IDAHO DEPARTMENT OF HEALTH & WELFARE

JAMES E. RISCH – Governor
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September 8, 2006

FILE COPY

Earl Fitzpatrick
Gooding County Memorial Hospital
P.O. Box 418
Gooding, ID 83330

Re: Provider #131302

Dear Mr. Fitzpatrick:

This is to advise you of the findings of the Medicare Recertification and Swing Bed survey of Gooding County Memorial Hospital which was concluded on August 29, 2006.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form HCFA-2567, listing Medicare Deficiencies and a similar State Form listing no state deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for **all** individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the deficient system to insure compliance is achieved and maintained. Included how the monitoring will be done and at what frequency.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, **return the original to this office by September 21, 2006,** and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office.

Sincerely,

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosures

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

PRINTED: 09/04/2006
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
	131302		08/29/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOODING COUNTY MEMORIAL HOSPITAL	1120 MONTANA STREET GOODING, ID 83330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	INITIAL COMMENTS The following deficiencies were cited during the Medicare recertification survey of your Critical Access Hospital. The surveyor conducting the Medicare recertification survey was: Penny Salow, R.N., H.F.S.	C 000	RECEIVED SEP 22 2006 FACILITY STANDARDS	
C 361	485.645(d)(1) RESIDENTS RIGHTS (483.10(b)(3)) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and policies, it was determined that the Critical Access Hospital (CAH) failed to ensure 4 of 4 Swing-bed patients (#1, 2, 3 and 4), whose closed records were reviewed, were informed of their rights. The findings include: 1. Closed records were reviewed and the following issues were identified: * Patient #1 was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. The closed record did not contain a signed list of patients' rights or other evidence the patient had been notified of her rights.	C 361	The Swing Bed Patient Rights and Responsibilities Policy (SB 001) has been reviewed/updated and approved on 9/20/06. The Social Worker when at work is responsible for obtaining the signature. In the Social Worker's absence the inpatient RN is responsible for obtaining the signature. (see attachment SB 001) This policy and change was shared at the Medical Staff meeting 9/20/06 and nursing staff meetings on 9/20 and 9/21/2006. The QA indicator is: "Patients will be admitted to swing beds only after the Patient Rights have been signed and placed in the chart." 100% of the swing bed charts will be reviewed for the next 12 months with the treshold set at 100%. After 12 months, the frequency of monitoring will be re-evaluated. Based upon the threshold being met, monitoring may decrease or may remain at 100% chart review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 9/21/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 361	Continued From page 1 * Patient #2 was admitted to Swing-bed status on 3/19/06 and discharged on 3/23/06. The closed record did not contain a signed list of patients' rights or other evidence the patient had been notified of his rights. * Patient #3 was admitted to Swing-bed status on 4/29/06 and discharged on 5/5/06. The closed record did not contain a signed list of patients' rights or other evidence the patient had been notified of her rights. * Patient #4 was admitted to Swing-bed status on 4/24/06 and discharged on 4/30/06. The closed record did not contain a signed list of patients' rights or other evidence the patient had been notified of her rights. 2. The Director of Health Information Management was interviewed on 8/28/06 at 4 PM. She confirmed the closed records lacked documentation of patients' rights notification. 3. Swing-bed policies were reviewed. Documentation in the manual indicated the policies were last reviewed 3/11/03. The manual contained a 3-page document titled "RESIDENT (PATIENT) RIGHTS IN SWING BED". The third page of the rights document contained places for the patient or their representative to sign the document, a place to list the reason the patient was unable to sign, if appropriate, a place for a witness to sign, and a place to date the document. The patients' rights document was not found in closed records for Patients #1, 2, 3 or 4.	C 361	Sharon Bohman, Social Worker is responsible for monitoring Swing Bed Rights and Responsibilities signatures with Lorraine Reinhardt, CNO providing oversight.	

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C 385	485.645(d)(4) PATIENT ACTIVITIES (483.15(f)) A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who-- o Is licensed or registered, if applicable, by the State in which practicing; and o Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or o Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or o Is a qualified occupational therapist or occupational therapy assistant; or o Has completed a training course approved by the State. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the CAH failed to ensure 4 of 4 Swing-bed patients (#1, 2, 3 and 4) were assessed for activities interests. This created the potential that Swing-bed patients would not be provided with meaningful activities. The findings include: 1. Swing-bed patient records were reviewed on	C 385	The Activity Policy has been reviewed/revised and approved on 9/19/06. (SB #101) Nursing staff are responsible for assessing the patient's activity interests and then creating an activity plan. Nursing staff will work under the direction of GCMH's contracted Occupational Therapist, Connie Van Kleek. An activity assessment form and activity form have been created. Nursing staff were informed of the changes 9/20 and 21/2006 and will implement on the next swing bed admission. (see attachments). In addition one Certified Nurse's Aid will be designated to work with the Occupational Therapist to create appropriate group activities. The QA indicator is: An activity plan will be developed for each swing bed patient with an activity log maintained. The threshold is set at 100%. The Social Worker will review the charts to ensure an activity plan has been created and the daily activity is being used. 100% of the swing bed patient charts will be reviewed over the next 12 months for compliance monitoring. After 12 months, the frequency of monitoring will	

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C 385	Continued From page 3 8/28/06 and the following issues were identified: * Patient #1, a 92 year old female, was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. The patient's record contained a document titled "Discharge Planning Assessment", which had been completed on 4/19/06 by the social worker. The section of the form titled "Swing Bed Assessment", which related to "Activity Pursuit Patterns", had not been completed. * Patient #2, an 88 year old male, was admitted to Swing-bed status on 3/19/06 and discharged on 3/23/06. The patient's record contained a document titled "Discharge Planning Assessment", which had been completed on 3/10/06 by the social worker. The section of the form titled "Swing Bed Assessment", which related to "Activity Pursuit Patterns", had not been completed. * Patient #3, a 57 year old female, was admitted to Swing-bed status on 4/29/06 and discharged on 5/5/06. The patient's record did not contain a completed "Swing Bed Assessment" relating to "Activity Pursuit Patterns". * Patient #4, an 82 year old female, was admitted to Swing-bed status on 4/24/06 and discharged on 4/30/06. The patient's record did not contain a completed assessment for activity interests. 2. The CAH's social worker, who was responsible for completing the activity assessments, was interviewed on 8/29/06 at 11:25 AM. She stated she was not aware of the requirements for activities assessments for Swing-bed patients.	C 385	be re-evaluated and a decision made as to 100% or less monitoring.	

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C 386	485.645(d)(5) SOCIAL SERVICES (483.15(g)) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and one year of supervised social work experience in a health care setting working directly with individuals. This STANDARD is not met as evidenced by: Based on staff interview and review of records and policies, it was determined the CAH failed to ensure 4 of 4 Swing-bed patients (#1, 2, 3 and 4) were provided with psychosocial assessments. This created the potential for unmet psychosocial needs. The findings include: 1. Swing-bed patient records were reviewed on 8/28/06 and the following issues were identified: * Patient #1, a 92 year old female, was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. No documentation was found to indicate a psychosocial assessment had been completed. * Patient #2, an 88 year old male, was admitted to	C 386	The Social Worker has contacted other agencies and created a new psychosocial assessment tool to be used on all swing bed patients. The Psychosocial assessment policy (SB 102) has been updated to reflect the role of the Social Worker in doing the psychosocial assessment and in the absence of the Social Worker the inpatient RN beginning the assessment. The Social Worker and nursing staff will be fulfilling these redefined roles effective 9/21/06. (see attachment SB 102 and Psychosocial assessment). The QA indicator is: Admissions will reflect a psycho-social assessment being completed per policy 100% of the time. 100% of the swing bed charts will be reviewed for the next 12 months with the threshold set at 100%. After 12 months, the frequency of monitoring will be re-evaluated. Based upon the threshold being met, monitoring may decrease or may remain at 100% chart review. Quality Monitoring will be done by the inpatient nursing staff under the direction of Lorraine Reinhardt, CNO.	

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C 386	Continued From page 5 Swing-bed status on 3/19/06 and discharged on 3/23/06. No documentation was found to indicate a psychosocial assessment had been completed. * Patient #3, a 57 year old female, was admitted to Swing-bed status on 4/29/06 and discharged on 5/5/06. No documentation was found to indicate a psychosocial assessment had been completed. * Patient #4, an 82 year old female, was admitted to Swing-bed status on 4/24/06 and discharged on 4/30/06. The patient's record did not contain a psychosocial assessment. 2. Swing-bed policies were reviewed. The manual contained a policy titled "Psychosocial/Discharge Assessment", as well as a form titled "PATIENT PSYCHOSOCIAL ASSESSMENT". The assessment form contained areas related to sleep, sight and hearing, communication, religion, activity pursuits patterns and discharge planning needs. No evidence was found to indicate the form had been utilized to assess Patients #1, 2, 3 or 4. 3. The CAH's social worker, who was responsible for completing the psychosocial assessments, was interviewed on 8/29/06 at 11:25 AM. She stated she was not aware of the requirements for psychosocial assessments for Swing-bed patients. She stated she used the form the individual before her used. She was not aware of the form described above.	C 386		

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C 395	485.645(d)(6) COMPREHENSIVE CARE PLANS (483.20(k)(1)) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This STANDARD is not met as evidenced by: Based on staff interview and review of records and policies, it was determined the CAH failed to ensure care plans were fully developed for 4 of 4 Swing-bed patients (#1, 2, 3 and 4), whose closed records were reviewed. This created the potential for unmet needs. The findings include: 1. Swing-bed patient records were reviewed on 8/28/06 and the following issues were identified: * Patient #1, a 92 year old female, was admitted to Swing-bed status on 4/25/06 and discharged on 5/2/06. No documentation was found to indicate a comprehensive care plan had been developed. * Patient #2, an 88 year old male, was admitted to Swing-bed status on 3/19/06 and discharged on	C 395	Comprehensive Care Plans The care plan policy has been reviewed/updated and approved on 9/19/06. (SB 107). The admitting RN will begin the comprehensive care plan on admission which means she/he will develop a new care plan (not the acute care plan). The comprehensive care plan will be completed within the time frames as stated in the policy. This change was discussed at nursing staff meetings on 9/20 and 9/21, 2006. The QA indicator is: "An individualized care plan will be initiated on admission to swing beds." 100% of the swing bed patient charts will be reviewed over the next 12 months for compliance monitoring. After 12 months, the frequency of monitoring will be re-evaluated and a decision made as to 100% or less monitoring. The Social Worker will review the charts for initial care plan creation with Lorraine Reinhardt CNO providing oversight.	

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C 395	Continued From page 7 3/23/06. No documentation was found to indicate a care plan had been developed. * Patient #3, a 57 year old female, was admitted to Swing-bed status on 4/29/06 and discharged on 5/5/06. No documentation was found to indicate a care plan had been developed. * Patient #4, an 82 year old female, was admitted to Swing-bed status on 4/24/06 and discharged on 4/30/06. The patient's record did not contain a care plan. 2. Swing-bed policies were reviewed. The manual contained a document titled "SKILLED SWING BED FROM ACUTE". The document listed the medical record contents for Swing-bed charts. The last item on the list was "NURSING CARE PLANS". No evidence was found to indicate nursing care plans had been developed for Patients #1, 2, 3 or 4. 3. The Director of Health Information Management was interviewed on 8/28/06 at 4 PM. She confirmed the closed Swing-bed records lacked nursing care plans. She explained that patients' acute care record and Swing-bed record were maintained in the same chart until the patient was discharged. The records were then separated. She provided the acute care records for Patients #1, 2, 3 and 4. The records contained nursing care plans. However, no system was in place to ensure nursing care plans would be copied or otherwise included in both records.	C 395		