



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 208-334-6628  
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**CERTIFIED MAIL: 7000 3020 0001 4038 9857**

June 13, 2014

Rod Jacobson, Administrator  
Bear Lake Memorial Hospital  
164 South Fifth Street  
Montpelier, ID 83254

**RECEIVED**

**JUL - 7 2014**

**FACILITY STANDARDS**

**RE: Bear Lake Memorial Hospital, Provider #131316**

Dear Mr. Jacobson:

Based on the survey completed at Bear Lake Memorial Hospital, on May 29, 2014, by our staff, we have determined Bear Lake 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 deficiency, which caused this condition to be unmet, substantially limit the capacity of Bear Lake Memorial Hospital, to furnish services of an adequate level or quality. The deficiency is 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 the deficiency which led to the finding of non-compliance with the Condition 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 for each deficiency cited;

Rod Jacobson, Administrator

June 13, 2014

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- 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 July 13, 2014. 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 July 2, 2014.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **June 26, 2014.**

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/pmt

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

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2014
NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83264	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS  The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were:  Don Sylvester, R.N., H.F.S., Team Leader Gary Guiles, R.N., H.F.S.  Acronyms used in this report include:  ACL- Anterior Cruciate Ligament ADON- Assistant Director of Nursing CAH - Critical Access Hospital CRNA- Certified Registered Nurse Anesthetist D - dextrose DON- Director of Nursing IV - intravenous line NICU - Neonatal Intensive Care Unit OR- Operating Room POC - plan of care RN- Registered Nurse RH- Relative Humidity	C 000		
C 226	485.623(b)(5) MAINTENANCE  [The CAH has housekeeping and preventive programs to ensure that-  there is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.  This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure OR humidity was documented. This directly impacted	C 226	RECEIVED  JUL - 7 2014  FACILITY STANDARDS  The alleged deficiency C 226 regarding documentation of OR humidity will be corrected by the following actions:  1) A humidity monitoring device was installed in our operating rooms. The device will track humidity in 5 minute increments and will notify staff if/when the humidity level falls outside the pre-set parameters programmed into the device. Accommodations will be made to regulate the humidity in the OR if it goes above 60% or below 20% during procedures.  Cont.	

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

TITLE

(X6) DATE

*[Signature]*

*Admin*

7-2-14

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 226	Continued From page 1 1 of 1 patient (#27) who was observed in the OR, and had the potential to impact all patients receiving surgery at the facility. The failure to manage the humidity resulted in the potential for patient health and safety to be compromised. Findings include:  1. The American Society for Heating, Refrigerating, and Air Conditioning Engineers (ASHRAE) Standard 170, Ventilation of Health Care Facilities, Addendum D requires RH in ORs to be maintained between 20 and 80 percent. In addition, this ASHRAE standard has been incorporated into the Facility Guidelines Institute 2010 Guidelines for Design and Construction of Health Care Facilities, and has been approved by the American Society for Healthcare Engineering of the American Hospital Association and the American National Standards Institute.  During a tracing of Patient #27 through the OR on 5/21/14, beginning at 10:30 AM, the surveyor asked the circulating nurse for humidity tracking logs. She stated the facility did not monitor OR humidity.  The Director of Maintenance was interviewed on 5/21/14 at 11:00 AM, and stated, he did not monitor and record humidity in the OR.  The facility failed to monitor and record humidity levels in the OR.	C 226	Cont.  The above action will correct the deficiency by first giving us the needed relative humidity information. Secondly, humidifiers and/or dehumidifiers will be used if/when necessary to maintain desired humidity levels.  The completion date was July 1, 2014.  Rod Jacobson, Administrator, and Carson Price, Maintenance Supervisor, will be responsible for implementing this plan and tracking compliance.  The deficiency C227 regarding emergency procedures will be corrected by the following actions:  1) The fire alarm policy was reviewed and updated. See addendum # 2.  2) All nursing staff was educated and trained on the fire alarm policy during an In-Service and Education training on June 26, 2014. Training included the plan for reporting alarms to all departments affected. The plan addresses communication with other departments when the alarm sounds. Nursing staff will sign an acknowledgement of the policy.  3) Safety meeting was held on June 25, 2014 and the updated policy and plans were reviewed.		
C 227	485.623(c)(1) EMERGENCY PROCEDURES  The CAH assures the safety of patients in non-medical emergencies by-  training staff in handling emergencies, including	C 227	Cont.		

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C 227	<p>Continued From page 2</p> <p>prompt reporting of fires, extinguishing of fires, protection and, where necessary, evacuation of patients, personnel, and guests, and cooperation with fire fighting and disaster authorities;</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of CAH safety meeting minutes, it was determined the CAH failed to ensure the staff responded to emergencies including prompt reporting of fires and the evacuation of patients, personnel, and guests. This had the potential to result in the delayed evacuation of persons in response to fire. Findings include:</p> <p>A dialysis unit was located in the basement of the CAH below the surgery department. Minutes from the CAH's "SAFETY MEETING," dated 1/29/14, stated "Dialysis had a patient late at night; the fire alarm went off during the treatment. When they called the nurses station to find out if they knew where the fire alarm was going off from they were told they do not have time for that."</p> <p>The Maintenance Director was interviewed on 5/22/14 beginning at 11:00 AM. He stated he was aware of the incident. He stated a fire alarm had sounded. He said a faulty smoke detector had triggered the alarm. He stated he was responsible to maintain the fire alarm system and said he had to come to the CAH to turn off the alarm. He stated the smoke detector had been replaced. He stated he was not aware of any investigation of the incident. He stated he did not have documentation whether the situation had been resolved. He stated he was not aware that any action had been taken to ensure all persons</p>	C 227	<p>Cont.</p> <p>4) All departments will be given a copy of the fire alarm policy per email after safety meeting has reviewed and medical staff approved.</p> <p>5) Dialysis department has reviewed and updated the policy for conducting dialysis treatments, including staff required and notification of after hour's scheduled dialysis treatments to acute care charge nurse. See Addendum #1</p> <p>The above actions will correct this deficiency by providing education on proper identification of alarm and reporting of alarms to appropriate departments.</p> <p>The completion date was July 1, 2014.</p> <p>The monitoring and tracking to ensure effectiveness will include the fire alarm policy will be reviewed and updated as needed. Fire drills will be scheduled and conducted quarterly with a review following the drill. Reviews will be used to further educate staff and improve drill response. Education will be conducted and reviewed annually. Dialysis dept. will review fire alarm policy including incorporating communications with nursing staff for alarm location.</p> <p>Brandi Froehlich RN, ICO, Risk Management and Megan Green RN cont.</p>	

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C 227	Continued From page 3 would be notified in the event of an emergency and needed to evacuate the building.	C 227	Cont. Dialysis Manager will be responsible for the action plan.	
C 270	485.635 PROVISION OF SERVICES  Provision of Services  This CONDITION is not met as evidenced by: Based on staff interview and review of medical records and CAH policies, it was determined the CAH failed to ensure 1) policies had been developed to direct medical and nursing staff in the provision of care to patients and 2) POCs addressed the medical needs of neonates. These failures resulted in a lack of direction to staff. Findings include:  1. Refer to C-275 as it relates to the failure of the CAH to ensure a policy had been developed that outlined guidelines for the medical management of health problems that included the conditions requiring medical consultation and/or patient referral.  2. Refer to C-278 as it relates to the failure of the CAH to ensure procedures were implemented to avoid the transmission of infections and communicable diseases.  3. Refer to C-298 as it relates to the failure of the CAH to ensure POCs addressed the medical needs of neonates.  The cumulative effect of these systemic	C 270	The alleged deficiency C 275 regarding a lack of guidelines for the medical management of health problems with regard to obtaining a medical consult for the referral will be corrected by the following policies:  "Consultations by qualified practitioners who are members of the Medical Staff should be considered for patients who have or develop conditions that may be beyond the approved privileges of the attending practitioner. The attending physician is primarily responsible for requesting a consultation when indicated. However, a consultation may be requested by the chairman of a patient care committee or the chief of staff if such a consultation is determined to be necessary to benefit the patient.  The patient's physician is responsible for requesting consultants when indicated. However, in those instances where appropriateness of care is questioned by the Nursing Supervisor, Allied Health Professional, or other Medical Staff member, the following procedure may be followed: Cont.	

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C 270	Continued From page 4	C 270	Cont.		
C 275	omissions resulted in an increased risk of complications to patients. 485.635(a)(3)(iii) PATIENT CARE POLICIES  [The policies include the following:]  guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or patient referral, the maintenance of health care records, and procedures for the periodic review and evaluation of the services furnished by the CAH.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and CAH policies, it was determined the CAH failed to ensure a policy had been developed that outlined guidelines for the medical management of health problems that included the conditions requiring medical consultation and/or patient referral. This affected the care of 1 of 3 neonates (#4), whose records were reviewed, and had the potential to affect all patients. The lack of a policy had the potential to result in the delay of practitioners seeking advice and guidance for the treatment of patients with complex medical conditions. Findings include:  1. Patient #4's medical record documented a preterm newborn male who was born via caesarean section at the CAH at 1:12 PM on 2/19/14. His gestational age was 36 weeks and 3 days. He was transferred by helicopter to another hospital on 2/22/14 at 12:00 noon. A physician "Progress note," dated 2/21/14 at 7:33 AM, stated Patient #4 was "...born without a heartbeat with	C 275	1. Contact the attending physician to discuss concerns. 2. If the situation is not resolved, then the appropriate Patient Care Committee Chairman or the Chief of Staff may be requested to review the medical record to determine that the standard of care is being met. (If the Chief of Staff is the primary physician, a member of the Medical Executive Committee will be requested to act in his/her place).  After the medical record is reviewed, the Patient Care Committee Chairman or Chief of Staff (or member of the Medical Executive Committee if the Chairman is the primary physician) may require the Attending Physician to obtain a consultation. The Consultant selected must be considered appropriate by the Committee Chairman or Chief of Staff, or the Medical Executive Committee.  See Addendum: Acute Care See Addendum: Emergency Department See Addendum: OB/Nursery See Addendum: Surgery  Cont.		

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G 275	<p>Continued From page 5</p> <p>Apgars of 0, 6 and 7 at 0, 5, and 10 minutes." The scores indicated the baby did not have a pulse and was not breathing at birth.</p> <p>Patient #4's "Discharge Summary," dated 2/22/14 at 8:42 AM, stated "Positive pressure ventilation was performed as well as about 20-30 seconds of chest compressions before a heart rate above 100 [beats per minute] was noted. Patient initially required 1/4 liter of oxygen [per nasal cannula]." The "Discharge Summary" stated his initial blood glucose level was below 20. (A physician progress note, dated 2/20/14, stated the laboratory analyzer could not measure blood glucose levels below 20.) Laboratory reports listed normal blood glucose levels between 51 and 96. The "Discharge Summary" stated Patient #4 received IVs with dextrose. The IVs were not effective at raising the baby's blood glucose levels.</p> <p>Cumulative laboratory values on a document titled "Laboratory--Comparative Report," dated 2/23/14 at 4:00 PM, listed the following blood glucose levels:</p> <p>2/19/14: 2:27 PM &lt;20, 3:01 PM &lt;20, 4:41 PM 24, 5:29 PM 21, 6:06 PM 23, 8:06 PM 33, 10:08 PM 27</p> <p>2/20/14: 12:13 AM 27, 2:14 AM 30, 4:13 AM 33, 7:59 AM 44, 10:33 AM 39, 12:20 PM 53, 5:01 61, 11:04 PM 50</p> <p>2/21/14: 7:21 AM 38, 12:34 PM 42, 6:34 PM 42</p> <p>2/22/14: 12:11 AM 38, 7:47 AM 40</p> <p>According to the "Medline Plus" website, a</p>	C 275	<p>Cont.</p> <p>The persons responsible for implementing the above policies is Rod Jacobson, Administrator and Dr. Jack Clark MD, Chief of Staff.</p> <p>The policies have been provided to the Medical Staff and will be up for approval at the August 5<sup>th</sup> Med Staff meeting.</p> <p>The completion date was July 2, 2014 with final approval of policies pending until next Med Staff meeting and board approval.</p>		

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C 275	<p>Continued From page 6</p> <p>service of the National Institutes of Health, accessed 5/27/14, "Severe or persistent low blood sugar levels may affect the baby's mental function. In rare cases, heart failure or seizures may occur."</p> <p>Patient #4's "Discharge Summary" also stated the baby was diagnosed with jaundice and hyperbilirubinemia (high bilirubin levels in the blood resulting in jaundice). The note stated his condition was serious and he was transferred to a NICU in a neighboring state.</p> <p>Patient #4's medical record documented a neonatal bilirubin level, drawn at 6:37 AM on 2/22/14, was 15.3. Normal bilirubin levels were listed as 0-13.2.</p> <p>Patient #4's "Discharge Summary," dated 2/22/14 at 8:42 AM, stated the case was discussed with the attending physician on the NICU at the receiving hospital. No documentation was present in physician progress notes stating that a neonatologist was consulted about the case prior to 2/22/14 at 8:42 AM.</p> <p>Patient #4 was cared for by a family practice physician. The physician was interviewed on 5/29/14 beginning at 12:05 PM. He confirmed Patient #4's condition and laboratory values. He stated, after Patient #4's birth, he did speak with a neonatologist at another hospital about Patient #4's care. However, he said he did not document this. He stated the hospital did not have a policy requiring physicians to consult regarding patient care. He stated he considered a policy that would require physicians to consult to be "...completely inappropriate."</p>	C 275		

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C 275	Continued From page 7 The physician Chief of Staff for the CAH was interviewed on 5/23/14 beginning at 8:10 AM. He stated the CAH had no policy that addressed conditions requiring medical consultation.	C 275	The alleged deficiency of C278 regarding the dietary freezer spillage and food waste on the floor was corrected by the following actions: 1) Employees were educated at department in-service held on June 18, 2014 to clean up spills as they occur in the kitchen. 2) The cleaning of the walk in freezer was added to the weekly cleaning schedule, and the PM Sunday cook was assigned this job duty.	
C 278	The CAH had not developed a policy which established guidelines for the medical management of health problems that included the conditions requiring medical consultation. 485.635(a)(3)(vi) PATIENT CARE POLICIES  [The policies include the following:]  a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel.  This STANDARD is not met as evidenced by: Based on staff interview, observation of patient care, and review of hospital policies, it was determined the facility failed to ensure the implementation of procedures to avoid potential transmission of infections and communicable diseases. This directly affected the care of 1 of 1 patient (#27) who was observed in the OR and had the potential to impact all patients. Failure to follow policies and standard precautions had the potential to allow for transmission of infections and foodborne illnesses. Findings include:  1. During a tour of the hospital's kitchen on 5/20/14, beginning at 1:30 PM with the Food Service Manager, the following sanitation concerns were noted:  a. An undated policy, titled "Sanitation of Dietary Department", stated, "The dietary staff shall	C 278	The deficiencies and monitoring of the cleaning schedule was addressed in the June 25 <sup>th</sup> newsletter and at the monthly in-service meeting on July 9, 2014. The information provided to staff with the addition to the cleaning list will correct and improve the cited deficiency. All staff will be required to sign the updated cleaning schedule to confirm they have read and understand it. The completion date for correction will be July 1, 2014. This will be monitored by Marissa Colvin, CDM-CFPP. See Addendum A "Weekly Cleaning Schedule Form"  The alleged deficiency C278 citing the ice machine lacked specific dates for cleaning was corrected by the following actions: 1) The cleaning of the ice machine has been added to the cleaning schedule and will be cleaned every 3 months on the first Monday.  Cont.	

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C 278	<p>Continued From page 8</p> <p>maintain the sanitation of the dietary department through compliance with a written, comprehensive cleaning schedule."</p> <p>The kitchen freezer had food spillage and food waste on the floor.</p> <p>The Food Service Manager stated the freezer is to be cleaned daily and as needed. There was no written cleaning schedule.</p> <p>b. The ice machine had a sticker with "February" documented as the last date cleaned. A specific date was not mentioned.</p> <p>The Food Service Manager stated, the "ice machine is cleaned monthly," and confirmed the last cleaning date was February 2014. The ice machine had not been cleaned for 3 months.</p> <p>c. A policy titled "Dietary Infection Control", undated, stated "... foods that are refrigerated are stored at or below 40 degrees F."</p> <p>The kitchen walk-in refrigerator log for May 2014 recorded, improper temperatures as follows: 44 F 5/05/14 at 6:00 AM, 48 F 5/06/14 at 7:00 PM, no temperature recorded 5/07/14 at 6:00 AM, 44 F 5/07/14 at 7:00 PM, 46 F 5/08/14 at 6:00 AM, 46 F 5/08/14 at 7:00 PM, 46 F 5/09/14 at 6:00 AM, 46 F 5/09/14 at 7:00 PM, 42 F 5/10/14 at 6:00 AM, 44 F 5/10/14 at 7:00 PM, 44 F 5/12/14 at 7:00 PM, 46 F 5/13/14 at 7:00 PM, 42 F 5/14/14 at 6:00 Am, 44 F 5/14/14 at 7:00 PM, 42 F 5/15/14 at 6:00 AM, 46 F 5/15/14 at 7:00 PM, 44 F 5/16/14 at 6:00 AM, 58 F 5/16/14 at 7:00 PM, 44 F 5/17/14 at 6:00 AM, 44 F 5/17/14 at 7:00 PM, 44 F 5/18/14 at 6:00 AM, no temperature recorded 5/19/14 at 6:00 AM, 46</p>	C 278	<p>2) A cleaning record was attached on the wall behind the ice machine to record the dates cleaned. 3) The duty of cleaning the ice machine has been assigned to the baker. This information was included in the monthly in-service held on June 18, 2014. All staff will be required to sign the updated cleaning schedule to confirm they have read and understand it. The deficiencies and monitoring of the cleaning of the ice machine was addressed in the monthly dietary newsletter. The completion date was July 1, 2014. The cleaning of the ice machine will be monitored by Marissa Colvin, CDM, CFPP. See Addendum B "Ice Machine Cleaning Schedule"</p> <p>The alleged deficiency C278 regarding the kitchen walk in refrigerator temperature not maintained at acceptable temperatures was corrected as follows: 1) The policy will reflect the following changes, h: "temperatures that are above 41 degrees Fahrenheit will be reported to the Dietary Manager and Maintenance, the date and time that Maintenance is notified will be recorded on the temperature log sheet. A subsequent temperature check will be made to verify the problem has been corrected."</p> <p>f "Temperatures that are above 0 degrees Fahrenheit will be reported to Dietary Manager and Maintenance. The date and time that maintenance is notified will be recorded on the temperature log sheet. A subsequent temperature check will be made to verify the problem has been corrected". 2) A place at the bottom of the freezer/refrigerator</p> <p>See Addendum D Cont.</p>	

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NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH FIFTH STREET MONTPELIER, ID 83254	
(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 278	<p>Continued From page 9</p> <p>F 5/19/14 at 7:00 PM, 48 F 5/20/14 at 6:00 AM, 46 F 5/20/14 at 7:00 PM, 46 F 5/21/14 at 7:00 PM, 42 F 5/22/14 at 6:00 AM, and 44 F 5/22/14 at 7:00 PM.</p> <p>The Food Service Manager confirmed the kitchen walk-in refrigerator was not maintained at acceptable temperatures.</p> <p>The hospital failed to ensure policies were followed to prevent food borne illness.</p> <p>2. A policy titled "Infection Control Nursery &amp; Postpartum", undated, stated, "Upon discharge and as needed, housekeeping will clean the nursery and post-partum units."</p> <p>A tour of the hospital's nursery was conducted with the DON on 5/20/14 beginning at 8:15 AM. A used blanket was observed in the baby warmer. Linen used by the last occupant was on a rocking chair and supplies were in disarray on a counter area.</p> <p>The DON stated a newborn patient had been admitted to the nursery on 5/19/14 and then discharged to the mother's room that same day. She stated the nursery had not been cleaned after the baby was discharged to the mother's room.</p> <p>The Infection Control Officer was interviewed on 5/21/14 at 1:35 PM. She stated the nursery should have been cleaned after the baby was discharged.</p> <p>The hospital failed to ensure infection control policies were followed in the nursery.</p>	C 278	<p>Cont. temperature log sheet has been added for recording the information. 3) Staff has been notified of the changes to the policy and procedure in the June 25<sup>th</sup> newsletter and will be reviewed at the monthly in-service meeting on July 9, 2014. All staff will be required to sign the updated policy and procedure and also the updated temperature log to confirm they have read and understand it. This information will also be included in the monthly newsletter. The completion date for correction was July 1, 2014. The monitoring of the temperature logs will be done by Marissa Colvin, CDM,CFPP. See addendum "C" and "E"</p> <p>The alleged deficiency C 278 (2) cites the Infection Control Nursery and Postpartum policy was not followed. The policy states "upon discharge and as needed, housekeeping will clean the nursery and post-partum units" The one and only newborn in our nursery was born on 05/19/14 and was discharged on 05/21/14. At the time of the survey of the nursery, 05/20/19, the infant was in the mothers' room, but had not been discharged. The cleaning actions taken to straighten the nursery on 05/20/14 followed the policy as the "as needed" cleaning. The nursery was thoroughly cleaned on 05/21/14, the day the mother and infant was discharged. We believe the policy stated above was followed as written and we were not out cont.</p>	

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C 278	Continued From page 10 3. A policy titled "Dress Code in the Operating Room," undated, stated, "Suitable attire must be worn by all O.R. staff and surgeons before entering O.R...Masks should be changed between cases."  An observation of a shoulder surgery on Patient #27 was conducted on 5/21/14 beginning at 10:30 AM. The surgeon had made his first incision, then 1 staff member and 1 student observer entered the OR without masks for approximately 15-20 seconds. The CNRA notified them to leave and don masks before returning.  The Infection Control Officer was interviewed on 5/21/14 at 1:35 PM. She stated an incident report had been completed and the event would be investigated. The Infection Control Officer confirmed, masks were required before entering the OR.	C 278	Cont. of compliance in our actions. This alleged deficiency was not discussed in our telephone exit conference on 05/29/14, and therefore we did not have the opportunity to discuss or clarify this situation.  The alleged deficiency C278 regarding dress code in the OR was corrected by the following actions: 1) The policy was reviewed and education provided in the Nursing In-Service on June 26 <sup>th</sup> and in Med Staff Meeting on July 1 <sup>st</sup> . 2) A sign will be posted on the doors of the OR stating "Masks and Caps are required beyond this point" 3) The OR circulators have been instructed to monitor the staff entering the room for compliance.  The above actions will correct this deficiency by providing the education to all OR staff and others. The sign will serve as a reminder before entering an OR.	
C 298	485.635(d)(4) NURSING SERVICES  A nursing care plan must be developed and kept current for each inpatient.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and CAH policies, it was determined the CAH failed to ensure a nursing POC was developed for 2 of 3 neonates (#4 and #28), whose records were reviewed. This resulted in a lack of direction to staff and had the potential to interfere with the consistency of care. Findings include:	C 298	Those providers who violate the policy will be required to meet with the administrator prior to their next scheduled case in the OR.  The completion date was July 1, 2014. Rod Jacobson, Administrator and Mickie Sparks RN, DNS, OR Manager and Lois Woolstenhulme CS Manager will be responsible for implementing the plan of correction and for monitoring and tracking the compliance of the OR staff.	

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NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 144 SOUTH FIFTH STREET MONTPELIER, ID 83264		
(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 298	<p>Continued From page 11</p> <p>1. Patient #4's medical record documented a preterm newborn male who was born via caesarean section at the CAH at 1:12 PM on 2/19/14. His gestational age was 36 weeks and 3 days. He was transferred by helicopter to another hospital on 2/22/14 at 12:00 noon.</p> <p>A physician "Progress note," dated 2/21/14 at 7:33 AM, stated Patient #4 was "...born without a heartbeat with Apgars of 0, 6 and 7 at 0, 5, and 10 minutes." The scores indicated the baby did not have a pulse and was not breathing at birth.</p> <p>Patient #4's "Discharge Summary," dated 2/22/14 at 8:42 AM, stated the baby was revived and was placed on oxygen. The "Discharge Summary" stated the baby had an IV throughout his stay.</p> <p>Laboratory reports listed normal blood glucose levels between 51 and 96. Laboratory reports documented Patient #4's initial blood glucose level was below 20.</p> <p>Cumulative laboratory values on a document titled "Laboratory--Comparative Report," dated 2/23/14 at 4:00 PM, listed the following blood glucose levels:</p> <p>2/19/14: 2:27 PM &lt;20, 3:01 PM &lt;20, 4:41 PM 24, 5:29 PM 21, 6:06 PM 23, 8:06 PM 33, 10:08 PM 27</p> <p>2/20/14: 12:13 AM 27, 2:14 AM 30, 4:13 AM 33, 7:59 AM 44, 10:33 AM 39, 12:20 PM 53, 5:01 PM 61, 11:04 PM 50</p> <p>2/21/14: 7:21 AM 38, 12:34 PM 42, 6:34 PM 42</p> <p>2/22/14: 12:11 AM 38, 7:47 AM 40</p>	C 298	<p>The alleged deficiency C298 includes the following actions to correct: 1) An In-Service was held on June 26<sup>th</sup> for all nursing staff. Education was provided on developing and maintaining a care plan. The importance of proper care plans was included in the education. 2) The Problem List library was reviewed and updated to include appropriate nursing diagnosis, interventions and goals.</p> <p>Education provided stressed the importance of a care plan and also the steps taken electronically in initiating and maintaining the care plan. The changes made to the electronic library will allow more patient specific options for a more individualized care plan.</p> <p>The procedures to implement the plan of correction include:</p> <ol style="list-style-type: none"> <li>In-service/Education</li> <li>Demonstration of care plan library</li> <li>Nightly care plan checks by charge nurses</li> <li>DNS inpatient chart reviews weekly</li> </ol>		

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NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83254		
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C 298	<p>Continued From page 12</p> <p>Patient #4's medical record, dated 2/20/14 at 8:58 AM, contained a section titled "PROBLEM ACTIVITY." It was written by an RN. It stated "PROBLEM: Altered Health Maintenance...Patient/family will discuss measures to increase/maintain functional ability. Patient/family will discuss measures to prevent disease. Patient/family will participate in discharge plan." The section did not provide direction to nursing staff in caring for Patient #4. It did not address respiratory problems, blood glucose problems, or his IV.</p> <p>The DON was interviewed on 5/29/14 beginning at 11:00 AM. She stated the section "PROBLEM/ACTIVITY" was Patient #4's nursing POC. She confirmed it did not provide direction to nursing staff.</p> <p>Patient #4 did not have a nursing POC that directed staff how to care for him.</p> <p>2. Patient #28's medical record documented a newborn female who was born via caesarean section on 2/27/14 at 7:30 PM. Her "HISTORY AND PHYSICAL," dated 2/27/14, stated she had Apgar scores of 0 at 1 minute and 7 at 5 minutes of age. The scores indicated the baby did not have a pulse and was not breathing at 1 minute of age. She was discharged home on 3/02/14.</p> <p>Laboratory reports documented Patient #28's initial blood glucose level was below 20 on 2/27/14 at 8:19 PM. Two other blood glucose levels were documented. These included 26 at 11:41 PM on 2/27/14 and 43 on 2/28/14 at 7:30 AM. No further blood glucose levels were documented. No blood glucose readings in the</p>	C 298	<p>The date of completion was July 1, 2014.</p> <p>Care plans will be monitored nightly by charge nurses as part of their 24 hour chart checks. The DNS will review random inpatient charts weekly for care plan completion and maintenance.</p> <p>Mickie Sparks RN, DNS will be the person responsible for implementing the plan of correction.</p>		

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C 298	Continued From page 13 normal range of 51 to 96 (based on the acceptable range listed in the laboratory reports) were documented.  Patient #28's medical record contained a section titled "PROBLEM ACTIVITY," dated 2/28/14 at 10:00 PM. It was written by an RN. It included problems of "Parental Role Conflict" and "Altered Parent/Child Attachment and Altered Health Maintenance." The section stated "Patient/family will discuss measures to increase/maintain functional ability. Patient/family will discuss measures to prevent disease. Patient/family will participate in discharge plan." The section did not provide direction to nursing staff in physically caring for Patient #28. It did not address blood glucose problems or monitoring her blood glucose levels.  The DON was interviewed on 5/28/14 beginning at 3:55 PM. She stated the section "PROBLEM/ACTIVITY" was Patient #28's nursing POC. She confirmed it did not provide direction to nursing staff regarding her physical care.	C 298	C298 plan addressed on previous page.	
C 302	486.638(a)(2) RECORDS SYSTEMS  The records are legible, complete, accurately documented, readily accessible, and systematically organized.  This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, the hospital failed to ensure documentation was complete and/or accurate for 4 of 38 patients (#3, #4, #24, and #28) whose	C 302		

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C 302	<p>Continued From page 14 records were reviewed. This resulted in incomplete or inaccurate medical records. It had the potential to interfere with clarity of information related to the course to treatment and completeness of the medical record. Findings include:</p> <p>1. Patient #24's medical record documented a 75 year old female who was admitted to the CAH on 4/02/14 for an outpatient colonoscopy procedure.</p> <p>Patient #24 signed a consent for anesthesia services, untimed, dated 4/02/14. The consent was not signed by the CRNA to indicate anesthesia risks were reviewed.</p> <p>The Assistant DON reviewed the record on 5/23/14 beginning at 8:00 AM. She reviewed the consent for anesthesia services and confirmed Patient #24's consent for anesthesia services was not signed by the CRNA.</p> <p>Patient #24's consent for anesthesia services was not signed by the CRNA.</p> <p>2. Patient #4's medical record documented a preterm newborn male who was born via caesarean section at the CAH at 1:12 PM on 2/19/14. He was transferred by helicopter to another hospital on 2/22/14.</p> <p>a. A physician "Progress note," dated 2/21/14 at 7:33 AM, stated Patient #4 was "...born without a heartbeat with Apgars of 0, 6 and 7 at 0, 5, and 10 minutes." An Apgar score is traditionally taken at 1 minute of age, not at 0 minutes of age. Patient #3 was Patient #4's mother. Patient #3's "OPERATIVE NOTE," dated 2/19/14 at 2:19 PM, stated Patient #4's Apgar scores were listed as</p>	C 302	<p>The alleged deficiency C 302 regarding the anesthesia consent for services has been corrected by the following actions:</p> <p>1) During the pre-op period the patient will be given the anesthesia consent form to read and be encouraged to ask questions if needed.</p> <p>2) The CRNA will provide informed consent regarding the type of anesthesia that will be provided during their procedure. The CRNA will obtain the patient signature after informed consent has been provided and at that time they will also sign the form confirming consent has been obtained.</p> <p>3) The RN Circulator will review the consents during her 'time out' period with the patient. She will verify the procedure consent and also the anesthesia consent as a second check.</p> <p>The above actions will correct the cited deficiency in providing a process for signature verification. If signatures have not been obtained, the patient will be held from entering the OR until they have been. The monitoring and tracking of this plan of correction will be done by Gary Griffin CRNA Manager and Mickie Sparks RN, DNS.</p> <p>See "Pre-Operative Evaluation"</p> <p>The date of completion was July 1, 2014. Cont.</p>	

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NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83264
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C 302	<p>Continued From page 15</p> <p>"0, 6 and 7 at 1, 5, and 10 minutes, respectively." The Apgar scores from the 2 records did not match.</p> <p>The RN who participated in the resuscitation of Patient #4 was interviewed on 5/22/14 beginning at 4:20 PM. She stated the Patient #4's Apgar score of 0 was measured at 1 minute of life.</p> <p>b. Patient #4's "Discharge Summary," dated 2/22/14 at 8:42 AM, stated "Positive pressure ventilation was performed as well as about 20-30 seconds of chest compressions before a heart rate above 100 [beats per minute] was noted. Patient initially required 1/4 liter of oxygen [per nasal cannula]." The "Discharge Summary" stated his initial blood glucose level was below 20. (A physician progress note, dated 2/20/14, stated the laboratory analyzer could not measure blood glucose levels below 20.) Laboratory reports listed normal blood glucose levels between 51 and 96. The "Discharge Summary" stated Patient #4 received IVs with dextrose. The IVs were not effective at raising the baby's blood glucose levels. The "Discharge Summary" indicated Patient #4 was transferred to the another hospital for stabilization of his blood glucose.</p> <p>No documentation was present in the medical record stating the physician consulted with a neonatologist regarding Patient #4's care.</p> <p>Patient #4's physician was interviewed on 5/29/14 beginning at 12:05 PM. He stated he contacted a neonatologist at an acute care hospital on 2/20/14 regarding Patient #4's care. He stated he did not document this.</p>	C 302	<p>The persons responsible for implementing this plan of corrections is Gary Griffin CRNA manager and Mickie Sparks RN, DNS.</p> <p>Regarding the alleged deficiency of C302 regarding documentation of consult, please refer to C275 pg. 5/19 #4.</p> <p>The alleged deficiency C 302 regarding incomplete or inaccurate medical records addresses the APGAR scores being documented differently in physician and nursing notes. The following actions have been done: 1) Review and update the current APGAR policy 2) Incorporate a team approach when assigning APGAR scores 3) Review and approve the policy update with medical staff and nursing staff.</p> <p>The team approach will improve accuracy of documentation by including the following update to APGAR policy and procedure: "Post-delivery discussion will be conducted of infant APGAR scores between physician and nursery staff assigned to infant. All team members will be in agreement of the APGAR score before documentation in the infants chart. Documentation will be done after agreement in the delivery record under</p> <p style="text-align: right;">Cont.</p>	

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C 302	<p>Continued From page 16</p> <p>Patient #4's medical record did not contain complete documentation.</p> <p>3. Patient #28's medical record documented a newborn female who was born via caesarean section on 2/27/14 at 7:30 PM. She was discharged home on 3/02/14.</p> <p>Patient #28's "HISTORY AND PHYSICAL" by the physician, dated 2/27/14 at 8:42 PM, stated her Apgar score was 0 out of 10 at 1 minute of life, indicating the newborn had no pulse and no respirations. The document stated the Apgar score had risen to 7 at 5 minutes.</p> <p>Patient #28's "Labor and delivery Summary," written by an RN but not dated or timed, stated the neonate's Apgar scores were 5 at 1 minute and 7 at 5 minutes of age.</p> <p>Patient #28's medical record was reviewed by the obstetrical nurse on duty on 5/23/14 beginning at 9:15 AM. She confirmed the discrepancy between physician and nursing documentation regarding Patient #28's Apgar scores.</p> <p>Patient #28's medical record contained conflicting documentation.</p>	C 302	<p>Cont.</p> <p>APGAR section, chart the score given for each of the five different systems that are assessed. Document the one minute and the five minute APGAR scores. If the one minute APGAR is &lt;6, a ten minute APGAR must be assessed and documented. A nursing in-service was held on Thursday June 26<sup>th</sup> to educate nursing staff on the policy and procedure change. The policy change was also presented to the providers at their monthly Med Staff meeting on July 1, 2014. See Addendum #1.</p> <p>The new policy will be implemented and followed as outlined in the plan of action. Education and implementation of policy changes will be presented in the above meetings with all nursing staff required to sign acknowledgment and understanding of policy.</p> <p>To monitor and track the effectiveness of the action plan all newborn charts will be reviewed. The reviews will be conducted over the next six months for compliance changes, then continued review of newborn charts will be done monthly. The completion date was July 1, 2014. Persons responsible for implementing the action plan will be Mickie Sparks RN, DNS and Brandi Froehlich RN, ADNS, ICO, Risk Management.</p>		
C 322	<p>485.639(b) ANESTHETIC RISK &amp; EVALUATION</p> <p>(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.</p> <p>(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.</p>	C 322			

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

PRINTED: 06/13/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  131316	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/29/2014
NAME OF PROVIDER OR SUPPLIER  BEAR LAKE MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 164 SOUTH FIFTH STREET MONTPELIER, ID 83264	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 322	<p>Continued From page 17</p> <p>(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that, prior to receiving anesthesia, patients were examined to evaluate the potential risks. This impacted 1 of 1 patient (#27) whose surgery was observed. This had the potential to result in negative patient outcome. Findings include:</p> <p>Patient #27 was a 43 year old male admitted to the facility on 5/21/14 for same day surgery on his right shoulder.</p> <p>On 5/21/14, beginning at 9:00 AM, Patient #27 was observed in his room as an RN was preparing him for surgery. At approximately 9:30 AM, the CRNA was observed to introduce himself to Patient #27. He asked Patient #27 if he had any prior issues with anesthesia, when he had last had anything by mouth, and about his health history. Patient #27 was then transferred to the recovery room where the CRNA prepared to administer a nerve block to his right shoulder. After the nerve block was placed, Patient #27 was taken to the OR. The CRNA did not listen to Patient #27's heart and lungs with a stethoscope before taken to the OR.</p> <p>The CRNA was interviewed on 5/23/14 at 10:45 AM. He confirmed that he should have completed a physical examination of Patient #27.</p> <p>Patient #27 did not receive a pre-anesthesia</p>	C 322	<p>The alleged deficiency C322 regarding the evaluation of the patient before surgery by the anesthesia provider will be corrected by the following actions:</p> <ol style="list-style-type: none"> <li>1) The CRNA will perform an assessment of the patient to evaluate the risk of anesthesia either during the ARTEC (advanced registration testing education center) interview done before the day of surgery, or the morning of surgery.</li> <li>2) This physical pre-op evaluation, along with their history assessment will be documented on the Pre-Operative Evaluation form.</li> <li>3) This form has been revised to include an assessment option for documenting physical assessment findings.</li> </ol> <p>By completing the above actions, the process of performing an evaluation of the patient during the pre-op period will assist in determining if a risk is present for the procedure being performed and/or the risk of anesthesia.</p> <p>The anesthesia providers will be responsible to complete the change to their pre-op form to include the documentation of their physical assessment findings. This form has been and will be presented at Med Staff meeting July 1, 2014.</p>	

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C 322	Continued From page 18 evaluation.	C 322	<p>Cont.</p> <p>The completion date was July 1, 2014.</p> <p>The monitoring and tracking for compliance to this plan of correction will be the responsibility of Gary Griffin CRNA, Anesthesia Manager.</p> <p>Gary Griffin CRNA will be responsible for the implementation of this plan of correction.</p>	

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B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the Idaho state licensure survey of your CAH. Surveyors conducting the review were:</p> <p>Don Sylvester, R.N., HFS, Team Leader Gary Gules, R.N., HFS</p> <p>Acronyms used in this report include:</p> <p>ACL- Anterior Cruciate Ligament ADON- Assistant Director of Nursing CAH - Critical Access Hospital CRNA- Certified Registered Nurse Anesthetists D - dextrose DON- Director of Nursing IV - intravenous line NICU - Neonatal Intensive Care Unit OR- Operating Room POC - plan of care RN- Registered Nurse RH- Relative Humidity</p>	B 000	<p>RECEIVED JUL - 7 2014 FACILITY STANDARDS</p> <p>For alleged deficiency BB210 refer to plan of correction for C278 page 8 of 19.</p>	
BB210	<p>16.03.14.320.09 Dietary Sanitation</p> <p>09. Dietary Sanitation. Sanitary standards for hospitals shall be those found in Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Rules Governing Food Sanitation Standards Food Establishments (UNICODE)". (12-31-91)</p> <p>This Rule is not met as evidenced by: Refer to C278.</p>	BB210		
BB317	<p>16.03.14.380.04 Records</p> <p>04. Records. Prior to surgery patient records shall</p>	BB317		

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

*God... [Signature]*

TITLE

*Admin*

(X6) DATE

*7-2-14*

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BB317	<p>Continued From page 1</p> <p>contain the following: (10-14-88)</p> <p>a. A properly executed informed consent; and (10-14-88)</p> <p>b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03)</p> <p>c. Appropriate screening tests, based on patient needs, completed and recorded prior to surgery. (10-14-88)</p> <p>d. Record requirements may be modified in emergency surgery cases to the extent necessary under the circumstances. (10-14-88)</p> <p>This Rule is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure medical history and physical examinations were performed prior to surgery for 4 of 5 surgical patients (#14, #15, #16 and #27) whose medical records were reviewed. This prevented staff from identifying pre-existing medical conditions that could complicate surgery or recovery. Findings include:</p> <p>1. Patient #14's medical record documented a 43 year old female who had a right anterior cruciate ligament reconstruction with auto graft hamstring tendon, performed on 4/18/14. A history and physical examination was documented in her medical record on 4/08/14. The facility failed to ensure, an updated history and physical examination was completed prior to the procedure.</p> <p>The ADON reviewed Patient #14's medical record</p>	BB317	<p>The alleged deficiency BB317 regarding the medical history and physicals was corrected by the following actions: 1) A stamp has been made that includes the date, time, and 2 check box options; "H&amp;P reviewed, patient examined and no change since H&amp;P completed, or option of "see changes"; and a signature line for provider.</p> <p>2) Education to physicians in Med Staff meeting on July 1, 2014. Nursing education was provided at the in-service on June 26, 2014.</p> <p>The above actions will improve the process of the provider reviewing the H&amp;P and assessing the patient the day of and prior to the procedure. Case Management personnel will monitor the dates the H&amp;Ps are done and prompt providers for updates, with the assistance of the stamp for a reminder.</p> <p>Staff education, both providers and nursing, is being performed to implement this plan of action.</p> <p>The completion date was July 1, 2014.</p> <p style="text-align: right;">Cont.</p>	

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BB317	<p>Continued From page 2</p> <p>on 5/23/14 at 8:00 AM. She confirmed a history and physical examination was completed on 4/08/14, but an updated review was not completed prior to surgery.</p> <p>An updated history and physical examination was not performed prior to the procedure.</p> <p>2. Patient #15's medical record documented a 60 year old female who had a hysteroscopy dilatation, curettage and uterine ablation, performed on 5/05/14. A history and physical examination was documented in her medical record on 3/29/14. However, an updated history and physical examination was not completed prior to the procedure.</p> <p>The ADON reviewed Patient #15's medical record on 5/23/14 at 8:00 AM. She confirmed a history and physical examination was completed on 3/29/14, but an updated review was not completed prior to surgery.</p> <p>An updated history and physical examination was not performed prior to the procedure.</p> <p>3. Patient #16's medical record documented a 78 year old female who had a right total hip arthroplasty performed on 4/09/14. A history and physical examination was documented in her medical record on 3/26/14. The record did not include an updated review completed prior to surgery.</p> <p>The ADON reviewed Patient #16's medical record on 5/23/14 at 8:00 AM. She confirmed a history and physical examination was completed on 3/26/14, but an updated review was not completed prior to surgery.</p>	BB317	<p>Cont.</p> <p>Case Management Personnel, Kristie DeClark RN, and Melony Maughn will monitor the dates on the H&amp;Ps for all scheduled procedures.</p> <p>Kristie DeClark RN, Case Management, will be responsible for implementing and monitoring this plan of correction.</p>	

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BB317	Continued From page 3  An updated history and physical examination was not performed prior to the procedure.  4. Patient #27's medical record documented a 43 year old male who had a right shoulder arthroscopy with decompression and distal clavicle resection, performed on 5/21/14. A history and physical examination was documented in his medical record on 5/13/14. The record did not include an updated review completed prior to surgery.  The ADON reviewed Patient #27's medical record on 5/23/14 at 8:00 AM. She confirmed a history and physical examination was completed on 5/13/14, but an updated review was not completed prior to surgery.  An updated history and physical examination was not performed prior to the procedure.	BB317		
BB332	16.03.14.390.01 Anesthesia Services, Policies and Procedures  390. ANESTHESIA SERVICES. These services shall be available when the hospital provides surgery or obstetrical services with C-section capacity and shall be integrated with other services of the hospital and shall include at least the following: (10-14-88)  01. Policies and Procedures. Policies and procedures shall be approved by the medical staff and the administration of the hospital. These written policies and procedures shall include at least the following: (10-14-88)  a. Designation of persons permitted to give anesthesia, types of anesthetics, preanesthesia,	BB332	For the alleged deficiency BB332 please refer to the plan of correction for C322 on page 17 of 19.	

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BB332	<p>Continued From page 4</p> <p>and post anesthesia responsibilities; and (10-14-88)</p> <p>b. Preanesthesia physical evaluation of a patient by an anesthetist, with the recording of pertinent information prior to surgery together with the history and physical and preoperative diagnosis of a physician; and (10-14-88)</p> <p>c. Review of patient condition immediately prior to induction; and (10-14-88)</p> <p>d. Safety of the patient during anesthetic period; and (10-14-88)</p> <p>e. Record of events during induction, maintenance, and emergence from anesthesia including; (10-14-88)</p> <p>i. Amount and duration of agents; and (10-14-88)</p> <p>ii. Drugs and IV fluids; and (10-14-88)</p> <p>iii. Blood and blood products. (10-14-88)</p> <p>f. Record of post-anesthetic visits and any complications shall be made within three (3) to forty-eight (48) hours following recovery; and (10-14-88)</p> <p>g. There shall be a written infection control procedure including aseptic techniques, and disinfection or sterilizing methods. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C322 as it relates to the facility's failure to ensure that prior to surgery or a procedure patients were examined to evaluate the potential risks.</p>	BB332		