IDAHO DEPARTMENT OF HEALTH & WELFARE

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

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

July 13, 2010

Brent Bryson
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

RE: Intermountain Hospital, provider #134002

Dear Mr. Bryson:

Based on the survey completed at Intermountain Hospital, on June 24, 2010, by our staff, we have determined Intermountain Hospital, is out of compliance with the following Medicare Hospital **Conditions of Participation: 42 CFR 482.12 Governing body – 42 CFR 482.21 Quality Assessment and Performance Improvement Program – 42 CFR 482.22 Medical Staff – 42 CFR 482.23 Nursing Services**. 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 Intermountain 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;
- 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 August 8, 2010. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than July 29, 2010.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **July 27, 2010**.

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/srp

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

INTERMOUNTAIN
HOSPITAL

RECEIVED
JUL 23 2010
FACILITY STANDARDS

July 23, 2010

Sylvia Creswell
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

RE: Intermountain Hospital of Boise, provider #134002

Dear Ms. Creswell:

Per your letter dated July 13, 2010 please find the enclosed copy of the Plan of Correction submitted by Intermountain Hospital from the June 24, 2010 survey.

If there any questions regarding this information, please contact our PI Director Jennifer Hunkovic at (208) 377-8400.

Sincerely,

Brent Bryson
CEO

303 N. Allumbaugh Street Boise, ID 83704 • www.IntermountainHospital.com Phone 208.375.5910 • Fax 208.377.3170

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

OMB NO. 0938-0391

Laura MacDonald STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOSPITAL	303 NORTH ALLUMBAUGH STREET BOISE, ID 83704

(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
A 000	**INITIAL COMMENTS** The following deficiencies were cited during the complaint/follow-up and recertification survey of your hospital. Surveyors conducting the survey were: Patrick Hendrickson, RN, Team Leader Gary Banister, RN, HFS Teresa Hamblin, RN, HFS Aimee Hastriter, RN, HFS Acronyms used in this report include: ADA = American Diabetic Association ADR = Adverse Drug Reaction BG = blood glucose BMI = Body Mass Index BP = blood pressure CMS= Center for Medicare and Medicaid Services COP = Conditions of Participation CPS = Comprehensive Pharmaceutical Services DNS = Director of Nursing Services gastroparesis = delayed stomach emptying HR = heart rate ICU = Intensive Care Unit MAR = Medication Administration Record mg = Milligrams NP = Nurse Practitioner P & T = Pharmacy & Therapeutics QAPI = Quality Assurance Performance Improvement RN = Registered Nurse > = greater than < = less than	A 000	RECEIVED JUL 23 2010 FACILITY STANDARDS	
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE CEO (x6) DATE 7-23-10

Any deficiency statement ending in an asterisk (*) denotes a deficiency which the institution may by excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the above findings and plans of correction are discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 043	Continued From page 1 hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body. This CONDITION is not met as evidenced by: Based on interviews and review of Quality Assurance and Performance Improvement documents, Medical Staff Bylaws, Medical Executive Committee meeting minutes, Peer Review Log, and patient records, it was determined the governing body failed to provide sufficient oversight and management over the hospital to ensure compliance with all the CoPs. This resulted in the inability of the facility to provide safe and appropriate care and services to patients. Findings include: 1. Refer to A049 as it relates to the failure of the governing body to ensure a medical review process was developed and implemented and that medical staff were accountable to the governing body for the quality of care provided to patients. 2. Refer to A083 as it relates to the failure of the governing body to ensure contracted services were incorporated into the hospital's Quality Assessment and Performance Improvement Program. 3. Refer to A263 Condition of Participation on Quality Assessment and Performance Improvement Program and related standard level deficiencies as they relate to the failure of the governing body to ensure the hospital's Quality Assessment and Performance Improvement Program was integrated into all of the hospital's	A 043	**482.12 GOVERNING BODY** Intermountain Hospital's Governing Body now ensures the provision of sufficient oversight and management over the hospital to ensure compliance with all CoPs. The Governing Body requires responsiveness and accountability of both the Medical Staff and Hospital leadership in the improvement of quality and amelioration of all deficiencies stated in this Statement of Deficiencies. **(Refer to tags A049, A083, A263,A338 and A385)**	

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A 043	Continued From page 2 departments. 4. Refer to A338 Condition of Participation on Medical Staff and related standard level deficiencies as they relate to the failure of the governing body to ensure a medical review process was developed and implemented and that medical staff were accountable to the governing body for the quality of care provided to patients and did not admit medically unstable patients. 5. Refer to A385 Condition of Participation on Nursing Services and related standard level deficiencies as they relate to immediate jeopardy to patient health and safety (abated 6/21/10) and the failure of the governing body to ensure nursing services were provided to meet patients' needs. The cumulative effect of these systemic negative practices resulted in the inability of the facility to provide care of adequate scope and quality.	A 043		
A 049	482.12(a)(5) MEDICAL STAFF - ACCOUNTABILITY [The governing body must] ensure that the medical staff is accountable to the governing body for the quality of care provided to patients. This STANDARD is not met as evidenced by: Based on staff and patient interviews and review of Quality Assurance and Performance Improvement documents, Medical Staff Bylaws, Medical Executive Committee meeting minutes, Peer Review log, and patient records, it was determined the governing body failed to ensure the medical staff was held accountable to the governing body and assumed full responsibility for	A049	**482.12(a)(5) MEDICAL STAFF-ACCOUNTABILITY** The Governing Body now ensures the medical staff is held accountable to the governing body and assumes full responsibility for the quality of medical care provided to patients 1. The Governing Body convened a meeting of the Medical Staff, and required the following corrective actions, now implemented:	7/13/10

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A 049	Continued From page 3 the quality of medical care provided to patients. This resulted in a lack of Medical Staff peer review of the medical care provided by general medicine physicians. Findings include: 1. The hospital's Medical Staff Rules and Regulations, dated 5/07, stated at 20.2, that all members of the active Medical Staff were required to participate in Monthly Peer Review Procedures or as otherwise mandated by the Medical Director. Qualifying Peer Review guidelines for cases to be reviewed under the peer review process, included, but were not limited to, patients leaving AMA (Against Medical Advise), patients who experienced adverse drug reactions, patients transferred to acute care ED's, and patients who experienced critical events. On 6/22/10 starting at 12:00 PM, a group interview was conducted. In attendance were the consulting General Medicine Physician, a NP, a PA, and the Chief of Medicine. The Chief of Medicine stated that no processes were developed to include a Peer Review process for General Medical Physicians. Review of the hospital's Peer Review Log, from July 2009 to June 2010, showed that no records underwent peer review that included services provided by General Medicine Physicians. The governing body failed to ensure processes were developed and implemented to thoroughly and effectively assess the quality of care provided by the hospital's General Medical Physicians. 2. Refer to A338 Condition of Participation on Medical Staff and related standards level deficiency, as they relate to the failure of the		a. Development of specific criteria for credentialing, privileging, assessment and assignment of general medicine physicians and mid level providers. b. Required the involvement of the Medical Executive Committee (MEC) in the development, implementation and oversight of any changes in clinical approaches and processes contemplated throughout the hospital. c. Expansion of criteria for, and implementation of, the Peer Review Process and ongoing evaluation. d. Development of review process for continuing medical education appropriateness. e. Revised and enhanced review process for contracted services. 2. The Medical Team now participates in monthly peer review. a. A peer review process was completed on the family Practice physician. b. Qualifying peer review guidelines include:	7/1/10

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A 049 A 083	Continued From page 4 hospital to ensure Medical Staff assumed full accountability for the medical care provided to patients. 482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions o participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on Quality Assurance and Performance Improvement documents, hospital policies and procedures, and staff interview, it was determinec the governing body failed to ensure of 3 of 4 (laboratory, dietary, pharmacy) contracted departments were integrated into the hospital's Quality Assurance and Performance Improvement Program. This negatively impacted 2 of 9 current patients (#16 and #17) whose records were reviewed. The failure of the governing body's oversight resulted in missed opportunities to improve patient care and outcomes. Findings include: 1. A review of the hospital's contract titled Professional Services Agreement - Stat Clinical Laboratory Services, did not state who was going to collect data for or address Performance Improvement Projects. The hospital's Director of Performance Improvement and Risk Management was interviewed on 6/24/10 starting at 2:30 PM. She	A 049	i. Patients who experience adverse drug reactions; ii. Patients transferred to acute care; and iii. Patients who experience critical events. **Persons Responsible:** Governing Body Medical Director CEO **How Monitored:** • The Medical Director now submits a Medical Staff written report which includes oversight, peer review, clinical changes, credentialing and any other significant matters to the Governing Body as part of its standing agenda. • The credentialing specialist now maintains a log of the cases reviewed through the Peer Review process in order to ensure ongoing monitoring and evaluation of members of the medical staff and quality review.	

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A 083	Continued From page 5 stated she had not implemented a quality assessment and performance improvement program for the hospital's laboratory services. During a tour of the hospital on 6/17/10, beginning at 8:40 AM, surveyors found the following expired laboratory equipment: * Adult Unit-1 grey top blood collection tube that expired on 12/08, 3 grey top blood collection tubes that expired on 6/09, and 2 grey top blood collection tubes that expired on 12/09. * ICU Overflow Medication Room-a vial of sterile water for parenteral administration that expired on 4/10, 2 viral transport kits that expired on 5/09, 3 viral transport kits that expired on 6/09, 3 viral transport kits that expired on 8/09, and 7 viral transport kit that expired on 9/09. * Medication room of the Adolescent Unit-3 grey top blood collection tubes that expired on 12/08, 3 expired grey top blood collection tubes that expired on 6/09, and 3 grey top blood collection tubes that expired on 12/09. * Adolescent North Unit-1 grey top tube that expired on 6/09. * New Start Unit-5 grey top tubes that expired on 6/09. All items and expiration dates were observed and confirmed by the DNS during the tour. The hospital's governing body failed to ensure the equipment was not expired. 2. The hospital's Director of Performance	A083	**482.12(e) Contracted Services** The Governing Body now ensures that all departments (including laboratory, dietary and pharmacy) contracted services are integrated into the hospital's QAPI plan. **Actions Taken:** 1. The Governing Body, Medical Staff and Director of PI/Risk Management received remedial education on their role and responsibility for ensuring all contract services were incorporated into the Hospital's QAPI Program. 2. The Director of PI and DNS met with Stat Clinical Laboratory Services to develop specific PI criteria. A new Laboratory PI plan was developed and implemented. Indicators include: a. Timeliness of draw b. Notification of critical Stat labs done within one hour c. Notification to RN of patient's refusal for labs d. Lab results filed in medical record within 24 hours e. Blood sampling collection equipment, transport kits and solutions not expired.	7/14/10 7/15/10

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A 083	Continued From page 6 Improvement and Risk Management was interviewed on 6/24/10 starting at 2:30 PM. She stated the contracted dieticians were not included within the hospital's Quality Assessment and Performance Improvement Program. The hospital's Dietician Consultant Description of Services form, that was not dated, stated the contracted dietician service would "Complete the Following QA (Quality Assurance) audits monthly..."; Dining room observations, sanitation survey, tray-line observation, test tray. The form stated the contracted dietitians would "Complete the Following QA audits quarterly;" Diet card accuracy check, tube feeding evaluation, and management review. The Dietician Consultation Director was interviewed on 6/23/10 starting at 10:30 AM. She stated she had not been involved in the hospital's Quality Assessment and Performance Improvement Program and did not have any aggregated data. 3. The hospital's Dietician Consultant Description of Services form, that was not dated, stated the dietician would help develop patients' Plans of Cares. This was not done. Examples include: a. Patient #16 was a 61-year-old male, who was admitted to the hospital on 6/14/10 for treatment of opiate detoxification. According to Patient #16's medical record, he had a long history of Diabetes Mellitus and was insulin dependent. Patient #16 was a current patient as of 6/18/10. Patent #16's record contained a Nursing Assessment, dated 6/14/10 that was not timed. The assessment included an evaluation of Patient	A083	3. Analysis of Laboratory data is now incorporated into the Hospital QAPI Program. 4. The PI Director and PSI Consultants met with the Registered Dietitian Consultants. A new Dietary PI plan was developed and implemented. Indicators include: a. Accuracy of therapeutic diets served to patients b. Timely and comprehensive referral, screening and assessment completion c. Treatment planning for all patient with clinical nutritional needs d. Sanitation and safety in the dietary department. 5. Analysis of dietary/registered dietitian data is now incorporated into the Hospital QAPI Program. 6. The PI Director met with CPS Pharmacy. A new Pharmacy PI plan was developed and implemented. Indicators included a. Patient's height/weight entered in HMS within 48 hours of admission b. Patient's pregnancy/lactation entered in HMS within 48 hours of admission	715/10 7/15/10

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A 083	Continued From page 7 #16's BMI. The assessment stated Patient #16 was 5 foot 10 inches tall and weighed 125 pounds. This resulted in a BMI of less than 19 (normal 19-24) which placed Patient #16 in the underweight category. Patent #16's record contained a verbal physician's order, dated 6/14/10 at 11:55 AM. The order included a dietary consult and an ADA diet for Patient #16. An ADA diet is set forth by the American Diabetes Association to help diabetics control BG levels by eating a consistent amount of carbohydrates distributed throughout the day and reduce calories to less than 2000 per day. A Nursing note, dated 6/15/10 at 5:05 AM, stated Patient #16 had a history of gastroparesis resulting in a 25 pound weight loss and he was described as looking emaciated. On 6/15/10 at 11:10 AM, the NP wrote orders for Patient #16. These orders included a second dietary consult referral and instructed nursing to provide a can of Ensure between meals and at bedtime. This would total 3 to 4 cans a day. Ensure has 250 calories per can and 60 grams of carbohydrates, 3 cans of ensure would provide 750 calories out of a 1500-2000 calories ADA diet and 180 grams of carbohydrates of the 250-275 grams of carbohydrates for the ADA diet. A History and Physical assessment, written by a NP, dated 6/15/10 at 12:28 PM, stated Patient #16 was malnourished and had poor nutritional status. Patient #16's record contained a dietary Nutritional Assessment, completed by a	A083	c. Patient's allergies profile entered in MAR within 48 hours of admission d. The Refrigeration temperature log completed 7. Pharmacy contracted services data is now incorporated into the Hospital QAPI Plan. 8. A special Performance Improvement Committee meeting was convened with each of the contracted departments in order to review and incorporate the departmental QAPI indicators and plans. a. The MEC and Governing Board approved the QAPI indicators for dietary, pharmacy and laboratory contracted services. 9. The Hospital QAPI plan was amended to include all clinical contracted services are incorporated into the QAPI program	6/25/10 7/27/10 7/15/10

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A 083	Continued From page 8 contracted Dietician, dated 6/16/10, that was not timed. The assessment did not include an assessment of Patient #16's calorie or carbohydrate intake. The assessment did not state how much of his meals he was eating or how many cans of Ensure Patient #16 was drinking. The assessment did not state what Patient's #16's BMI was or what his normal weight was. The assessment stated Patient #16 had a weight loss, but did not define how much weight he lost and in what period of time. The assessment did not include Patient #16's current and past dietary compliance or snacking habits. The assessment documented the Dietician recommended to encourage Patient #16 to decrease his Ensure as he began to eat more food. The assessment did not include recommendations such as, monitoring Patient #16's oral intake, monitoring Patient #16's compliance with the ADA diet, providing healthy snacks and weighing Patient #16 each week or at more frequent routine interval. Patient #16's Plans of Cares, dated 6/14-6/16/10, did not include Patient #16's poor nutritional status and his malnutrition. Patient #16's Plans of Cares did not document the Dietician had reviewed and contributed to the development of the Care Plans. The above findings were confirmed by the Dietician Consultation Director on 6/23/10 during an interview that started at 10:30 AM. b. Patient #17 was 36-year-old female admitted to the hospital on 6/11/10 for treatment of alcoholism. Patient #17's record contained a history and physical assessment, dated 6/17/10 at 7:75 AM.	A083	10. The Annual Evaluation of Contracted Services form was developed and approved by the MEC and Governing Board. **Person(s) Responsible:** CEO Medical Director Director of PI/Risk Management **How Monitored:** • Monthly PI progress reports are now submitted by all contract services to the Director of PI. • PI Data is now submitted to and monitored by the Quality Council monthly, and to the MEC and Governing Board quarterly. • Evaluation of Contracted Services is now reported to and monitored by the Quality Council, MEC and Governing Board for approval, as part of their standing agenda.	7/27/10

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A 083	Continued From page 9 The history and physical assessment was done by the hospital's General Medicine Physician. It stated Patient #17 had had a gastric bypass, pernicious anemia (anemia caused by the inabilit to absorb vitamin B-12 due to the patients gastric bypass), and microcytic anemia (anemia caused by the inability to absorb iron due to the patients gastric bypass) The results of Patient #17's laboratory blood tests dated 6/18/10 at 6:50 AM were as follows: Iron 7 (normal 30-70) Present of iron saturation 2 (normal 20-50) Hemoglobin 8.4 (normal 12-15) Hematocrit 27.4 (normal 36-48) These laboratory tests verified Patient #17 was very anemic. On 6/12/10 at 11:15 AM, the General Medicine Physician wrote an order for Patient #17 to take a iron supplement every day with orange juice (the vitamin C in the orange juice helps the uptake of the iron during the digestive process). Patient #17's 6/11/10 through 6/24/10 Plans of Cares were reviewed. The Care Plans did not mention Patient #17 was to be provided orange juice with her iron. Patient #17's record contained a Nutritional Assessment, completed by a contracted Dietician dated 6/21/10 that was not timed. The assessment did not include an assessment of Patient #17's calorie intake. The assessment did not state how much of her meals she was eating. The assessment did not include Patient #17's current and past dietary compliance or snacking	A083		

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A 083	Continued From page 10 habits. The assessment recommended Patient #17 eat foods high in iron such as meats, beans, fortified cereals, leafy greens and foods high in vitamin C. The assessment also recommended Patient #17 limit her coffee/tea beverages. Patient #17's 6/11/10 through 6/24/10 Plans of Care were reviewed. The Care Plans did not include the dietician's nutritional recommendations as stated in the 6/21/10 assessment. Patient #17's 6/11/10 through 6/24/10 Plans of Care were reviewed by the Dietician Consultation Director and a dietician during an interview on 6/23/10 starting at 10:30 AM. They both confirmed the Care Plans were not updated after the 6/21/10 Nutritional Assessment. The hospital's governing body failed to oversee the quality contracted dietetic services. 4. On 6/23/10 between approximately 1:00 PM and 2:00 PM, three pharmacists were interviewed together, including the Regional Director for Comprehensive Pharmacy Services (CPS), the hospital's pharmacy management company; a pharmacist hired on a per diem basis after the Director of Pharmacy left in February 2010 (and later changed to Interim Pharmacy Director); and the newly hired Director of Pharmacy who had been on the job a total of 3 days. When asked how pharmacy management was ensuring all pharmacy policies were being reviewed annually per hospital policy, the Regional Director for CPS and the Per Diem Pharmacist (Interim Pharmacy Director) both stated they were not sure. The	A083		

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A 083	Continued From page 11 Regional Director explained the two Directors of Pharmacy left abruptly, one in 11/09 and one in 2/10. There was no "hand-off" to determine what processes were in place. She confirmed the date of the last review was not included on the policies She stated she would ensure a process was put in place and might add review dates at the end of the policies for clarity. The following two hospital policies indicated the pharmacy's Policy and Procedure manual would be reviewed at least annually: "Pharmacy and Therapeutics Committee," and a hospital policy, dated 3/00 and revised 03/03, titled "Role Review and Revision of Policy and Procedure Manual." The policies did not indicate how the hospital would document the review was complete (such as updating the revision date on the policy). When asked during the interview on 6/23/10 between 1:00-2:00 PM, what problems or issues had been identified in the pharmacy, the Per Diem Pharmacist (Interim Pharmacy Director) stated she had become aware of some problems. For example, she became aware of slow response times from nursing and medical staff to clarifying physician orders. She began tracking the problems on an untitled form where concerns were being tracked that required pharmacy interventions. She stated she had been tracking "concerns" for about a month and planned to report the information at the next P & T Committee. She also stated patient information was missing that was needed related to safety of dispensing medication (e.g., height, weight, allergies, pregnancy status). She estimated a third of the			

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A 083	Continued From page 12 time important patient information was missing. She developed a form called "Patient Information Request" for nursing staff to complete the missing items. She stated a result of this process, the frequency of missing information decreased. She stated this process was done informally and she did not track specifics related to the numbers of problems or the specific improvements During an interview on 6/23/10 at 3:00 PM, the Regional Director for CPS stated she had worked with the Per Diem Pharmacist (Interim Pharmacy Director) since February to improve pharmacy processes, such as processes to increase communication. She said she had created the "concern tool." This was a tool for reporting pharmacist interventions. She stated previously the directors had been involved with Quality meetings, however, the last Director had no hours allocated to Quality. In the above referenced interview, the Regional Director for CPS explained she did a pre-survey audit of the CMS Conditions of Participation in March, 2010 to help prepare the hospital to be re-surveyed. She provided results of the audit to the CEO of the hospital, addressed in a letter, dated 3/24/10. The letter included her findings and recommendations for quality improvement activities related to each standard within the Condition of Pharmacy Services. The following are some examples of findings and recommendations listed on the letter: ' Pharmacy will improve communication with nursing and medical staff regarding non-formulary medication, "Do Not Use," abbreviations, Range Orders, Indication for Use, etc., and document corrections in patient medical records and			

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A 083	Continued From page 13 pharmacy interventions during the P & T Committee meetings. * Pharmacy to increase involvement in reviewing possible adverse drug reactions (ADRs) and routinely report findings to Risk Management and P & T Committee. * Pharmacy to check available sources of drug information at the nursing station and/or drug storage area to determine if they are current (nothing prior to 2008). Nursing and pharmacy staff should understand use of www.drugs.com <http://www.drugs.com> website for information. The Regional Director for CPS (in the above referenced interview) stated when CPS provided their survey results, CPS expected pharmacy staff to communicate with the hospital and keep them informed. She stated she served as a resource for the pharmacy and her primary communication was with the pharmacist in charge; and it was the responsibility of the pharmacist in charge to communicate with the broader hospital. When asked by the surveyor if a Plan of Correction (POC) had been established in response to the CMS pre-survey audit, the Regional Director for CPS stated there had not been a POC established. She acknowledged the Performance Improvement Process for pharmacy had not been formalized but she intended to formalize the process. During an interview on 6/23/10 at 2:45 PM, the Director of Performance Improvement/Quality Assurance stated the Pharmacy Department had not been integrated into the QAPI program. When asked what would be involved to integrate			

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A 083	Continued From page 14 the Pharmacy Department into QAPI, she explained there was a formal process of presentation and approval and stated this had no been done. She stated she was not familiar with the issues in pharmacy. The governing body failed to ensure pharmacy services were integrated into the hospital's Quality Assurance and Performance Improvement Program.			
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on review of QAPI data, hospital contracts and policies, review of medical records, and staff interview, it was determined the hospital failed to develop, implement, and/or integrate an effective, ongoing, data-driven quality assessment and performance improvement program for 3 of 4 contracted services (laboratory, pharmacy, and consulting dieticians). This failure resulted in missed opportunities for improvement in delivery	A263	**482.21 QAPI** The Governing Body at Intermountain Hospital now ensures and oversees the development, implementation and integration of an effective, ongoing, data-driven quality assessment and performance improvement program for the laboratory, pharmacy and consulting dieticians. **See A264**	

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A 263	Continued From page 15 of safe and effective patient care. Findings include: Refer to A 264 as it relates to the hospital's failure to ensure the development of QAPI programs for all contracted services. The cumulative affect of this systemic failure resulted in the inability of the hospital to identify problems and initiate corrective actions necessary for safe and effective patient care.	A263		
A 264	482.21(a) QAPI PROGRAM SCOPE Standard: Program Scope This STANDARD is not met as evidenced by: Based on review of QAPI data, hospital contracts and policies, review of medical records, and staff interview, it was determined the hospital failed to ensure the development of QAPI programs for 3 of 4 contracted services (laboratory, pharmacy, and consulting dieticians). This failure directly impacted 2 of 9 patients (#16 and #17) and had the potential to affect all patients cared for by hospital staff. This failure resulted in missed opportunities for improvement in delivery of safe and effective patient care. The findings include: 1. The Director of Performance Improvement and Risk Management was interviewed on 6/24/10 starting at 2:30 PM. She confirmed a QAPI program had not been established for the hospital's laboratory services. The hospital's contract, titled Professional Services Agreement - Stat Clinical Laboratory Services, was reviewed. The contract failed to specify an individual responsible for overseeing aboratory services and collecting data to be	A264	**482.21(a) QAPI Program Scope** Intermountain Hospital now ensures the development of QAPI programs for laboratory, pharmacy and consulting dieticians. **Actions Taken:** 1. The QAPI program scope and processes were reviewed and revised to now include the development of QAPI programs for each department, including contracted services, and to integrate those programs into the overall Hospital QAPI plan. 2. Each contract service now has a set of indicators that are prioritized by risk, and a thorough plan for improvement. 3. Performance data is now collected, tracked, trended analyzed and reported in order to assess efficacy and measure improvement.	7/13/10 7/20/10 7/20/10

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A 264	Continued From page 16 incorporated into Performance Improvement Projects. 2. During an interview on 6/23/10 at 2:45 PM, the Director of Performance Improvement and Risk Management stated the Pharmacy Department had not been integrated into the QAPI program. She explained there was a formal process of presentation and approval prior to the integration of a department into the QAPI program, and this had not been done. She stated she was not familiar with the issues in pharmacy. The following issues demonstrated a need for quality assurance overview of pharmaceutical services: a. A hospital policy, revised 03/03, titled "Role Review and Revision of Policy and Procedure Manual," indicated the pharmacy's Policy and Procedure manual would be reviewed at least annually. However, the policies did not indicate how the hospital would document the review was complete (such as updating the revision date on the policy). On 6/23/10 between 1:00 PM and 2:00 PM, the Regional Director for CPS (the hospital's pharmacy management company), the Interim Pharmacy Director (hired on a per diem basis after the Director of Pharmacy left in February 2010), and the newly hired Director of Pharmacy who had been on the job 3 days were interviewed together. The Regional Director for CPS and Interim Pharmacy Director both stated they were not sure how pharmacy management was ensuring all pharmacy policies were being reviewed annually per hospital policy. The Regional Director explained two Directors of	A 264	4. Representatives of each department and contracted service now conduct Departmental Performance Improvement (PI) Meetings and participate in hospital-wide PI meetings. 5. Data is submitted in advance of each meeting to the PI Director a. Measures are reviewed at each meeting and any new trends are incorporated into the PI process. 6. Strategies for prevention of risk and quality improvements are now discussed and implemented in all contracted services departments. **Person(s) Responsible:** Director of PI/Risk Management Medical Director CEO **How Monitored:** • The Medical Executive Committee and the Governing Body now review and approve the Hospital QAPI plan, ensuring that it includes indicators and measures for all contracted services and departments	7/22/10 7/29/10 7/29/10

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A 264	Continued From page 17 Pharmacy left abruptly, one in November of 2009 and one in February of 2010. There was no "hand-off" to determine what processes were in place. She confirmed the date of the last review was not included on the policies. She stated she would ensure a process was put in place and might add review dates at the end of the policies for clarity. b. During an interview on 6/23/10 at 3:00 PM, the Regional Director for CPS stated she had worked with the Interim Pharmacy Director to improve pharmacy processes, such as processes to improve communication between pharmacy staff and other staff members. She created the "concern tool," the tool for reporting data related to pharmacist interventions relative to receiving and distributing medication orders. c. During the interview on 6/23/10 beginning at 1:00 PM, the Interim Pharmacy Director explained that she noticed a slow response time from both nursing and medical staff related to physician order clarifications. She began tracking specific issues involved in delays using the "concern tool." She stated she had been tracking this data for about a month and planned to report the information at the next Pharmacy and Therapeutics Committee. d. During the interview on 6/23/10 beginning at 1:00 PM, the Interim Pharmacy Director also stated patient information was missing that was needed related to safety of dispensing medication (e.g., height, weight, allergies, pregnancy status). She estimated a third of the time, important patient information was missing. She developed a form called "Patient Information Request" to assist nursing staff to provide the missing items. As a result of this process, the amount of missing	A 264	• Monthly Departmental PI and Hospital PI meetings now focus on, and ensure, that the scope of QAPI program integrates contracted services. • Minutes of the meetings, and written PI plans and progress reports reflect and evidence the appropriateness, quality and efficacy of the plans.	

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A 264	Continued From page 18 information decreased. She stated this process was done informally and she did not track the data related to the how much information was missing before instituting the new form, and the improvement noticed once the form was utilized. e. During an interview on 6/23/10 at 3:00 PM, the Regional Director for CPS explained she conducted a pre-survey audit of the CMS Conditions of Participation in March, 2010 to help prepare the hospital to be re-surveyed. She provided results of the audit to the CEO of the hospital, addressed in a letter, dated 3/24/10. The letter included her findings and recommendations for quality improvement activities related to each standard within the Condition of Pharmacy Services. The following were examples of findings and recommendations listed in the letter: · Pharmacy would improve communication with nursing and medical staff regarding non-formulary medication, "Do Not Use," abbreviations, Range Orders, Indication for Use, etc., and document corrections in patient medical records and pharmacy interventions. · Pharmacy was to increase involvement in reviewing possible ADRs and routinely report findings to Risk Management and P & T Committee. · Pharmacy was to check available sources of drug information at the nursing station and/or drug storage area to determine if they were current (there was to be nothing prior to 2008 available). Nursing and pharmacy staff would understand use of www.drugs.com <http://www.drugs.com> website for information.	A 264		

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A 264	Continued From page 19 The Regional Director for CPS, during the interview on 6/23/10 at 3:00 PM, stated when CPS provided their survey results, CPS expected pharmacy staff to communicate with the hospital and keep them informed. She stated she served as a resource for the pharmacy and her primary communication was with the pharmacist in charge and it was the responsibility of the pharmacist in charge to communicate with the broader hospital. The Regional Director for CPS stated that the Pharmacy Department had been involved with Quality meeting "2 or 3 directors ago," but that "hours were not allocated to Quality for the last Director." She acknowledged that the Performance Improvement Process for pharmacy had not been formalized, however intended to formalize the process. The hospital failed to ensure contracted Pharmacy services were involved in the hospital's QAPI Program. This resulted in missed opportunities for improvement in the safe delivery and administration of medications. 3. The Director of Performance Improvement and Risk Management was interviewed on 6/24/10 starting at 2:30 PM. She confirmed that consulting dieticians were not incorporated into the hospital's QAPI program, and acknowledged a lack of quality assurance oversight with this contracted service. This resulted in the following: a. The hospital's Dietician Consultant Description of Services form, that was not dated, stated the contracted dietary service (contracted dieticians) would "Complete the Following QA (Quality Assurance) audits monthly...": Dining room observations, sanitation survey, tray-line	A 264		

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A 264	Continued From page 20 observation, test tray. The form stated the contracted dietary service would "Complete the Following QA audits quarterly"; Diet card accuracy check, tube feeding evaluation, and management review. The Dietician Consultation Director was interviewed on 6/23/10 starting at 10:30 AM. She stated she had not been involved in the hospital's Quality QAPI program and data had not been collected. b. The hospital's Dietitian Consultant Description of Services form, that was not dated, stated the contracted dietitian would assist in the development and updating of dietary Plans of Care. The following examples failed to demonstrate a dietician's involvement in the development of a POC: i. Patient #16 was a 61-year-old male, who was admitted to the hospital on 6/14/10 for treatment of opiate detoxification. According to Patient #16's medical record, he had a long history of Diabetes Mellitus and was insulin dependent. Patient #16 was a current patient as of 6/18/10. Patient #16's record contained a dietary Nutrition Assessment, completed by the consulting dietician on 6/16/10. The assessment did not include an assessment of Patient #16's calorie or carbohydrate intake. The assessment did not indicated the quantity of meals Patient #16 ate, or how many cans of the supplemental protein drink he was drinking. The assessment did not state what Patient's #16's Body Mass Index (BMI) was or what his normal weight was. The assessment did state that Patient #16 experienced weight	A 264		

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A 264	Continued From page 21 loss, but did not define how much weight was lost and in what period of time. The assessment did not include Patient #16's current and past dietary compliance, or snacking habits. The assessment documented the Dietitian's recommendations to encourage Patient #16 to decrease his Ensure as he began to eat more food. The assessment did not include recommendations such as, monitoring Patient #16's oral intake, monitoring Patient #16's compliance with ADA diet, providing healthy snacks and weighing Patient #16 each week. Patient #16's POC, dated 6/1410 through 6/16/10, did not include Patient #16's poor nutritional status or his malnutrition. The POC did not include evidence that the Dietician contributed, and subsequently reviewed Patient #16's POC. This was confirmed by the Dietitian Consultation Director on 6/23/10 starting at 10:30 AM. ii. Patient #17 was 36 year-old female that was admitted to the hospital on 6/11/10 for treatment of alcoholism. Patient #17's record contained a History and Physical dated 6/17/10 at 7:75 AM. The History and Physical was done by the hospital's General Medicine Physician. It stated that Patient #17 had a gastric bypass, pernicious anemia (anemia caused by the inability to absorb vitamin B-12 due to the patients gastric bypass), and microcytic anemia (anemia caused by the inability to absorb iron due to the patients gastric bypass). Patient #17's record contained a Nutritional assessment, completed by the consulting dietician on 6/21/10. The assessment recommended that Patient #17 eat foods high in iron such as meats, beans, fortified cereals, leafy	A 264		

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A 264	Continued From page 22 greens and foods high in vitamin C. The assessment also recommended that Patient #17 limit her coffee/tea beverages. Patient #17's POC, dated 6/11/10 through 6/24/10, were reviewed. The POC did not include the dietary recommendations included in the Nutritional Assessment. Patient #17's medical record was reviewed with the Dietician Consultation Director during an interview on 6/23/10 starting at 10:30 AM. She confirmed the POC did not include evidence that the Dietician contributed, and subsequently reviewed Patient #17's POC. The hospital failed to ensure that contracted dietician services were involved in the hospital's QAPI Program. This resulted in missed opportunities for improvement in patient care and satisfaction. The hospital failed to ensure all contracted services were incorporated into a hospital-wide QAPI program.	A 264		
A 338	482.22 MEDICAL STAFF The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on staff interviews and review of Medical Staff Rules and Regulations, Medical Executive Committee meeting minutes, Peer Review log, and patient records, it was determined the psychiatric hospital failed to ensure the rules and	A338	**482.22 MEDICAL STAFF** Intermountain Hospital now ensures the rules and regulations developed by the medical staff to regulate themselves apply equally to all members of the medical staff and ensure that the rules and regulations are followed. **See Tag A353**	

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A 338	Continued From page 23 regulations developed by the medical staff to regulate themselves applied equally to all members of the medical staff and that the rules and regulations were followed. This resulted in missed opportunities to improve patient outcomes related to physical health and the admission of a medically unstable patient. Findings include: 1. Refer to A353 for hospital failed to ensure medical staff followed the hospital's Medical Staff Rules and Regulations. The cumulative effect of these negative facility practices significantly impeded the ability of the hospital to provide care of adequate quality.	A 338		
A 353	482.22(c) MEDICAL STAFF BYLAWS The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must: This STANDARD is not met as evidenced by: Based on staff and patient interviews and review of Medical Staff Rules and Regulations, Medical Executive Committee meeting minutes, Peer Review log, and patient records, it was determined the hospital failed to ensure Medical Staff Rules and Regulations were enforced. This directly impacted the care of 1 of 9 current diabetic patients (#16), whose records were reviewed. This resulted in a patient being admitted to the hospital with unstable BGs and missed opportunities to improve patient care related to physical health. Findings include: 1. The hospital's Medical Staff Rules and Regulations, dated 5/07, stated at 20.2, all members of the active Medical Staff were required to participate in Monthly Peer Review Procedures or as otherwise mandated by the	A353	**482.22(c) MEDICAL STAFF BYLAWS** Intermountain Hospital now ensures that all Medical Staff Rules and Regulations are enforced. **Actions Taken:** 1. The Medical Staff Rules and Regulations were reviewed and amended to now specifically state that the peer review process will be conducted by a peer within the same practice. 2. Remedial education was provided to all members of the Medical Staff on the quality and peer review process, how to apply medical standards of care, what peer review action to take and identification of practice patterns requiring more in-depth review.	7/27/10 7/13/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2010

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A 353	Continued From page 24 Medical Director. Qualifying Peer Review guidelines for cases to be reviewed under the peer review process, included, but were not limited to, patients leaving AMA (Against Medical Advise), patients who experienced adverse drug reactions, patients transferred to acute care ED's, and patients who experienced critical events. The hospital's Peer Review Log, from 7/2009 to 6/2010, was reviewed. None of the records noted on the log as having undergone peer review, included services provided by General Medicine Physicians. On 6/22/10 starting at 12:00 PM, a group interview was conducted. In attendance were a General Medical Physician, the hospital's Chief of Medicine, a NP, and a PA. The Chief of Medicine stated that no processes had been developed to include a Peer Review process for General Medicine Physicians. The Medical Staff failed to ensure its rules and regulation/by-laws were enforced for all medical staff providing services to patients. 2. The Medical Executive Meeting minutes, dated 5/04/07, were reviewed. The minutes included documentation describing a new Diabetic Medication Administration and Pharmacy Profile form which had been developed and approved on 5/04/07. It was also documented that the hospital would no longer admit patients with a BG level exceeding 300. The hospital's Medical Staff Rules and Regulations, dated 5/07, stated at 2.1, all admissions to the facility must meet the facility's admission criteria. At 2.1.1 of the Medical Staff	A 353	3. Special emphasis was placed on non-psychiatric members of the medical staff, including the criteria and participation in monthly peer review and quality review processes. 4. The Medical Director, General Medical Physicians and Mid Level Providers met to identify quality indicators based on high volume, high risk or problem prone aspects of care. Quality indicators included: a. Inadequate H&P consultation documentation; b. Medical transfers to the ED c. Quality of care concerns d. Potential adverse clinical outcomes 5. The ongoing peer review process for non-psychiatric members of the medical staff now includes the random case review of a minimum of one case per practitioner quarterly. 6. The Peer Review Case Evaluation Form was approved by the General Medical Physicians to be completed for each record review. This form includes findings, conclusions and recommendations.	7/01/10 7/21/10 7/21/10 7/21/10

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A 353	Continued From page 25 Rules and Regulations the facility's admission criteria was listed. It stated that patients must be free of uncontrolled diabetes before admission. A group interview, which included the Director of Assessments and Referrals, was held on 6/18/10 starting at 4:00 PM. She stated that prior to Patient #16's admission to the hospital, she had received a report from the transferring hospital that Patient #16 was a brittle diabetic (exceptionally difficult to control his BGs). Patient #16 was awaiting transfer to the hospital's Addiction Recovery Center on 6/14/10. Patient #16 was admitted to the hospital as documented on the Interdisciplinary Assessment dated 6/14/10 at 8:45 PM. The patient was documented as having a BG level of 328 on admit. The psychiatrist was notified and it was documented that he allowed the admission despite the high BG level, contrary to the 5/04/07 Committee Meeting Minutes. Patient #16's Emergency Room Transfer Report, dated 6/14/10 at 11:55 PM, stated "do not accept a patient with a blood sugar (BG) of over 300." Patient #16's Diabetic Assessment dated 6/14/10 that was not timed, stated "Note! A patient with a blood sugar (BG) over or 300 will not be accepted." On 6/24/10 during the exit conference that started at 3:00 PM, the hospital's Director of Assessment and Referral stated Patient #16's BGs were stable at the referring hospital. She was advised to provide documented evidence of stable serial BGs from the transferring hospital. This was not done.	A 353	7. The Peer Review process, quality indicators, ongoing practice case evaluations and the Peer Review Case Evaluation form was discussed in the MEC and approved. **Person(s) Responsible:** Medical Director General Medical Physicians **How Monitored:** • Results of the General Medical Physicians Review are incorporated into the PI program through quarterly reports to the MEC and the Governing Board. • The results of the Medical Staff Peer Review process are reviewed as part of the Quality Profile in the reappointment process. • The MEC now conducts an annual assessment of the implementation and enforcement of Medical Staff Bylaws, Rules and Regulations, and addresses any deficiencies immediately.	7/27/10

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A 353	Continued From page 26 The hospital failed to ensure Patient #16's psychiatrist followed the hospital's Medical Staff Rules and Regulations and did not admit a medically unstable patient.	A 353		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on review of clinical records and hospital policies, observations, and staff and patient interviews, it was determined the hospital failed to maintain a well-organized nursing service to meet the needs of patients. This resulted in immediate jeopardy of serious harm or death to one patient (#16) and the potential for other patients to experience negative health outcomes. Findings include: 1. Refer to A395 as it relates to the failure of the hospital to ensure nursing staff evaluated, managed and supervised patients' care, thereby placing of an insulin dependent diabetic patient in immediate jeopardy of serious harm or death. 2. Refer to A393 as it relates to hospital failure to ensure nursing plans of care were developed and updated for patients. The cumulative effect of these systemic negative practices resulted in the inability of the facility to provide care of adequate scope and quality. Note: The facility was notified of the findings related to the immediate jeopardy on 6/17/10	A 385	**482.23 NURSING SERVICES** Intermountain Hospital now ensures a well organized nursing service to meet the needs of the patients. **Refer to approved Plan of Correction submitted and approved on June 21, 2010 lifting the Immediate Jeopardy. ATTACHED**	

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A 385	Continued From page 27 starting at 5:00 PM. A Plan of Correction was reviewed and accepted on 6/21/10 at 12:30 PM. A survey of current insulin dependent patient's was conducted on 6/21/10 starting at 2:00 PM. Patient #16 was transferred to an acute care hospital on 6/20/10. The hospital was in compliance with insulin dosing and the immediate jeopardy was abated.	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of clinical records and hospital policies, observations, and staff interviews, it was determined the hospital failed to ensure an RN supervised and evaluated the nursing care for 4 of 9 current patients (#7, #15, #16 and #17) whose records were reviewed and who was observed. The failure of nursing staff to evaluate the care of patients, led to poor management of patients' dietary needs, incorrect medication management, and a lack physician notification abnormally high vital signs. This placed one patient (#16) at risk of serious harm or death and created the potential for negative health outcomes for all patients admitted to the hospital. Findings include: 1. The Medical Executive Meeting minutes, dated 5/04/07, were reviewed. The minutes included documentation describing a new Diabetic Medication Administration and Pharmacy Profile form which had been developed and approved on 5/04/07. This form allowed nursing staff to document all diabetic care in one place, including medications administered, BG levels and other	A395	**482.23(b)(3) RN SUPERVISION OF NURSING CARE** Intermountain Hospital now ensures that an RN supervises and evaluates the nursing care of patients. **Actions Taken:** 1. All RNs received comprehensive, remedial education on the role and responsibility of RNs in the supervision, assessment and reassessment of patients, and the oversight of all nursing care. 2. Return demonstration of competency was required, and is now tested ongoing. 3. Policies and tools for staff/patient assignments, nursing assessment and re-assessment, identification and communication of changes noted in the patients condition(s) and needs,	7/26/10 7/26/10 7/26/10

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A 395	Continued From page 28 pertinent information pertaining to diabetic care. The minutes also documented the approval of a standing sliding scale insulin order that contained three available options for physicians. It was also documented that the hospital would no longer admit patients with a BG level exceeding 300. Finally, the minutes introduced a change in the standard treatment for hypoglycemia which would direct nursing staff to give 2-3 oz of juice followed with a protein snack such as yogurt or peanut butter. These changes to the standardized care of diabetes were initiated by a previous immediate jeopardy citation on 4/27/07, for the failure of the hospital to manage patient's diabetic needs. The 2001 Mosby's Diagnostic and Laboratory Test Reference states that a possible critical BG level was greater than 400 and less than 50. Patient #16 was a 61-year-old male, who was admitted to the hospital on 6/14/10 for treatment of opiate detoxification. According to Patient #16's medical record, he had a long history of Diabetes Mellitus and he was insulin dependent. Patient #16 was a current patient as of 6/16/10. A group interview, which included the Director of Assessments and Referrals, was held on 6/18/10 starting at 4:00 PM. She stated that prior to Patient #16's admission to the hospital, she had received a report from the transferring hospital that Patient #16 was a brittle diabetic (exceptionally difficult to control his BGs). Patient #16 was awaiting transfer to the hospital's Addiction Recovery Center on 6/14/10. The Admissions Coordinator stated she obtained the admitting hospital's "Humalog" (a medication used to control BG levels) sliding scale insulin	A 395	were reviewed and revised to facilitate compliance and quality. 4. Revised policies and tools were included in the RN training. 5. Additional training for Nursing staff to aid in their supervision of patient care related to Dietary needs included: a. Remedial training on assessment of the patient's dietary needs. b. Implementation of new forms - therapeutic diet cards, revised clinical nutritional documentation by the RDs; c. Hand off communication d. Dietary considerations for commonly used medications e. Training on Treatment planning related to patient specific dietary requirements. 6. Remedial training for RNs related to physician orders included: a. Early identification and communication of new physician orders; b. Processing new physician orders including medications, treatments, diets, etc;	7/21/10 7/23/10 7/26/10 7/26/10

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A 395	Continued From page 29 order that was being used for Patient #16 at the admitting hospital. The Director of Assessments and Referrals stated she then used the admitting hospital's Humalog sliding scale insulin order to obtain a verbal physician's order on 6/14/10 at 11:55 AM from Patient #16's Psychiatrist. Patent #16's record contained a verbal Physician's order, dated 6/14/10 at 11:55 AM. The order included the Humalog Sliding Scale Insulin dosing order. The insulin was to be given five times daily at 2:00 AM, 7:30 AM, 11:30 AM, 5:30 PM, and 9:00 PM. The Humalog dosing was to be given as follows: Blood Glucose 150-199 = 1 unit Blood Glucose 200-249 = 3 units Blood Glucose 250-299 = 5 units Blood Glucose 300-349 = 7 units >349 = 8 units Additional orders stated the 2:00 AM Humalog insulin dose was to be cut in half and 1 unit of Humalog was to be given after each meal. The orders directed staff to give a 16 gram tablet of oral glucose if needed for a BG level result of less than 70. The order did not clarify when the physician was to be notified of high or low BG levels. The orders also directed staff to re-check Patient #16's BG level 1 hour after the administration of Humalog sliding scale insulin. However, Patient #16's record did not include any documentation indicating that this order had been followed. This was confirmed by the Director of Nursing Services (DNS) during a group interview on 6/18/10 starting at 4:00 PM.	A 395	c. Carrying out physician orders in a timely fashion; d. Use of the kardex for implementing physician orders e. Hand off communication on physician order follow up; f. Daily oversight of the process by the nursing supervisors; g. Night shift staff reeducated to review and verify physicians order sheets in night audits; h. Licensed staff accountability for following through on all physician orders in a timely fashion. 7. A new admissions RN position was incorporated to the admitting process to assist with assessment, admitting orders and admission process of new patients.	7/19/10 7/19/10 7/26/10 7/21/10 7/26/10 7/26/10 7/21/10

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A 395	Continued From page 30 Patient #16 was admitted to the hospital as documented on the Interdisciplinary Assessment dated 6/14/10 at 8:45 PM. The patient was documented as having a BG level of 328 on admit. The physician was notified and it was documented that he allowed the admission despite the high BG level, contrary to the 5/04/07 Committee Meeting Minutes. Patient #16's diabetic medication record documented that on 6/15/10 at 2:00 AM the BG level was 193. The 193 BG level should have prompted nursing staff to give 1.5 units of Humalog insulin per the Sliding Scale Insulin order. The diabetic medication administration record documented that Patient #16 refused the insulin. A Nursing note, dated 6/15/10 at 5:05 AM, stated Patient #16 refused his 2:00 AM insulin dose and stated he would rather wait for his morning insulin (7:00 AM). No documentation was found that Patient #16's physician had been notified of the refused insulin. The record was reviewed and the lack of documentation confirmed by the DNS during a group interview that was held on 6/18/10 at 1:50 PM. Patient #16's Diabetic Administration Record documented that on 6/15/10 at 5:30 PM, Patient #16's BG level was 482. The record did not contain documentation that Patient #16's physician had been notified of the high BG level. During a group interview on 6/18/10 starting at 1:50 PM, the DNS reviewed the record end confirmed that there was no documentation indicating the physician had been notified of the high BG level but stated that he probably should have been contacted.	A 395	8. Nursing received remedial training related to hand-off communication, including: a. The use of SBAR process for hand-off communication. b. Revised levels of observation and special precautions and assignment sheets to now include observation levels, precautions, dietary needs, staff's unit responsibilities for the shift. 9. Nursing received additional education regarding following drug manufacturer's recommendations for administration of oral hypoglycemics. 10. A cafeteria schedule has been posted in the medication room to assist the nursing staff in knowing when to administer oral hypoglycemic. An oral hypoglycemic fact sheet has also been posted in a prominent place in the medication room. 11. All nursing units and medication rooms now have current medication references available.	7/21/10 7/26/10 7/26/10 7/19/10 7/19/10

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A 395	Continued From page 31 Patient #16's Diabetic Administration Record documented that on 6/15/10 at 9:00 PM, Patient #16's BG level was 286. According to the sliding scale insulin order, 5 units of insulin should have been administered. However, the record stated the RN only administered 3 units. This was reviewed and confirmed by the DNS during a group interview on 6/18/10. Patient #16's Diabetic Administration Record documented on 6/16/10 at 7:30 AM, a BG level of 60. A Nursing note, dated 6/16/10 at 7:30 AM, stated Patient #16 refused oral glucose as instructed in the sliding scale insulin order, but did eat crackers and drank 8 ounces of orange juice. The Medical Executive Committee meeting minutes, dated 5/04/07, stated the new standard of care for treatment of hypoglycemia [low BG] was to give 2-3 ounces of juice followed by a protein snack. The Nursing note contained no documentation the physician was notified of the low BG level, refusal of the glucose tablets, or the alternate intervention. Patient #16's record did not contain documentation stating whether or not he ate breakfast after the snack or if he had been given 1 unit of insulin as ordered by the physician after the 6/16/10 morning meal. The Diabetic Administration Record documented that at 11:30 AM, Patient #16's BG level was elevated to 546. The Diabetic Medication Record documented that on 6/16/10 at 5:30 PM, Patient #16's BG level was 410. The record did not contain evidence that the physician had been notified of the high levels. During a group interview on 6/18/10 starting at 1:50 PM, the DNS reviewed the records and confirmed the findings.	A 395	12. Remedial training of licensed staff on MAR documentation of actual administration times versus scheduled times. 13. Pharmacist provided in-service to the nursing staff on indications of oral hypoglycemics with post test. 14. In order to ensure that Nursing Staff is competent to closely monitor intake and output (I&O) for patient with renal insufficiency, remedial training was provided on established medical conditions requiring I&O as a primary problem on the treatment plan. a. Daily weights are now included as a more reliable indicator of I&O. b. A revised nursing assessment form including indicators of fluid balance symptoms such as edema and congestion has been implemented. c. A daily weight chart form has been implemented. 15. The RN responsibility for the proper assessment of the patient minimally every 8 hours, including I&O status as indicated, was emphasized and reinforced.	7/26/10 7/26/10 7/26/10 7/21/10

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A 395	Continued From page 32 A Nursing note dated 6/17/10 at 2:00 AM, stated Patient #16's BG level was 273 and that insulin had been given. However the record did not specify the amount of insulin administered. Patient #16's Diabetic Administration Record, dated 6/17/10, did not contain documented evidence that the patient's BG level had been checked at 7:30 AM or if sliding scale insulin had been administered. The record also did not state whether Patient #16 ate breakfast or if 1 unit of insulin had been administered after the meal per the physician's orders. These findings were confirmed by the DNS during an interview held on 6/18/10 starting at 1:50 PM. A Physician's Order Sheet, dated 6/17/10 un-timed, documented that Patient #16's physician had changed the sliding scale Humalog insulin order. The new orders were as follows: Humalog sliding scale: 150-200 = 1 unit 201-250 = 3 units 250-300 = 6 units 300-350 = 10 units >350 = 13 units and call Physician. These orders had the potential to cause confusion as to how many units of insulin were to be administered if Patient #16 had a BG level of 250, 300 or 350. Both 3 and 6 units were ordered to be administered for BG level of 250, both 6 and 10 units of insulin was ordered if BG level was 300, and both 10 and 13 units of insulin were ordered for a BG level of 350. This order was not clarified by the nursing staff until 6/18/10 at 8:35 AM. The Diabetic Administration Record documented	A 395	16. Physician Notification of Changes in Patient Condition policy was revised, and Nursing staff have been trained. 17. Remedial training was provided for all licensed nursing staff on: a. Written criteria describing early warning signs of a change in a patient's condition; b. Physician notification; c. Timely response to changes in patient condition; d. Documenting actions taken; e. Timely follow up on additional physician orders in response to a change in the patient's condition; f. Hand-off communication to the next shift. 18. Remedial training was provided for all nursing staff on the revised Vital Signs policy.	7/22/10 7/26/10 7/26/10

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A 395	Continued From page 33 on 6/17/10 at 11:30 AM, that Patient #16's BG level was 370. The record did not contain documentation that the physician was contacted regarding the high BG level as per the new sliding scale physician's order. On 6/18/10, the Diabetic Administration Record documented the scheduled 2:00 AM BG check was not done until 4:00 AM. On 6/18/10 starting at 4:00 PM, the DNS, Director of Performance Improvement and Risk Management, Director of Social Services, Director of Assessment and Referral, and the Director of Adolescent Programs discussed and reviewed Patient #16's record. They were unable to provide any additional information to explain the above findings. Patient #16's record contained a clarification Humalog sliding scale insulin order dated 6/19/10 at 6:35 AM. The new orders were as follows: Humalog sliding scale: 150-200 = 1 unit 201-250 = 3 units 251-300 = 6 units 301-350 = 10 units >350 = 13 units and call Physician. Patient #16's record contained a physician's order dated 6/18/10 at 2:45 PM, by the hospital's Consulting Medical Physician. The order stated to give an additional 5 units of Humalog insulin after lunch and dinner. The order did not direct staff as to how much lunch/dinner needed to be ingested to administer the insulin. The Diabetic Administration Record documented that on 6/18/10 at 9:00 PM, that Patient #16's BG	A 395	Additional education was provided to clinical staff including: a. Performing vital signs as ordered and MD notification when vital signs are out of established parameters; b. Documentation of vital signs and actions taken; c. Utilization of the revised Vital Signs Log; d. Hand-off communication to the next shift with follow up information; e. Licensed staff review of vital signs prior to the end of the shift to ensure all vital signs were taken as ordered; f. Nursing supervisor's role in providing daily oversight of the process on each unit. 19. Licensed staff are now required to review the vital signs prior to the end of the shift to ensure all vitals signs were taken as ordered 20. Nursing supervisors now provide oversight of this process in each unit and monitor follow through on vital signs being taken as ordered.	7/26/10 7/26/10 7/26/10

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A 395	Continued From page 34 level was 155. The nurse documented they had given Patient #16 six units of insulin, rather than the one unit that was ordered per the insulin sliding scale. The Diabetic Administration Record documented that on 6/19/10 at 2:00 AM, Patient #16's BG level was 64. A Nursing note, dated 6/19/10 5:20 AM, stated at 2:00 AM, Patient #16's BG level was 64 and he was given orange juice, graham crackers and milk. The note then stated that at 3:00 AM, Patient #16's BG level was then at 77 and by 5:00 AM, his BG level was 84. The record did not contain documentation that the physician was notified of the low BG level results. The Diabetic Administration Record did not documented that on 6/19/10 at 7:30 AM, that Patient #16's BG level was taken, or if he received the ordered insulin sliding scale. A Nursing note, dated 6/19/10 at 1:00 PM, stated Patient #16 was "Eating crackers and fruit throughout the day." The Nursing note did not list the consumption of all meals or snacks that Patient #16 ate that day. A Nursing note, dated 6/19/10 at 2:00 PM, documented Patient #16 was placed on 1 to 1 nursing. A Nursing note, dated 6/19/10 at 3:20 PM, stated that Patient #16 was compliant with all nursing cares except " ...dietary restrictions ..." and his diabetic diet, and did not want people telling him what he can and cannot eat. The nursing note did not list the consumption of what Patient #16	A 395	**Person(s) Responsible:** Director of Nursing Nurse Educator Medical Director CEO **How Monitored:** • All RNs were required to return demonstration of competency. • The Director of Nursing and RN Supervisors now conduct random, focused rounds on each shift to observe for appropriate RN supervision and evaluation of patient care. Any deficiencies are immediately addressed. • The Director of Nursing and Medical Director now randomly review a sample of open medical records to ensure the quality and appropriateness of RN supervision and evaluation of patient care. Any deficiencies are immediately addressed. • MARs are now audited nightly to ensure accuracy. • A PI Indicator for timeliness of oral hypoglycemic and meal intake have been developed and implemented.	

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NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704		

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A 395	Continued From page 35 ate. The Diabetic Administration Record documented that on 6/19/10 at 5:30 PM, Patient #16's BG leve was 151. Patient #16's record did not document that he received 1 unit of insulin per the physician's insulin sliding scale order. A Nursing note, dated 6/20/10 at 7:00 AM, stated Patient #16 ate toast, butter, 4 poached eggs, hash browns, oatmeal, bacon, juice, and black coffee with sugar. Calorie and carbohydrate references were from the American Diabetes Association Exchange List. One piece of toast is 100 calories and 15 grams of carbohydrates. A normal serving size of butter is 45 calories. One egg is 75 calories. A normal serving size of hash browns is 80-150 calories and 15 grams of carbohydrates. A normal serving size of oatmeal is 120 calories and 15 grams of carbohydrates. One strip of bacon is 75 calories. A normal serving size of juice is 120 calories and 15 grams of carbohydrates. A normal serving size of coffee with sugar is 15 grams of carbohydrates. A Nursing note, dated 6/20/10 at 12:00 PM,	A 395	• Night Shift staff audit has been expanded to now include a review of the Vital Signs Log, MAR, daily weights, therapeutic diets and the Kardex. • A monitoring tool for weekly random observations to determine whether changes in patient's condition have been responded to in a timely fashion has been developed and implemented. Any deficiencies are immediately addressed. • Data is now collected, analyzed and submitted to the PI Director.	

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A 395	Continued From page 36 stated Patient #16 ate a hamburger with cheese that had lettuce and tomato, macaroni salad, sweet potato fries, vegetable soup and drank 2% milk. One hamburger has 200 calories and 30 grams of carbohydrates. One slice of cheese has 100 calories. A normal serving size of macaroni salad is 400 calories and 45 grams of carbohydrates. A normal serving size sweet potato fries is 150 calories and 30 grams of carbohydrates. A normal serving size of vegetable soup is 80 calories and 15 grams of carbohydrates. A normal serving size of 2% milk is 120 calories and 12 grams of carbohydrates. A Nursing note, dated 6/20/10 at 1:00 PM, stated Patient #16 requested apple juice but was given milk. A normal serving size of 2% milk is 120 calories and 12 grams of carbohydrates. By 1:00 PM on 6/20/10, Patient #16 consumed 2240 calories of his 1800 to 2000 calories ADA diet and 278 carbohydrates of his 250 to 275 carbohydrates per day. A Nursing note, dated 6/20/10 at 3:00 PM, stated Patient #16's BG level was 53 and despite interventions, his BG level continued to drop to 44 and then came up to 50 but Patient #16 became unresponsive. Patient #16 was discharged from the hospital on 6/20/10 after the event. Patient #16 was taken to an acute care hospital by	A 395		

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A 395	Continued From page 37 ambulance for continued treatment of his diabetic management. Nursing staff failed to appropriately manage the diabetic nursing care for Patient #16. 2. Patient #17 was 36 year-old female that was admitted to the hospital on 6/11/10 for treatment of alcoholism. Patient #17's record contained a History and Physical assessment, dated 6/17/10 at 7:75 AM. The History and Physical was done by the hospital's General Medicine Physician. It stated Patient #17 had had a gastric bypass, pernicious anemia (anemia caused by the inability to absorb vitamin B-12 due to the patients gastric bypass), and microcytic anemia (anemia caused by the inability to absorb iron due to the patients gastric bypass). Patient #17's 6/18/10 6:50 AM blood results were as follows: Iron 7 (normal 30-70) Present of iron saturation 2 (normal 20-50) Hemoglobin 8.4 (normal 12-15) Hematocrit 27.4 (normal 36-48) These laboratory tests showed Patient #17 was very anemic. On 6/12/10 at 11:15 AM, the General Medicine Physician ordered Patient #17 to take a iron supplement every day with orange juice (the vitamin C in the orange juice helps the uptake of the iron during the digestive process). Patient #17 was interviewed on 6/21/10 starting at:	A 395		

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A 395	Continued From page 38 3:30 PM. She stated that she needed to remind nursing staff daily to provide orange juice with her iron. Patient #17's record contained a physician's order dated 6/15/10 at 11:20 AM. The order requested nursing staff to assess Patient #17's CWIA in private (CWIA is a series of questions and vital signs to assess patients' withdrawal symptoms). Patient #17 was interviewed on 6/21/10 starting at 3:30 PM. She stated that she was offended that staff would assess her in front of other patients and she complained to staff. Patient #17's record contained a Nutritional Assessment, dated 6/21/10, that was not timed. The assessment recommended that Patient #17 eat foods high in iron such as meats, beans, fortified cereals, leafy greens and foods high in vitamin C. The assessment also recommended that Patient #17 limit her coffee/tea beverages. The Charge Nurse was asked to give report of the unit that Patient #17 was on starting at 2:15 PM on 6/22/10. The charge nurse made no mention of the above medical and privacy issues. Patient #17's record did not contain documented evidence that nursing staff was monitoring Patient #17's dietary needs or her privacy. This was confirmed by the unit's Charge Nurse on 6/22/10 at 4:10 PM. On 6/23/10 at 1:10 PM, the dietary manager was interviewed. She stated she was unaware of Patient #17's dietary needs. Nursing staff failed to manage and supervise Patient #17's dietary and privacy needs.	A 395		

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A395	Continued From page 39 3. Patient #15 was a 53-year-old female who was admitted on 6/13/10. Patient #15's record included a physician order for Clonidine 0.1 mg by mouth twice a day and to recheck her blood pressure one hour after each dose. Clonidine is an antihypertensive (lowers blood pressure). According to the Nursing 2010 Drug Handbook, severe rebound hypertension (dangerously high blood pressure) was listed as side effect of Clonidine. Patient #15's MAR, dated 6/19/10, documented a handwritten note in the box for the Clonidine, to check BP and HR. According to Patient #15's MAR Clonidine was given the following dates and times: 6/19/10 at 9:00 AM 6/20/10 at 9:00 AM 6/21/10 at 9:00 AM 6/22/10 at 9:00 AM Surveyors found no documentation that Patient #15's BP or HR was assessed from 6/19/10 till 6/22/10, one hour after Clonidine was given, as was ordered by the physician. According to Patient #15's MAR Clonidine was given the following dates and times: 6/19/10 at 6:00 PM 6/20/10 at 6:00 PM	A 395		

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A 395	Continued From page 40 6/21/10 at 6:00 PM 6/22/10 at 6:00 PM Surveyors found documented in Patient #15's record, the hospital's form titled Adult Vital Sign Flow Sheet, as follows: 6/19/10 both BP and HR were assessed at 6:17 PM 6/20/10 both BP and HR were assessed at 7:15 PM 6/21/10 both BP and HR were assessed at 6:35 PM 6/22/10 both BP and HR were assessed at 6:35 PM Surveyors found no documentation that Patient #15's BP or HR was assessed from 6/19/10 till 6/22/10, one hour after Clonidine was given, as was ordered by the physician. On 6/24/10, Patient #15's MAR documented the discontinuation of Clonidine and a handwritten note,"One time only 6/18." There was no documentation of physician order as such. Patient #15's record also contained a handwritten and asterisked note, dated 6/18/10, to check Patient #15's BP and HR 4 times that day. Surveyors documented Patient #15's Adult Vital Sign Flow Sheet form, his BP and HR three different times on 6/18/10. The RN failed to follow physicians orders. This failure of standards of practice for the	A 395		

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A 395	Continued From page 41 administration of said medication had the potential to affect the efficacy of said medication and could have a direct impact on Patient #15's BP. 4. Patient #7 was a 68-year-old male with a history of diabetes mellitus and renal insufficiency, who was admitted to the hospital on 6/03/10 for treatment of schizophrenia. Patient #7 was a current patient as of 6/24/10. Patent #7 's record contained admission orders, dated 6/03/10 at 5:45 PM, which directed nursing staff to give 850 mg Metformin twice daily and Prandin 1 mg twice daily. The Nursing 2010 Drug Handbook states that Metformin is an adjunct to diet to lower BG levels in type 2 (non-insulin-dependent) diabetes. The Nursing 2010 Drug Handbook recommends that the dosage of Metformin should be conservative because of potential decrease in renal function and the drug should be given daily with morning and evening meals. According to the Nursing 2010 Drug Handbook Prandin is also used for type 2 diabetes, however, the drug is to be given either immediately before morning and evening meals or up to 30 minutes before. The The Nursing 2010 Drug Handbook recommends that if a meal is skipped then that dose should be skipped. The Nursing 2010 Drug Handbook did not document the same renal function problems with Prandin as it did with Metformin. According to Lippencott's Manual of Nursing Practice 8th edition, the standard of practice for control of renal insufficiency is to monitor closely the patient's intake (i.e., food and drink) and	A 395		

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A 395	Continued From page 42 output (anything the patient excretes, i.e., urine, liquid stool, vomitus, etc.) The record contained no documentation that this was done. The website eMedicine defined renal insufficiency as the loss of kidney function, with resultant accumulation of water, waste, and toxic substances, in the body, that are normally excreted by the kidney causing anemia, high blood pressure, acidosis (excessive acidity of body fluids), disorders of cholesterol and fatty acids, and bone disease. The following was documented in Patient #7's MAR: According to Patient #7's MAR Metformin was documented as given on the following dates and times: from 6/05/10 to 6/18/10 at 9:00 AM and 6:00 PM 6/03/10 at 10:00 PM (no AM dose documented) 6/04/10 at 9:00 AM and 10:00 PM 6/19/10 at 9:00 AM and 8:30 PM 6/20/10 at 9:00AM and 6:00 PM 6/21/10 at 9:00 AM and 6:00 PM According to Patient #7's MAR Prandin was given the following dates and times: from 6/06/10 to 6/13/10 at 9:00 AM and 6:00 PM 6/04/10 at 10:00 PM (no AM dose documented) 6/05/10 no dose documented (handwritten note stating-not available until spouse brings in) 6/06/10 8:00 PM (no AM dose documented) 6/07/10 at 9:00 AM and 8:00 PM 6/14/10 at 9:00 AM (no PM dose recorded-handwritten note-not available) 6/15/10 at 10:00 AM and 6:00 PM	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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A 395	Continued From page 43 6/16/10 at 9:00 AM and 6:00 PM 6/17/10 at 9:00 AM and 6:00 PM 6/18/10 at 10:15 AM and 6:00 PM 6/19/10 at 9:00 AM and 8:30 PM 6/20/10 at 9:00 AM and 6:00 PM 6/21/10 at 9:00 AM and 6:00 PM According to the scedule of activities surveyors received, breakfast is served at 8:00 AM and dinner is documented to begin at 5:15 PM. Therefore, Patient #7 received the Metformin, on average, one hour after morning meals and 45 minutes after evening meals, when it is recommended that the drug be given with meals. According to Patient #7's record, he received the Prandin, on average, one hour after morning meals and 45 minutes after evening meals, when it is recommended that the drug be given up to 30 minutes before meals. Patient #7 was observed on 6/18/10 from 9:30 AM to 10:50 AM. During that time, Patient #7 remained asleep in an isolation room. Patient #7's physician was on the unit seeing patients until 10:30 AM when he left the unit. Patient #7's RN had not yet administered his physician's ordered Metformin during the time of observation. On 6/18/10 starting at 10:40 AM, the RN was questioned as to why she had not yet provided Patient #7's Metformin. The RN explained that Patient #7 had experienced a "rough night" and had been administered Thorazine [an anti-psychotic medication]. At this time, Patient #7 was still sleeping and the RN did not want to disturb him. When questioned by the surveyor, the RN stated she had not yet notified Patient #7's physician that the Metformin had been held.	A 395		

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A 395	Continued From page 44 When prompted by the surveyor at 10:45 AM, the RN called Patient #7's physician. Following the call, the RN woke Patient #7 and administered the missed Metformin dose at 10:50 AM. A handwritten note, written vertically in the first column of Patient #7's MAR, documents, "All 0900 meds given at 10:15. Dr. [name] notified 6-18-10-1030." The note was initialed by the RN. On 6/23/10 at 10:30 AM, a review of Patient #7's MAR documented 9:00 AM medications were not given. A review of the nursing notes for Patient #7 dated 6/23/10 showed documentation that Patient #7 had refused his morning medications but failed to show documentation that Patient #7's physician had been notified of his refusal. The RN failed to follow the drug manufacturers recommendations and failed to notify physicians of held medications. This failure of standards of practice for the administration of said medications had the potential to affect the efficacy of said medications and could have a direct impact on Patient #7's diabetes and renal insufficiency. Further the lack of documentation of Patient #7's intake and output had the potential to impact his outcome. 3. Patient #15 was a 53-year-old female who was admitted on 6/13/10. A review of Patient #15's record documented her physician ordering Clonidine 0.1 mg by mouth twice a day and to recheck her blood pressure one hour after dose. Clonidine is an antihypertensive (lowers blood pressure). According to the Nursing 2010 Drug Handbook, severe rebound hypertension	A 395		

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A 395	Continued From page 45 (dangerously high blood pressure) was listed as side effect of Clonidine. According to Patient #15's MAR Clonidine was given the following dates and times: 6/19/10 at 9:00 AM 6/20/10 at 9:00 AM 6/21/10 at 9:00 AM 6/22/10 at 9:00 AM Patient #15's record contained no documented evidance that nursing staff had assessed Patient #15's BP or HR from 6/19/10 till 6/22/10, one hour after Clonidine was given, as was ordered by the physician. According to Patient #15's MAR, Clonidine was also given on the following dates and times: 6/19/10 at 6:00 PM 6/20/10 at 6:00 PM 6/21/10 at 6:00 PM 6/22/10 at 6:00 PM Patient #15's record, contained a form titled Adult Vital Sign Flow Sheet. The sheet documented Patient #15's BP and HR were assessed as follows: 6/19/10 both BP and HR were assessed at 6:17 PM, 17 minutes after the Clonidine dose.			

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A 395	Continued From page 46 6/20/10 both BP and HR were assessed at 7:15 PM, 1 hour and 15 minutes after the Clonidine dose. 6/21/10 both BP and HR were assessed at 6:35 PM, 35 minutes after the Clonidine dose. 6/22/10 both BP and HR were assessed at 6:35 PM, 35 minutes after the Clonidine dose. Patient #15's record did not contain documented evidence that nursing staff had assessed Patient 15's BP or HR from 6/19/10 till 6/22/10, one hour after Clonidine was given, as was ordered by the physician. The RN failed to follow physicians orders. This failure of standards of practice for the administration of said medication had the potential to affect the efficacy of said medication and could have a direct impact on Patient #15's BP. 4. Patient #7 was a 68-year-old male with a history of diabetes mellitus and renal insufficiency, who was admitted to the hospital on 6/03/10 for treatment of schizophrenia. Patient #7 was a current patient as of 6/24/10. Patent #7 's record contained admission orders, dated 6/03/10 at 5:45 PM, which directed nursing staff to give 850 mg Metformin twice daily and Prandin 1 mg twice daily. The Nursing 2010 Drug Handbook states that Metformin is an adjunct to diet to lower BG levels in type 2 (non-insulin-dependent) diabetes. The Nursing 2010 Drug Handbook recommends that the dosage of Metformin should be conservative because of potential decrease in renal function	A 395		

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A 395	Continued From page 47 and the drug should be given daily with morning and evening meals. According to the Nursing 2010 Drug Handbook Prandin is also used for type 2 diabetes, however the drug is to be given either immediately before morning and evening meals or up to 30 minutes before. The The Nursing 2010 Drug Handbook recommends that if a meal is skipped then that dose should be skipped. The Nursing 2010 Drug Handbook did not document the same renal function problems with Prandin as it did with Metformin. According to Lippencott's Manual of Nursing Practice 8th edition, the standard of practice for control of renal insufficiency is to monitor closely the patient's intake (i.e., food and drink) and output (anything the patient excretes, i.e., urine, liquid stool, vomitus, etc.) The record contained no documentation that this was done. The website eMedicine defined renal insufficiency as the loss of kidney function, with resultant accumulation of water, waste, and toxic substances, in the body, that are normally excreted by the kidney causing anemia, high blood pressure, acidosis (excessive acidity of body fluids), disorders of cholesterol and fatty acids, and bone disease. The following was documented in Patient #7's MAR: According to Patient #7's MAR Metformin was documented as given on the following dates and times: from 6/05/10 to 6/18/10 at 9:00 AM and 6:00 PM	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2010
NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704		

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A 395	Continued From page 48 6/03/10 at 10:00 PM (no AM dose documented) 6/04/10 at 9:00 AM and 10:00 PM 6/19/10 at 9:00 AM and 8:30 PM 6/20/10 at 9:00AM and 6:00 PM 6/21/10 at 9:00 AM and 6:00 PM According to Patient #7's MAR Prandin was given the following dates and times: from 6/08/10 to 6/13/10 at 9:00 AM and 6:00 PM 6/04/10 at 10:00 PM (no AM dose documented) 6/05/10 no dose documented (handwritten note stating-not available until spouse brings in) 6/06/10 8:00 PM (no AM dose documented) 6/07/10 at 9:00 AM and 8:00 PM 6/14/10 at 9:00 AM (no PM dose recorded-handwritten note-not available) 6/15/10 at 10:00 AM and 6:00 PM 6/16/10 at 9:00 AM and 6:00 PM 6/17/10 at 9:00 AM and 6:00 PM 6/18/10 at 10:15 AM and 6:00 PM 6/19/10 at 9:00 AM and 8:30 PM 6/20/10 at 9:00 AM and 6:00 PM 6/21/10 at 9:00 AM and 6:00 PM According to the scedule of activities, that was not dated, breakfast was served at 8:00 AM and dinner was documented to begin at 5:15 PM. Therefore, Patient #7 received the Metformin, on average, one hour after morning meals and 45 minutes after evening meals, when it is recommended that the drug be given with meals. According to Patient #7's record, he received the Prandin, on average, one hour after morning meals and 45 minutes after evening meals, when it is recommended that the drug be given up to 30 minutes before meals.	A 395		

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A 395	Continued From page 49 Patient #7 was observed on 6/18/10 from 9:30 AM to 10:50 AM. During that time, Patient #7 remained asleep in an isolation room. Patient #7's physician was on the unit seeing patients until 10:30 AM when he left the unit. Patient #7's RN had not yet administered his physician's ordered Metformin during the time of observation. On 6/18/10 starting at 10:40 AM, the RN was questioned as to why she had not yet provided Patient #7's Metformin. The RN explained that Patient #7 had experienced a "rough night" and had been administered Thorazine [an anti-psychotic medication]. At this time, Patient #7 was still sleeping and the RN did not want to disturb him. When questioned by the surveyor, the RN stated she had not yet notified Patient #7's physician that the Metformin had been held. When prompted by the surveyor at 10:45 AM, the RN called Patient #7's physician. Following the call, the RN woke Patient #7 and administered the missed Metformin dose at 10:50 AM. A handwritten note, written vertically in the first column of Patient #7's MAR, documents, "All 0900 meds given at 10:15. Dr. [name] notified 6-18-10-1030." The note was initialed by the RN. On 6/23/10 at 10:30 AM, a review of Patient #7's MAR documented 9:00 AM medications were not given. A review of the nursing notes for Patient #7 dated 6/23/10 showed documentation that Patient #7 had refused his morning medications but failed to show documentation that Patient #7's physician had been notified of his refusal. The RN failed to follow the drug manufacturers recommendations and failed to notify physicians of held medications. This failure of standards of practice for the administration of said medications	A 395		

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A 395	Continued From page 50 had the potential to affect the efficacy of said medications and could have a direct impact on Patient #7's diabetes and renal insufficiency. Further the lack of documentation of Patient #7's intake and output had the potential to impact his outcome.	A 395		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure nursing plans of care were developed for 5 of 21 patients (#7, #8, #16, #17 and #18) whose medical records were reviewed. This resulted in a lack of direction to nursing staff caring for patients. The findings include: 1. Patient #16 was a 61-year-old male, who was admitted to the hospital on 6/14/10, for treatment of opiate detoxification. He had a long history of diabetes mellitus and was insulin dependent. Patient #16 was suffering from malnutrition and gastroparesis. Patient #16 was a current patient as of 6/18/10. Patent #16's record contained a Nursing Assessment, dated 6/14/10 that was not timed. The assessment included an evaluation of Patient #16's BMI. It stated Patient #16 was 5 foot 10 inches tall, and weighed 125 pounds. This resulted in a BMI of less than 19 (normal 19-24), which placed Patient #16 in the underweight category.	A 396	**482.23(b)(4) NURSING CARE PLAN** Intermountain Hospital now ensures nursing plans of care are developed for all patients. **Actions Taken:** 1. A 100% audit of all open records was immediately conducted to ensure that each record included a current and appropriate nursing care plan. 2. All RNs received remedial education and training, with return demonstration of competency, in the requirements for assessment and development of comprehensive nursing care plans. Reassessment, review of progress, and revision of plans were also emphasized. 3. A revised comprehensive admission nursing assessment was implemented and is now completed by the RN.	7/16/10 7/14/10 7/22/10

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A 396	Continued From page 51 A Nursing note, dated 6/15/10 at 5:05 AM, stated Patient #16 had a history of gastroparesis resulting in a 25 pound weight loss and he was described as looking emaciated. Patent #16's record contained a verbal physician's order, dated 6/14/10 at 11:55 AM. The order included a dietary consult and for the patient to be on an ADA diet. An ADA diet is set forth by the American Diabetes Association to help diabetics control blood glucose levels by eating a consistent amount of carbohydrates, distributed throughout the day, to reduce calories to less than 2000 per day. On 6/29/10 starting at 2:10 PM, the Director of Dietary services was interviewed. She stated that ADA diabetic diets for male adults were to be 1800 to 2000 calories and include 250 to 275 carbohydrates per day. A History and Physical assessment, written by a NP, dated 6/15/10 at 12:28 PM, stated Patient #16 was malnourished and had poor nutritional status. On 6/15/10 at 11:10 AM, the NP wrote orders for Patient #16. These orders included a second dietary consult referral and for nursing to provide a can of Ensure between meals and at bedtime. This would be a total of at least 3 cans a day. Ensure has 250 calories per can and 60 grams of carbohydrates; 3 cans of ensure would provide 750 calories out of a 1500 - 2000 calorie ADA diet and 180 grams of carbohydrates of a 250 - 275 grams of carbohydrates for the ADA diet. A Nursing note, dated 6/15/10 at 1:45 PM, stated Patient #16 was instructed on meal planning and to drink Ensure "if needed." This note	A 396	4. This revised nursing assessment includes physical components to optimize timely and accurate inclusions of nursing care issues: a. Fall risk; b. Hydration issues; c. Nutritional status to include blood glucose check and d. special diets; e. Cardiovascular status to include vital signs; f. Hygiene; g. Treatment compliance issues; h. Withdrawal symptoms i. Skin assessment 5. A structured process for nursing reassessment on all changes of patient conditions and update treatment plan is now facilitated with the revised assessment form. 6. SBAR format has been implemented for hand-off communication between shifts, nursing staff and physicians/NPs/PAs related to medical issues. 7. Medical care plans have been implemented to address medical issues that are actively being treated.	7/22/10 7/15/10 7/15/10 7/23/10

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A 396	Continued From page 52 contradicted the NP's order to provide one can between meals and at bedtime. Patient #16's record contained only two entries showing he drank the Ensure per the physician's orders. One entry was noted on the MAR on 6/17/10 at 9:40 PM. The other was on a Nursing note, dated 6/20/10 at 10:00 AM. A Nursing note dated 6/20/10 at 3:00 PM, stated Patient #16's BG level was 53 and despite interventions. His BG level continued to drop to 44 and then came up to 50, but Patient #16 became unresponsive. On 6/20/10, Patient #16 was transported to an acute care hospital by ambulance for continued treatment of his diabetic condition. On 6/22/10, starting at 12:00 PM, a group interview was conducted. In attendance were the consulting General Medicine Physician responsible for Patient #16's medical care, a NP, a PA, and the Chief of Medicine. The Chief of Medicine stated it was thought that Patient #16 was being non compliant with his dietary orders and so when adjustments were made to Patient #16's insulin, it was only based on his BG results. He stated that when nursing "supervised" Patient #16's oral intake, the doses of insulin were too high for Patient #16's ADA diet. Patient #16's Care Plans, dated 6/14 through 6/16/10, did not include Patient #16's poor nutritional status and his malnutrition. Patient #16's Care Plans did not direct staff to monitor Patient #16's oral intake, monitor Patient #16's compliance with his ADA diet, provide healthy snacks and monitor Patient #16's weight. This was confirmed by the Dietician Consultation	A 396	8. Remedial training was also provided to all nursing staff by PSI Consultants on the assessment process, treatment planning and documentation of medical conditions. **Person(s) Responsible:** Director of Nursing Nurse Educator Medical Director **How Monitored:** • An audit tool has been implemented to compare MD/NP/PA orders, all progress notes and consultation recommendations to the treatment plan for evidence of comprehensive inclusion of actively treated problems.	7/14/10

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A 396	Continued From page 53 Director and a dietician during an interview on 6/23/10 starting at 10:30 AM. Further, a nursing note, dated 6/16/10 at 10:46 PM, stated Patient #16 did not appear to be using "proper hygeine". A Physician's Progress note, dated 6/16/10 at 4:10 PM, stated Patient #16 was poorly groomed. A nursing note, dated 6/17/10 at 2:10 PM, and a second nursing note dated 6/17/10 at 8:10 PM, stated Patient #16's hygiene appeared to be poor. Patient #16's Care Plans, dated 6/14 through 6/16/10, did not include Patient #16's poor hygiene practices. The hospital failed to ensure Patient #16's nursing plans of care were fully developed to include all of his needs. 2. Patient #17 was 36 year-old female that was admitted to the hospital on 6/11/10 for treatment of alcoholism. Patient #17's record contained a History and Physical assessment, dated 6/17/10 at 7:75 AM. The History and Physical was done by the hospital's General Medicine Physician. It stated that Patient #17 had a gastric bypass, pernicious anemia (anemia caused by the inability to absorb vitamin B-12 due to the patients gastric bypass), and microcytic anemia (anemia caused by the inability to absorb iron due to the patients gastric bypass). Patient #17's 6/18/10 6:50 AM laboratory blood	A 396		

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A 396	Continued From page 54 test results were as follows: Iron 7 (normal 30-70) Present of iron saturation 2 (normal 20-50) Hemoglobin 8.4 (normal 12-15) Hematocrit 27.4 (normal 36-48) These laboratory tests documented Patient #17 was very anemic. On 6/12/10 at 11:15 AM, the General Medicine Physician ordered Patient #17 to take an iron supplement every day with orange juice (the vitamin C in the orange juice helps the uptake of the iron during the digestive process). Patient #17 was interviewed on 6/21/10 starting at 3:30 PM. She stated that she needed to remind nursing staff daily to provide orange juice with her iron. Patient #17's Care Plans, dated 6/11 through 6/24/10 were reviewed. The Care Plans did not mention that Patient #17 was to be provided orange juice with her iron. Patient #17's record contained a physician's order, dated 6/15/10 at 11:20 AM. The order requested nursing staff to assess Patient #17's CWIA in private (CWIA is a series of questions and vital signs to assess patients withdrawl symptoms). Patient #17 was interviewed on 6/21/10 starting at 3:30 PM. She stated she was offended that staff would assess her in front of other patients and she complained to the staff. Patient #17's Care Plans, dated 6/11 through	A 396		

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A 396	Continued From page 55 6/24/10 were reviewed. The Care Plans did not direct nurseing staff to assess Patient #17's CWIA in private. Patient #17's record contained a nutritional assessment, dated 6/21/10, that was not timed. The assessment recommended that Patient #17 eat foods high in iron, such as meats, beans, fortified cereals, leafy greens and foods high in vitamin C. The assessment also recommended that Patient #17 limit her intake of coffee/tea beverages. Patient #17's Care Plans dated 6/11 through 6/24/10 were reviewed. The Care Plans did not include the nutritional assessment recommendations. Patient #17's Care Plans, dated 6/11 through 6/24/10 were reviewed by the Dietician Consultation Director, and a dietician during, an interview on 6/23/10 starting at 10:30 AM. They both confirmed the Care Plans were lacking important information such as the nutritional assessment recommendations of eat foods high in iron, such as meats, beans, fortified cereals, leafy greens and foods high in vitamin C, provide pricacy during CWIA assessments and provide orange juice with Patient #17's iron. The hospital failed to ensure Patient #17's nursing plans of care were fully developed to include all of her needs. 3. Patient #8 was 13 year-old female admitted to the hospital on 6/06/10, for aggressive behaviors. Patient #8's record contained an Interdisciplinary Assessment, dated 6/06/10 at 3:58 AM. The Interdisciplinary Assessment stated Patient #8	A 396		

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A 396	Continued From page 56 had MRSA in her nose and lip that started a few days prior to the assessment. Patient #8's record contained a consultation note, written by a NP, dated 6/09/10 at 9:20 AM, that stated Patient #8 had a history of MRSA. A physician order, dated 6/07/10 at 6:00 PM, stated Patient #8 could attend program groups but needed to wear a mask, gloves, clean scrubs and gown. The order directed the patient to sleep in a room by herself and to use a shower that no other patients were using. The order directed Patient #8 to also eat by herself in her room. Patient #8's Care Plans, dated 6/06 through 6/09/10 were reviewed. The Care Plans did not mention Patient #8 was on isolation precautions. This would have directed staff on how to coordinate Patient #8's care. During an interview with the hospital's Infection Control Officer, on 6/18/10 starting at 4:00 PM, she stated Patient #8's isolation precautions should have been care planned. She confirmed it was not done. The hospital failed to ensure nursing plans of care were developed for Patient #8's isolation precautions. 4. Patient #18 was a 68-year-old female who was admitted on 6/15/10. A review of Patient #18's record documented a history of 3 transient ischemic attacks (little strokes), last one on 10/31/09. A hospital form titled Adult Vital Sign Flow Sheet, dated 6/15/10, documented an asterisk and was highlighted, "Fall Risk."	A 396		

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A 396	Continued From page 57 During an interview with Patient #18 on 6/21/10 a 3:28 PM, she stated the little strokes affected her inner ear and she had some balance issues, but she said her balance was getting better. In an interview with the RN taking care of Patient #18 on 6/21/10 at 3:45 PM, she said she was aware of Patient #18's history and that she had been watching her walk and she did not note any problems with her balance. The RN then stated the staff did not care plan for "fall risks." Review of Patient #18's plans of care, dated 6/17/10, confirmed no plan of care had been developed regarding her fall risk. Patient #18's plan of care had not been developed or updated to include her risk of falls. 5. Patient #7 was a 68-year-old male with a history of diabetes mellitus and renal insufficiency, who was admitted to the hospital on 6/03/10, for treatment of schizophrenia. Patient #7 was a current patient as of 6/24/10. Patient #7's record contained a History and Physical assessment, dictated on 6/05/10 at 11:13, by a NP. The NP documented Patient #7 had renal insufficiency. The website eMedicine defined renal insufficiency as the loss of kidney function, with resultant accumulation of water, waste, and toxic substances, in the body, that are normally excreted by the kidney causing anemia, high blood pressure, acidosis (excessive acidity of body fluids), disorders of cholesterol and fatty acids, and bone disease.	A 396		

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A 396	Continued From page 58 According to Lippencott's Manual of Nursing Practice 8th edition, the standard of practice for control of renal insufficiency is to monitor closely the patient's intake (i.e., food and drink) and output (anything the patient excretes, i.e., urine, liquid stool, vomitus, etc.) Patient #7's care plans, dated 6/06/10 to 6/21/10, did not direct nursing staff to monitor his fluid intake and output. Nursing staff failed to initiate, develop, and review Patient #7's plan of care for renal insufficiency.	A 396		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations and staff interview it was determined the hospital failed to ensure laboratory blood sampling collection equipment, transport kits, and solutions, that were available for patient testing, had not expired. The use of expired laboratory equipment could result in incorrect laboratory results. Findings include: During a tour of the hospital on 6/17/10, beginning at 8:40 AM, surveyors found the following expired equipment: Adult Unit-1 grey top blood collection tube that expired on 12/08, 3 grey top blood collection tubes that expired on 6/09, and 2 grey top blood collection tubes that expired on 12/09. ICU Overflow Medication Room-a vial of sterile	A 724	**482.41(c)(2) FACILITIES SUPPLIES EQUIPMENT MAINTENANCE** Intermountain Hospital now ensures all laboratory blood sampling collection equipment, transport kits and solutions that are available for patient testing are not expired. **Actions Taken:** 1. A 100% audit of all blood sampling equipment, transport kits and solutions available for patient testing was conducted to ensure that none were expired. 2. The lead phlebotomist now conducts weekly environmental rounds to ensure that no expired blood sampling collection equipment or transport kits are found on any of the hospital units. .	7/19/10 7/16/10

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A 724	Continued From page 59 water for parenteral administration that expired on 4/10, 2 viral transport kits that expired on 5/09, 3 viral transport kits that expired on 6/09, 3 viral transport kits that expired on 8/09, 7 viral transport kit that expired on 9/09, an open suture removal kit, and a bottle of saline for parenteral administration that expired on 7/09. Medication room of the adolescent ward-3 grey top blood collection tubes that expired on 12/08, 3 expired grey top blood collection tubes that expired on 6/09, and 3 grey top blood collection tubes that expired on12/09. Adolescent North-1 grey top tube that expired on 6/09. New Start-5 grey top tubes that expired on 6/09 and an opened Hydrogen Peroxide without an open date on the label. All items and expiration dates were observed and confirmed by the Director of Nursing during the tour. The hospital failed to ensure that all expired laboratory equipment accessible for patient testing was out of circulation.	A 724	Any deficiencies are immediately addressed. 3. The Lead Phlebotomist now documents findings on a Laboratory Equipment Audit Checklist in order to track and trend data, now included in the Laboratory contracted services department's PI plan. **Person(s) Responsible:** Lead Phlebotomist Director of PI/Risk Management Director of Nursing **How Monitored:** • Routine, random checks of laboratory equipment are now conducted by the Director of Nursing and Nursing Supervisors, to ensure that none that are available are expired. • Laboratory PI data is submitted to and monitored by the Quality Council, Medical Executive Committee and Governing Body.	7/16/10

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/18/2010

NAME OF PROVIDER OR SUPPLIER
INTERMOUNTAIN HOSPITAL

STREET ADDRESS, CITY, STATE, ZIP CODE
303 NORTH ALLUMBAUGH STREET
BOISE, ID 83704

(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
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint/follow-up and recertification survey of your hospital. Surveyors conducting the survey were: Patrick Hendrickson, RN, Team Leader Gary Banister, RN, HFS Acronyms used in this report include: H& P = History and Physical ICU = Intensive Care Unit mg = Milligrams NP = Nurse Practitioner RN = Registered Nurse	A 000		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on review of clinical records and hospital policies, observations, and staff interview, it was determined the hospital failed to maintain a well-organized nursing service to meet the needs of 1 of 1 current insulin dependent patient (#16) whose record was reviewed and who was observed. This resulted in the health and safety of one patient being placed in immediate jeopardy of serious harm or death. It also created the potential for other insulin dependent diabetics, who may be admitted to the hospital, being placed in immediate jeopardy if immediate correction does not occur. The facility was notified of the findings related to the immediate jeopardy on 6/17/10 starting at 5:00 PM. The	A 385	Per Patrick Hendrickson, RN, please see attached accepted plan of correction Dipting The IJ, Monday 6/21/2010 @ 10:30 am.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 6-21-10

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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A 385	Continued From page 1 findings include: Refer to A395 as it relates to the failure of the hospital to ensure nursing staff had evaluated, managed and supervised the care of an insulin dependent diabetic patient.	A 385		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of clinical records and hospital policies, observations, and staff interviews, it was determined the hospital failed to ensure an RN supervised and evaluated the nursing care for 1 of 1 current insulin dependent diabetic patient (#16) who was observed and whose record was reviewed. The failure of nursing staff to evaluate the care of diabetic patients led to medication errors that included incorrect or missed insulin administration, failure to follow physicians' orders or notify physicians when blood sugars were abnormally low or high. This created the potential for serious harm or death to one patient and immediate jeopardy due to the inability of nursing staff to manage the patient's diabetes. The findings include: The Medical Executive Meeting minutes, dated 5/04/07, were reviewed. The minutes included documentation describing a new Diabetic Medication Administration and Pharmacy Profile form which had been developed and approved on 5/04/07. This form allowed nursing staff to document all diabetic care in one place, including medications administered, blood glucose levels and other pertinent information pertaining to	A 395		

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A 395	Continued From page 2 diabetic care. The minutes also documented the approval of a standing sliding scale insulin order that contained three available options for physicians. It was also documented that the hospital would no longer admit patients with a blood glucose level exceeding 300. Finally, the minutes introduced a change in the standard treatment for hypoglycemia which would direct nursing staff to give 2-3 oz of juice followed with a protein snack such as yogurt or peanut butter. These changes to the standardized care of diabetes were initiated by a previous immediate jeopardy citation on 4/27/07, for the failure of the hospital to manage patient's diabetic needs. The 2001 Mosby's Diagnostic and Laboratory Test Reference states that a possible critical blood glucose was greater than 400 and less than 50. Patient #16 was a 61-year-old male, who was admitted to the hospital on 6/14/10 for treatment of opiate detoxification. According to Patient #16's medical record, he had a long history of Diabetes Mellitus type II (insulin dependent.) Patient #16 was a current patient as of 6/18/10. A group interview, which included the Director of Assessments and Referrals, was held on 6/18/10 starting at 4:00 PM. She stated that prior to Patient #16's admission to the hospital, she had received a report from the transferring hospital that Patient #16 was a brittle diabetic (exceptionally difficult to control his blood sugars). Patient #16 was awaiting transfer to the hospital's Addiction Recovery Center on 6/14/10. The Admissions Coordinator stated she obtained the admitting hospital's "Humalog" (a medication used to control blood sugar) sliding scale insulin	A 395		

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A 395	Continued From page 3 order that was being used for Patient #16 at the admitting hospital. The Director of Assessments and Referrals stated she then used the admitting hospital's Humalog sliding scale insulin order to obtain a verbal physician's order on 6/14/10 at 11:55 AM from Patient #16's Psychiatrist. Patent #16's record contained a verbal Physician's order, dated 6/14/10 at 11:55 AM. The order included the Humalog Sliding Scale Insulin dosing order. The insulin was to be given five times daily at 2:00 AM, 7:30 AM, 11:30 AM, 5:30 PM, and 9:00 PM. The Humalog dosing was to be given as follows: Blood Glucose 150-199 = 1 unit Blood Glucose 200-249 = 3 units Blood Glucose 250-299 = 5 units Blood Glucose 300-349 = 7 units >349 = 8 units Additional orders stated the 2:00 AM Humalog insulin dose was to be cut in half and 1 unit of Humalog was to be given after each meal. The orders directed staff to give a 16 gram tablet of oral glucose if needed for a blood sugar result of less than 70. The order did not clarify when the physician was to be notified of high or low blood glucose levels. The orders also directed staff to re-check Patient #16's blood sugar 1 hour after the administration of Humalog sliding scale insulin. However, Patient #16's record did not include any documentation indicating that this order had been followed. This was confirmed by the Director of Nursing Services during a group interview on 6/18/10 starting at 4:00 PM.	A 395		

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A 395	Continued From page 4 Patient #16 was admitted to the hospital as documented on the Interdisciplinary Assessment dated 6/14/10 at 8:45 PM. The patient was documented as having a blood glucose level of 328 on admit. The physician was notified and it was documented that he allowed the admission despite the high blood glucose level, contrary to the 5/04/07 Committee Meeting Minutes. Patient #16's diabetic medication record documented that on 6/15/10 at 2:00 AM the blood sugar was 193. The 193 blood sugar level should have prompted nursing staff to give 1.5 units of Humalog insulin per the Sliding Scale Insulin order. The diabetic medication administration record documented that Patient #16 refused the insulin. A Nursing Note, dated 6/15/10 at 5:05 AM, stated Patient #16 refused his 2:00 AM insulin dose and stated he would rather wait for his morning insulin (7:00 AM). No documentation was found that Patient #16's physician had been notified of the refused insulin. The record was reviewed and the lack of documentation confirmed by the DNS during a group interview that was held on 6/18/10 at 1:50 PM. Patient #16's Diabetic Administration Record documented that on 6/15/10 at 5:30 PM, Patient #16's blood glucose was 482. The record did not contain documentation that Patient #16's physician had been notified of the high blood glucose level. During a group interview on 6/18/10 starting at 1:50 PM, the DNS reviewed the record and confirmed that there was no documentation indicating the physician had been notified of the high blood glucose but stated that he probably should have been contacted.	A 395		

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A 395	Continued From page 5 Patient #16's Diabetic Administration Record documented that on 6/15/10 at 9:00 PM, Patient #16's blood glucose was 286. According to the sliding scale insulin order, 5 units of insulin should have been administered. However, the record stated the RN only administered 3 units. This was reviewed and confirmed by the DNS during a group interview on 6/18/10. Patient #16's Diabetic Administration Record documented on 6/16/10 at 7:30 AM, a blood sugar of 60. A Nursing Note, dated 6/16/10 at 7:30 AM, stated Patient #16 refused oral glucose as instructed in the sliding scale insulin order, but did eat crackers and drank 8 ounces of orange juice. The Medical Executive Ccommittee meeting minutes, dated 5/04/07, stated the new standard of care for treatment of hypoglycemia [low blood glucose] was to give 2-3 ounces of juice followed by a protein snack. The Nursing Note contained no documentation the physician was notified of the low blood glucose, refusal of the glucose tablets, or the alternate intervention. Patient #16's record did not contain documentation stating whether or not he ate breakfast after the snack or if he had been given 1 unit of insulin as ordered by the physician after the 6/16/10 morning meal. The Diabetic Administration Record documented that at 11:30 AM, Patient #16's blood sugar level was elevated to 546. The Diabetic Medication Record documented that on 6/16/10 at 5:30 PM, Patient #16's blood glucose level was 410. The record did not contain evidence that the physician had been notified of the high levels. During a group interview on 6/18/10 starting at 1:50 PM, the DNS reviewed the records and	A 395		

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A 395	Continued From page 6 confirmed the findings. A Nursing Note dated 6/17/10 at 2:00 AM, stated Patient #16's blood glucose level was 273 and that insulin had been given. However the record did not specify the amount of insulin administered. Patient #16's Diabetic Administration Record, dated 6/17/10, did not contain documented evidence that the patient's blood glucose had been checked at 7:30 AM or if sliding scale insulin had been administered. The record also did not state whether Patient #16 ate breakfast or if 1 unit of insulin had been administered after the meal per the physician's orders. These findings were confirmed by the DNS during an interview held on 6/18/10 starting at 1:50 PM. A Physician's Order Sheet, dated 6/17/10 un-timed, documented that Patient #16's physician had changed the sliding scale Humalog insulin order. The new orders were as follows: Humalog sliding scale: 150-200 = 1 unit 201-250 = 3 units 250-300 = 6 units 300-350 = 10 units >350 = 13 units and call Physician. These orders had the potential to cause confusion as to how many units of insulin were to be administered if Patient #16 had a blood glucose level of 250, 300 or 350. Both 3 and 6 units were ordered to be administered for blood glucose of 250, both 6 and 10 units of insulin was ordered if blood glucose was 300, and both 10 and 13 units of insulin were ordered for a blood glucose level of 350. This order was not clarified	A 395		

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A 395	Continued From page 7 by the nursing staff until 6/18/10 at 8:35 AM. The Diabetic Administration Record documented on 6/17/10 at 11:30 AM, that Patient #16's blood sugar level was 370. The record did not contain documentation that the Physician was contacted regarding the high blood glucose as per the new sliding scale physician's order. On 6/18/10, the Diabetic Administration Record documented the scheduled 2:00 AM blood glucose check was not done until 4:00 AM. On 6/18/10 starting at 4:00 PM, the DNS, Director of Performance Improvement and Risk Management, Director of Social Services, Director of Assessment and Referral, and the Director of Adolescent Programs discussed and reviewed Patient #16's record. They were unable to provide any additional information to explain the above findings. Nursing staff failed to appropriately manage the diabetic nursing care for Patient #16, which placed his health and safety in immediate jeopardy.	A 395		

INTERMOUNTAIN
HOSPITAL

June 20, 2010

Patrick Hendrickson, RN
Bureau of Facility Standards
Idaho Department of Health and Welfare
3232 Elder Street
PO Box 83720-0036
Boise, Idaho 83720-0036

Dear Mr. Hendrickson,

The following corrective action plan has been initiated in response to the finding of Immediate Jeopardy at Intermountain on June 18, 2010. These comprehensive actions were immediately implemented in order to assure that all patients are safe and that diabetes is well managed.

The records of all patients with diabetes were thoroughly reviewed to ensure that all care was managed appropriately. Current policies and procedures for the care of diabetic patients were reviewed and revised where indicated.

Remedial education and training of licensed staff on revised policies addressing the care of the diabetic patient was conducted and will continue each shift until all licensed staff have been trained.

Key Departments involved in the care of the diabetic patient have been a part of this plan of correction. Pharmacy, dietary and Assessment and Referral will continue to be key contributors to this plan of correction.

To address the specific issues identified by team on 6/18/2010, we would like to submit for your approval the following measures to be taken to ensure proper care and management of all diabetic patients treated at Intermountain Hospital. The following actions were initiated on Saturday, June 19, 2010:

Identifying diabetic patients:

1. Each diabetic patient admitted to the hospital will be identified by A&R (Assessment and Referral) and an initial diabetic risk assessment (Diabetic Assessment) will be completed. The risk assessment will include history of diabetic illness, usual blood glucose (BG) range, and current medication orders, including insulin needs. The patient's usual routine for BG checks, last insulin dose, frequency of hypoglycemic or hyperglycemic episodes and any history of keto-acidosis or loss of consciousness due to blood sugar issues will also be determined. All current available information regarding patient's outpatient treatment will be obtained from their prescribing physician. The patient's weight, special dietary orders and initial blood glucose will be documented by A&R as well. Diabetic patients with an initial BG of >300 or patients that require extensive monitoring of BG levels will be deemed medically unstable for purposes of admission to this facility. Patients will be transferred to a higher level of care for medical stabilization.

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2. After A&R has completed the Diabetic Assessment, the Nursing Supervisor will be notified to determine appropriateness of admission to a specific unit to meet the patient's treatment needs. Prior to admission to the assigned unit, proper hand off communication will be completed between the A&R RN and the Unit RN.

Remedial Training

Remedial training was provided to licensed nursing staff on Saturday June 19 and Sunday, June 20th on the management of diabetic patients. Training included but was not limited to:

a. Process of obtaining MD orders on diabetic management and verification of all orders by two licensed nursing staff.
b. Completion of a third check of order verification by the night shift RN during the 24 hour chart check.
c. Documentation in the MAR of dietary consultations to ensure timely completion.
d. Documentation in the MAR by licensed staff of Humphries Consultation orders
e. Daily verification of this process by the Diabetic coordinator.
f. Maintaining and completing the diabetic log/diabetic care audit form; Nursing Supervisors and/or Diabetic coordinator are responsible for monitoring this.
g. Diabetic checklist implementation to ensure compliance with the management of the diabetic patient. The checklist includes:
    - Diabetic assessment
    - Complete orders for random glucose checks (abnormal levels)
    - Yellow diabetic MAR – double checked by two licensed staff
    - Fax Dietary consult request to Dietary department
    - Fax Humphrey's Educational Consult
    - Verify Initial weight
    - MTP to be initiated for diabetic care/management
h. Remedial training on diabetic patients requesting to leave AMA
i. Remedial training on initiating the master treatment plan to include diabetic management/nursing care.
j. Remedial training on all revised policies on diabetic management.
k. Remedial training on hand off communication from shift to shift by nursing staff.
l. Medication Variances currently under investigation.

Prevention of further occurrences:

The Nurse Educator/Diabetic Coordinator has been assigned to coordinate the care of the diabetic patients treated at Intermountain. Primary responsibilities include :

a. Daily assessment of each new admission with a diagnosis of diabetes to ensure that all policies and procedures for diabetic patients are being followed.
b. Daily patient monitoring for stability and efficacy of the current orders to maintain desired BG levels. Any indication of instability of patient status will be immediately addressed with the attending physician for possible transfer to a higher level of care.
c. Follow-up for timely compliance with nutritional consults, documentation and follow up.
d. Monitoring physician orders to ensure that they are clear and followed by nursing staff.

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e. Continuing education to all nursing staff to include new hires and current nursing staff.
f. Revising clinical policies to ensure delivery of patient care conforms to the most current evidence based practice.
g. Working closely with the Medical Staff and Director of Nursing Service to ensure training needs are being addressed in a timely fashion.
h. Investigation of all medication variances and remedial training as needed with specific nursing staff.

Monitoring of compliance:

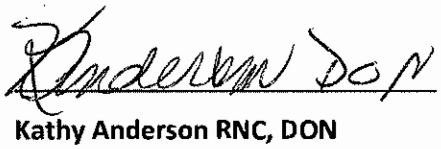
1. The Diabetic Coordinator will maintain a diabetic intervention log that will include a checklist verification of all aspects of the patient's diabetic needs/orders (see attached).
2. The log will be audited and results will be compiled and reported to the PI Committee monthly to include Medication Variance audits.
3. The audits will be reviewed monthly and data will be analyzed and trended. Findings will be submitted monthly to the PI director.
4. The Nurse Educator/Diabetic Coordinator will follow up on all findings with specific trainings and evaluate training needs.

Date of Compliance: Monday, June 21, 2010

Responsible Persons: Director of Nursing Services will be responsible for ensuring that the above measures are followed.

See Attached Revised Policies, Checklist, Assessment forms, Educational Materials

Respectfully submitted,



Kathy Anderson RNC, DON

Brent Bryson CEO

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INTERMOUNTAIN
HOSPITAL

Diabetic Education:

General Information, Documentation, and Expectations

HYPOGLYCEMIA

"Low Blood Sugar"

What is it? Simply: It is the inability of the pancreas to produce enough insulin to effectively utilize food for the body's energy production

Signs/Symptoms

(May or may not come on suddenly)

- **Skin:** Pale or Ashen. Increased perspiration, moist, cool and/or clammy ("Cool & Clammy, Need some Candy")
- **Behavioral:** Irritable, Nervous, shaky, confused, difficulty speaking, anxious; excess hunger, weak
- **BS**: less than 70 mg/dl (A blood sugar < 50 is critical!)

REMEMBER! : Your patient may show all of these signs or may only show a few.
Ask yourself: Could what I'm seeing in my patient be related to his diabetes?
Is his sugar low or is it high?

Causes of Hypoglycemia

- Meals or Snacks that are too small, delayed or skipped
- Too much insulin
- Increased activity or exercise
- Excess intake of alcohol

REMEMBER! If your patient takes his insulin but then doesn't eat his meal (or eats very little of it) the insulin will still continue to lower the blood sugar but will not find the food that it is designed to break down. This results in "BAD COMPANY". That is: hypoglycemia is just around the corner! Expect it!!

Treatment for Hypoglycemia

"Cool and Clammy. . . Need Some Candy"

- Licensed Nurse Only: Take STAT finger stick blood sugar
- Nurse or Tech to take vital signs
- If Blood Sugar is abnormal per P&P, give 'simple carbohydrate' as per Policy and Procedure.
- Nurse to call the Attending MD to report abnormally low blood sugar, vital signs, last meal intake amount and time, last insulin dosage and time. Nurse to call other medical staff as per P&P.
- Nurse to take new orders. Be sure to ask the physician what snack he/she wishes the patient to have after the BS is stable.
- If blood sugar and vitals are normal, continue to observe the patient and report any changes to the Charge Nurse or Shift Supervisor.
- Chart when this all happened, what you saw, what you did, how the patient responded to your actions. Don't forget to note any new MD orders as well as sending pharmacy any changes made to medications.

- Make sure that if the MD orders a snack for the patient, that the patient gets his snack. If the patient does NOT get his snack or refuses to eat it, the MD MUST be notified so that changes can be made for insulin coverage.
- When charting the patient's meals, the chart MUST reflect the AMOUNT of food consumed as well as WHAT food was eaten. For example:

"Patient ate most of meal: 25% of salad, 1slice bread, all of beef patty, about 6oz milk" vs. "Pt at 25% meal"

HYPERGLYCEMIA

"High Blood Sugar"

What is it? Simply: It is the body's accumulation of glucose (from foods) in the blood and not enough insulin to break it down

Signs/Symptoms

(May or may not be sudden)

- Skin: dry, reddened lips, rosy cheeks, maybe some sweating
- Behavioral: pronounced hunger, pronounced thirst, frequent urination, fatigue, decreased LOC, confusion, maybe anxiety
- Other: 'acetone-like' or 'fruity' breath odor; vomiting/nausea, may complain of blurred vision
- BS: more than 125mg/dl

Treatment for Hyperglycemia

- Treatment of hyperglycemia in the diabetic patient is to administer insulin per physician orders.
- Chart what happened: what you saw, what you did, how the patient responded to your actions. Don't forget to note any new MD orders as well as sending pharmacy any changes in orders.
- When insulin is to be administered, two licensed nurses will check/verify the following with each other: Type of insulin ordered is type of insulin to be given and the correct dosage is drawn in the syringe. Both nurses will initial on the Insulin MAR sheet.

Remember!! Hypoglycemia and Hyperglycemia can be quickly corrected if it is recognized early on. If not, it will rapidly become an emergency situation!!

General Insulin Information

- When insulin is to be administered, two licensed nurses will check/verify the following with each other: Type of insulin ordered is type of insulin to be given and the correct dosage is drawn in the syringe. Both nurses will initial on the Insulin MAR sheet.

- Each nurse should know that insulin is categorized by the Onset of Action, the Peak of Action and Duration of Action and is always measured in units.

Rapid Acting (Clear)	Onset 5-15mins Peaks 45-90 min Lasts 4-5 Hrs	(i.e., Humalog, Novolog)

What this means is that the patient will need to eat within 15minutes of receiving insulin. The blood sugar will be lowered the most in about 45-90 minutes and will last about 4-5 hrs.

Short Acting (Regular) (Clear)	Onset 30 min Peaks 2-4 Hrs Lasts 5-8 Hrs	(i.e., Humulin-R)
Intermediate Acting (Cloudy)	Onset 2-4 Hrs Peaks 4-10 Hrs Lasts up to 18 Hrs	(i.e., Humulin-N, NPH, Lente)
Long Acting	Onset 6-10 Hrs Lasts 20Hrs or more	(i.e., Ultralente)
Very Long Acting	Onset 1 Hr Lasts evenly for 24Hrs	(i.e., Glargine)

- When insulin is opened, the bottle should be dated, timed and initialed and discarded after 28days. Refer to the Pharmacy P&P for specifics on disposal.
- As with all medicines, the expiration date should be noted prior to using
- Insulin should be brought to room temperature prior to administering it
- Insulin suspension should never be shaken, but rather rolled between the palms to ensure even dispersion prior to injecting
- Do not administer insulin that is discolored. If this is noticed, Do NOT discard the medication. Contact pharmacy (or Shift Nursing Supervisor) and handle per Hospital/Pharmacy P&P. An incident report should be prepared noting this situation and passed to the Shift Nursing Supervisor to complete.
- When giving insulin (or observing the patient give his own insulin) this is a good time to assess the skin and ensure that injection sites are rotated in order to prevent lipodystrophy (thickening/hardening of the SQ layers of skin). In addition, a general assessment of the patient's skin and foot condition/cleanliness (to prevent skin breakdown) would be in order.
- Ensure that diabetic patients do not walk around without foot protection.

GLUCOMETER USAGE

Nursing Staff performing D-Sticks will be performance-checked on the correct use of the monitor.

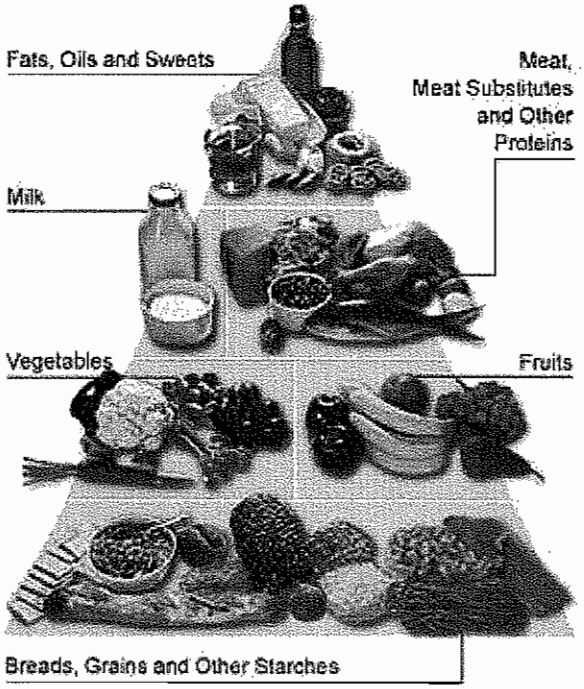
- To be calibrated every day during the 11-7 shift, *BEFORE* midnight.
- A log ("*Glucometer Calibration Log*") will be kept and signed by individual designated to calibrate the device.
- The Glucometer Calibration Log will be kept near the diabetes testing equipment and the designated individual will log the date/time the calibration was done, note the code # for the strips and the glucometer and that they are the same, that the date and memory (30-dy) are correct and then sign.
- Ensure that the bottle of glucose strips have the same code as he code noted on the glucometer. If not, then find a monitor/strips that 'match.' DO NOT test glucose without assuring that the glucometer and strips 'match.
- Ensure date/time is correct on the monitor and that there is 30day memory storage for data. If incorrect, refer to user manual.
- Wash hands; don gloves.
- Place strip into monitor, pointed side out. The monitor will turn on by itself and do a self check.
- While monitor is 'booting up,' clean the patient's finger with alcohol swipe, air dry and perform a finger stick.
- Place a large, single drop of blood over the entire marked area of the test strip. Wait for reading.
- Promptly record the patient's blood sugar and report/follow up as indicated.
- Wipe glucometer down with another clean alcohol pad and store safely

Nutritional Care for the Diabetic Patient

Staff overseeing diabetic patient care at meal times should have a general understanding of the "Diabetes Food Pyramid" as designed by the National Institute of Diabetes and Digestive and Kidney Disease. The pyramid can help Intermountain staff provide patient education on making appropriate food item choices based on their target caloric goal to improve blood sugar stabilization.

Diabetic Food Pyramid

Diabetes Food Pyramid was designed by the American Diabetes Association and the American Dietetic Association. Unlike the USDA Food Guide Pyramid, diabetic food pyramid guide you with group of foods based on their carbohydrate and protein content because these foods affect blood glucose levels, which is indeed the primary concern to people with diabetes. You may find differences like potatoes and other starchy vegetables in the grains, beans and starchy vegetables group instead of the vegetables group, cheese is in the meat group instead of the milk group.



A serving of pasta or rice is 1/3 cup in the Diabetes Food Pyramid and ½ cup in the USDA pyramid. Fruit juice is ½ cup in the Diabetes Food Pyramid and ¾ cup in the USDA pyramid. This difference is to make the carbohydrate about the same in all the servings listed.

Grains and Starches

Situated at the base of the pyramid, these are foods contain mostly carbohydrates. Bread, cereal, rice, and pasta are food in this group mostly made of grains, such as wheat, rye, and oats. Starchy vegetables like potatoes, corn, and peas also belong to this group, along with dry beans such as black eyed peas and pinto beans. Starchy vegetables and beans are in this group because they have about as much carbohydrate in one serving as a slice of bread. As for beans and starches, they are group together because they affect blood glucose in the same way.

Recommended serving: 6 -11 servings per day.

Vegetables

Vegetables are full of vitamins, minerals, fiber, and naturally all of them are low in fat. Vegetables that should be at the top of your food list should be dark green and deep yellow vegetables, such as spinach, kale, broccoli, romaine lettuce, carrots, cucumbers, chilies and peppers. Try to get fresh or frozen vegetables rather than canned vegetables because they have less sauces, fats and salt added.

Recommended serving: 3 - 5 servings per day.

Fruits

Fruits are fabulous because they provide important vitamins, minerals, and

fiber. Fruits also contain carbohydrates. Most dietitians recommend consuming whole fruits rather than juices because of the fiber contained. Avoid fruits and fruit juices that contain sweeteners or syrups added. This group includes blackberries, grapefruit and tangerines, cantaloupe, strawberries, oranges, apples, bananas, peaches, pears, and apricots.

Recommended serving: 2 - 4 servings per day.

Milk

Milk products contain a lot of protein and calcium as well as many other vitamins. When looking at milk or yogurt, try to choose low-fat or nonfat milk products for the great taste and nutrition without the saturated fat.

Recommended serving: 2 - 3 servings per day.

Meat and Meat Substitutes

Includes in this group are beef, chicken, turkey, fish, eggs, tofu, dried beans, cheese, cottage cheese and peanut butter. Meat and meat substitutes are great sources of protein and many vitamins and minerals. Nutritionists usually recommend fish and poultry over red meat, because it's less fatty. Keep your portion sizes small and trim away all the visible fat off meat. Baking, roasting or grilling is preferable to frying.

Recommended serving: 2 - 3 servings per day.

Sweets, Fats and Alcohol

Sitting at the very top of the pyramid simply means that your body should have smaller amounts of them. Your body needs fat for some things, but it's smart to avoid eating too much of it. And although sugary foods like candy and cookies are simple carbohydrates that can give you quick energy, they are usually loaded with calories and don't offer much in the way of nutrients. In the right amount, though, fats, alcohol and sweets can spike up the flavor in meals and snacks.

How much should I eat each day?

Have about **1,200 to 1,600 calories** a day if you are a

- small woman who exercises
- small or medium-sized woman who wants to lose weight
- medium-sized woman who does not exercise much

Choose this many servings from these food groups to have **1,200 to 1,600 calories** a day:

- 6 starches
- 2 milks
- 3 vegetables
- 4 to 6 ounces meat and meat substitutes
- 2 fruits
- up to 3 fats

Talk with your diabetes teacher about how to make a meal plan that fits the way you usually eat, your daily routine, and your diabetes medicines. Then make your own plan.

Have about **1,600 to 2,000 calories** a day if you are a

- large woman who wants to lose weight
- small man at a healthy weight
- medium-sized man who does not exercise much
- medium-sized or large man who wants to lose weight

Choose this many servings from these food groups to have **1,600 to 2,000 calories** a day:

- 8 starches
- 2 milks
- 4 vegetables
- 4 to 6 ounces meat and meat substitutes
- 3 fruits
- up to 4 fats

Talk with your diabetes teacher about how to make a meal plan that fits the way you usually eat, your daily routine, and your diabetes medicines. Then make your own plan.

Have about **2,000 to 2,400 calories** a day if you are a

- medium-sized or large man who exercises a lot or has a physically active job
- large man at a healthy weight
- medium-sized or large woman who exercises a lot or has a physically active job

Choose this many servings from these food groups to have **2,000 to 2,400 calories** a day:

- 10 starches
- 2 milks
- 4 vegetables
- 5 to 7 ounces meat and meat substitutes
- 4 fruits
- up to 5 fats

Talk with your diabetes teacher about how to make a meal plan that fits the way you usually eat, your daily routine, and your diabetes medicines. Then make your own plan.

Diabetic Care Competencies

1. Signs of hypoglycemia are as follows:
   a. Sudden hunger, weakness or restlessness, ashen
   b. Paleness of the skin, increased perspiration
   c. Giddy, stubborn sleepy, dizziness, vertigo, and convulsions and coma
   d. all of the above

2. Signs of acidosis are as follows:
   a. Drowsiness, smell of acetone on the breath
   b. Dry skin, reddened lips, rosy cheeks, increased respirations
   c. Occasional nausea and vomiting, stomach aches, coma
   d. all of the above

3. The nursing staff will encourage:
   a. Cleanliness to avoid skin breakdown and infection
   b. Good foot care: patients cannot walk around barefoot and toe nails are to be cut by a podiatrist
   c. Importance of lifetime care
   d. all of the above

4. When distributing patient food tray, the staff must ensure:
   a. The food being served is the ordered diet for the patient
   b. The patient receives any food he/she prefers
   c. Receives a tray; if a tray is not available, you may take another patient's tray in the meantime as long as you call the dietary department to replace it.
   d. Consumes all of their meals.

5. How do you identify a patient who is on a special/diabetic diet?
   a. Ask the doctor
   b. Ask the patient
   c. Call the dietary department to find out
   d. Check the orders

6. The five categories of insulin according to Onset, Peak and Duration following administration are:

   a. Rapid, Fast, Regular, Long, Very Long
   b. Rapid, Short, Intermediate, Long, Very Long
   c. Rapid, Long, Regular, Fast, Very Fast

7. All insulin is measured in:
   a. ml
   b. units/ml
   c. micrograms
   d. dl

8. Why is it important to rotate sites (stomach, thighs, and arms) to when administrating SC maintenance doses?
   a. To prevent clots
   b. To prevent bleeding
   c. To prevent lipodystrophy
   d. To prevent it from hurting too much

9. The following are true when preparing insulin:
   a. Date and time when opening a new bottle; the bottle is only usable for 28 days after the opened date or until the expiration date, whichever is first
   b. The dates are to be checked prior to each usage; if the bottle is opened and not dated, it is to be considered expired and returned to pharmacy
   c. Always allow insulin to reach room temperature before administrating it
   d. Roll the bottle of insulin suspension gently between palms to ensure uniform dispersion
   e. all of the above

10. What should you do when the insulin looks like it has changed color?
   a. Shake the bottle until the color becomes clear
   b. Double check the bottle to ensure it is not expired
   c. do not use it; return it immediately to the pharmacy
   d. Contact the nursing supervisor immediately

Flow of Diabetic Care at IMH

Role of Assessment and Referral:

All admitting patients will be assessed for an established history of Diabetes Mellitus (DM). If DM is identified on assessment, A&R will initiate a baseline capillary blood glucose check then will **initiate the orange colored Diabetic Assessment form**. A&R will then call the accepting Physician with collected information and receive **diabetic standing orders, customized diabetic orders, capillary blood glucose check parameters**, and an **ADA diet order**.

Role Expectations of Unit Staff:

Upon admission, the licensed nurse will conduct a more thorough medical history and document findings on the Section II. The following steps MUST then be completed:

A. Yellow Diabetic Mar Initiated with **two nurse signatures (NEW).**

B. **Dietary Request sent ASAP** (24 hours to see dietician) Write **on MAR** as if it is a medication to ensure compliance with in 24 hours. (Place fax verification in back of chart).

c. Humphries **consult form completed and faxed** (place confirmation in back of chart). Diabetic educator has 48 hours to see patient...**PLACE ON MAR** as a medication to ensure compliance.

d. Assess and ensure for availability of ordered antiglycemics.

e. Document Admission weight (not stated) on section II.

f. Verify Pharmacy has received all orders.

g. **Every Diabetic Patient will have a new check list to be completed and placed on front cover of chart (New).**

h. Diabetic Patients wishing to leave Against Medical Advice (AMA) must have a face to face evaluation by attending/covering physician with in one hour. Always notify Shift supervisor of any issues with either diabetic

patients or patients wishing to leave AMA.

INTERMOUNTAIN
HOSPITAL

Date: Name:

1. The patient has refused a 22:00 dose of Lantus for a blood sugar of 94. What is hospital procedure?

2. How long does the Dietitian have to evaluate an insulin dependent diabetic patient?

3. Why is insulin generally not recommended for HS Capillary BG coverage?

4. **All** diabetic patients should have a _____ diet.
5. BG Sliding scale states:

BG < 100 = no insulin

BG 100-200 = 1 unit

BG 200-300 = 2 units

Before checking Blood Glucose, you know to call the MD because?

INTERMOUNTAIN
HOSPITAL

Date: Name:

6. A&R admit order states to use Humalog for sliding scale. It is after pharmacy hours and Novalog is the only insulin available. Select the appropriate answer.
    a. Novalog and Humalog are almost the same and it is OK to use interchangeably
    b. Call Supervisor for instructions
    c. Call the attending / admitting physician for clarification
7. Your newly admitted diabetic patient is demanding to discharge against medical advice. Which is the correct answer?
    a. The MD may give D/C orders over the phone
    b. The patient must stay the night to see MD in the morning
    c. Notify the Nursing Supervisor
    d. Call the MD for a face to face evaluation within an hour of discharge request
    e. All of the above
    f. Both c and d

Intermountain Hospital

Title: Management of the Diabetic	Policy Number: 1000.104
Function: Nursing Specific Policies	Date Development: 7/06 Revised 02/2009
Manual: Clinical Services Manual	Page(s): 7
Developed By: Clinical Services (Nursing)	Attachment(s) Diabetic protocol & Instructions

Policy: Nursing staff will provide treatment to maintain adequate physical health for the diabetic patient, per Physician Order and in accordance with the diabetic Protocol approved by the Medical Staff.

Procedure:

1. The Diabetic assessment will be done by Assessment and Referral staff. This will assess the patients understanding of his/her diabetic condition to determine the educational needs.
2. If the patient is admitted on insulin the RN will get an MD order for a sliding scale, RD consult, Humphries Consult and an ADA diet as well as routine blood sugars. See attachment.
3. Any insulin and blood sugar orders will be placed on the diabetic administration record which is yellow. See attachment.
4. The Nurse will perform blood glucose monitoring as ordered by the Physician. Factors that may vary the glucose level include:
    a. Diet
    b. Physical Activity
    c. Infection
    d. Emotional Stress.
    e. The nursing staff will ensure that the patient receives adequate diet to maintain normal weight.
5. The Nursing staff will encourage:
    a. Cleanliness to avoid skin breakdown and infection.
    b. Good foot care. Toe nails should be cut by a podiatrist.
    c. Importance of lifetime care.
6. The Nursing staff will observe closely for untoward symptoms:
    a. Signs of Insulin Shock
        - Sudden hunger
        - Weakness and restlessness
        - Paleness of the skin
        - Increased perspiration
        - Emotional responses: i.e. giddy, stubborn, sleepy, dizziness, vertigo, and finally convulsions and coma
    b. Signs of Acidosis:
        - Drowsiness
        - Dry skin, reddened lips, rosy cheeks
        - Increased respirations
        - Smell of acetone on the breath
        - Occasional nausea and vomiting, stomach aches

- Coma

Attachments:
A. Diabetic Assessment
B. Diabetic Physicians Orders
C. Dietary/Registered Dietitian Referral Request
D. Humphries Referral Request
E. Diabetic Medication Administration Record

Designed:

INTERMOUNTAIN HOSPITAL
DIABETIC MEDICATION ADMINISTRATION RECORD / PHARMACY PROFILE

Ht: _____ Wt: _____

Diagnosis: _____

Allergies:

Nursing Signature/Initials:

_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____
_____ / _____

Label:

Unit:

ORDERS:			Date:			Date:			Date:			Date:			Date:		
Sliding Scale, Blood Glucose, Insulin Administration		Times Ordered	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No
Date: Nurse:	Blood Glucose (Finger Stick) Indicate when to be covered																
Date: Nurse:	Insulin Administration Scheduled Doses																
Date: Nurse:	Insulin Administration Sliding Scale		Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site
Review Daily By Night Shift RN:																	

Other Instructions:

***√ Indicates No Dose Given

DIETARY / REGISTERED DIETICIAN REFERRAL REQUEST

INTERMOUNTAIN HOSPITAL

Patient Label:

IMH Unit: _____

Referred By: _____

Date/Time of Order: _____

☐ – **DIETARY ALERT / REQUEST** ***(Fax to Kitchen — 321-1631)*** ***Dietary Initials:***

☐ – **Food Allergies:** _____ _____

☐ – **Food Intolerance:** _____ _____

☐ – **Cultural / Religious:** _____ _____

☐ – **Physician's Order for Special Diet:** _____ _____

_____

☐ – **Other** *(including special preferences - i.e., no fish, vegetarian, etc.)*: _____ _____

_____

_____

☐ – **Cake Order:** Date Cake is Needed: _____ *(please provide at least 1 day notice)* _____

(Please list the occasion, specific wording on cake, and flavors of cake/filling/frosting requested):

_____

_____

_____

☐ – **REGISTERED DIETICIAN CONSULT** ***(Fax to Kitchen — 321-1631)*** ***R.D.'s Initials:***

☐ – **Physician's Order for Dietary Consult** _____

☐ – **Nutritional Assessment *for Insulin Dependent Diabetic Patient*** *(within 24 hours)* _____

** *Must call "S&S Nutritional Network" at 861-3998 to alert Dietician* **

☐ – **Nutritional Assessment *for Non-Insulin Dependent Diabetic Patient*** *(within 72 hours)* _____

☐ – **Nutritional Assessment *indicated by Nursing Assessment*** *(within 72 hours)* _____

Additional Information / Special Instructions / Comments: _____

_____

_____

_____

_____

Referral Request Submitted by: _____ ***Date:*** _____ ***Time:*** _____

05/2010

HDC
HUMPHREYS
DIABETES CENTER

1226 River Street – Boise, ID 83702
208-331-1155

INPATIENT REFERRAL/ORDER FOR DIABETES EDUCATION SERVICES

DIRECTIONS – TO BEST PREPARE FOR THE VISIT:

Clinical Resource Manage/Nurse to complete and fax with patient face sheet to Inpatient Scheduler at:

St. Luke's Boise & Meridian – 855-4822 ***Saint Alphonsus – 383-0190*** ***Intermountain – 383-0190***

Appointment confirmation will be faxed by Inpatient Scheduler to unit for placement on chart.
Confirmation faxed to Saint Alphonsus Translation Services if interpreter needed. (Fax: 367-4056)

Location: St. Luke's Boise Rm #_____ Saint Alphonsus Rm #_____
St. Luke's Meridian Rm#_____ Intermountain Rm #_____

Hospital to Complete This Section

Contact Person:_____**Unit Phone:**_____**Unit Fax #:**_____

Clinical Resource Manager:_____**Clinical Resource Mgr. Ph :**_____

Scheduling Priority: □ **within 36 hrs** □ **within 48 hrs** □ **within 72 hrs** □ **May be seen as out patient**

Patient Name:_____**DOB:**_____

Anticipated Discharge Date: _____

Ordering Practioner:_____**Admit Diagnosis:**_____

Education Needed: □ **Monitor** □ **Insulin** □ **DKA** □ **Hypoglycemia** □ **Pregnant**
□ **Child** □ **New Type 1** □ **New Type 2** **Other**_____

Special Needs: □ **Vision** □ **Hearing** □ **Physical** □ **Cognitive Impairment** □ **Language**

□ **Interpreter: Language spoken:** _____

Is this a New Insulin Start? □ **Yes** □ **No**

Does Patient Wear an Insulin Pump? □ **Yes** □ **No**

On Insulin Before Admission □ **Yes** □ **No**

Patient has Glucose Meter for Home Use? □ **Yes** □ **No**

Should Family Member Be Present? □ **Yes** □ **No**

Insurance/Financial □ **Medicare** □ **Medicaid** □ **Private** □ **None**

Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____

Intermountain Hospital

Title: Management of the Diabetic	Policy Number: 1000.104
Function: Nursing Specific Policies	Date Development: 7/06 Revised: 6/10
Manual: Clinical Services Manual	Page(s): 7
Developed By: Clinical Services (Nursing)	Attachment(s) Diabetic protocol & Instructions

Policy: Nursing staff will provide treatment to maintain adequate physical health for the diabetic patient, per Physician Order and in accordance with the diabetic Protocol approved by the Medical Staff.

Procedure:

1. The Diabetic assessment will be done by Assessment and Referral staff. This will assess the patients understanding of his/her diabetic condition to determine the educational needs.
2. If the patient is identified as diabetic, the RN will get the necessary MD orders to safely manage the patient. This will include a Registered Dietitian (RD) consult, a Humphreys Certified Diabetic Educator consult, ADA diet orders, parameters for capillary blood glucose checks, and Insulin and/or other needed antihyperglycemics.
3. A Dietary/Registered Dietician Referral Request form (see attachment) is to be completely filled out indicating the request for an ordered ADA diet and an RD consult. The completed form will then be faxed to the Dietary Department and the fax conformation sheet is to be dated, timed, initialed be placed under the "Other" divider of the patient's chart. A new entry will be made on the standard Medication Administration Record (MAR) to indicate the due date and time that the consult is due. The RD consult must be completed within 24 hours of the admit time. Responsibility to assure that the consult has been completed is to be delegated to the Medication Nurse (Med Nurse) working at the time that the 24 hour waiting period expires. If the consult has not been completed at that time the Med Nurse will notify Dietary to attempt to get a timeframe for when the consult can expect to be completed. The Med Nurse will then notify either the attending or covering Physician and document the reason for the delay and that the MD was notified in the Interdisciplinary Treatment Notes.
4. The RD will document the session in the Interdisciplinary Assessment and will make recommendations to the Physician by documenting "RD Recommendations…" on the Physician Orders. The recommendation will be in a holding status until the MD/NP/PA reviews the order and approves the recommendations. If the nurse suspects an imminent need based from the RD recommendations it is expected that they notify the appropriate provider to receive telephone orders.
5. A Humphreys Consult Referral Request form (see attachment) is to be completely filled out indicating the request for a Diabetic Education consult. The completed form will then be faxed to Humphreys Diabetic Center and the fax conformation sheet is to be dated, timed, initialed and placed under the "Other" divider of the patient's chart. A new entry will be made on the standard Medication Administration Record (MAR) to indicate the due date and time that the consult is due. The Diabetic Education consult must be completed within 48 hours of the admit time. Responsibility to assure that the consult has been completed is to be delegated to the Med Nurse working at the time that the 48 hour waiting period expires. If the consult has not been completed at that time the Med Nurse

will contact Humphreys to attempt to get a timeframe for when the consult can expect to be completed. The Med Nurse will then notify either the attending or covering Physician and document the reason for the delay and that the MD was notified in the shift narrative.

6. The Certified Diabetic Educator will document the session in the Interdisciplinary Treatment Notes and will make recommendations to the Physician by documenting "Diabetic Education Recommendations..." on the Physician Orders. The recommendation will be in a holding status until the MD/NP/PA reviews the order and approves the recommendations. If the nurse suspects an imminent need based from the Diabetic Education recommendations it is expected that they notify the appropriate provider to receive telephone orders.

7. Any insulin and blood sugar orders will be placed on the yellow diabetic administration record. See attachment.

8. Transcription of the Diabetic orders onto the yellow diabetic MAR must be verified by two licensed nurses before the MAR can be used unless there is an emergent situation with the patient's condition requiring immediate treatment.

9. Diabetic packets will be maintained on the unit and will include a blue Diabetic Checklist and Instructions sheet, a blank yellow diabetic MAR, referral requests for both Dietary/RD and Humphreys, and a Preprinted Master Treatment Plan for Diabetes. The Diabetic Checklist and Instruction Sheet is to be placed on the front cover of the chart on admission and is to be checked off as tasks are completed. Each shift is responsible for ensuring that all tasks are completed. Unfinished tasks must be reported to the next shift Nurse. Upon discharge the Diabetic Checklist may be discarded. Upon admission the Preprinted Diabetic Master treatment Plan (see attachment) must be initiated with the Section II.

10. The Nurse will perform blood glucose monitoring and administer any ordered insulin or other medications. The nurse is required to document adequate dietary intake of both solid foods and hydration, assess adequate elimination patterns, and document either patient's compliance to treatment or notification to the MD of the patient's noncompliance.

11. Nursing staff will obtain an admission weight and will weigh the patient weekly to monitor patient's health status. A weight loss of greater that 5 pounds in a week should be reported the physician and documented in the Interdisciplinary Treatment Notes

12. Diabetics are at an increased risk for infection and other physical morbidity, as such, the Nurse will monitor for any signs of infection and will report abnormal findings to MD. Nursing staff are not permitted to trim the toe nails of diabetic patients. Staff will encourage cleanliness and foster an understanding of the need for lifelong care.

13. The Nursing staff will monitor each Diabetic patient for the following conditions:

a. Signs of Insulin Shock:
   - Sudden hunger
   - Weakness and restlessness
   - Paleness of the skin
   - Increased perspiration
   - Emotional Response: i.e. giddy, stubborn, sleepy, dizziness, vertigo, and convulsions, unresponsiveness, or death
   - Changes in mentation

b. Signs of Acidosis:
   - Drowsiness
   - Dry skin, red lips, and rosy cheeks
   - Increased Respiration
   - Fruity (acetone) smell on breath
   - Nausea, vomiting, loss of appetite, and/or stomach aches

Insulin Shock (critically low blood glucose) and Acidosis are medical emergencies. If suspected the nurse is to notify the house supervisor and the MD immediate assistance. If determined by the physician to be either condition orders should be sought to transfer to higher level of care (Emergency Department).

14. The Diabetic Coordinator will be a designated licensed nurse that will be responsible for overseeing and auditing the care of all diabetic inpatients. In the absence of the Diabetic Coordinator the acting House Supervisor will assume responsibility of this role. It will be the responsibility of the House Supervisor to report any trending or significant problems to the Diabetic Coordinator who will then report unresolved issues to the Director of Nursing Services.

Attachments:

A. Diabetic Checklist and Instructions
B. Diabetic Assessment
C. Diabetic Physician's Orders
D. Dietary/Registered Dietician Referral Request
E. Humphreys (Certified Diabetic Education) Request
F. Diabetic Medication Administration Record

DIABETIC CHECKLIST

&

INSTRUCTIONS

- ☐ Orange Diabetic Assessment Complete from A&R
- ☐ Complete orders for Blood Glucose Monitoring.
- ☐ Yellow Diabetic Mar Completed. Orders must be verified by (2) Nurses.
- ☐ Verify availability of Antiglycemics.
- ☐ Fax **Dietary/Registered Dietician Referral Request** to dietary (321-1631).
  - (Dietitian must meet with diabetic patient within 24 hours). Place confirmation of fax in "Other" section of chart.
  - Record 24 hour time/date from time of fax in MAR for follow up.
- ☐ Fax completed **Humphries Referral/Order** to: 383-0190.
  - (Humphries must meet with insulin dependent diabetic patient within 48 hours) Place confirmation of fax in "Other" section of chart.
  - Record 48 hour time/date from time of fax in MAR for follow up.
- ☐ Document actual weight of patient, not stated.
- ☐ Complete preprinted Master Treatment plan for Diabetic Care and file in "Treatment Plan" section of patient chart. Must be completed within (12) hours of receipt of orders.
- ☐ If either the Dietician or Humphries does not complete their consults within the allotted time, call physician. Document your communication with physician and pass on to next shift.

(Please tape to front of chart)

INTERMOUNTAIN HOSPITAL

LABEL

Diabetic Assessment

How long have you had diabetes?_____

Are you currently on oral anti-hyperglycemics? _____ BS Range: _____

Are you currently on insulin? _____ How often do you check your blood glucose?_____

Describe what you take and how you take it:_____

_____

_____

_____

Last time you had medications:_____

_____

_____

What are the ranges of your blood sugar?_____

Do you often have hypoglycemia (low blood sugar)?_____

Do you often have hyperglycemia (high blood sugar)?_____

Describe:_____

_____

Have you ever had keto-acidosis (passed out because of low/high blood sugar)?_____

Did you have to go to the hospital?_____ Were you admitted?_____

What doctor helps/treats you for your diabetes?_____

When did you last see this doctor?_____

Have your medication been changed recently?_____

Blood sugar now:_____ HAIC:_____

Do you have any problems with circulation (ie your feet or eyes)?_____

Do you have any other problems with your diabetes?_____

_____

Patient's weight:_____ Are you on a special diet?_____

Other medical problems:_____

_____

_____

Other medication:_____

_____

_____

Note! A patient with a blood sugar (BS) over 300 or will not be accepted.

Date / Time:_____

Assessment completed by:_____

INTERMOUNTAIN
HOSPITAL

PHYSICIAN'S ORDERS – DIABETIC PROTOCOL

1. ☐ EDUCATION: Educate patient on signs & symptoms of hypoglycemia and hyperglycemia.
2. ☐ Dietary Consult and Diabetic Consult
3. DIET: ☐ ADA Adult Diet ☐ ADA Adolescent Diet ☐ Regular Diet
4. BLOOD GLUCOSE MONITORING: ☐ BG AC & HS ☐ BG in addition to AC & HS: _____
5. ☐ Recheck BG one (1) hour after administering sliding scale insulin (contact physician if BG not WNL).
6. ☐ Do not give insulin for HS Blood Glucose

SLIDING SCALE INSULIN ORDERS FOR DIABETES

☐ **Regular Insulin** *or* ☐ **Novolog** *or* ☐ **Other:** _____

ORDER ONLY ONE SLIDING SCALE INSULIN OPTION BELOW

☐ Option 1		☐ Option 2		☐ Option 3	
BG Level:	**Administer:**	**BG Level:**	**Administer:**	**BG Level:**	**Administer:**
BG < 70	2-3 oz Orange Juice PO + 2-4 oz Milk/Yogurt Contact MD	BG < 70	2-3 oz Orange Juice PO + 2-4 oz Milk/Yogurt Contact MD	BG < 70	2-3 oz Orange Juice PO + 2-4 oz Milk/Yogurt Contact MD
70 - 150	No Insulin	70 - 150	No Insulin	70 - 150	No Insulin
151 - 200	No Insulin	151 - 200	3 units Subq	151 - 200	4 units Subq
201 - 250	2 units Subq	201 - 250	5 units Subq	201 - 250	6 units Subq
251 - 300	4 units Subq	251 - 300	7 units Subq	251 - 300	10 units Subq
301 - 350	6 units Subq	301 - 350	9 units Subq	301 - 350	12 units Subq
351 - 400	8 units Subq	351 - 400	11 units Subq	351 - 400	15 units Subq
BG > 400	Contact Physician	BG > 400	Contact Physician	BG > 400	Contact Physician

Physician Name *(print)*:_____ ☐ - ***Telephone/Verbal Order Read Back***

Nurse's Signature _____ **Date/Time** _____

Physician's Signature _____ **Date/Time** _____

HYPOGLYCEMIA symptoms include:

* *Cold, clammy skin*
* *Trembling or feelings of nervousness*
* *Fainting or unconsciousness*
* *Irritability or confusion*
* *Lack of motor coordinotion & fatigue*
* *Blurred vision, headache or dizziness*
* *Nausea or stomach pain*

HYPERGLYCEMIA symptoms include:

* *Increased thirst and urination*
* *Sweet odor to the breath*
* *Fatigue*
* *Agitation and confusion*
* *High levels of ketones in the urine*
* *Weight loss*

Patient Label:

INTERMOUNTAIN HOSPITAL

Patient Label

DIETARY / REGISTERED DIETITIAN
REFERRAL REQUEST

Date:_____ Unit:_____ Referred By:_____RN/LPN

Information for DIETARY STAFF:

Dietary Alerts:	**Dietary Staff Initials:**
___ Allergies: Describe:_____	_____
___ Food Intolerance: Describe:_____	_____
___Cultural /Religious: Describe:_____	_____
___ Other: Include Specific Preferences (i.e. No fish)_____	_____
___ M.D. Order for Special Diet: ._____	_____

***Note the order and fax to the Kitchen Immediately – Fax 321-1631
***Picture must accompany all Diet Orders.

For REGISTERED DIETITIAN ONLY	**RD Initials:**
☐ M.D. Admit Order for Dietary Consult	_____
☐ Nutritional Assessment for Insulin Dependent Diabetic – within 24-hours **Must call S&S Nutritional Network and forward Referral Request Form 861-3998.	_____
☐ Nutritional Assessment Non-Insulin Diabetic -- within 72-hours	_____
☐ Nutritional Assessment indicated by Nursing Assessment – within 72-hours Note: Picture must accompany all requests for Special Diets or Dietary alerts.	_____

Other Information:_____

_____

_____

_____

_____

HDC
HUMPHREYS
DIABETES CENTER

1226 River Street – Boise, ID 83702
208-331-1155

INPATIENT REFERRAL/ORDER FOR DIABETES EDUCATION SERVICES

DIRECTIONS – TO BEST PREPARE FOR THE VISIT:

Clinical Resource Manage/Nurse to complete and fax with patient face sheet to Inpatient Scheduler at:

St. Luke's Boise & Meridian – 855-4822 ***Saint Alphonsus – 383-0190*** ***Intermountain – 383-0190***

Appointment confirmation will be faxed by Inpatient Scheduler to unit for placement on chart.
Confirmation faxed to Saint Alphonsus Translation Services if interpreter needed. (Fax: 367-4056)

Location: St. Luke's Boise Rm #_____ Saint Alphonsus Rm #_____
St. Luke's Meridian Rm#_____ Intermountain Rm #_____

Hospital to Complete This Section

Contact Person:_____**Unit Phone:**_____**Unit Fax #:**_____

Clinical Resource Manager:_____**Clinical Resource Mgr. Ph :**_____

Scheduling Priority: □ **within 36 hrs** □ **within 48 hrs** □ **within 72 hrs** □ **May be seen as out patient**

Patient Name:_____**DOB:**_____

Anticipated Discharge Date: _____

Ordering Practioner:_____**Admit Diagnosis:**_____

Education Needed: □ **Monitor** □ **Insulin** □ **DKA** □ **Hypoglycemia** □ **Pregnant**
□ **Child** □ **New Type 1** □ **New Type 2** **Other**_____

Special Needs: □ **Vision** □ **Hearing** □ **Physical** □ **Cognitive Impairment** □ **Language**

□ **Interpreter: Language spoken:** _____

Is this a New Insulin Start? □ **Yes** □ **No**

Does Patient Wear an Insulin Pump? □ **Yes** □ **No**

On Insulin Before Admission □ **Yes** □ **No**

Patient has Glucose Meter for Home Use? □ **Yes** □ **No**

Should Family Member Be Present? □ **Yes** □ **No**

Insurance/Financial □ **Medicare** □ **Medicaid** □ **Private** □ **None**

Additional Information:

_____
_____
_____
_____
_____
_____
_____
_____

MASTER TREATMENT PLAN

INTERMOUNTAIN HOSPITAL

PROBLEM **Diabetes**

As evidenced by:

Long-term Goal:
(discharge criteria)

Short Term Goals:

Date / Time	Discipline Responsible Staff	Frequency	Intervention	Date Resolved / Updated
			Diabetes Care Plan: ☐ Blood glucose monitoring AC / PC or as order by MD ☐ Dietary consult for dietary program / caloric program ☐ Patient education for diet control diabetes ☐ Patient education for insulin dependent diabetes ☐ Medication Management ☐ a. oral hypoglycemic medications ☐ b. insulin use ☐ c. sliding scale needs ☐ d. documentation of medication used, including dose, route, time, site ☐ Patient education regarding oral medication administration ☐ Patient education regarding insulin use, including the following: ☐ a. Patient will learn needle safety ☐ b. Rotation of injection sites will be taught by staff ☐ c. Patient will be taught signs / symptoms of injection site infection ☐ d. Nursing will instruct on proper dispensing of units to be given with 1:1 RN demonstration	

patient label

INTERMOUNTAIN HOSPITAL
DIABETIC MEDICATION ADMINISTRATION RECORD / PHARMACY PROFILE

Ht: _____ Wt: _____ Diagnosis: _____	Allergies:	Nursing Signature/Initials: _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____ _____ / _____	Label: Unit:

ORDERS:			Date:			Date:			Date:			Date:			Date:		
Sliding Scale, Blood Glucose, Insulin Administration		Times Ordered	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No	BS	Initial	Insulin Yes / No
Date: Nurse:	Blood Glucose (Finger Stick) Indicate when to be covered																
Date: Nurse:	Insulin Administration Scheduled Doses																
Date: Nurse:	Insulin Administration Sliding Scale		Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site	Dose	Int / Int	Site
Review Daily By Night Shift RN:																	

Other Instructions:

***√ Indicates No Dose Given

Intermountain Hospital

Memo

To: Nursing Staff

From: William Fullmer RN Clinical Education

Date: 6/20/2010

Re: MD Notification

The MD **MUST** be notified of any of the following:

-Significant Changes in Patient Condition/Assessment

-Any order that cannot be completed in a timely manner as instructed, including,

- Patients refusal for any ordered care

- Unavailability of ordered medications, treatments, or supplies

-Any reason that prevents an order from being completed

-Blood Glucose Levels below 70 or greater than 400.

-Vital Signs that are out of normal range (defined on detox flow sheets)

When any of these conditions are met the nurse MUST notify the ordering Physician (on call after hours), explain to the patient what is happening, correctly document what happened, and report to next shift.

Situational Protocols:

Example1. Unable to get lab draw (for whatever reason).

1. Notify nurse (if unresolved)
2. Notify House Supervisor (if unresolved)
3. Notify Practitioner
4. Document as follows:

Unable to perform ordered lab draw because _____.. Attempted (to provide patient teaching, order needed supply, have a second person attempt to collect, or whatever your interventions. Charge nurse, House Supervisor, and MD/NP was notified. Reported to next shift. Then Document what MD/NP instructed. Must document on following forms; **1.** Physicians order sheet for any orders received. **2.** Interdisciplinary treatment note must have a detailed narrative of the event. **3.** Lab requisition should have a dated and timed note explaining the problem. **4.** Note should be left on the unit communication board for follow up. **5.** Must be passed on to future shifts for follow up. This cycle must be completed daily until either the issue is resolved or the order discontinued. Any lapses in the protocol must be written up and submitted to the supervisor for potential disciplinary consideration.

Example 2. Medication Noncompliance (for whatever reason).

Attempt to troubleshoot the issue yourself. If missing medication then call pharmacy. If patient refuses provide any needed medication education. Ask patient to bring own home meds not in formulary (an order for permission to use own home meds must be obtained and home meds must be checked in and dispensed by pharmacy). If you cannot resolve the issue then complete the following:

1. Notify charge nurse (if unable to unresolved)
2. Notify Pharmacy
3. Notify House Supervisor (if unable to unresolved)
4. Notify Practitioner
5. Document as follows:

1. Interdisciplinary narrative: Unable to administer ordered medication because__. Attempted to___(your intervention to resolve issue)! Notified charge nurse, pharmacy, house supervisor, and MD. Orders received. Report given to next shift. **2.** Circle missed dose on MAR write "See Notes" and initial. ALWAYS notify MD, complete documentation, and report to next shift.

INTERMOUNTAIN HOSPITAL
INPATIENT CHART AUDITS

Admission Time _____ Patient Name Label

This is to be done within 24 hours of the patient's admission and turned in to the DON!

Chart Audit Items Listed in Order	Yes	No	NA
Allergies on front of chart			
Face sheet in chart			
Pictures taken and in front of chart			
Patient valuables placed in valuables bag and sent to safe (or locked in narcotic cabinet if admissions is not opened) with envelope # noted on belongings sheet and envelope tab stapled to belongings sheet			
Correspondence log			
Personal belongings inventory completed			
Treatment plan initiated within 8 hours of admission			
Problem list initiated (admitting dx is # 1, psych probs, medical probs follow)			
Treatment plan signed by patient			
Medical screening completed by Assessment and Referral and signed by admitting RN			
Direct Admit form completed (if medical screening from A&R was not done)			
Nursing assessment completed within 8 hours of admission			
Does admission note include whether or not patient wants clergy notified?			
Nutritional screen completed during nursing assessment and dietary consult ordered for BMI <19 or >30			
Fall assessment completed and Fall treatment initiated if score is >9			
Is seclusion and restraint reduction plan completed			
RN admission note present and complete			
Psychosocial evaluation within 72 hours			
AT Assessment within 72 hours			
Medication reconciliation form completed			
Orders noted with date & time			
"Read Back" documented for phone orders			
Authorization of telephone orders (Doctor signature within 24 hours)			
Allergies on order sheets			
Authentication of admit orders			
Patient/Family education sheet initiated			
Documentation to treatment plan			
First dose documentation present			
Effectiveness of medication charted "RC" code			
Group notes (Good / Fair / Poor)			
Labs obtained per MD order			
Lab results in chart			
MD notified of abnormal lab results			
Consent to treat signed by patient (if patient is voluntary)			
Original L2K in chart if patient is involuntary			
Advance directives and organ donation sheet signed			
Telephone, visitor log completed			
Patient rights signed by patient			
Confidentiality agreement completed			
HIPPA form signed			
Medication consent signed			
Rounds / flow sheet (Q15 and ordered precautions)			
Legibility of handwriting / signatures			
Kardex initiated			
Allergies on kardex			
Picture on kardex			
Diet on kardex			
Diagnosis on MAR			
Allergies on MAR			
Name labels on MAR			
Picture on MAR			

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOSPITAL	303 NORTH ALLUMBAUGH STREET BOISE, ID 83704

(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
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint/follow-up and recertification survey of your hospital. Surveyors conducting the survey were: Patrick Hendrickson, RN, Team Leader Gary Banister, RN, HFS Teresa Hamblin, RN, HFS Aimee Hastriter, RN, HFS	B 000	**16.03.14.200.01 Governing body and Administration (A043)** Intermountain Hospital's Governing Body now ensures the provision of sufficient oversight and management to ensure compliance with all the CoPs. The Governing Body requires responsiveness and accountability of both the Medical Staff and Hospital leadership in the improvement of quality and amelioration of all deficiencies stated in this Statement of Deficiencies.	
BB115	16.03.14.200.01 Governing Body and Administration 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) 01. Bylaws. The governing body shall adopt 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) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88)	BB115	**Medical Staff Accountability (A049)** The Governing Body now ensures the medical staff is held accountable to the governing body and assumes full responsibility for the quality of medical care provided to patients. **Actions Taken:** The Governing Board convened a meeting of the Medical Staff and required the following corrective actions, now implemented: a. Development of specific criteria for credentialing, privileging, assessment and assignment of general medicine physician and mid level providers. b. Required the involvement of the Medical Executive Committee (MEC) in the	7/13/10

RECEIVED
JUL 23 2010
FACILITY STANDARDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB115	Continued From page 1 ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88) ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) 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) 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 biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants,	BB115	development, implementation and oversight of any changes in clinical approaches and processes contemplated throughout the hospital. c. Expansion of criteria for, and implementation of the Peer Review Process and regular evaluation regardless of a focus review. d. Development of review process of continuing medical education appropriateness. e. Revised and enhanced review process for contracted services. 2. The Medical Team now participates in monthly peer review. a. A peer review process was completed on the family practice physician. b. Qualifying peer review guidelines include: i. Patients who experience adverse drug reactions; ii. Patients transferred to acute care; and iii. Patients who experience critical events. Persons Responsible: Governing Body Medical Director CEO	7/1/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/24/2010

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BB115	Continued From page 2 appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) 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) 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) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) 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) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) 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)	BB115	How Monitored: 1. The Medical Director now submits a Medical Staff written report which includes oversight, peer review, clinical changes, credentialing and any other significant matters to the Governing Body as part of its standing agenda. 2. The Credentialing specialist now maintains a log of the cased reviewed through the Peer Review process in order to ensure ongoing monitoring and evaluation of member of the medical Staff and quality review. **Contracted Services (A083)** The Governing Body now ensures that all departments (including laboratory, dietary and pharmacy) contracted services are integrated into the hospital's QAPI plan. **Actions Taken:** 1. The Governing Body, Medical Staff and Director of Performance Improvement/Risk Management received remedial education on their role and	7/14/10

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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BB115	Continued From page 3 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) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician. (10-14-88) This Rule is not met as evidenced by: Refer to A043 as it relates to the Governing Body's failure to provide sufficient oversight and management to ensure compliance with all the CoPs. This resulted in the inability of the facility to ensure appropriate care and services to patients. Refer to A049 for the failure of the governing body to ensure a medical review process was developed and implemented and that medical staff were accountable to the governing body for the quality of care provided to patients. Refer to A083 for the failure of the governing body to ensure contracted services furnished services that permitted the hospital to comply with conditions of participation and at acceptable standards. Refer to A263 Condition of Participation, Quality Assessment and Performance Improvement Program for the failure of the governing body to ensure the Quality Assessment and Performance Improvement Program was integrated in to all of the hospital's departments.	BB115	responsibility for ensuring all contract services were incorporated into the Hospital's QAPI program. 2. The Director of PI and DNS met with Stat Clinical Laboratory Services to develop specific PI criteria. A new Laboratory PI plan was developed and implemented. Indicators include: a. Timeliness of draw; b. Notification of critical stat labs done within one hour; c. Notification to RN of patient's refusal for labs; d. Lab results filed in medical record within 24 hours e. Blood sampling collection equipment, transport kits and solutions not expired. 3. Analysis of Laboratory data is now incorporated into the Hospital QAPI Program. 4. The PI Director and PSI Consultant met with the Registered Dietitian Consultants. A new Dietary PI plan was developed and	7/15/10 7/15/10

Bureau of Facility Standards

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BB115		BB115	implemented. Indicators include: a. Accuracy of therapeutic diets served to patients; b. Timely and comprehensive referral, screening and assessment completion; c. Treatment planning for all patients with clinical nutritional needs; d. Sanitation and safety in the dietary department. 5. Analysis of dietary/registered dietitian data is now incorporated into the Hospital's QAPI Program. 6. The Director of PI and PSI Consultant met with CPS Pharmacy. A new Pharmacy PI plan was developed and implemented. Indicators include: a. Patient's height/weight entered in HMS within 48 hours of admission; b. Patient's pregnancy/lactation	7/15/10

Bureau of Facility Standards

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BB115		BB115	within 48 hours of admission; c. Patient's allergies profile entered in MAR within 48 hours of admission; d. Refrigeration temperature log completed. 7. Pharmacy contracted services data is now incorporated into the Hospital QAPI plan. 8. A special PI committee meeting was convened with each of the contracted departments in order to review and incorporate the departmental QAPI indicator and plans. a. The MEC and Governing Board approved the QAPI indicators for dietary, pharmacy and laboratory contracted services. 9. The hospital QAPI plan was amended to include all clinical contracted services are incorporated into the QAPI program. 10. The annual evaluation of contracted services form was developed and	6/25/10 7/27/10 7/15/10 7/27/10

Bureau of Facility Standards

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BB115		BB115	approved by the MEC and Governing Board. **Persons Responsible:** CEO Medical Director Director of PI/Risk Management How Monitored: 1. Monthly PI progress reports are now submitted by all contract services to the Director of PI. 2. PI data is now submitted to and monitored by the Quality Council monthly, and to the MEC and Governing Board quarterly. 3. Evaluation of Contracted Services is now reported to and monitored by the Quality Council, MEC and Governing Board for approval as part of their standing agenda. **QAPI (A263)** **The Governing Board at Intermountain Hospital now ensures and oversees the development, implementation and integration of an effective, ongoing, data-driven quality assessment and performance improvement program for the**	

Bureau of Facility Standards

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BB115		BB115	**laboratory, pharmacy and consulting dieticians.**	
			Actions Taken:	
			1. The QAPI program scope and process were reviewed and revised to now include the development of QAPI program for each department, including contracted services and to integrate those programs into the overall Hospital QAPI plan.	7/13/10
			2. Each department and contract service now had a set of indicators that are prioritized by risk and a thorough plan for improvement.	7/20/10
			3. Performance data is now collected, tracked, trended and analyzed and reported in order to assess the efficacy and measure improvement.	7/20/10
			4. Representatives of each department and contracted service now conduct department Performance Improvement (PI) meetings and participate in hospital wide PI meetings.	7/22/10

Bureau of Facility Standards

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BB115		BB115	5. Data is submitted in advance of each meting to the PI Director. a. Measures are reviewed at each meeting and new trends are incorporated into the PI process.	7/29/10
			6. Strategies for prevention of risk and quality improvements are now discussed and implemented in all contracted services.	7/29/10
			Persons Responsible: Director of PI/Risk Management Medical Director CEO	
			How Monitored:	
			1. The Medical Executive Committee and the Governing Body now review and approve the Hospital QAPI plans, ensuring that it includes indicators and measure or all contracted services and departments.	
			2. Monthly departmental PI and Hospital PI meetings now focus on, and ensure, that the scope of the QAPI	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
NAME OF PROVIDER OR SUPPLIER INTERMOUNTAIN HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 303 NORTH ALLUMBAUGH STREET BOISE, ID 83704		

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BB115		BB115	program integrates contracted services. 3. Minutes of the meetings, written PI plans and reports reflect and evidence the appropriateness, quality and efficacy of the plans. **Medical Staff (A338)** The Governing Board at Intermountain Hospital now ensures and oversees the development and implementation of a medical review process. Intermountain Hospital now ensures the medical staffs are accountable to the Governing Board for the quality of care provided to patients. **Actions Taken:** 1. The Medical Staff Rules and Regulations were reviewed and amended to now specifically state that the peer review process will be conducted by a peer within the same practice.	7/27/10
			2. Remedial education was provided to all members of the Medical Staff on the quality and peer review process and activities, identification of practice	7/13/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB115		BB115	patterns requiring more in-depth review, how to apply medical standards of care and what peer review action to take.	
			3. Special emphasis was placed on non-psychiatric members of the medical staff, including the criteria and participation in monthly peer review and quality review processes.	7/01/10
			4. The Medical Director, General Medical Physicians and Mid Level Providers met to identify quality indicators based on high volume, high risk or problem prone aspects of care. Quality indicators included: a. Inadequate H&P consultation documentation; b. Medical transfers to ED; c. Quality of care concerns; d. Potential adverse clinical outcomes.	7/21/10
			5. The ongoing peer review process for non-psychiatric members of the medical staff now includes the random case review of a minimum of one case per practitioner quarterly.	7/21/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB115		BB115	6. The Peer Review Case Evaluation form was approved by the General Medical Physicians to be completed for each record review. This form includes findings, conclusions and recommendation.	7/21/10
			7. The Peer Review process, quality indicators, ongoing practice case evaluations and the Peer Review Case Evaluation form was discussed in the MEC and approved.	7/27/10
			Persons Responsible: Medical Director General Medical Physicians	
			How Monitored: • Results of the General Medical Physicians Review are incorporated into the PI program through quarterly reports to the MEC and the Governing Board. • The results of the Medical Staff Peer Review process are reviewed as part of the Quality Profile in the reappointment process.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOSPITAL	303 NORTH ALLUMBAUGH STREET BOISE, ID 83704

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BB115		BB115	• The MEC now conducts an annual assessment of the implementation and enforcement of Medical Staff Bylaws, Rules/Regulations and addresses any deficiencies immediately.	
			NURSING SERVICES (A385) The Governing Board at Intermountain Hospital now ensures nursing services meet the needs of the medically unstable patients. **See attached IJ POC approved June 21, 2010**	
			Actions Taken: 1. The records of all patients with diabetes were thoroughly reviewed to ensure that all care was managed appropriately.	6/19/10
			2. Current policies and procedure or the care of the diabetic patients was reviewed and revised.	Initiated 6/19/10
			3. Remedial education and training of nursing staff on revised policies addressing the care of the diabetic patient was conducted and ongoing to include:	6/19/10 On-going

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB115		BB115	a. Obtaining MD orders on diabetic management and verifying all orders by two licensed nursing staff; b. Completion of a third check of order verification by the night shift RN during the 24 hour chart check; c. Documentation in the MAR of dietary consultations to ensure timely completion; d. Documentation in the MAR of Humphries consultation orders; e. Daily verification of this process by the diabetic coordinator; f. Maintaining and completion of the diabetic log/diabetic care audit form by the Nursing supervisors and/or diabetic coordinator; g. Diabetic checklist implemented to ensure compliance with the management of the diabetic patient;	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB115		BB115	4. Remedial training on diabetic patients requesting to leave AMA;	6/19/10 On-going
			5. Remedial training to nursing staff on initiating the master treatment plan to include diabetic management/nursing care;	6/20/10 On-going
			6. Remedial training on hand off communication between shifts by nursing staff;	6/20/10 On-going
			7. The Nurse Educator/Diabetic Coordinator was assigned to coordinate the care of the diabetic patients. Primary responsibilities include:	6/19/10 On-going
			a. Daily assessment of each new admission with a diagnosis of diabetes to ensure that all policies and procedures for diabetic patients are being followed;	
			b. Daily monitoring for patient stability and efficacy of the current orders to maintain desired BG levels;	
			c. Any indication of instability of patient's status will be immediately	

Bureau of Facility Standards

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BB115		BB115	addressed with the attending physician for possible transfer to a higher level of care; d. Follow up on timely compliance with nutritional consults and documentation; e. Continuing education with nursing staff to include new hires and current nursing staff; **Persons Responsible:** DON Diabetic Coordinator CEO **How Monitored:** a. The Diabetic Coordinator will maintain a diabetic intervention log that will include a checklist verification of all aspects of the patient's diabetic needs/orders; b. The Diabetic intervention log will be audited and results will be compiled and reported to Quality Council monthly to include medication variance audits.	

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BB115	Continued From page 4 Refer to A338 Condition of Participation, Medical Staff, for the failure of the governing body to ensure a medical review process was developed and implemented and that medical staff were accountable to the governing body for the quality of care provided to patients and did not admit medically unstable patients. Refer to A385 Condition of Participation, Nursing services for the failure of the governing body to ensure nursing services meet the needs of medically unstable patients. The cumulative effect of these systemic failures resulted in the inability of the facility to ensure care was delivered in safe manner.	BB115	c. Data from audits will be reviewed monthly, analyzed, trended and findings will be submitted to the PI Director monthly, MEC and Governing Board quarterly.	
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Refer to A263 as it relates the hospital failure to develop, implement and/or intergrate an effective, ongoing, data-driven quality assessment and performance improvement program for contracted departments and General Medicine Physicians into the hospital's Quality Assurance and Performance Improvement Program.	BB124	**16.03.14.200.10 QUALITY ASSURANCE (A263)** The Governing Body at Intermountain Hospital now ensures and oversees the development, implementation and integration of an effective, ongoing, data driven quality assessment and performance improvement program for contracted departments. **Actions Taken:** 1. The QAPI program scope and processes were reviewed and revised to now include the development of QAPI programs for each department, including contracted services and to	7/13/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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			integrate those programs into the overall Hospital QAPI plan.	
			2. Each department and contract service now has a set of indicators that are prioritized by risk and a thorough plan for improvement.	7/20/10
			3. Performance data is now collected, tracked, trended, analyzed and reported in order to assess efficacy and measure improvement.	7/20/10
			4. Representatives of each contracted service now conduct departmental PI meetings and participate in hospital-wide PI meetings.	7/22/10
			5. Data is submitted to the PI Director.	7/29/10
			6. Measures are reviewed at each meeting and new trends are incorporated into the PI process.	7/29/10
			7. Strategies for prevention of risk and quality improvements are now discussed and implemented in all contract services.	7/29/10
			Persons Responsible: Director of PI/Risk Management, Medical Director, CEO	
			How Monitored:	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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			a. The Medical Executive Committee and the Governing Body now review and approve the Hospital QAPI plan, ensuring that it includes indicators and measures for all contracted services and departments. b. Monthly departmental PI and hospital PI meetings now focus on and ensure that the scope of the QAPI program integrates contracted services. c. Minutes of the meetings, written PI plans and progress reports reflect and evidence the appropriateness, quality and efficacy of the plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOSPITAL	303 NORTH ALLUMBAUGH STREET BOISE, ID 83704

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BB144	Continued From page 5	BB144	**Qualifications and Privileges (A338)**	
BB144	16.03.14.250.01 Medical Staff Qualifications and Privileges 250. MEDICAL STAFF. The hospital shall have an active medical staff organized under bylaws approved by the governing body and responsible to the governing body for the quality of all medical care provided the patients, and for the professional practices and ethical conduct of the members. (10-14-88) 01. Medical Staff Qualifications and Privileges. All medical staff members shall be qualified legally and professionally, for the privileges which they are granted. (10-14-88) a. Privileges shall be granted only on the basis of individual training, competence, and experience. (10-14-88) b. The medical staff, with governing body approval, shall develop and implement a written procedure for determining qualifications for medical staff appointment, and for determining privileges. (10-14-88) c. The governing body shall approve medical staff privileges within the limits of the hospital's capabilities for providing qualified support staff and equipment in specialized areas. (10-14-88) This Rule is not met as evidenced by: Refer to A338 as it relates the hospital failure to ensure a medical review process was developed, implemented and that medical staff were accountable to the for the quality of care provided to patients. Refer to A353 for hospital failed to ensure medical staff followed the hospital's Medical Staff	BB144	Intermountain Hospital now ensures the rules and regulations developed by the medical staff to regulate themselves apply equally to all members of the medical staff and ensure that rules and regulations are followed. **Refer to A353** **Medical Staff Bylaws (A353)** Intermountain Hospital now ensures that all Medical Staff Rules and Regulations are enforced. 1. The Medical Staff Rules and Regulations were reviewed and amended to now specifically state that the peer review process will be conducted by a peer within the same practice. 2. Remedial education was provided to all member of the Medical Staff on the quality and peer review process and activities, identification of practice patterns requiring more in-depth review, how to apply medical standards of care and what peer review action to take. 3. Special emphasis was placed on non-psychiatric members of the medical staff, including the criteria and participation	7/27/10 7/13/10 7/01/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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			in monthly peer review and quality review processes.	
			4. The Medical Director, General Medical Physicians and mid level providers met to identify quality indicators based on high volume, high risk or problem prone aspects of care. Quality indicators included: a. Inadequate H&P consultation documentation; b. medical transfers to the ED; c. quality of care concerns; d. potential adverse clinical outcomes.	7/21/10
			5. The ongoing peer review process for non-psychiatric members of the medical staff now includes the random case review of a minimum of one case per practitioner quarterly.	7/21/10
			6. The Peer Review Case Evaluation form was approved by the General Medical Physicians to be completed for each record review. This form includes findings, conclusions and recommendations.	7/21/10
			7. The Peer Review process, quality indicators, ongoing practice case evaluations and the Peer Review Case	7/27/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 06/24/2010
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			Evaluation form was discussed in the MEC and approved. **Persons Responsible:** Medical Director General Medical Physicians **How Monitored:** Results of the General Medical Physicians Review are incorporated into the PI program through quarterly reports to the MEC and the Governing Board. The results of the Medical Staff Peer Review process are reviewed as part of the Quality Profile in the reappointment process. The MEC now conducts an annual assessment of the implementation and enforcement of Medical Staff Bylaws, Rules and Regulations and addresses any deficiencies immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	134002		C 06/24/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERMOUNTAIN HOSPITAL	303 NORTH ALLUMBAUGH STREET BOISE, ID 83704

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BB144	Continued From page 6 Rules and Regulations.	BB144		
BB173	16.03.14.310.01 Director of Nursing Services 310. NURSING SERVICE. There shall be an organized nursing department with a plan that delineates authority, responsibility and duties of each category of nursing personnel, and a functional structure for cooperative planning and cooperation. An organizational chart shall be in the nursing service office and in all policy manuals. Job descriptions shall be available and in use which delineate responsibilities, functions or duties, and qualifications for each category of nursing positions. (10-14-88) 01. Director of Nursing Services. The nursing service shall be under the overall direction of a qualified registered nurse with education and experience commensurate with size and complexity of the hospital whose duties are as follows: (10-14-88) a. To organize, coordinate, and evaluate nursing service functions and staff; and (10-14-88) b. To be responsible for development and implementation of policies and procedures as they relate to care of patients; and (10-14-88) c. To select, promote, and terminate nursing staff; and (10-14-88) d. To establish a procedure to insure staff licenses are valid and current. (10-14-88) This Rule is not met as evidenced by: Refer to A385 as it relates to the failure of the hospital to ensure nursing service meet the	BB173	**16.03.14.310.01 Nursing Services (A385)** Intermountain Hospital now ensures a well organized nursing service to meet the needs of the patients. **Refer to approved Plan of Correction submitted and approved on June 21, 2010. The approval of this POC lifted the IJ.** **ATTACHED** **Actions Taken:** 1. Job descriptions for all new RN positions are available and delineate responsibilities, functions of duties and qualifications for each category of nursing positions. 2. The Director of Nursing Services now receives direct supervision from the PSI Master-prepared Nursing Consultant on as needed basis to review: a. Monthly indicators to include grave incidents; b. Provision of care, policies and procedures;	7/29/10 7/29/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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BB173	Continued From page 7 needs of insulin dependent patients and maintain a well-organized nursing service to meet the needs all patients.	BB173	c. Programs to measure, assess and improve quality of nursing care; d. Staff training; e. High risk indicators and other clinical concerns; f. Areas of improvement.	
			3. All RNs received remedial education on the role and responsibility of the RN's in the supervision, assessment and reassessment of patients and the oversight of all nursing care.	7/26/10
			4. Policies and tools for staff/patient assignments, reassessment, identification and communication of changes noted in the patient's condition and needs were reviewed and revised to facilitate compliance and quality.	7/26/10
			5. Revised policies and tools were included in the RN training.	7/21/10
			6. Additional training for nursing staff to aid in their supervision of patient care related to the dietary needs of the patients. a.Remedial training on assessment of the patient's dietary needs; b. implementation of new forms including therapeutic diet cards, revised clinical	7/23/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134002	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 06/24/2010
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			nutritional documentation by the RDs; c. hand off communication; d. dietary considerations for commonly used medications; e. training on treatment planning related to patient dietary requirements. 7. Remedial Training for RNs related to physician orders included: a. Early identification and communication of new physician orders; b. Processing new physician orders including medications, treatments, diets, etc; c. Carrying out physician orders in a timely fashion; d. Use of the kardex for implementing physician orders; e. Hand off communication on physician order follow up; f. Daily oversight of the process by the nursing supervisors; g. Night shift staff re-educated to review and verify physicians order sheets in night audits; h. Licensed staff accountability for following through on all physician orders in a timely fashion.	7/26/10
			8. A new admissions RN position was incorporated to the	7/21/10

Bureau of Facility Standards

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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
			admitting process to assist with assessment, admitting orders and admission process of new patients.	
			9. Nursing received remedial training related to hand-off communication, including: a. The use of SBAR process for hand-off communication; b. Revised levels of observation and special precautions and assignement sheets to now include observation levels, precautions, dietary needs, staff's unit responsibilities for the shift.	7/21/10
			10. Nursing received additional education regarding following drug manufacturer's recommendation for administration for oral hypoglycemic.	7/26/10
			11. A cafeteria schedule has been posted in the medication room to assist the nursing staff in knowing when to administer oral hypoglycemic. An oral hypoglycemic fact sheet has also been posted in a prominent place in the medication room.	7/19/10
			12. All nursing units and medication room now have	7/19/10

Bureau of Facility Standards

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			current medication references available.	
			13. Remedial training of licensed staff on MAR documentation of actual administration times versus scheduled times.	7/26/10
			14. Pharmacist provided inservice to the nursing staff on indications of oral hypoglycemic with post test.	7/26/10
			15. Remedial training was provided on established medical conditions requiring I & O as a primary problem on the treatment plan. a. Daily weights are now included as a more reliable indicator of I &O b. A revised nursing assessment form including indicators of fluid balance symptoms such as edema and congestion has been implemented. c. A daily weight chart form has been implemented.	7/26/10
			16. The RN responsibility for the proper assessment of the patient minimally every 8 hours, including I & O status every shift as indicated, was emphasized and reinforced.	7/21/10

Bureau of Facility Standards

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			17. Physician Notification of Changes in Patient Condition policy was revised and nursing staff have been trained.	7/22/10
			18. Remedial training was provided for all licensed nursing staff on: a. Written criteria describing early warning signs of a change in a patient's condition; b. Physician notification; c. Timely response to changes in patient's condition; d. Documenting actions taken; e. Timely follow up on additional physician orders in response to a change in the patient's condition; f. Utilization of the physician notification log; g. Hand-off communication to the next shift.	7/26/10
			19. Remedial training was provided for all nursing staff on the revised Vital Signs policy and log.	7/26/10
			Additional education was provided to clinical staff including: a. Performing vital signs as ordered and MD notification when vital signs are nout of established parameters;	7/26/10

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			b. Documentation of vital signs and actions taken; c. Utilization of the revised vital signs log; d. Hand-off communication to the next shift with follow up information; e. Licensed staff review of vital signs prior to the end of the shift to ensure all vital signs were taken as ordered; f. Nursing supervisor's role in providing daily oversight of the process on each unit.	
			20. Licensed staff are now required to review the vital signs prior to the end of the shift to ensure all vital signs were taken as ordered.	7/26/10
			21. Nursing supervisors now provide oversight of this process in each unit and monitor follow through on vital signs being taken as ordered.	7/29/10
			Persons Responsible: Director of Nursing Nurse Educator Medical Director CEO	
			How Monitored: All RNs were required to return demonstration of competency.	

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			The Director of Nursing and RN supervisors now conduct random, focused rounds on each shift to observe for appropriate RN supervision and evaluation of patient care. Any deficiencies are immediately addressed. The Director of Nursing and Medical Director now randomly review a sample of open medical records to ensure the quality and appropriateness of RN supervision and evaluation of patient care. Any deficiencies are immediately addressed. MARs are now audited nightly to ensure accuracy. A PI Indicator for timeliness of oral hypoglycemic and meal intake have been developed and implemented. Night shift staff audit has been expanded to now include a review of the Vital signs Log, MAR, daily weights, therapeutic diets and the Kardex. A monitoring tool for weekly random observations to determine whether changes in patient's condition have been responded to in a timely fashion has been developed and implemented. Any deficiencies are immediately addressed.	

Bureau of Facility Standards

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			Data is now collected, analyzed and submitted to the PI Director.	

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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
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July 27, 2010

Richard Bangert
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bangert:

On **June 24, 2010**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004590

Allegation #1: Patients' dietary needs were not met.

Findings #1: An unannounced visit was made to the hospital, entering on 6/17/10 and exiting on 6/24/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff and patients, and reviewed the hospital's policies and procedures.

During the survey it was noted that nursing staff did not monitor patient's oral intake and therapeutic diets including that of the individual identified in the complaint.

The facility was cited at CFR: 482.23 for failure of nursing staff to monitor patient's oral intake and therapeutic diets.

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

Allegation #2: Patient's had long waits for their scheduled medications.

Findings #2: An unannounced visit was made to the hospital, entering on 6/17/10 and exiting on 6/24/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff and patients, and reviewed the hospital's policies and procedures.

Two of the 21 patient records documented patients who were not given prescribed medications because the hospital was not able to get the medication in the time frame ordered. One record documented that medications were being held because a patient was sleeping and the physician was not notified of the held medications.

The complainant's record documented that medications were held due to the fact that "home medications" were brought in. It was the hospital's policy to send all home medications to the hospital's pharmacy to verify the medications. This process does delay the dispensing of the medications to the patient. However, the facility was cited at CFR: 482.23 for the failure of nursing staff to notify physicians when patient's medications were being held or delayed.

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

Allegation #3: Patient's personal food and hygeine items were lost by the hospital.

Findings #3: An unannounced visit was made to the hospital, entering on 6/17/10 and exiting on 6/24/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff and patients, and reviewed the hospital's policies and procedures.

The hospital did not allow outside food to be brought into the facility due to health and safety reasons and the ability to have contraband within the food and/or its containers. One patient's family did bring in food. The food was not given to the patient but was thrown out after the patient was discharged. The hospital's Quality Manager stated that when the patient was discharged, he had forgotten to get his personal items. She stated the patient's wife had called and requested the items. The hospital did send the patient's hygiene items to his house.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Hospital staff did not do 15 minute checks on patients.

Findings #4: An unannounced visit was made to the hospital, entering on 6/17/10 and exiting on 6/24/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff and patients, and reviewed the hospital's policies and procedures.

All 21 records contained completed 15 minute checks forms for each day of the patients stay at the hospital. Observations of staff during the survey confirmed that staffs were completing the required 15 minute checks on patients. The allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were not allowed to use the phone and patients were not advised of incomming phones calls.

Findings #5: An unannounced visit was made to the hospital, entering on 6/17/10 and exiting on 6/24/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff and patients, and reviewed the hospital's policies and procedures.

During the survey it was noted that nursing staff did not allow patients to use the phone during therapy groups or wake them up while they were sleeping. The practice was documented in policy and in the patients admission paperwork that was signed by the patient.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #6: The hospital did not respond to patients' complaints.

Findings #6:The hospital's grievance process was reviewed. Policies and procedures regarding grievances were in place and the hospital had documentation of investigations and responses to complainants. One complaint stated that the complaint was resolved at the time of the complaint. The hospital's policy and federal regulations do not require a written response to complaints that can be resolved at the time of the complaint. Therefore the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #7: Patients were not encouraged to attend group therapy and were not informed of what groups were available.

Findings #7: The hospital's ICU unit was toured and observations were made. During the tour and observations of the unit, a schedule of activities was noted as being posted on the wall of the unit. This posting included group times and group topics. Staff was observed telling patients when group was starting and when patients refused to attend the group this was documented n the patient's record. This was the case for the

person identified in the complaint. The record documented the patient refused groups because he was sleeping.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/srp

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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DEBRA RANSOM, R.N., R.H.I.T., Chief
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August 6, 2010

Brent J. Bryson, CEO
Intermountain Hospital
303 North Allumbaugh Street
Boise, ID 83704

Provider #134002

Dear Mr. Bryson:

On **June 24, 2010**, a complaint survey was conducted at Intermountain Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004610

Allegation #1: Patients were not provided orientation to the hospital's units.

Findings #1: An unannounced visit was made to the hospital, entering on 6/17/10 and again on 8/03/10. During the complaint investigation, surveyors interviewed staff, reviewed hospital policies and procedures, Incident/Accident reports, peer review cases, administrative meeting minutes (Medical Executive Committee, Governing Body, and Quality Assurance), medical staff by-laws, and patient occurrences/concerns/complaints. Twenty-one patient records were reviewed and ten patients were interviewed.

One patient record contained a hospital document titled "Interdisciplinary Treatment Notes," dated 3/18/10 signed by a nurse. The nursing note documented that the patient received, "...rationale/process of unit for safety explained, nutrition/hydration and medication regimen discussed."

Another hospital document, titled "Social Services/Discharge Planning Progress

Note" dated 3/19/10, documented that the social worker gave the patient an orientation packet and a journal.

All 21 patient records reviewed contained documents (signed by the patients), that the patients had received orientation to the unit and a schedule that included programs, breaks, and meals. Orientation to the unit was further documented within all 21 patient medical records in the Social Services notes and Nursing notes.

In an interview on 6/18/10 at 11:30 AM, the Director of Assessments and Referrals stated that as a patient is being admitted to the hospital, the patient receives an orientation packet that contains information about activities, meals, and the patient's rights. She stated that every document in that packet is reviewed with the patient at that time.

Ten of 10 patients interviewed reported they were oriented to the unit, the cafeteria, breaks, and group during their admission process.

No evidence was found to indicate patients were not provided orientation.

Conclusions: Unsubstantiated. Lack of sufficient evidence

Allegation #2: Patient was threatened with a medical hold if the patient left the hospital and the hospital refused to transfer the patient to another facility.

Findings #2: One patient record contained the hospital's "Interdisciplinary Treatment Notes," dated 3/18/10 at 9:05 PM. The record documented that the patient had requested to be transfer back to a secondary hospital's Emergency Department for admission. The note stated the patient's request was forwarded immediately to the Director of Nursing, who suggested that staff find a bed at another facility since the patient was there voluntarily. Documentation showed that staff told the patient they were looking for admission to another facility. The patient then agreed to stay and be treated at the current hospital.

In an interview with the patient's physician, he stated that he did tell the patient that she could be placed on a hold if necessary, however the patient agreed to voluntarily admit herself to the receiving hospital.

A physician's discharge summary, dated 3/19/10 at 2:49 PM, documented the patient was requesting to be discharged and had contracted for outpatient safety (a contract that the patient would do no harm to self). The patient was discharged that evening

per her request.

Conclusions: Unsubstantiated. Lack of sufficient evidence

Allegation #3: Medications were not administered according to physicians' orders. A patient was given an overdose of Mucomyst, offered Tylenol, and a sleeping pill by the hospital's nursing staff.

Findings #3: One patient record reviewed documented that 3/16/10 the patient was admitted to an acute care hospital after a self-reported overdose of Tylenol and a narcotic. The patient also reported consuming alcohol. The record documented the patient was transferred from a secondary hospital's telemetry unit to the current hospital on 3/18/10.

Contained within the patient's record were admission orders, dated 3/18/10 at 12:50 PM. The admission orders contained a verbal physician's order signed and dated 3/18/10 at 12:50 PM, for Mucomyst (antidote for Tylenol) to be administered every 4 hours for a total of 17 doses. There was documentation following that order which stated the first dose of Mucomyst was given on 3/17/10 at 11:00 PM and the second dose was given on 3/18/10 at 9:00 AM. The order continued with the times for dosing scheduled as follows: 1:00 PM, 5:00 PM, 9:00 PM, 1:00 AM, and 5:00 AM.

The patient's Medical Administration Record (MAR) documented that the patient had received all but one of the subsequent doses of Mucomyst at the prescribed times. The last dose that was documented as given on the MAR was on 3/19/10 at 5:00 PM The patient was discharged home after that dose per the patient's request. The record contained no orders for Tylenol or sleep medications to be given to this patient.

A nursing note dated 3/18/10 at 3:00 PM, documented the 1:00 PM dose of Mucomyst was delayed due to the hospital's inability to obtain the medication until 3:00 PM. The note goes on to document that the hospital's pharmacy had concerns about the 5:00 PM dose being given too close to the 3:00 PM dose. The nurse documented that after the hospital's pharmacy talked with Poison Control about their concerns; Poison Control advised that the next Mucomyst dose could be given as scheduled at 5:00 PM.

Also contained in the patient's medical record was a dictated physician's progress note, dated 3/19/10 at 2:49 PM. The physician's progress note stated the patient expressed concerns about the Mucomyst to the physician and the physician explained to the patient why the medication administration was delayed. The physician's

progress note continued with documentation that the physician was aware of the communication between the hospital's pharmacy and Poison Control and that he concurred with the Poison Control's recommendation to give the one dose of Mucomyst as scheduled on 3/18/10 at 5:00 PM.

The physician's progress note stated that the patient requested to be discharge and was discharged that same day.

No evidence was found to indicate the individual identified in the complaint received medications contrary to physician's orders. However, it was found that other patient did not receive medications consistent with physician's orders. The facility was cited at CFR: 482.23 for the failure of nursing staff to notify physicians when patient's medications were being held or delayed.

Conclusions: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #4: Patients have an extensive wait to see the psychiatrist.

Findings #4: An unannounced visit was made to the hospital, on 6/17/10 and on 8/03/10. During the complaint investigation, surveyors reviewed 21 patient records, interviewed staff, and reviewed the hospital's policies and procedures.

Twenty-one patient records documented the patients were seen by a psychiatrist within 24 hours of admission.

In an interview with the patient's physician, he stated that he had seen the patient at the referring hospital just before she was transferred. He stated he felt there was no emergent need for the patient to be seen by a psychiatrist at the receiving hospital upon her arrival. The patient was discharged the next day following her admission.

A review of the hospital's document titled "Medical Staff Rules and Regulations," dated 5/07, states that a psychiatric evaluation and mental status examination must be completed and dictated within 24 hours after the patient was admitted.

There was no evidence that patients had extensive waits to see the psychiatrist.

Conclusions: Unsubstantiated. Lack of sufficient evidence

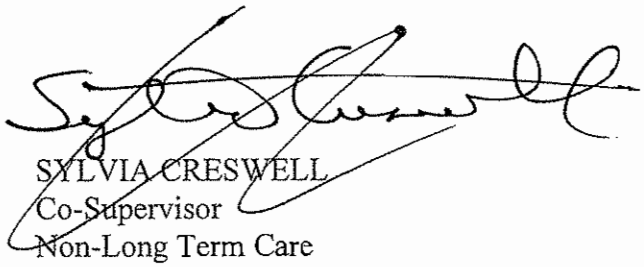
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan

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,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/srp