift on the house supervisor report. CCS to review the house supervisor's report daily and compare incidents reported into the incident report system. CCS to notify appropriate department managers if incident report not completed on incident noted in house supervisor report. DNO to add decannulations to the house supervisor level of care tool to monitor for number of decannulations per patient. CCS to report all decannulations to Clinical Process Committee for analysis. Trends and analysis of incident reports to be reported to Quality Council, Medical Executive Committee, and Governing Body.	

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		BB152	Continued from page 2 Education provided to nursing staff and wound care nurse on verbal/telephone orders to contain the name of the person giving the order and the first initial and last name of the professional designation of the health care practitioner receiving the order. Education will also include clarification of the order prior to initiating the order if received incorrectly. DNO to monitor physicians' orders for completeness and report trends to Clinical Process Committee, Quality Council, Medical Executive Committee, and Governing Body. Physician authentication of orders will be tracked through HIM and reported into MEC and GB quarterly. Data regarding compliance will be collected on 100% of patients admitted starting 11/20/12 and presented to the QC, MEC, and GB quarterly for at least one quarter. If compliance is obtained during this quarter, data will be collected regarding compliance may be reduced as directed by MEC and GB.	