



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7000 1670 0011 3315 1705

October 7, 2014

Jim Broyles, Administrator
Benewah Community Hospital
229 South 7th Street
St Maries, ID 83861

RE: Benewah Community Hospital, Provider #131317

Dear Mr. Broyles:

Based on the survey completed at Benewah Community Hospital, on September 19, 2014, by our staff, we have determined Benewah Community Hospital, is out of compliance with the Medicare Hospital **Organizational Structure (42 CFR 485.627)**, **Provision of Services (42 CFR 485.635)** and **Organ, Tissue, Eye Procurement (42 CFR 485.643)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

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

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Jim Broyles, Administrator
October 7, 2014
Page 2 of 2

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

Such corrections must be achieved and compliance verified by this office, before November 3, 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 October 26, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **October 20, 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



Benewah Community Hospital
St. Maries Family Medicine
229 S. 7th Street
St. Maries, ID 83861
(208) 245-5551
www.bchmed.org

October 17, 2014

Sylvia Creswell, Co-Supervisor
Non-Long Term Care
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P. O. Box 83720
Boise, ID 83720-0009

RECEIVED

OCT 20 2014

FACILITY STANDARDS

RE: Benewah Community Hospital, Provider #131317

Dear Ms. Creswell:

In response to your letter of October 7, 2014, we are enclosing our Credible Allegation/Plan of Correction which you provided.

Please find enclosed a Table of Contents listing all attachments which are specifically related to each deficiency. A copy of this letter and attachments will be mailed on this date.

Thank you to the surveyors for assisting us in addressing each of these items during their visit.

Implementing and building a more consistent plan for our medical center is key to moving our facility forward.

Sincerely,

A handwritten signature in cursive script that reads "James R. Broyles".

James R. Broyles, RN
Administrator/Director of Nursing Services

Attachments

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/19/2014
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH 7TH STREET ST MARIES, ID 83881	
(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	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were:</p> <p>Don Sylvester, R.N., H.F.S., Team Leader Nancy Bax, R.N., H.F.S. Susan Costa, R.N., H.F.S. Laura Thompson, R.N., H.F.S</p> <p>Acronyms used in this report include:</p> <p>AHP - Allied Health Professional APRN - Advanced Practice Registered Nurses CAH - Critical Access Hospital CNA - Certified Nurse Assistant CRNA - Certified Registered Nurse Anesthetist DEA - Drug Enforcement Administration DON - Director of Nursing EGD - Esophagogastroduodenoscopy H&P - History and Physical IC - Infection Control LPN - Licensed Practical Nurse PT - Physical Therapist RN - Registered Nurse RRT - Registered Respiratory Therapist UT - Utah</p>	C 000		
C 154	<p>485.608(d) LICENSURE, CERTIF. OR REGIST. OF PERSONNEL</p> <p>Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.</p> <p>This STANDARD is not met as evidenced by: Based on personnel record review, patient</p>	C 154		

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OCT 22 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *DNS/Adm* (X6) DATE: *10/22/14*

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 154	<p>Continued From page 1</p> <p>record review, and staff interviews, it was determined the facility failed to ensure that 1 of 2 full time contracted CRNAs (CRNA A) were fully credentialed before performing patient care and preceptor activities. This directly impacted 2 of 2 patients reviewed (#19 and #29) who received anesthesia during the survey (9/15/14-9/19/14). This resulted in services being provided by unqualified individuals and the potential for negative patient outcomes. Findings include:</p> <p>Patient #19 was a 32 year old female admitted to the facility on 9/15/14 for obstetrical care and delivery of her infant. She had an epidural infusion for the management of pain during labor.</p> <p>A consent for treatment, dated 9/15/14, and signed by Patient #19, included the following statement "...and that the treatment and procedures will be performed by physicians or hospital employees."</p> <p>A consent for anesthesia services was signed by Patient #19 for a spinal or epidural on 9/15/14 at 8:10 AM. The consent for anesthesia included the statement "I hereby consent to the anesthesia service checked above and authorize that it be administered by [the names of CRNA A and the student] or his/her associates, all of whom are credentialed to provide anesthesia services at this facility."</p> <p>Patient #29 was an 82 year old male admitted to the facility on 9/17/14 for a surgical repair of his left shoulder.</p> <p>A consent for treatment, dated 9/17/14, and signed by Patient #29, included the following statement "...and that the treatment and</p>	C 154	<p>CRNA's privileges were immediately suspended. CRNA was reinstated after we received an active Idaho State Board of Pharmacy license and proof of DEA with Idaho address. See attachment 1-A for complete credential file of CRNA Brent Bowles. Credential check list has been created by Becca Plante, Medical Staff Coordinator for initial appointments and reappointments to assure credential files are 100% complete before approval of privileges. See attach. 1-B for checklists, Becca Plante, Medical Staff Coordinator updated privilege sheets adding the privilege to supervise approved AHP's, see attachment 1-C for updated privilege sheet. Current CRNA's will have to apply for this additional privilege and get Medical Staff and Board approval before they are allowed to supervise a student. Becca Plante, Med. Staff Coord.</p>	10/1/14	

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83801	
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C 154	Continued From page 2 procedures will be performed by physicians or hospital employees." A consent for anesthesia services was signed by Patient #29 for a major nerve block and general anesthesia on 9/17/14 at 6:30 AM. The consent for anesthesia included the statement "I hereby consent to the anesithesia service checked above and authorize that it be administered by [the names of CRNA A and the student] or his/her associates, all of whom are credentialed to provide anesthesia services at this facility." Credentials files were reviewed. There was no evidence the anethesla student was credentialed to provide anethesla at the facility or otherwise authorized by the state to provide services. CRNA A's credentials file was reviewed on 9/17/14. It was found he did not have a current Idaho Controlled Substance registration, and therefore, was not authorized to provide services in Idaho. The Interim Administrator was interviewed on 9/17/14 beginning at 9:45 AM. He stated CRNA A did not have a current Idaho Controlled Substance reglstrallon. Additionally, he stated he was unaware of an agreement with the school the anesthesia student was from that outlined the scope of practice for the students. The CAH failed to ensure practitioners providing services were qualified to do so.	C 154	Bobbi Machado, Surgical Services Manager contacted Missouri State University regarding our agreement with them. See attach. 2-A, agreement with MSU. Surg. Services. Manager is working on a policy for CRNA students at BCH. See attach. 2-B, Draft CRNA Student Policy. Becca Plante, Med. Staff Coord. created a credentialing check list for items needed before a CRNA student is allowed to come to BCH. See attach. 2-C, CRNA student check list. Student will complete attach. 2-D, student application. CRNA/ Surgeon PACU discharge order form and draft policy are included in attach 2-E.	10/16/14
G 204	485.610(b)(2) EQUIPMENT AND SUPPLIES [The items available must include the following:] Equipment and supplies commonly used in life	G 204		

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C 204	<p>Continued From page 3</p> <p>saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters.</p> <p>This STANDARD is not met as evidenced by: Based on observations, review of crash cart checklists, and staff interviews, it was determined the hospital failed to ensure all emergency medical equipment was maintained for all patients receiving care at the facility. This resulted in the potential for patients' health and safety to be compromised in the event of a medical emergency. Findings include:</p> <p>A tour of the facility's emergency room and medical/surgical floor was conducted on 9/16/14 starting at 8:30 AM. During the tour, the facility's emergency crash carts were observed. Each cart had a checklist that indicated the cart was to be checked daily at 9:00 AM and 9:00 PM. The crash cart checklists for the month of September 2014, were reviewed. Checks were not consistently completed as follows:</p> <p>a. Emergency Room Trauma Room #1 crash cart:</p> <p>There was no documentation the crash cart was checked on the following dates/times:</p> <p>-9/05/14, No documentation of a 9:00 AM check.</p> <p>-9/11/14, No documentation of a 9:00 PM check.</p> <p>-9/12/14, No documentation of a 9:00 AM or 9:00</p>	C 204	<p>'Check me' signs have been posted above crash carts and checklists. See attach. 3 for photos. Nurses will check crash carts twice a day, 9:00a.m. and 9:00p.m., and they will document these checks on the checklists. Jim Broyles, Administrator/DNS.</p>	10/13/14	

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C 204	<p>Continued From page 4 PM check.</p> <p>-9/13/14, No documentation of a 9:00 AM check.</p> <p>-9/17/14, No documentation of a 9:00 PM check.</p> <p>-9/18/14, No documentation of a 9:00 PM check.</p> <p>b. Emergency Room Trauma Room #2 crash cart:</p> <p>-9/09/14, No documentation of a 9:00 PM check.</p> <p>-9/05/14, No documentation of a 9:00 AM check.</p> <p>-9/07/14, No documentation of a 9:00 AM or 9:00 PM check.</p> <p>-9/10/14, No documentation of a 9:00 AM check.</p> <p>-9/11/14, No documentation of a 9:00 PM check.</p> <p>-9/12/14, No documentation of a 9:00 AM or 9:00 PM check.</p> <p>-9/13/14, No documentation of a 9:00 AM check.</p> <p>Staff ZZ, an emergency room RN, was interviewed on 9/16/14 at 8:45 AM. She stated emergency room crash carts are checked twice a day, at 9:00 AM and 9:00 PM, using the crash cart checklist. She confirmed staff on each shift did not consistently check off trauma rooms, 1 and 2.</p> <p>c. Medical/Surgical Floor crash cart:</p> <p>The crash cart checklist did not include documentation of a 9:00 AM check on 9/02/14,</p>	C 204			

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C 204	Continued From page 5 9/03/14, 9/06/14, 9/09/14, 9/10/14, 9/11/14, 9/12/14, 9/13/14, 9/17/14, and 9/18/14. The Interim Administrator/DON was interviewed on 9/17/14 at 2:40 PM. He confirmed the medical/surgical floor crash cart had not been checked at 9:00 AM on the 10 dates above. The facility failed to ensure emergency medical equipment was checked.	C 204			
C 240	485.627 ORGANIZATIONAL STRUCTURE Organizational Structure This CONDITION is not met as evidenced by: Based on staff interview, observation, and review of bylaws, credentials files, and CAH affiliation agreements, it was determined the CAH's organizational systems were not sufficient to ensure services were provided by qualified staff and all Conditions of Participation were met. This resulted in patients receiving services from unqualified and/or uncredentialed practitioners, the lack of an organized infection control program, lack of resolution of adverse event investigations, and lack of an operational system for organ, tissue, and eye procurement. Findings include: 1. Refer to C241 as it relates to the Governing Body's failure to ensure policies were implemented and monitored. 2. Refer to C270 Condition of Participation of Provision of Services and related standard level deficiencies as they relate to the lack of an organized infection control program and lack of resolution of adverse event investigations.	C 240	Credentiaing to become a single job responsibility for the Med. Staff Coord., Becca Plante, effective 11/1/14. Personnel selected for Admin. Receptionist to take on reception duties. Med. Staff Coord. will have dedicated private office space and will start training to use the credentialing software MD Staff to track files. Jim Broyles, Administrator, DNS. See attachment 5, Infection Prevention Plan. Surgical Services Manager/IP Coord., Bobbi Machado.	10/1/14 10/16/14	

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C 240	Continued From page 6	C 240			
	3. Refer to C344 Condition of Participation of Organ, Tissue, Eye Procurement and related standard level deficiencies as they relate to the lack of an operational system organ, tissue, and eye procurement.		See attachment 8 for Organ and Tissue donation. BCH has created a new policy, and all procedures have been updated with new agreement/OPO. Completed by Jim Broyles, RN Administrator/DNS.	10/15/14	
C 241	The cumulative effect of these deficient practices seriously impeded the ability of the CAH to provide services of sufficient scope and quality. 485.627(a) GOVERNING BODY OR RESPONSIBLE INDIVIDUAL The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing, and monitoring policies governing the CAH's total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment. This STANDARD is not met as evidenced by: Based on staff interview, observation, and review of bylaws, credentials files, and CAH affiliation agreements, it was determined the CAH's Governing Body failed to assume responsibility for implementing and monitoring compliance with policies. This directly impacted 2 of 2 sample patients (Patients #19 and #29 who received anesthesia during the survey (9/15/14 - 9/19/14). The lack of oversight resulted in patients being treated by unqualified personnel. Findings include: 1. Article 1 of the Medical Staff Bylaws, dated 6/22/06, stated, "the purposes and responsibilities	C 241	See plan under C 154		

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83081
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C 241	<p>Continued From page 7</p> <p>for the Medical Staff are to develop and implement, with the Board of Trustees approval, a written procedure for determining qualifications for Medical Staff appointment and for determining privileges."</p> <p>Medical Staff Bylaws, Article 6, related to AHPs, stated "...they may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the Board of Trustees, after consulting with the Medical Executive Committee, has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Bylaws and Rules."</p> <p>Medical Staff Bylaws Article 12.6.2 "Drug Enforcement Administration (DEA) Certificate" stated, "a. Revocation, Suspension and Expiration. Whenever a member's DEA certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term."</p> <p>CRNA's credentials file was reviewed. It included a document, dated 8/11/14, written by the facility's Medical Staff Coordinator, and addressed to CRNA. The document stated, "Our records indicate that the following documents have or will expire in the near future: "Proof of Liability Insurance (expires 8/20/2014), Controlled Substance License."</p> <p>CRNA's credentials file, also, included a document from the State of Utah Department of</p>	C 241		
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C 241	<p>Continued From page 8</p> <p>Commerce indicating CRNAA had an active license. Included in the document was "CRNA Controlled Substance Schedule 2-5, expiration 1/31/2014." Also, included was a DEA registration number, expiration date 7/31/15, with a state of Utah address.</p> <p>An email in the CRNA A's credentials file, dated 9/03/14, from the DEA District Office in the State of Utah, to CRNAA, referenced unlawful activity and stated "Your DEA registration is a federal registration, but it is restricted to one physical address in one physical state of licensure. It is a violation of federal regulation to cross state lines with your DEA registration without first obtaining complete, valid state license in the state where you are moving to, and then you must absolutely have your DEA registration moved to the physical location in that state before you can begin practicing-period. The type of practice you perform is of no consequence. It does not alter the law."</p> <p>In response to the above email, CRNAA forwarded the email to the Medical Staff Coordinator on 9/15/14. In the email CRNAA stated, "Waiting on Idaho Specialist as per email is out office till Sept 23."</p> <p>The Interim Administrator was interviewed on 9/17/14 beginning at 9:45 AM. He stated, CRNA A did not have a current Idaho Controlled Substance registration, and had been practicing as a CRNA. He confirmed the facility had knowledge of the discrepancy prior to 9/17/14, and had not taken action. On 9/17/14 at approximately 1:15 PM, the Interim Administrator presented a letter to the CRNAA informing him his contract and privileges with the facility were</p>	C 241			

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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C 241	<p>Continued From page 9 suspended effective immediately. It was in regard to the email communication with CRNAA and the DEA.</p> <p>The Governing Body did not enforce bylaws requiring a CRNA to have a current Controlled Substance registration.</p> <p>2. During an observation of Patient #29's preparation for a surgical procedure on 9/17/14, beginning at 6:30 AM, a student nurse anesthetist conducted a nerve block in Patient #29's left shoulder. CRNAA was observed assisting the student. Patient #29 was transported to the operating room. The student nurse anesthetist administered sedating medications and placed a breathing tube to Patient #29. CRNAA observed the student.</p> <p>CRNAA and a nurse anesthetist student also provided services to Patient #19. Patient #19 was a 32 year old female admitted to the facility on 9/15/14 for obstetrical care and delivery of her infant. She had an epidural infusion for the management of pain during labor.</p> <p>A consent for anesthesia services was signed by Patient #19 for a spinal or epidural on 9/15/14 at 8:10 AM. The consent for anesthesia included the statement "I hereby consent to the anesthesia service checked above and authorize that it be administered by [names of CRNAA and the student]."</p> <p>An affiliation agreement, dated 7/13/13, between an out-of-state university anesthesia program and the CAH, for training registered nurse anesthetist students, was reviewed. Article III of the agreement, "RESPONSIBILITIES AND</p>	C 241	See plan under C 154	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/19/2014
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861		
(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 241	<p>Continued From page 10</p> <p>OBLIGATIONS OF THE CLINICAL SITE INSTITUTION", Included "1. Conduct an orientation for each student with regard to the policies of the Clinical Site Institution and to provide each student a copy of the applicable policies and procedures. 2. Appoint a CRNA, who will be responsible for directing and coordinating Department students' experiences at the Clinical Site Institution. All supervision will be in accordance with Council on Accreditation policy and procedures."</p> <p>A document in the CRNA's credentials file titled, "DELINEATION OF PRIVILEGES", dated 12/24/13, was reviewed. It did not include privileges for supervising registered nurse anesthetist students.</p> <p>The Medical Staff Bylaws, dated 6/22/06, stated at Article 6.3.2, "An AHP must apply and qualify for practice privileges as set forth in the Bylaws and Rules. Practitioners who desire to supervise or direct AHPs providing dependent services must apply and qualify for privileges to supervise approved AHPs."</p> <p>The Interim Administrator was interviewed on 9/18/14 beginning at 10:45 AM. He confirmed the facility's Bylaws and Rules did not address affiliation agreements with a certified nurse anesthetist university program. Additionally, he confirmed there were no guidelines for CRNA privileging, appointment or supervising roles of students. He also confirmed there was no formal orientation program or policies that governed certified nurse anesthetist students.</p> <p>The Governing Body failed to grant specific privileges to CRNA for supervising students and</p>	C 241			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 241	Continued From page 11 failed to ensure the scope of service provided by nurse anesthetist students was specified in writing.	C 241		
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, adverse event logs, and CAH policies, it was determined the CAH failed to ensure 1) Policies and procedures were followed for the completion of investigations of adverse drug reactions, and errors in the administration of drugs. 2) Policies and procedures were implemented and followed for an active infection control program. These failures resulted in a lack of direction for staff, and had the potential to result in negative patient outcomes. Findings include:	C 270		
C 277	1. Refer to C277 as it relates to the failure of the CAH to ensure policies and procedures for investigating adverse drug reactions and errors in the administration of drugs were followed. 2. Refer to C278 as it relates to the failure of the CAH to ensure an infection control plan was implemented to avoid the transmission of infections and communicable diseases. The cumulative effect of these systemic omissions resulted in an increased risk of complications to patients. 486.635(a)(3)(v) PATIENT CARE POLICIES [The policies include the following:] Procedures for reporting adverse drug reactions	C 277	See attachment 4, Incident Logs for July-Dec. 2013 and Medication incident logs Jan.-Oct. 2014, and Policy. Nancy Moss, RN, Quality/Risk Manager. See attachment 5, New IP Plan with guidelines, surveillance, and logs. Bobbi Machado, Surgical Services Manager/IP Coord.	10/16/14 10/16/14

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

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C 277	Continued From page 12 and errors in the administration of drugs. This STANDARD is not met as evidenced by: Based on staff interview, and review of the hospital's incident log and policies, it was determined the CAH failed to ensure medication errors and adverse drug events had a final disposition or resolution. This failure had the potential to result in adverse patient outcomes. Findings include: The "OCCURRENCE/EVENT NOTIFICATION MEDITECH RISK MANAGEMENT MODULE POLICY", dated 11/30/12 stated, "The hospital is committed to providing a safe environment for all patients, visitors, and employees within our facility. An event which occurs that is not consistent with the routine operations of a hospital or within the prescription and treatment of a particular patient will be documented so that appropriate response, follow-up, investigation, and resolution may be initiated and corrective action implemented, if necessary." Section, 4 e of the policy stated "Within 14 days of receipt of the original event notifications, the final disposition or resolution should be determined and documented within the event notification record." The facility's "NOTIFICATIONS AND EVENTS REPORT", dated 7/01/13 through 9/16/14, were reviewed. Final disposition/resolution had not been determined and documented for the following events: -12/23/13, wrong drug/solution -12/24/13, wrong dose/rate -12/28/13, wrong drug/solution -04/14/14, wrong time/delayed -04/22/14, wrong dose/rate -04/28/14, wrong dose/rate	C 277			

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

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OMB NO. 0938-0391

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C 277	Continued From page 13 -05/03/14, medicine reconciliation incomplete -05/27/14, wrong dose/rate -07/06/14, wrong dose/rate -08/08/14, adverse drug reaction -08/09/14, adverse drug reaction The Risk Manager was interviewed on 9/19/14 at 8:40 AM. She confirmed final resolution of the above events had not yet occurred.	C 277	Risk Manager documented resolution of completed events. MedEvents and Incident logs updated, and list of events documents incidents that continue to be open. See attach. 4.	10/16/14
C 278	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 and review of policies, it was determined the CAH failed to ensure systems to identify and investigate infections had been clearly defined and implemented. This resulted in the lack of direction to staff and the potential for patients to experience avoidable infections. Findings include: The "INFECTION CONTROL PROGRAM POLICY" (DRAFT), unsigned, dated, 5/05/08, was reviewed. It did not include a plan for the CAH's IC program. Additionally, it did not specify a method for infection control surveillance and did not define nosocomial or hospital acquired infections. The IC Officer was interviewed on 9/16/14	C 278	Surgical Services Manager/IP Coord. created an Infection Prevention Plan, see attachment 5. Included in this plan is: job description, committee minutes, monitoring/ surveillance logs, as well as numerous policies and signage related to IP.	10/16/14

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

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C 278	Continued From page 14 beginning at 1:50 PM. She stated the CAH administration did not formally designate her in writing nor did she have a job description. She stated the CAH did have an IC Committee and it was to meet quarterly. She confirmed the IC Committee had met only 2 quarters in 2014, on 2/06/14 and 4/22/14. She stated the Medical Staff reviewed IC data but did not provide policy direction for staff. She stated the IC Committee had not determined processes such as, procedures to clean surfaces and equipment or procedures to maintain a sanitary environment. She stated she tried to provide surveillance activities for the CAH, but an official procedure for surveillance of infections had not been approved. She further stated the hospital had not adopted an official definition of nosocomial (hospital acquired) infections.	C 278			
C 302	The hospital failed to develop and implement a complete IC program. 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 record review and staff interview it was determined the facility failed to ensure complete and accurate records were maintained for 2 of 6 surgical patients (#4 and #24) whose records were reviewed. This had the potential to interfere with coordination of patient care, result in misinterpretation of information, or cause a medical error. Findings include: 1. Patient #4 was a 73 year old female admitted	C 302			

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

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C 302	<p>Continued From page 15</p> <p>on 9/4/2013 to Outpatient Surgery for an EGD (a procedure used to visually examine your upper digestive system with a tiny camera) and Colonoscopy (a procedure in which a small camera is used to view the inner lining of the large intestine).</p> <p>A form "Anesthesia Intra-Op Record" documented medications used during the procedure by CRNA B. The medication Propofol was circled but no dosage or amount was documented as given.</p> <p>The same form contained an area for Post-Anesthesia Recovery discharge vital signs and boxes to indicate whether Patient #4 had been discharged home or moved to the hospital floor. The box "Home" was checked indicating she had been discharged home, but there were no vital signs documented to indicate she was stable for discharge. Further, there was no date or time to indicate when CRNA B had evaluated Patient #4 for discharge, as these lines were left blank.</p> <p>During an interview on 9/18/2014 at 5:25 PM, CRNA B reviewed Patient #4's record. He confirmed the Propofol was given during the procedure. He also confirmed he had not documented how much was used. Further, CRNA B confirmed that no date, time, or vital signs had been documented in the Post-Anesthesia Recovery discharge section.</p> <p>Patient #4's medical record was not complete or accurately documented.</p> <p>2. Patient #24 was a 72 year old female admitted on 7/17/2014 to Outpatient Surgery for Right Total Knee Arthroplasty (a procedure which removes</p>	C 302	<p>Anesthesia documentation; see attach. 2. Bobbi Machado, Surgical Service Manager, IP Coord.</p> <p>See attachment 6 for MediTech OR Module request. Bobbi Machado, Surgical Service Manager, IP Coord.</p> <p>Issues addressed in staff meeting. Minutes included in attach. 5. Bobbi Machado, Surgical Service Manager, IP Coord.</p>	<p>10/16/14</p> <p>10/15/14</p> <p>10/15/14</p>
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C 302	Continued From page 16 damaged cartilage and bone from the knee joint and replaces them with a man-made surface of metal and plastic). Patient #24 received anesthesia for her procedure. Anesthesia was performed by a student nurse anesthetist during the procedure, which was indicated by the student's signature at the bottom of the "ANESTHESIA RECORD." The same form contained a section "POST ANESTHESIA NOTE," which had checkboxes for "Patient without anesthesia complications or complaints," "See Progress Note," and "Outpatient." There were also lines for signature of the Anesthetist, date, and time. The entire section was left blank, with no markings in any of the boxes and no signature, date, or time. During an interview on 9/19/2014 at 5:26 PM, CRNA B reviewed the record. He confirmed the section was blank and should have been filled out after recovery from anesthesia. CRNA B also confirmed he should have co-signed the form with the student nurse anesthetist. Patient #24's medical record was not complete or accurately documented.	C 302	Issues under C 302 & C 304 addressed in staff meeting. Minutes included in attach. 5. Bobbi Machado, Surgical Service Manager, IP Coord.	10/15/14
C 304	485.638(a)(4)(i) RECORDS SYSTEMS For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- Identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief	C 304		

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

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C 304	<p>Continued From page 17 summary of the episode, disposition, and instructions to the patient;</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, policy review, and record review it was determined the facility failed to ensure evidence of a properly executed informed consent for 1 of 6 surgical patients (#3) whose records were reviewed. This resulted in the potential for patients to not be fully informed about proposed anesthesia, surgical procedures, and the expected outcomes prior to the procedures. Findings include:</p> <p>A policy "INFORMED CONSENT AND RIGHT OF REFUSAL" revised 11/30/2012, stated "Consents are required for any procedure of an invasive nature, involving anesthetic risk or a substantial element of risk or failure."</p> <p>Patient #3 was a 32 year old male admitted to Outpatient Surgery on 7/25/14 at 8:30 PM, for an EGD (a procedure used to visually examine your upper digestive system with a tiny camera).</p> <p>A form in Patient #3's record titled "Consent for Anesthesia Services" had a section at the bottom for the patient and witness to sign, date, and time receipt of the informed consent. Next to the patient signature the line for the required date and time was left blank. Also, next to the witness signature the line for the required date and time did not include a time.</p> <p>During an interview with the DON on 9/19/2014 at 12:10 PM, the record was reviewed. He confirmed the consent for anesthesia did not</p>	C 304			

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

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C 304	Continued From page 18 have a date or time next to Patient #3's signature. He also confirmed there was no time next to the witness signature.	C 304			
C 308	The facility failed to ensure Patient #3 had a properly executed informed consent. 485.638(b)(1) PROTECTION OF RECORD INFORMATION The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the hospital failed to ensure patients' records were maintained confidential on the medical/surgical floor. This resulted in the potential for patients' telemetry information being viewed by unauthorized individuals. Findings include: A tour of the facility's medical/surgical floor was completed on 9/18/14 beginning at 3:36 PM. The telemetry monitor (registers patients' heart rhythms) was located on the end of a counter, facing outward, behind the nursing station. The telemetry monitor was easily seen from the front of the nursing station, with patient names and their heart rhythms. The surveyor was able to observe the telemetry monitor for 10 minutes, while the nursing station was unattended. Staff Z, an RN, was interviewed on 9/19/14 at 8:40 AM. She confirmed patient names and heart rhythms on the telemetry monitor could be in view of the public.	C 308	Telemetry monitor moved to nurses' desk and out of public eye. Patient names are substituted with initials and DOB. Will apply screen protector. See attach. 7. Jim Broyles, Administrator/DNS, IT Director Jake Craner will apply screen protector. TV screen monitor for room 208 moved to nurses' desk, out of public view. See attach. 7. Jim Broyles, Administrator/DNS	10/15/14 10/15/14	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 308	Continued From page 19	C 308		
C 344	<p>485.643 ORGAN, TISSUE, EYE PROCUREMENT</p> <p>The CAH must have and implement written protocols [with respect to organ, tissue & eye donation]</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of closed records, it was determined the facility failed to ensure written protocols were developed and implemented to address to organ, tissue and eye procurement. This had the potential to result in lack of identification of suitable organ, tissue and eye donors. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to C345 as it relates to the facility's failure to notify the OPO of individuals whose death is imminent or who have died in the facility. 2. Refer to C346 as it relates to the facility's failure to incorporate an agreement with at least one tissue bank and at least one eye bank to assure that all usable tissues and eyes are obtained from potential donors. 3. Refer to C347 as it relates to the facility's failure to identify and obtain training for a designated requestor to approach potential donor families and request organ or tissue donation. 4. Refer to C349 as it relates to the facility's failure to work with the designated OPO, tissue bank and eye bank to educate staff on organ, tissue and eye donation issues. 	C 344	<p>Nurse Reminder Call on all Death form posted in the OR, ER, and Med/Surg., see attachment 8.</p> <p>New agreements: LifeNet Health, SightSave.</p> <p>BCH Policy Update</p> <p>BCH all staff education, scheduled for 11/03/14.</p> <p>Donor inquiry to funeral home, Jim Broyles, Administrator/DNS</p>	10/15/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 344	Continued From page 20	C 344			
C 345	<p>The cumulative effect of this systemic practice created the potential for suitable organ, tissue and eye donors to not be identified.</p> <p>485.643(a) ORGAN, TISSUE, EYE PROCUREMENT</p> <p>[The CAH must have and implement written protocols that:] incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the CAH. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the CAH, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the CAH for this purpose;</p> <p>This STANDARD is not met as evidenced by: Based on review of closed records and staff interview, it was determined the facility failed to ensure the Organ Procurement Organization (OPO) was notified of the deaths of 3 of 6 patients (#8, #9 and #10), who expired in the facility and whose records were reviewed. This resulted in the potential for suitable organ, tissue and eye donors to not be identified. Findings include:</p> <p>The "ORGAN AND TISSUE DONATION" policy and procedure, revised 11/19/2012 stated, "The procurement coordinator will be notified, in a timely manner, of all individuals whose death is</p>	C 345	<p>See plan under C 344. All hospital staff education by procurement agency is scheduled for 11/3/14.</p> <p>Jim Broyles, Administrator/DNS</p>	10/15/14	

PRINTED: 10/07/2014
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OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 131317	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/19/2014
NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH 7TH STREET ST MARIES, ID 83881		
(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 345	<p>Continued From page 21</p> <p>Imminent or who have died to determine eligibility for donation.</p> <p>Under "PROCEDURE" the document stated, "Contact the procurement coordinator on-call to evaluate the patient's eligibility to donate. On the 'Donor Inquiry/Information to Funeral Home' form, document the Procurement Coordinators name, the case number, and whether or not the patient is a candidate."</p> <p>This Policy and Procedure was not followed. Examples include:</p> <ol style="list-style-type: none"> 1. Patient #8 was a 78 year old female admitted to the facility on 5/19/14, with diagnoses of sepsis and pneumonia. She expired on 5/23/14. <p>Patient #8's record did not include documentation of a call to the OPO, tissue or eye bank. Additionally, her record did not include the form titled, "Donor Inquiry/Information to Funeral Home".</p> <p>During an interview on 9/18/14 at 4:10 PM, the Interim Administrator confirmed there was no documentation to indicate the OPO had been contacted prior to, or following, Patient #8's death.</p> <p>The facility did not contact the OPO, tissue bank or eye bank at the time of Patient #8's death, to determine eligibility for organ and tissue donation.</p> <ol style="list-style-type: none"> 2. Patient #9 was a 95 year old male admitted to the facility on 8/16/14, with a diagnosis of end stage COPD. He expired on 8/19/14. <p>Patient #9's record did not include documentation</p>	C 345		

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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C 345	Continued From page 22 of a call to the OPO, tissue or eye bank. Additionally, his record did not include the form titled, "Donor Inquiry/Information to Funeral Home". During an interview on 9/18/14 at 4:10 PM, the Interim Administrator confirmed there was no documentation to indicate the OPO had been contacted prior to, or following, Patient #9's death. The facility did not contact the OPO, tissue bank or eye bank at the time of Patient #9's death, to determine eligibility for organ and tissue donation. 3. Patient #10 was an 83 year old male admitted to the facility on 8/28/14, with diagnoses of acute respiratory failure and lung cancer. He expired on 9/02/14. Patient #10's record did not include documentation of a call to the OPO, tissue or eye bank. Additionally, his record did not include the form titled, "Donor Inquiry/Information to Funeral Home". During an interview on 9/19/14 at 4:10 PM, the Interim Administrator confirmed there was no documentation to indicate the OPO had been contacted prior to, or following, Patient #10's death. The facility did not contact the OPO, tissue bank or eye bank at the time of Patient #10's death, to determine eligibility for organ and tissue donation.	C 345			
C 346	485.643(b) ORGAN, TISSUE, EYE PROCUREMENT	C 346			

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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C 346	<p>Continued From page 23</p> <p>[The CAH must have and implement written protocols that] incorporate an agreement with at least one tissue bank and at least one eye bank to cooperate in the retrieval, processing, preservation, storage and distribution of tissues and eyes, as may be appropriate to assure that all usable tissues and eyes are obtained from potential donors, insofar as such an agreement does not interfere with organ procurement;</p> <p>This STANDARD is not met as evidenced by: Based on review of contracts and staff interview, it was determined the facility failed to incorporate an agreement with at least one tissue bank and at least one eye bank to coordinate retrieval of tissues and eyes from donors. This had the potential to result in failure of the facility to identify potential tissue and eye donors. Findings include:</p> <p>A contract, titled "ORGAN RECOVERY AGREEMENT", dated 7/15/13, outlined an agreement between the facility and an OPO. Attached to the contract was a document with the OPO's letterhead, titled, "Commonly Asked Questions". The document included the question, "Does an agreement with (name of OPO) include the needed tissue and eye agreements?" The answer stated, "If you work with (name of OPO) for tissue recovery services, the necessary tissue and eye agreements are included as an addendum to the organ procurement agreement. If you work with another tissue recovery provider, you will need to work with them to ensure you have a separate agreement in place." The contract did not include an addendum related to tissue and eye recovery services.</p>	C 346	<p>See attachment 8: LifeNet Health and SightSave services are integrated. A single call initiates an evaluation for tissue, eye, or organ donation. Jim Broyles, Administrator/DNS</p> <p>Life Center NW continues to be sole resource for organ procurement. Jim Broyles, Administrator/DNS</p>	<p>10/15/14</p> <p>10/15/14</p>

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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C 346	Continued From page 24	C 346			
C 347	<p>During an interview on 9/19/14 at 11:00 AM, the Interim Administrator reviewed the contract and confirmed it did not include an addendum related to tissue and eye recovery services. Additionally, he confirmed the facility did not have a contract with another tissue recovery provider.</p> <p>The facility did not have a contract with a provider of tissue and eye recovery services.</p> <p>485.643(c) ORGAN, TISSUE, EYE PROCUREMENT</p> <p>[The CAH must have and implement written protocols that:] ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its option to either donate or not donate organs, tissues, or eyes. The individual designated by the CAH to initiate the request to the family must be a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation;</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, it was determined the facility failed to ensure potential donor families would be approached by an individual trained in the methodology for approaching potential donor families and requesting organ, tissue or eye donation. This had the potential to result in failure of the facility to inform the family of their donation options. Findings include:</p> <p>During an interview on 9/18/14 at 10:30 AM, the</p>	C 347	<p>Protocol for family consults to be the direct responsibility of LifeNet Health services.</p> <p>BCH personnel are discouraged per LifeNet Health in addressing families concerning tissue, eye, or organ donation. Jim Broyles, Administrator/DNS</p>	10/15/14	

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

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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C 347	Continued From page 25 OR Manager stated the facility had employed an MSW who was trained as a designated requestor, however, that individual no longer worked for the facility and another individual had not been trained. During an interview on 9/18/14 at 4:10 PM, the Interim Administrator confirmed the facility did not employ an individual who had completed a course offered or approved by the OPO.	C 347	No MSW available. Direct all calls to LifeNet Health. Jim Broyles, Administrator/DNS	10/15/14
C 349	485.649(e) & (f) ORGAN, TISSUE, EYE PROCUREMENT [The CAH must have and implement written protocols that ensure that:] (e) the CAH works cooperatively with the designated OPO, tissue bank and eye bank in educating staff on donation issues, reviewing death records to improve identification of potential donors, and maintaining potential donors while necessary testing and placement of potential donated organs, tissues, and eyes takes place. (f) For purposes of these standards, the term "organ" means a human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs). This STANDARD is not met as evidenced by: Based on staff interview and review of personnel records, it was determined the facility failed to work with the designated OPO to educate the facility staff on organ, tissue and eye donation	C 349	No longer using trained individuals from facilities to approach families. Jim Broyles, Administrator/DNS All staff education program by LifeNet Health scheduled for 11/3/14. Jim Broyles, Administrator/DNS	10/15/14 10/15/14

PRINTED: 10/07/2014
FORM APPROVED
OMB NO. 0938-0391

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

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C 349	<p>Continued From page 26</p> <p>Issues for 25 of 25 employees (Staff A to Y) whose records were reviewed. This had the potential to result in failure of the facility employees to identify potential organ, tissue and eye donors, as well as failure to inform potential donor families of their donation options. Findings include:</p> <p>On 9/18/14, 25 employee files were requested from the Human Resources Director. Inservice and training records were reviewed for each of the 25 employees, which included 12 RNs, 3 LPNs, 1 CNA, 1 PT, 1 Laboratory Manager, 1 Housekeeper, 1 Radiology Technician, 1 RRT, 1 Pharmacy Technician, and 3 Surgery Technicians. No training related to organ, tissue and eye donation issues were recorded in the 25 employee files reviewed.</p> <p>During an interview on 9/18/14 at 8:30 AM, the Interim Administrator confirmed the facility had not worked with the designated OPO to provide training on organ, tissue and eye donation issues to its employees.</p> <p>The facility did not provide training to employees regarding donation issues.</p>	C 349		
C 377	<p>485.646(d)(2) TRANSFER & DISCHARGE NOTICE</p> <p>[The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:]</p> <p>Transfer, and discharge rights (§483.12(a)(4)):</p> <p>"Before a facility transfers or discharges a resident, the facility must-</p>	C 377		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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C 377	<p>Continued From page 27</p> <p>(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.</p> <p>(ii) Record the reasons in the resident's clinical record; and</p> <p>(iii) Include in the notice the items described in paragraph (a)(6) of this section."</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to notify swing bed patients and/or family members, in writing, of discharge dates, the reason for discharge, and the patients' right to appeal the facility's decision to discharge, for 2 of 2 swing bed patients (#1 and #20) whose records were reviewed. This had the potential to result in lack of discharge planning and impeded the patients' opportunity to appeal discharge. Findings include:</p> <p>Patient #20 was an 89 year old female admitted to a swing bed on 6/12/14, for therapy services following surgery to repair a fracture in her lower leg. Her record was reviewed.</p> <p>Patient #20 was discharged on 6/19/14, however, her record did not include a written notice of discharge.</p> <p>Patient #1 was a 54 year old female admitted to a swing bed on 9/12/14, for therapy services following a total knee replacement. Her record</p>	C 377	<p>See attachment 9.</p> <p>Includes all related information for swing bed program. For example: Notice of transfer, OT Therapy, Comprehensive assessment, dental services, etc. Nancy Moore, Case Manager & Jim Broyles, Administrator/DNS</p>	10/15/14
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C 377	Continued From page 28 was reviewed. Patient #1 was discharged on 9/15/14, however, her record did not include a written notice of discharge. The Case Manager who managed swing bed services at the CAH was interviewed on 9/17/14 beginning at 3:15 PM. She stated the CAH had a "Letter of Non-Coverage" to inform swing bed patients of their discharge date, including the patients' right to appeal, however, they had not been using the form. The Case Manager confirmed swing bed patients were not informed in writing of discharge, or of their right to appeal the facility's decision to discharge. The CAH did not notify swing bed patients, in writing, of their discharge dates, or of their right to appeal the facility's decision to discharge.	C 377	See attachment 9, letter of non-coverage. Nancy Moore, Case Manager.	10/15/14	
C 385	485.645(d)(4) PATIENT ACTIVITIES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.16(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. Quality of Life - activities (§483.15(f))	C 385	See attachment 9, Therapy Services Agreement. Nancy Moore, Case Manager	10/15/14	

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

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OMB NO. 0938-0391

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C 385	<p>Continued From page 29</p> <p>"(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>(2) The activities program must be directed by a qualified professional who-</p> <p>(i) Is a qualified therapeutic recreation specialist or an activities professional who-</p> <p>(A) Is licensed or registered, if applicable, by the State in which practicing; and</p> <p>(B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or</p> <p>(ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or</p> <p>(iii) Is a qualified occupational therapist or occupational therapy assistant; or</p> <p>(iv) Has completed a training course approved by the State."</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, it was determined the CAH failed to provide an ongoing program of activities to swing bed patients. This resulted in the lack of recreational activities for swing bed patients, and had the potential to result in unmet</p>	C 385	<p>See attachment 9, OT agreement. OT evaluation of swing bed patient. OT to provide individualized plan of care. Nancy Moore, Case Manager</p>	10/15/14
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2014
FORM APPROVED
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C 388	<p>Continued From page 31</p> <p>(ix) Continence. (x) Disease diagnoses and health conditions. (xi) Dental and nutritional status. (xii) Skin condition. (xiii) Activity pursuit. (xiv) Medicallons. (xv) Special treatments and procedures. (xvi) Discharge potential. (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols. (xviii) Documentation of participation in assessment.</p> <p>The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts."</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to complete a comprehensive assessment of the patients' needs, for 2 of 2 swing bed patients (#1 and #20) whose records were reviewed. This had the potential to result in lack of information necessary to develop a care plan and provide services based on the individuals' status. Findings include:</p> <p>Patient #20 was an 89 year old female admitted to a swing bed on 6/12/14, for therapy services following surgery to repair a fracture in her lower leg. Her record, including the assessment completed at the time of admission, was reviewed.</p>	C 388		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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C 388	Continued From page 32 Patient #20's record included an assessment completed by the RN on 6/12/14. However, the assessment did not include information related to her customary routine, cognitive patterns, mood and behavior patterns, or discharge potential. Patient #1 was a 54 year old female admitted to a swing bed on 9/12/14, for therapy services following a total knee replacement. Her record was reviewed. Patient #1's record included an assessment completed by the RN on 9/12/14. However, the assessment did not include information related to her customary routine, cognitive patterns, mood and behavior patterns, or discharge potential. The Case Manager who managed swing bed services at the CAH was interviewed on 9/17/14 beginning at 3:15 PM. She stated the CAH did not have an assessment tool that was specifically used for swing bed admissions. She stated the admission assessment used for swing bed admissions was the same assessment used for patients admitted to the CAH for acute care. The Case Manager stated she was aware that the assessment did not cover all areas required for swing bed admissions. Patients admitted to swing beds at the CAH did not receive a comprehensive assessment to determine all of their needs.	C 388		
C 407	485.646(d)(8) DENTAL SERVICES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:	C 407	See attachment 9, Office of Dr. Ewert, DDS in process of credentialing and finalizing MOU. Jim Broyles, Administrator/DNS & Med. Staff Coord., Becca Plante.	10/15/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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C 407	<p>Continued From page 33</p> <p>Dental services (\$483.55 of this chapter.) " (b) Nursing facilities. The facility (1) Must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; "</p> <p>This STANDARD is not met as evidenced by: Based on staff interview, it was determined the CAH failed to ensure dental services were available to swing bed patients. This resulted in the potential for patients' dental needs to go unmet. Findings include:</p> <p>The Case Manager who managed swing bed services at the CAH was interviewed on 9/17/14 beginning at 3:15 PM. She stated the CAH did not have a contract with a provider for dental services and such services were not available for swing bed patients.</p> <p>Dental services were not available, as needed, for swing bed patients.</p>	C 407		
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDC1AX	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/19/2014
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyors conducting the Medicare recertification survey were:</p> <p>Don Sylvester, R.N., H.F.S., Team Leader Nancy Bax, R.N., H.F.S. Susan Costa, R.N., H.F.S Laura Thompson, R.N., H.F.S</p> <p>Acronyms used in this report include:</p> <p>AHP - Allied Health Professional APRN - Advanced Practice Registered Nurses CAH - Critical Access Hospital CNA - Certified Nurse Assistant CRNA - Certified Registered Nurse Anesthetist DEA - Drug Enforcement Administration DON - Director of Nursing EGD - Esophagogastroduodenoscopy H&P - History and Physical IC - Infection Control LPN - Licensed Practical Nurse PT - Physical Therapist RN - Registered Nurse RRT - Registered Respiratory Therapist UT - Utah</p>	B 000	<p>See attachment 10 for copy of Draft Medical Staff Bylaws per copy of IHA template. To Medical Staff Director 10/17/14. Draft to be reviewed and revised by Med. Staff Coord., Med. Staff Director, and Administrator.</p>	10/17/14
BB115	<p>16.03.14.200.01 Governing Body and Administration</p> <p>200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88)</p> <p>01. Bylaws. The governing body shall adopt</p>	BB115	<p>See attachment 11, BCH governing board bylaws, anticipate ongoing study and revision per board. Reviewed with executive board members on 10/14/14. Jim Broyles, RN, Administrator/DNS.</p>	10/14/14

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

J. Broyles RN

TITLE

DNS/Administrator

(X6) DATE

10/22/14

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BB115	<p>Continued From page 1</p> <p>bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88)</p> <p>a. Membership of Governing Body, which consist of: (12-31-91)</p> <p>i. Basis of selecting members, term of office, and duties; and. (10-14-88)</p> <p>ii. Designation of officers, terms of office, and duties. (10-14-88)</p> <p>b. Meetings, (12-31-91)</p> <p>i. Specify frequency of meetings. (10-14-88)</p> <p>ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88)</p> <p>iii. Minutes of all governing body meetings shall be maintained. (10-14-88)</p> <p>c. Committees, (12-31-91)</p> <p>i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88)</p> <p>ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88)</p> <p>d. Medical Staff Appointments and Reappointments; (12-31-91)</p> <p>i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88)</p>	BB115		

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83881
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BB115	<p>Continued From page 2</p> <p>ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88)</p> <p>iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least blannually. (10-14-88)</p> <p>iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88)</p> <p>v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88)</p> <p>vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced. (10-14-88)</p> <p>e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88)</p> <p>f. The bylaws shall specify an appropriate and</p>	BB115		

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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 220 SOUTH 7TH STREET ST MARIES, ID 83861
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BB115	<p>Continued From page 3</p> <p>regular means of communication with the medical staff. (10-14-88)</p> <p>g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88)</p> <p>h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88)</p> <p>i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88)</p> <p>j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88)</p> <p>k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88)</p> <p>l. Bylaws shall be dated and signed by the current governing body. (10-14-88)</p> <p>m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C241.</p>	BB115		
BB148	16.03.14.250.05 Medical Staff Bylaws, Rules, and Regulations	BB148		

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BB148	<p>Continued From page 4</p> <p>05. Medical Staff Bylaws, Rules, And Regulations. These shall specify at least the following: (10-14-88)</p> <p>a. A description of the medical staff organization which includes: (10-14-88)</p> <p>i. Officers and their duties; and (10-14-88)</p> <p>ii. Staff committees and their responsibilities; and (10-14-88)</p> <p>iii. Frequency of staff and committee meetings; and (10-14-88)</p> <p>iv. Agenda for all meetings and the type of records to be kept. (10-14-88)</p> <p>b. A statement of the necessary qualifications for appointment to the staff, and the duties and privileges of each category of medical staff. (10-14-88)</p> <p>c. A procedure for appointment, granting and withdrawal of privileges. (10-14-88)</p> <p>d. A mechanism for hearings and appeals of decisions regarding medical staff membership and privileges. (10-14-88)</p> <p>e. A statement regarding attendance at staff meetings. (10-14-88)</p> <p>f. A statement of qualifications and a procedure for delineation of clinical privileges for all categories of nonphysician practitioners. (10-14-88)</p>	BB148	<p>See Draft Medical Staff Bylaws in attachment 10. Used IHA template as a model for bylaws. Dr. Davenport, Chief of Staff, received this draft copy on 10/16/14 for review and revision. Jim Broyles, Administrator/DNS and Becca Plante, Med. Staff Coord, have created this draft. Will also go to the medical staff for review as well as the board.</p>	10/16/14

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BB148	<p>Continued From page 5</p> <p>g. A requirement for keeping accurate and complete medical records. (10-14-88)</p> <p>h. A requirement that all tissue surgically removed will be delivered to a pathologist for a report on such specimens, unless the medical staff, in consultation with the pathologist, adopts uniform exceptions to sending tissue specimens to the laboratory for analysis. (10-14-88)</p> <p>i. A statement requiring a medical history and physical examination be performed no more than seven (7) days before or within forty-eight (48) hours after admission. The findings from this history and physical examination, including a provisional diagnosis, must be included in the medical record prior to surgery, except in emergencies. (5-3-03)</p> <p>j. A requirement that consultation is necessary with unusual cases, except in emergencies. Unusual cases shall be defined by the hospital medical staff. (10-14-88)</p> <p>This Rule is not met as evidenced by: Refer to C241.</p>	BB148		
BB179	<p>16.03.14.310.07 Policies and Procedures</p> <p>07. Policies and Procedures. Written policies supported by written procedures shall be available for all nursing staff which includes all areas for delivery of nursing services and shall be consistent with generally accepted nursing practice. The following shall be included with all other policies and procedures for nursing services: (10-14-88)</p>	BB179		

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BB179	Continued From page 6 a. There shall be a written procedure for reporting and processing incidents/accidents to patients; and (10-14-88) b. There shall be a written procedure for reporting and processing medication errors. (10-14-88) This Rule is not met as evidenced by: Refer to C277.	BB179	BCH Policy #1031, Occurance/Event Notification MediTech RM Module. Logs attach. 4. BCH Policy #1772, Medication Related Incident/Occurrence/Error-Definition of.	
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) f. Consultation written and signed by consultant	BB283	Med Staff Bylaws, Jim Broyles, Administrator/DNS & Dr. Davenport, Chief of Staff. Append. A. 1.1 Append. A 2.2, Consent 5.3, 5.4 Append. A 3.3 Append. A 2.2, 2.13 Append. A 3.5	10/16/14

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BB283	<p>Continued From page 7</p> <p>which includes his findings; and (10-14-88)</p> <p>ii. Progress notes written by the attending physician; and (10-14-88)</p> <p>iii. Progress notes written by the nursing personnel; and (10-14-88)</p> <p>iv. Progress notes written by allied health personnel. (10-14-88)</p> <p>f. Reports of special examinations including but not limited to: (10-14-88)</p> <p>i. Clinical and pathological laboratory findings; and (10-14-88)</p> <p>ii. X-ray interpretations; and (10-14-88)</p> <p>iii. E.K.G. Interpretations. (10-14-88)</p> <p>g. Conclusions which include the following: (10-14-88)</p> <p>i. Final diagnosis; and (10-14-88)</p> <p>ii. Condition on discharge; and (10-14-88)</p> <p>iii. Clinical resume and discharge summary; and (10-14-88)</p> <p>iv. Autopsy findings when applicable. (10-14-88)</p> <p>h. Informed consent forms. (10-14-88)</p> <p>i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90)</p>	BB283	<p>Append. A 3.6</p> <p>Append. A 3.9</p> <p>Progress notes per consult reported in MediTech.</p> <p>Append. A 2.4 Outsource Consultation Review. 3.5, 8.1, 8.2</p> <p>Append. A 1.2- Discharge Protocol Append. A 2.14 Code Status Append. A 3.8- Discharge Summary Append A 3.8- Discharge Summary</p> <p>Append. A 2.6- Autopsy</p> <p>Append. A 2.2.- General, 5.3-Surgical, 5.4- Anesthesia</p> <p>DPO, BCH Policy 1823</p>	

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BB283	Continued From page 8 i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to C304 related to Informed consent.	BB283	DPO. BCH Policy 1823 DPO. BCH Policy 1823 DPO. BCH Policy 1823 DPO. BCH Policy 1823	
BB303	16.03.14.370.07 Equipment and Supplies 07. Equipment and Supplies. (10-14-88) a. Parenterals, drugs, instruments, equipment, and supplies shall be readily available to the emergency room for use. (10-14-88) b. Emergency drugs shall be available based upon a formulary designed by medical staff and pharmacy staff. (10-14-88) This Rule is not met as evidenced by: Refer to C204.	BB303	ER Drug Inventory, Chris Land, RN, ED Coordinator. Formulary Available, Mike Angelo, Registered Pharmasist.	10/16/14 10/16/14
BB317	16.03.14.380.04 Records 04. Records. Prior to surgery patient records shall contain the following: (10-14-88) a. A properly executed informed consent; and (10-14-88) b. Medical history and record of physical examination performed and recorded no more than seven (7) days before or within forty-eight	BB317	Informed Consent, Med. Staff Bylaws 5.3, 5.4. Bobbi Machado, Surgical Services Manager/JP Coord. Med Staff Bylaws, 3.3. Dr. Davenport, Chief of Staff, Jim Broyles, Administrator/DNS.	10/16/14 10/16/14

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BB317	<p>Continued From page 9</p> <p>(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 record review It was determined the facility failed to ensure an H&P was performed and recorded no more than seven days before or within 48 hours after admission for 2 of 6 surgical patients (#1 and #24) whose records were reviewed. This had the potential to prevent the finding of possible contraindications to the procedures being performed. Findings include:</p> <p>1. Patient #24 was a 72 year old female admitted on 7/17/2014 to Outpatient Surgery for Right Total Knee Arthroplasty (a procedure which removes damaged cartilage and bone from the knee joint and replaces them with a man-made surface of metal and plastic).</p> <p>The form "DAY SURGERY HISTORY & PHYSICAL" was dated 8/04/2014 at the top of the form. The physician's electronic signature at the bottom of the page was dated 8/19/2014 at 9:57 AM.</p> <p>During an interview with the Director of Risk Management on 9/18/2014 at 3:55 PM, the record was reviewed. She confirmed the H&P was dated 43 days prior to the procedure. She also confirmed the physician's electronic signature was dated 33 days after admission for</p>	BB317	<p>Med Staff Bylaws, 3.3, Dr. Davenport, Chief of Staff, Jim Broyles, Administrator/DNS.</p> <p>Med Staff Bylaws, 3.3, Dr. Davenport, Chief of Staff, Jim Broyles, Administrator/DNS.</p>	

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BB317	<p>Continued From page 10</p> <p>the procedure.</p> <p>The facility failed to ensure Patient #24 had an updated H&P prior to the procedure.</p> <p>2. Patient #1 was a 64 year old female admitted on 9/09/2014 to Outpatient Surgery for a Right Total Knee Replacement.</p> <p>The form "PREOP HISTORY AND PHYSICAL" was dictated by the surgeon on 8/18/2014 at 9:20 AM and signed by electronic signature on 8/19/2014 at 10:01 AM. It also stated at the top of the form "Anticipated Date of Admission: 09/09/2014."</p> <p>During an interview with the Director of Risk Management on 9/18/2014 at 3:55 PM, the record was reviewed. She confirmed the H&P was dated 21 days prior to the procedure.</p> <p>The facility failed to ensure Patient #1 had an updated H&P prior to the procedure.</p>	BB317		
BB332	<p>16.03.14.390.01 Anesthesia Services, Policies and Procedures</p> <p>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)</p> <p>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)</p>	BB332	<p>See Draft Policies for BB332 A-G. Policies written by Bobbi Machado, Surgical Services Manager/IP Coord.</p>	10/16/14

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BB332	<p>Continued From page 11</p> <p>a. Designation of persons permitted to give anesthesia, types of anesthetics, preanesthesia, and post anesthesia responsibilities; and (10-14-88)</p> <p>b. Preanesthesia physical evaluation of a patient by an anesthesiologist, 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 C302.</p>	<p>BB332</p> <p>a</p> <p>b</p> <p>c</p> <p>d</p> <p>e i,ii,iii</p> <p>f</p> <p>g</p>	<p>Draft Policy- Scope of Service</p> <p>Draft Policy- Anesthesia Documentation and Form- Intraoperative Anesthesia Record.</p> <p>Draft Policy- Assessment Prior to Induction of Anesthesia/ Sedation</p> <p>Draft Policy- Patient Safety in the Operating Room</p> <p>Draft Policy- Intraoperative Anesthesia Care and Form- Intraoperative Anesthesia Record.</p> <p>Draft Policy- Postoperative Anesthesia Care.</p> <p>Draft Policy- Infection Prevention and Control Measures.</p>	<p>10/16/14</p> <p>10/16/14</p> <p>10/16/14</p> <p>10/16/14</p> <p>10/16/14</p> <p>10/16/14</p> <p>10/16/14</p>

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDC1AX	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/19/2014
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NAME OF PROVIDER OR SUPPLIER BENEWAH COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 229 SOUTH 7TH STREET ST MARIES, ID 83861
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE
BB456	16.03.14.470.03 Policies and Procedures 03. Policies and Procedures. Policies and procedures governing the service shall be developed by appropriate representatives of each discipline and in collaboration with other appropriate services. (10-14-88) This Rule is not met as evidenced by: Refer to C241 and C278.	BB456	Surgical Services Committee reviews policies written by Bobbi Machado, Surg. Services Manager, Dr. Wheeler, Chief of Surgery, and Jim Broyles, Administrator/DNS.	10/16/14
BB539	16.03.14.540.02 Infection Control Program 02. Infection Control Program. The program shall include at least the following elements: (10-14-88) a. Definition of nosocomial infection, as opposed to community acquired infections; and (10-14-88) b. A procedure for hospital surveillance of and for nosocomial infections; and (10-14-88) c. A procedure for reporting and evaluating nosocomial infections. The procedure must enable the hospital to establish the following on at least a quarterly basis: (10-14-88) i. Level or rate of nosocomial infections; and (10-14-88) ii. Site of infection; and (10-14-88) iii. Microorganism involved. (10-14-88) This Rule is not met as evidenced by: Refer to C278.	BB539	Please see attachment 5, IP Plan. Bobbi Machado, Surgical Services Manager/IP Coordinator	10/16/14