IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSDM, R.N.,R.H.I.T.,; Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

February 9, 2010

Louis Kraml
Bingham Memorial Hospital
P.O. Box 751
Blackfoot, ID 83221

RE: Bingham Memorial Hospital, provider #131325

Dear Mr. Kraml:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on January 26, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

Also enclosed is a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the hospital into compliance, and that the hospital remains in compliance with the regulatory requirements;

- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Please sign and date both of the forms and return them to our office by **February 22, 2010**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

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

Sincerely,

Teresa Hamblin/sc

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

Enclosures

# BINGHAM MEMORIAL HOSPITAL

*Experience Bingham!*

February 22, 2010

RECEIVED

FEB 23 2010

FACILITY STANDARDS

Debra Ransom, R.N., R.H.I.T., Chief
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334 – 6626
Fax: (208) 364 – 1888

Dear Ms. Ransom,

Enclosed is our corrective action plan from the acute-care survey on January 26th, 2010. I trust that the changes to our processes, the development of improved policies and procedures, staff training, and the implementation of this plan will better meet the needs of the communities we serve.

If you have any questions, please feel free to contact me.

Sincerely,

Louis Kraml, CEO
Bingham Memorial Hospital
98 Poplar Street
Blackfoot, ID 83221
(208) 785 – 3804

' DEPARTMENT OF HEALTH AND HUMAN SERVICES
ENT

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| | 131325 | | C 01/26/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BINGHAM IVIEMORIAL HOSPITAL | 98 POPLAR sTREET BLACKFOOT, ID 83221 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| C 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the complaint investigation of your Critical Access Hospital. The surveyors conducting the survey were:<br><br>Teresa Hamblin, RN, MS, Team Leader<br>Trish O'Hara, RN, HFS<br><br>The following abbreviations were used in the report:<br><br>CAH = Critical Access Hospital<br>DVT = Deep Vein Thrombosis<br>ED = Emergency Department<br>IV= Intravenous<br>NG= Nasogastric<br>PICC= Peripheral Intravenous Central Catheter<br>RN = Registered Nurse | C 000 | RECEIVED<br>FEB 23 2010<br>FACILITY STANDARDS | |
| C 294 | 485.635(d) NURSING SERVICES<br><br>Nursing services must meet the needs of patients.<br><br>This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of hospital policies, it was determined the CAH failed to adequately train, orient, supervise, and provide policies for nursing staff in relation to assessment, prevention and management of skin breakdown and other potential problems in patients. This directly impacted 4 of 6 patients (#1,#2,#3 and #6) whose records were reviewed. This failure impaired the ability of the CAH to meet the skin care needs and other pertineht patients' needs due to incomplete nursing assessments and missing or inadequate care planning. Findings include: | C 294 | 485.635(d) NURSING SERVICES<br><br>The nursing supervisor will develop a policy and procedure titled Skin Assessment, Prevention and Management to address assessment, prevention and management of skin break down and other potential problems. Policy will be reviewed by nursing management and the Medicine Chairman of the medical staff and approved by March 15, 2010. A training curriculum module , schedule, and documentation log of training completion by all acute care nursing personnel will be developed for this policy and procedure by the nursing supervisor in order to orient and educate the patient care team. This training will be completed by March 22, 2010.<br><br>In addition, the policy includes the mechanisms for management, supervision, documentation and follow-up to ensure appropriate nursing assessment and care planning regarding assessment and management of skin breakdown. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 2-22-10

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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| BINGHAM MEMORIAL HOSPITAL | 98 POPLAR STREET BLACKFOOT, ID 83221 |

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| C 294 | Continued From page 1<br>1. Patient #1 was a 91 year old male admitted on 1/18/10. He was a current patient at the time of the survey. The "Initial Patient Data Collection and Assessment" form, dated 1/18/10 at 8:10 PM, documented a Braden score of "9." According to the form, a score of "9" was considered to be a "very high risk" (of development of pressure ulcers). The form listed a number of recommended interventions for individuals considered at high risk. They included but were not limited to the following:<br>a.) Manage Moisture (use commercial moisture barrier; use absorbent pads or diapers that wick and hold moisture; address cause if possible; offer bedpan/urinal and glass of water in conjunction with turning schedule);<br>b.) Manage Nutrition (Increase protein intake; increase calorie intake to spare proteins; Supplement with multi-vitamin; act quickly to alleviate deficits; consults dietician);<br>c.) Manage Friction and Shear (elevate head of bed no more than 30 degrees; use trapeze when indicated; use lift sheet to move patient; protect elbows and heels if exposed to friction);<br>d.) Other General Care Reminders (No massage of reddened bony prominences; No donut type devices; maintain good hydration; avoid drying skin).<br><br>In addition to documentation of the Braden score, the "Initial Patient Data Collection and Assessment" form, documented Patient #1 had redness in the groin and penis tip and a small sore outside of Patient #1's heel that had scabbed and was healing.<br><br>Although the initial assessment indicated the patient was at high risk for skin breakdown, skin issues were inadequately addressed on Patient | C 294 | 1. The nursing supervisor will review and revise the policy and procedure titled Patient Assessment to address the inadequate nursing assessments and care plan and inconsistent and incomplete skin care assessment follow up, documentation and communication among the patient care givers. This policy will be reviewed by nursing management and the Medicine Chairman of the medical staff and approved by March 15, 2010. A training curriculum module , schedule, and documentation log of training completion by all acute care nursing personnel will be developed by the nursing supervisor to orient and educate the patient care team. This training will be completed by March 22, 2010.<br><br>In addition, this training will be included in the new nurse orientation, the annual evaluation for all nursing staff and the mandatory annual skills lab. All training activities will be documented in each employee's personnel file.<br><br>In addition, the policy includes the mechanisms for management, supervision, documentation and follow-up to ensure appropriate nursing assessment and care planning regarding assessment and management of skin breakdown. | |

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| C 294 | Continued From page 2<br>#1's care plan, dated 1/23/10. The only "problem" listed relating to skin breakdown was "Injury, High Risk Related to possible skin breakdown due to diarrhea. The interventions included "KCl overlay with frequent positioning. The additional skin interventions recommended on Patient #1's "Initial Patient Data Collection and Assessment" form were not carried forward onto the patient's nursing care plan. Therefore, the ongoing assessment and care planning were incomplete.<br><br>Also, there was inconsistent and incomplete follow-up of skin care assessments. For example, the following nursing notes failed to provide Braden scores and failed to document nursing assessment of the skin conditions previously described as red or scabbed: 1/22/10 at 7:15 PM, 1/23/10 at 6:45 AM and 7:10 PM, and 1/25/10 at 2:50 PM. During an interview on 1/25/10 at 4:00 PM, the RN Supervisor reviewed the record and confirmed documentation of skin assessments were incomplete. During an interview on 1/26/10 at 4:00 PM, the Chief Process Officer and Nursing Supervisor were interviewed together. They stated they expected the nurses to perform a head to toe assessment each shift as part of a basic standard of professional care.<br><br>2. Patient #3 was an 85 year old male admitted to the hospital on 5/03/09. The "Initial Patient Data Collection and Assessment" form, dated 5/03/09 at 3:25 PM, documented Patient #3 had a dark area on the coccyx. The Braden score, which measured level of risk for skin breakdown, was left blank. Without assessment and documentation of the Braden score at initial assessment, there would be no baseline from | C 294 | 2. The policy and procedures titled Skin Assessment, Prevention and Management and Patient Assessment referenced in response above will include the training on how to identify the appropriate Braden score and document the score on the Initial Patient Data Collection and Assessment. | |

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| C 294 | Continued From page 3<br>which to compare changes in skin condition. A nursing note, dated 5/03/09 at 7:25 PM indicated the patient was having diarrhea, his rectum and coccyx were reddened, and he had a Stage 1 decubitus on his left buttocks. Subsequent nursing notes documented a progression of skin breakdown. A nursing note, date 5/05/09 at 6:40 AM documented slight redness to the buttock region with a small blister. The nursing note, dated 5/05/09 at 6:00 PM, documented a Stage II decubitus on the coccyx *with* 4 blisters and a 4 inch diameter reddened area.<br><br>There was no documentation that nursing staff evaluated any of the described areas of concern on the nursing shift assessment notes that follow: 5/04/09 07:00 AM, 5/06/09 at 7:00 AM, 5/07/09 at 7:10 PM, 5/08/09 at 6:40 AM and 7:00 PM, or 5/09/09 at 7:00 PM. There were no Braden assessments present in any of the nursing documentation. During an interview on 1/26/10 at 4:00 PM, the Chief Process Officer and Nursing Supervisor were interviewed together. They stated they expected the nurses to perform a head to toe assessment each shift as part of a basic standard of professional care.<br><br>During an interview on 1/25/10 at 4:00 PM, the Nursing Supervisor reviewed Patient #3's medical record and confirmed documentation relating to skin assessment information was incomplete. She also confirmed the nursing care plans (dated 5/03/09 through 5/08/09) failed to identify skin issues as a problem.<br><br>3. Patient #6 was a 100 year old female admitted to the hospital on 12/28/09 with admitting diagnosis of heart failure. The "Initial Patient | C 294 | In addition, the training will include documentation of a head to toe assessment including the the Braden score on the care plan and on every nursing shift assessment note.<br><br>3. The policy and procedure titled Patient Assessment referenced in response #1 will include assessment and | |

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

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| C 294 | Continued From page 4<br>Data Collection and Assessment" form, dated 12/28/09 at 4:45 PM, was left blank under the sections marked cardiac, respiratory, gastrointestinal, and genitourinary. The skin assessment section noted the patient's skin was dry with poor turgor. No Braden skin assessment was done and the Braden score was left blank. Patient #6's initial care plan, dated 12/28/09, was developed based on the above assessment. No entries were made under the problem list on the patient's care plan, dated 12/28/09, pertaining to care and maintenance of the patient's skin. No interventions were mentioned on the patient's care plan for skin care or protection. On 1/26/10 at 3:30 PM the Chief Process Officer reviewed the patient's record and confirmed the comprehensive assessment was incomplete. | C 294 | documentation training as it relates to the complete and comprehensive assessment to include a Braden skin score and problems list with documentation of interventions on the patient care plan. | |
| | 4. Patient #2 was a 74 year old male, admitted to the hospital on 1/21/10. Admitting diagnosis was possible pulmonary embolism. The "Initial Patient Data Collection and Assessment" form, dated 1/21/10 at 5:00 PM, documented the patient as being on anticoagulation medication since open heart surgery six months prior. The DVT Risk Assessment section was left blank. The Braden Score Assessment section was left blank. This assessment was used to develop Patient #2's initial care plan, dated 1/22/10. Patient #2's care plan did not include potential problems or nursing interventions related to skin care or blood clotting issues. On 1/26/10 at 3:30 PM the Chief Process Officer reviewed the patient's record and confirmed the comprehensive assessment was incomplete. | | 4. The policy and procedure titled Patient Assessment referenced in response #1 will include assessment and documentation training as it relates to the complete and comprehensive assessment to include a Braden skin score, problems list and DVT risk with documentation of interventions on the patient care plan. | |
| | 5. The CAH failed to provide specific training to nursing staff on what they were expected to complete and document in relation to | | 5. The nursing supervisor will develop a training curriculum module , schedule, and documentation log of training on | |

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| C 294 | Continued From page 5<br>comprehensive assessments on the "Initial Patient Data Collection and Assessment," form, dated 3/02/09, and the "Patient Data Shift Assessment" form, dated 3/02/09, which were primary assessment tools for nurses. According to the Chief Nursing Officer and the Nursing Supervisor during an interview on 1/26/10 at 8:45 AM, new nurse hires received 4-12 weeks of orientation; all nurses had mandatory yearly training. They confirmed there was no specific training on the completion of the "Initial Patient Data Collection and Assessment," revised 3/02/09, or the "Patient Data Shift Assessment." During the same interview, the Nursing Supervisor stated she assumed nurses understood they should thoroughly complete the forms initially and at each shift. | C 294 | "Initial Patient Data Collection and Assessment" and "Patient Data Shift Assessment" including complete and comprehensive documentation will be completed by all acute care nursing personnel by March 22, 2010.<br><br>In addition, this training will be included in the new nurse orientation, the annual evaluation for all nursing staff and the mandatory annual skills lab. All training activities will be documented in each employee's personnel file. | |
| | 6. The hospital failed to have a policy to guide nursing staff on expectations for skin assessment and prevention and management of skin breakdown. Failure to have a written policy may have contributed to the failure of nurses to consistently complete skin assessments and initiate appropriate care planning. During an interview on 1/26/10 at 8:45 AM, the Chief Process Officer confirmed the hospital did not have a policy. | | 6. The policy and procedure titled Patient Assessment as referenced in response #1 will be implemented on March 15, 2010. | |
| | 7. The primary forms, previously referenced, "Initial Patient Data Collection and Assessment," and "Patient Data Shift Assessment" had areas on the forms to write patients' Braden scores, which represented patient risk for developing pressure ulcers. Neither form had a guide on how to calculate a Braden score to determine the level of risk. The CAH failed to have a readily accessible Braden scoring tool for nursing staff to reference while paper charting skin assessments | | 7. The nursing supervisor will develop a policy and procedure titled Braden Scoring Guide detailing a guide on how to calculate a patient's Braden score. Policy and procedure will be reviewed by nursing management and the Medicine Chairman of the medical staff and approved by March 15, 2010 . A training curriculum module , schedule, and documentation log of training completion | |

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| C 294 | Continued From page 6<br>on patients. Failure to have a readily accessible tool available to nursing staff may have contributed to the failure of nurse's to document Braden scores on patients.<br><br>Five RNs were interviewed on 1/25/10 and 1/26/10. All nurses confirmed the forms did not include guidance on how to calculate the Braden scores. When individually asked how they knew how to calculate the Braden scores, they provided a variety of responses. One RN stated that the scoring tool was available in the computer. Another RN said that if the patient came through the ED, then the scoring tool was on the ED documents and she referenced the ED's tool. Another nurse said she was not sure how to score a Braden but she took pictures of skin breakdown to document her findings. Another RN stated there was not a way to score it because the scoring tool wasn't provided.<br><br>The CAH failed to have a double check system in place to evaluate nursing staffs' understanding of and compliance with addressing patients' skin care issues. | C 294 | by all acute care nursing personnel will be develop for this policy and procedure by the nursing supervisor in order to orient and educate the patient care team. This training will be completed by March 22, 2010.<br><br>A consistent Braden score reference tool will be provided to the nursing staff and included in the training referenced above.<br><br>As stated in response # 1, Policy and procedure titled Patient Assessment will include the mechanisms for management, supervision, documentation and follow-up to ensure appropriate nursing assessment and care planning regarding assessment and management of skin breakdown. | |
| C 298 | 485.635(d)(4) NURSING SERVICES<br><br>A nursing care plan must be developed and kept current for each inpatient.<br><br>This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of hospital policies, it was determined the CAH failed to ensure nursing staff developed or kept current nursing care plans that reflected the initial or changing needs of patients in 3 of 6 patients (#1,#3 and #5) whose records were reviewed. This resulted in a failure to have a coordinated plan with interventions addressing | C 298 | 485.635(d)(4) NURSING SERVICES<br><br>The nursing supervisor will review and revise the policy and procedure titled Patient Care Plans to address the failure of nursing staff to development and keep current nursing care plans that reflect the initial or changing needs of patients and corresponding nursing care treatments with short and long term goals. Policy will be reviewed by nursing management and the Medicine Chairman of the medical staff and approved by March 15, 2010. | |

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| C 298 | Continued From page 7<br>individual patient problems. Findings include:<br><br>A hospital policy, "Nursing Care Plans (Critical Access)," revised 2/02/10, referred to the Care Plans as "problem lists." It stated that identified problems would have corresponding nursing care treatments with short and long term goals.<br><br>During an interview on 1/25/10 at 1:45 PM, the Chief Process Officer described two forms nursing staff used to document assessments. She explained that one form, titled "Initial Patient Data Collection and Assessment," revised 3/02/09, was completed by nursing staff at the time of patient admission. A second form "Patient Data Shift Assessment," dated 3/02/09, was completed each shift.<br><br>In addition to the forms completed by nursing staff, the Chief Nursing Officer, during an interview on 1/25/10 at 1:15 PM, explained that problems lists (care plans) were developed and updated at least in part as a result of interdisciplinary communication daily during "stand up" meetings. She explained that representatives from nursing, physical therapy, pharmacy, social services, utilization review, dietary and nutrition services, medical staff, and administration met 5 days per week to discuss patients and their needs. She further explained that a social worker took notes during the meetings and added to each patients' care plan based on the problems identified and discussed. She stated other disciplines also had the option of going into the computer and adding to patient care plans.<br><br>On 1/26/10 at 4:00 PM, the Chief Process Officer and Nursing Supervisor were interviewed together | C 298 | A training curriculum module , schedule, and documentation log of training completion by all acute care nursing personnel will be developed for this policy and procedure by the nursing supervisor in order to orient and educate the patient care team. This training will be completed by March 15, 2010.<br><br>In addition, the policy will include the mechanisms for management, supervision, documentation and follow-up to ensure appropriate nursing care plans.<br><br>Nursing supervisor will review and revise the policy and procedure titled Patient Care Plans to include a section on the the responsibilities of the interdisciplinary stand up meeting to address the proper documentation by the nursing staff in the patients plan of care regarding any and all information obtained from the different disciplines during any stand up meeting seven days a week. Policy will be reviewed by nursing management and the Medicine Chairman of the medical staff and approved by March 15, 2010.<br><br>In addition, the policy will include the mechanisms for management, supervision, documentation and follow-up to ensure effective interdisciplinary involvement in the patient care plan.<br><br>A training curriculum module , schedule, and documentation log of training completion by all interdisciplinary team members will be developed for this policy and procedure by the nursing supervisor in order to orient and educate the patient | |

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| C 298 | Continued From page 8 and jointly contributed to the following information. They stated that when physical therapy shared their findings and plans during the "stand up" meeting, the social worker would add the information to the "Problem List" for use by nurses. They stated that other disciplines, such as nurses and nursing aides could add to the Problem List documented by Social Work. They also stated the "Lead" RN would be responsible to make sure the care plans were complete. They stated they expected the nurses to perform a head to toe assessment each shift as part of a basic standard of professional care<br><br>The "Initial Patient Data Collection and Assessment" form listed Braden Skin Assessment Scores (used to determine level of risk for skin breakdown) and corresponding nursing actions related to various levels of risk (at risk; moderate risk; high risk; very high risk). The form listed a number of recommended nursing interventions for individuals considered at high risk. They included, but were not limited to: 1) implementation of turning schedules; 2) maximal remobilization; 3) protecting heels; 4) use of foam wedges for 30 degree lateral positioning; 5) use of pressure-relieving surfaces; 6) measures to manage moisture, nutrition and friction and shear. In addition, the form offered the nurse additional general care reminders, such as: avoid massaging reddened bony prominences, avoid donut type devices, maintain good hydration and avoid drying skin.<br><br>The following information contains examples of patients whose nursing care plans failed to reflect the initial or changing needs of the patients.<br><br>1. Patient #3 was an 85 year old male admitted | C 298 | care team. This training will be completed by March 22, 2010.<br><br>1. Included in the revision of the policy | |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 131325 | | 01/26/2010 |

NAME OF PROVIDER OR SUPPLIER
**BINGHAM MEMORIAL HOSPITAL**

STREET ADDRESS, CITY, STATE, ZIP CODE
**98 POPLAR STREET**
**BLACKFOOT, ID 83221**

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| C 298 | Continued From page 9<br>to the hospital on 5/03/09. The "Initial Patient Data Collection and Assessment" form, dated 5/03/09 at 3:25 PM, documented Patient #3 had a dark area on the coccyx. The Braden score, which measured level of risk for skin breakdown, was left blank and therefore the assessment was incomplete. A nursing note, dated 5/03/09 at 7:25 PM indicated the patient was having diarrhea, his rectum and coccyx were reddened, and he had a Stage 1 decubitus on his left buttocks. Subsequent nursing notes documented a progression of skin breakdown. A nursing note, date 5/05/09 at 6:40 AM documented slight redness to the buttock region with a small blister. The nursing note, dated 5/05/09 at 6:00 PM, documented 4 blisters, a 4 inch diameter reddened area and a stage II wound located on the coccyx.<br><br>There was no documentation on the nursing assessment notes (5/04/09 07:00 AM, 5/06/09 at 7:00 AM, 5/07/09 at 7:10 PM, 5/08/09 at 6:40 AM and 7:00 PM, or 5/09/09 at 7:00 PM) that nursing staff evaluated any of the described areas of concern. There were no Braden assessment scores documented on any nursing notes during the course of hospitalization.<br><br>A physical therapy note, dated 5/06/09 at 2:44 PM, documented a skin evaluation in response to a physician's order. The note documented Patient #3 had an open wound with non-viable tissue and drainage and would require debridement, wound cleaning and dressing changes every other day. The information was not transferred to the interdisciplinary problem list or "care plan" dated 5/06/09 (or later) utilized by nursing staff. A physical therapist was interviewed on 1/26/10 at 3:30 PM. She stated | C 298 | and procedure titled Patient Care Plans and added to the training curriculum, the nursing supervisor will include a section to address the proper communication and documentation in the patient care plan of findings and recommendation by interdisciplinary team members and/or physicians. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (Xi) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| BINGHAM MEMORIAL HOSPITAL | 98 POPLAR STREET BLACKFOOT, ID 83221 |

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| C 298 | Continued From page 10<br>that physical therapy shared their findings and plan at the "stand up" meeting but physical therapists did not routinely carry their plans over to the interdisciplinary problem list. She explained that physical therapists kept their own notes on goals and interventions.<br><br>A nutritional therapy note, dated 5/07/09 at 11:05 AM, documented Patient #3 was assessed to be at moderate nutritional risk related to skin breakdown, poor appetite, and a history of cancer and chemotherapy. The same note documented a nutritional care plan, including a fortified diet and encouraging nutritional intake and providing preferences as able. These nutritional recommendations were not included Patient #3's nursing care plan, dated 5/07/09 (and later) to ensure nursing staff reinforced and followed the dietician's recommended interventions.<br><br>During an interview on 1/25/10 at 4:00 PM, the Nursing Supervisor reviewed Patient #3's medical record and confirmed documentation relating to skin assessment information was incomplete. She also confirmed the care plan failed to identify skin issues as a problem.<br><br>2. Patient #1 was a 91 year old male admitted on 1/18/10 and was a current patient at the time of the survey. An "Initial Patient Data Collection and Assessment" form, dated 1/18/10 at 8:10 PM, documented Patient #1 had a Braden score of "9." According to the form a score of "9" was considered a "very high risk" for development of pressure ulcers. The initial assessment also specifically documented Patient #1 had redness in the groin and on the tip of his penis and a small, scabbed over sore on the outside of his heel. The "Initial Patient Data Collection and | C 298 | 2. The policy and procedure revision titled Patient Care Plans referenced in opening comments of 485.635(d)(4) will include a section on the failure of the nursing staff to document nursing interventions and adequately incorporate them into the nursing care plan/problem list. This portion of the revision will be included in the training curriculum. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| C 298 | Continued From page 11 Assessment" form listed a number of recommended interventions for individuals considered at high risk.<br><br>Although the initial assessment indicated the patient was at high risk for skin breakdown, skin issues were inadequately addressed on Patient #1's care plan, dated 1/23/10. The only "problem" listed relating to skin breakdown was "Injury, High Risk Related to possible skin breakdown due to diarrhea. The interventions included "KCI overlay with frequent positioning. The additional skin interventions recommended on Patient #1's "Initial Patient Data Collection and Assessment" form were not carried forward onto the patient's nursing care plan. During an interview on 1/25/10 at 4:00 PM, the Nursing Supervisor reviewed the record and confirmed the skin care problem and recommended nursing interventions were not adequately incorporated into the nursing care plan/problem list and associated nursing interventions.<br><br>3. Patient #5 was an 80 year old female admitted on 1/02/10 with a bowel obstruction. The patient's condition deteriorated and, according to the clinical record in the Patient Progress Notes, a PICC line was inserted, for the administration of IV fluids, sometime between 12:00 PM and 7:00 PM on 1/04/10. The actual time of the procedure was not documented. An NG tube was also placed at 2:10 PM on 1/04/10, for drainage of stomach contents. While these procedures were documented in the Patient Progress Notes, no additions or nursing interventions were created on the patient's care plan (problem list), dated 1/03/10, to address these changes in the patient's condition. The patient's care plan was not updated to reflect additional patient needs. | C 298 | 3. The policy and procedure revision titled Patient Care Plans referenced in opening comments of 485.635(d)(4) will include a section on the failure of the nursing staff to document time of procedures, nursing interventions and adequately incorporate them into the nursing care plan/problem list. This portion of the revision will be included in the training curriculum. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
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| C 298 | Continued From page 12<br><br>On 1/26/10 at 3:45 PM the Chief Process Officer reviewed the patient's record and confirmed the care plan did not reflect the patient's change in condition.<br><br>The CAH failed to ensure care plans were appropriately created and updated for all patients. | C 298 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| B 000 | 16.03.14 Initial Comments<br><br>The following deficiencies were cited during the complaint investigation of your Critical Access Hospital. The surveyors conducting the survey were:<br><br>Teresa Hamblin, RN, MS, Team Leader<br>Trish O'Hara, RN, HFS | B 000 | RECEIVED<br><br>FEB 23 2010<br><br>FACILITY STANDARDS | |
| BB175 | 16.03.14,310.03 Patient Care Plans<br><br>03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)<br><br>a. Nursing care treatments required by the patient; and (10-14-88)<br><br>b. Medical treatment ordered for the patient; and (10-14-88)<br><br>c. A plan devised to include both short-term and long-term goals; and (10-14-88)<br><br>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)<br><br>e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88)<br><br>This Rule is not met as evidenced by:<br>Refer to Federal Tag A 298 as it relates to the CAH's failure to initiate and keep current patient care plans. | BB175 | 16.03.14,310.03 Patient Care Plans<br><br>The policy and procedure revision titled Patient Care Plans referenced in opening comments of 485.635(d)(4) will include sections on :<br><br>a. Nursing care treatments required by the patient; and (10-14-88)<br><br>b. Medical treatment ordered for the patient; and (10-14-88)<br><br>c. A plan devised to include both short-term and long-term goals; and (10-14-88)<br><br>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)<br><br>e, A description of socio-psychological needs of the patient and a plan to meet those needs.(10-14-88) | |

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 2-22-10

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 83720-0036
PHONE 208-334-6626
FAX 208-364-1888



February 9, 2010

Louis Kraml
Bingham Memorial Hospital
P.O. Box 751
Blackfoot, ID 83221

Provider #131325

Dear Mr. Kraml:

On **January 26, 2010**, a complaint survey was conducted at Bingham Memorial Hospital. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004191**

Allegation: The hospital failed to prevent and manage a patient's skin breakdown.

Findings: An unannounced survey was conducted at the CAH on 1/25/10. During the complaint investigation, surveyors interviewed staff and patients and reviewed hospital policies and 6 patient records.

Review of patient records revealed inconsistent or inadequate assessments of the condition of patients' skin. It also revealed inconsistent or inadequate nursing care planning related to the prevention and management of skin breakdown.

For example, one record documented an 85 year old male admitted to the hospital on 5/03/09. The "Initial Patient Data Collection and Assessment" form, dated 5/03/09 at 3:25 PM, documented he had a dark area on the coccyx. The Braden score, which measured the level of risk for skin breakdown, was left blank. Therefore the initial skin assessment was incomplete.

A nursing note, dated 5/03/09 at 7:25 PM, indicated the patient was having diarrhea, his rectum and coccyx were reddened, and he had a Stage 1 decubitus (pressure sore) on his left buttocks.

Subsequent nursing notes documented a progression of skin breakdown. A nursing note, dated 5/05/09 at 6:40 AM documented slight redness to the buttock region with a small blister. The nursing note, dated 5/05/09 at 6:00 PM, documented 4 blisters, a 4 inch diameter reddened area and a stage II wound located on the coccyx.

There was no documentation on the nursing shift assessment notes (5/04/09 07:00 AM, 5/06/09 at 7:00 AM, 5/07/09 at 7:10 PM, 5/08/09 at 6:40 AM and 7:00 PM, or 5/09/09 at 7:00 PM) that nursing staff evaluated any of the described areas of concern. There were no Braden assessment scores documented on any nursing notes during the course of hospitalization. Therefore, assessments of skin condition were incomplete.

During an interview on 1/25/10 at 4:00 PM, the Nursing Supervisor reviewed the medical record and confirmed documentation relating to skin assessment information was incomplete. She also confirmed the nursing care plans failed to identify skin issues as a problem.

Review of hospital policies and administrative information indicated the hospital failed to have policies in place to guide nurses on expectations for assessment, prevention, and management of skin breakdown.

The hospital was cited for failing to adequately train, orient, supervise, and provide policies for nursing staff in relation to assessment, prevention and management of skin breakdown. It was also cited for failing to ensure nursing staff developed or kept current nursing care plans that reflected the initial or changing needs of patients.

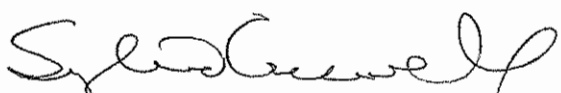
Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

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

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

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care