DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

October 21, 2010

Doug Crabtree, CEO
Eastern Idaho Regional Medical Center
3100 Channing Way
Idaho Falls, ID 83404

CMS Certification Number: 13-0018

Re: Results of Validation Survey

Dear Mr. Crabtree:

The Centers for Medicare and Medicaid Services (CMS) is confirming the results of the sample validation survey, completed by the Idaho Bureau of Facility Standards (State survey agency), on September 28, 2010, at Eastern Idaho Regional Medical Center.

CMS finds that your acute care hospital is in compliance with all the Medicare Conditions of Participation and will continue to be certified as meeting Medicare requirements. We have forwarded a copy of this letter and the findings from the survey to the Joint Commission.

During this same survey, the State survey agency also reviewed the hospital's prospective payment system (PPS) excluded rehabilitation and psychiatric units. CMS requires a plan of correction for the deficiencies identified on the CMS-2567 under Tag A9999. The components of an acceptable plan of correction are noted below.

It is not a requirement to submit a plan of correction for the other deficiencies; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable within ninety days of completion.

You may therefore wish to submit your plans for correcting the health and life safety code deficiencies cited. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving 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;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Please send a copy of your plan of correction within 10 days receipt of this letter to CMS and the State survey agency. If you choose to not submit a plan a correction, please sign and date the first page of each Form CMS-2567 and return to CMS.

Kate Mitchell, Division of Survey and Certification
Centers for Medicare and Medicaid Services
2201 Sixth Avenue, Mail Stop RX-48
Seattle, Washington 98121

And

Sylvia Creswell, Supervisor
Idaho Bureau of Facility Standards
PO Box 83720
Boise, ID 83720-0036

We thank you for your cooperation, and look forward to working with you on a continuing basis in the administration of the Medicare program. Please contact Kate Mitchell of my staff at (206) 615-2432 if you need additional information.

Sincerely,

Kate Mitchell

for Jerilyn McClain, RN, MPH
Survey, Certification and Enforcement Branch Manager

Enclosure

cc: Idaho Bureau of Facility Standard
CMS Central Office
Joint Commission

COPY

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 83720-0009
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

October 20, 2010

Doug Crabtree
Eastern Idaho Regional Medical Center
3100 Channing Way
Idaho Falls, Id 83404

RE: Eastern Idaho Regional Medical Center, provider #130018

Dear Mr. Crabtree:

This is to advise you of the findings of the state licensure survey at Eastern Idaho Regional Medical Center which was concluded on September 28, 2010.

A copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567 was forwarded to you by CMS Region X office on October 20, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure 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 changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

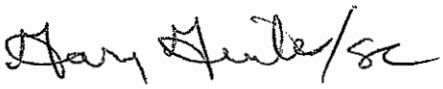
3. Identify the date each deficiency has been, or will be, corrected.

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 **November 2, 2010**, 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 at (208) 334-6626.

Sincerely,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm

Enclosures

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

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

PRINTED: 10/20/2010
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
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 validation survey of your hospital. The surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Aimee Hastriter, RN, HFS Gary Banister, RN, HFS Teresa Hamblin, RN, MS, HFS Acronyms used in this report include the following: CEO - Chief Executive Officer ED - Emergency Department H&P - History and Physical ICU - Intensive Care Unit LIP - Licensed Independent Practitioner L&D - Labor and Delivery LPN - Licensed Practical Nurse PPS = Prospective Payment System Rehab = Rehabilitation RN - Registered Nurse VAC - Vacuum Assistive Closure device	A 000	RECEIVED NOV 01 2010 FACILITY STANDARDS	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on staff interviews, review of hospital	A 123		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 123	Continued From page 1 policies, and review of grievance-related documents, it was determined the hospital failed to provide either written responses or complete written responses to 5 of 8 patients (#62, #63, #66, #67, and #68) and/or patient representatives whose grievances were reviewed. This resulted in a lack of clarity about whether the grievances had been thoroughly investigated and resolved. It had the potential to interfere with patient understanding and satisfaction. Findings include: A hospital policy titled, "PATIENT COMPLAINT & GRIEVANCE MANAGEMENT POLICY," last reviewed 1/05/10, contained a section describing the patient grievance resolution process. The policy stated, "Upon receipt of a grievance, the Executive Director of Risk Management (or designee) shall confer with the appropriate Department Director/Manager to review, investigate, and resolve the issue with the patient and/or patient representative within 30 days of the receipt of the grievance." Any written complaint was considered a grievance. Any verbal complaint was considered a grievance that could not be resolved at the time of the complaint by staff present, was postponed for later resolution, or required investigation or further action. Additionally, the policy stated the hospital must provide the complainant with a written notice of the decision, which included the steps taken on behalf of the patient to investigate the grievance, the results of the grievance investigation, and the date of completion of the investigation. The policy stated that any written complaint was considered a grievance. This policy was not followed. Examples include: 1. Patient #62 was a 70 year old male,	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 123	Continued From page 2 hospitalized on 12/22/09. A family member submitted a letter, dated 2/17/10, of grievance related to patient care issues. The hospital responded to the grievance in a letter, dated 3/12/10. However, the letter failed to describe the steps taken to investigate the grievance, the results of the investigation, and the date of the completed investigation. In an interview on 9/21/10, beginning at 2:18 PM, the Executive Director of Risk Management reviewed the letter and confirmed the letter was incomplete. 2. Patient #63 was a newborn infant who was hospitalized on 12/12/09. A "PATIENT COMPLAINT REPORTING FORM," dated 12/15/09, documented a complaint alleging lack of nursing care and medical care, causing injury to Patient #63. Email communication from the Director of Surgical Services, dated 4/01/10, to the Executive Director of Risk Management, reported having had conversations with the parent and having discussed the issue with a nurse that was involved with Patient #63's care. There was no documentation of a written response to the parent who registered the complaint. According to the Executive Director of Risk Management, during an interview on 9/21/10 beginning at 2:18 PM, the hospital should have sent a letter of response, but because the communication from the parent had been incorrectly classified as a complaint, rather than a grievance, a letter had not been sent. He	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 123	Continued From page 3 explained it was not the hospital's policy to send letters of response on complaints. He also stated upon review of the complaint, he realized it should have been listed as a grievance and a letter of response should have been sent. The hospital's policy, referenced above, stated all written complaints were classified as grievances. 3. Patient #66 was admitted to the facility on 4/08/10 and discharged on 4/11/10. A "PATIENT COMPLAINT REPORTING FORM," dated 5/07/10, alleged a lack of nursing care. The complaint form was accompanied by a written complaint from Patient #66 on a form titled, "Notes for My Caregivers." The note detailed her concerns about care. A letter addressed to the complainant, dated 5/18/10, from the the Executive Director of Risk Managment stated it was his understanding Patient #66's concerns had been addressed. Further, it stated the hospital would adjust the billing charges to the patient. However, the letter failed to describe the steps taken to investigate the grievance, the results of the investigation, and the date the investigation was considered complete. In an interview with the Executive Director of Risk Management on 9/21/10 beginning at 2:18 PM, he stated he thought the letter that was sent was adequate. 4. Patient #67 had an infusion done at the hospital's Cancer Center on 6/15/10. The hospital's grievance/complaint file contained a two-paged section with Patient #67's last name. The first page contained an e-mail dated 6/17/10	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 123	Continued From page 4 at 10:36 AM, from the Cancer Center Manager to the Risk/Quality Coordinator. It stated Patient #67 expressed a desire to file a formal complaint regarding the lack of care he received at the Cancer Center. The second page contained a photocopy (date unreadable) of the hand written complaint from Patient #67. There was no documentation to indicate a letter of response was sent to Patient #67. During an interview on 9/21/10 starting at 2:18 PM, the Executive Director of Risk Management stated the investigation had not been completed and a letter had not yet been sent. 5. Patient #68 had back surgery on 6/23/10. An email communication, dated 7/21/10, from the Executive Director of Risk Management to another hospital staff member, documented Patient #68 alleged receiving an injury as a result of nursing care. The grievance file contained hand-written notes and email communication, indicating some investigation of Patient #68's allegation. There was no evidence a letter of response had been sent to Patient #68. In an interview on 9/21/10 beginning at 2:18 PM, the Executive Director of Risk Management confirmed Patient #68's grievance file was incomplete and did not contain a letter of response regarding the investigation. He stated Patient #68 had changed her account of the alleged incident twice and threatened to hire an attorney.	A 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 123	Continued From page 5 The hospital failed to ensure written responses to grievances were sent to patients or patient representatives.	A 123		
A 164	482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records, it was determined the hospital failed to ensure 2 of 2 patients (#4 and #5), who were restrained by net beds, were restrained only when assessments demonstrated less restrictive interventions had been determined to be ineffective. This resulted in the potential for unnecessary restraint use. Findings include: 1. Patient #4's medical record documented a 50 year old male who was admitted to the Rehabilitation Unit on 8/20/10 and was discharged to a Surgical Unit on 9/04/10. His diagnosis was stroke. He was readmitted to the Rehabilitation unit on 9/13/10 following prostate and bladder surgery. He was currently a patient as of 9/24/10. Physician orders, dated 8/20/10 but not timed, stated Patient #4 was to have a Vail Bed or 1 to 1 precautions. (Vail beds, net beds, and enclosed beds are all terms for a bed with a mesh enclosure from which a patient cannot get out. These terms were used interchangeably by the hospital.) Daily orders for an enclosed net bed restraint were documented from 8/21/10 through 8/29/10. These orders consisted of a sticker placed on the chart which	A 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 164	Continued From page 6 contained boxes for the physician to check. Each of the orders included a checked box which stated "Reason for continued use: Patient unable to follow directions to avoid self-injury." An individualized assessment of the likelihood of Patient #4 being injured without restraints or of less restrictive measures that could be implemented instead of restraints was not documented. The medical record documented the enclosed bed was utilized for Patient #4 from 8/20/10 through 8/29/10. The "Rehab History and Physical," dated 8/20/10, stated Patient #4's mood was appropriate and his mental status was awake, alert, and flat. The H&P did not include an assessment of the need for restraints nor did it indicate a reason for their use. Subsequent physician progress notes did not document an assessment of the need for restraints. An "Inpatient Rehabilitation Interdisciplinary Team Meeting Note," dated 8/24/10 and signed by social services, physical therapy, occupational therapy, speech therapy, nursing, and the physician, did not mention the need for restraints. The "ADMISSION ASSESSMENT" by the RN, dated 8/20/10 at 3:30 PM, stated Patient #4's "Affect appropriate for situation: Cooperative. responds appropriately: Maintains appropriate eye contact." An assessment of the need for restraints by nursing staff was not documented. Subsequent nursing notes did not document an assessment of the need for restraints. The order to continue restraints for Patient #4 was not renewed on 8/30/10 and the restraint was discontinued. The physician progress note, dated 8/30/10 but not timed, stated the patient was confused and said "Will do 1:1 nursing." The	A 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 164	Continued From page 7 progress note did not state why the restraint order was not renewed or contain an assessment of the need for restraints. Patient #4 was readmitted to the Rehabilitation Unit on 9/13/10. He was not restrained but had an order for 1:1 nursing. On 9/15/19, untimed, an order to discontinue the 1:1 staffing was documented. At 1:00 PM on 9/15/10, an order written by the physician for a net bed restraint was documented. Daily orders to continue the net bed restraint were documented from 9/16/10 through 9/23/10. No assessment of the need for restraints was documented by physicians or nursing staff. An observation of Patient #4 was made from 10:30 AM until 11:02 AM on 9/24/10. He was awake in the net bed at the beginning of the observation. The Physical Therapist arrived at 10:37 AM, assisted him out of bed, and performed therapy with him. Patient #4 was confused but pleasant and cooperative. He moved slowly and required repeated attempts to grasp objects and move purposefully. The need for restraints was not obvious. The Co-Medical Director of the Rehabilitation Unit, was interviewed on 9/22/10 at 12:30 PM. He wrote the order for the net bed for Patient #4 on 9/21/10. He stated an assessment specific to the need for the restraint had not been performed. Staff failed to assess the need to restrain Patient #4. 2. Patient #5's medical record documented a 67 year old male who was admitted to the	A 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 164	Continued From page 8 Rehabilitation Unit on 5/28/10 and was discharged on 6/18/10. His diagnosis was stroke. A physician order, dated 5/28/10 at 1:30 PM, stated Patient #5 was to have an Enclosed Bed restraint. Daily orders for an enclosed net bed were documented from 5/28/10 through 6/02/10. These orders consisted of a sticker placed on the chart which contained boxes for the physician to check. Each of the orders included a checked box which stated "Reason for continued use: Patient unable to follow directions to avoid self-injury." An individualized assessment of the likelihood of Patient #5 being injured without restraints or of less restrictive measures that could be implemented instead of restraints was not documented. The medical record documented the enclosed bed was utilized for Patient #5 from 5/28/10 through 6/02/10. The "Rehab History and Physical," dated 5/29/10, stated Patient #5's mood and affect were flat. The H&P did not include an assessment of the need for restraints nor did it indicate a reason for the use of restraints. Subsequent physician progress notes did not document an assessment of the need for restraints. An "Inpatient Rehabilitation Interdisciplinary Team Meeting Note," dated 6/01/10 and signed by social services, physical therapy, occupational therapy, speech therapy, nursing, and the physician, did not mention the need for restraints. The initial "Nursing Assessment," dated 5/28/10 at 1:20 PM, stated Patient #5's "Affect appropriate for situation: Cooperative. responds appropriately: Maintains appropriate eye contact." An assessment of the need for restraints by nursing staff was not documented. Subsequent nursing notes did not document an assessment of the need for	A 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 164	Continued From page 9 restraints. The order to continue restraints for Patient #5 was not renewed on 6/03/10. Physician progress notes, dated 6/02/10 and 6/03/10 did not state why the restraint order was not renewed or contain an assessment of the need for restraints. Patient #5's primary physician, was interviewed on 9/22/10 at 12:30 PM. He stated an assessment specific to the need for the restraint had not been performed. Staff failed to assess the need to restrain Patient #5.	A 164		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on staff interview and review of records and policies, it was determined the hospital failed to ensure restraints were used in accordance with valid physician orders for 4 of 7 restrained patients (#2, #6, #22, and #25) whose records were reviewed. This had the potential to interfere with coordination and safety of patient care. Findings include: A hospital policy, "Restraint and/or Seclusion," dated 4/02/10, addressed restraint orders. It stated orders for restraints were to be obtained	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 168	Continued From page 10 from an LIP/physician responsible for the care of the patient prior to the application of restraints. The order was to specify clinical justification for restraints, the date and time of the orders, the duration of use of restraints, the type of restraints to be used, and the criteria for release. The duration of restraint orders (for non-violent or non-self destructive behavior) could not exceed twenty-four hours. If reassessment indicated an ongoing need for restraint, a new order had to be written each calendar day by the LIP/physician. This policy was not followed. Examples include: a. Patient #6 was a 14 year old male admitted to the hospital's ICU on 8/07/10 after sustaining a head injury. Nursing restraint monitoring forms documented Patient #14 was being monitored for restraints from 8/15/10 through 8/19/10. There was no initial order for restraints in the medical record. A sticker stating, "Restraint for Medical Management Re-order" was used when restraints were re-ordered after the initial order. There were three incomplete (undated and untimed) physician restraint re-order forms for bilateral upper extremity (wrist) restraints present in Patient #6's medical record. Two of the three restraint re-order forms were also not signed by a physician. During an interview on 9/21/10 at 4:00 PM, the Nurse Educator for the ICU reviewed the record and stated she did not see an initial order for restraints in the record. She also confirmed the restraint re-order forms were incomplete and stated they should have been signed, dated, and timed.	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 168	Continued From page 11 b. Patient #22 was a 60 year old female who was a current patient in the hospital's ICU as of 9/21/10. Nursing notes, dated 8/31/10 and 9/04/10 from 6:00 AM to midnight, documented that soft wrist restraints were applied to Patient #22's because she was pulling at her tubes. However, Patient #22's medical record did not contain physician orders for restraints. This was confirmed on 9/21/10 at 1:52 PM during an interview with the ICU's Department Manager and the Director of Rehabilitation. c. Patient #25 was a 42 year old male admitted to the hospital on 7/16/10 after sustaining a head injury. A physician's order, dated 7/17/10 at 4:04 PM, was documented on a form titled "RESTRAINTS FOR MEDICAL MANAGEMENT - INITIAL ORDER." The order did not document the following elements required by hospital policy: the reason for use of the restraints, whether least restrictive measures were ineffective, the type of restraint, and the criteria for release. A sticker stating, "Restraint for Medical Management Re-order" was used when restraints needed to be re-ordered. There were five incomplete (undated, untimed) physician restraint re-order forms present in Patient #6's medical record. During an interview on 9/23/10 at 3:45 PM, the Director of Clinical Quality and Patient Safety reviewed Patient #25's medical record. She confirmed the physician orders for restraints were not complete. d. Patient #2 was a 72 year old male admitted to	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 168	Continued From page 12 the hospital on 8/08/10 with a diagnosis of "right subdural hematoma" (a collection of blood on the surface of the brain). A physician's order, dated 8/09/10 at 7:00 AM, for bilateral/soft wrist restraints, was present on a form titled "RESTRAINTS FOR MEDICAL MANAGEMENT - INITIAL ORDER." The form did not document the reason for ordering the restraints, as required by hospital policy. During an interview on 9/21/10 at 11:40 AM, the Nurse Educator for ICU reviewed the record and confirmed the restraint order was incomplete and stated the physician should have documented the reason for the restraint on the order form. The hospital failed to ensure restraints were used in accordance with valid physician orders.	A 168		
A 287	482.21(c)(2) QAPI IMPROVEMENT ACTIVITIES [Performance improvement activities must track medical errors and adverse patient events,] and analyze their causes, and ... This STANDARD is not met as evidenced by: Based on staff interview and review of quality improvement documents, it was determined the hospital failed to ensure the causes of 3 of 3 adverse patient events (involving Patients #22, #71, and #72) in which patients removed their own endotracheal tubes, were analyzed. This prevented the hospital from developing plans to prevent further adverse patient events. Findings include: "Risk Management Reports," from 9/09 through 9/10, documented 3 patients who self-extubated. Examples include:	A 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 287	Continued From page 13 a. The "Risk Management Report," dated 8/29/10, stated Patient #22 extubated herself on that date. The report stated the event was discovered when a Monitor Technician noticed her oxygen saturation levels dropping. The tube had to be replaced. A section of the report labeled "SPECIFIC CAUSES" stated, "IMPULSIVE BEHAVIOR, PATIENT MONITORING." Details of an investigation of the incident were not documented. The report also stated the Unit Manager had discussed the incident with the "Primary RN." The report did not state what had been discussed. The report was reviewed with the Executive Director for Risk Management on 9/23/10 at 11:30 AM. He stated an investigation to determine the reasons Patient #22 was able to extubate herself, i.e. if staffing was adequate or if policies/orders were followed, was not documented. b. The "Risk Management Report," dated 9/27/09, stated Patient #72 extubated himself on that date. The report stated the event was discovered when the ventilator alarmed. The tube had to be replaced. A section of the report labeled "SPECIFIC CAUSES" stated, "PERFORMANCE OF DUTIES." Details of an investigation of the incident were not documented. The report also stated the unit manager had discussed the incident with "STAFF." The report was reviewed with the Executive Director for Risk Management on 9/23/10 at 11:30 AM. He stated an investigation to determine the reasons Patient #72 was able to extubate himself, was not documented.	A 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 287	Continued From page 14 c. The "Risk Management Report," dated 1/26/10, stated Patient #71 extubated himself on that date. The report did not state how the event was discovered. The tube had to be replaced. A section of the report labeled "SPECIFIC CAUSES" stated, "UNWILLING/UNABLE TO COOPERATE." Details of an investigation of the incident were not documented. The report also stated the unit manager had discussed the incident with "STAFF." The report was reviewed with the Executive Director for Risk Management on 9/23/10 at 11:30 AM. He stated an investigation to determine the reasons Patient #71 was able to extubate himself, was not documented. The hospital failed to analyze adverse patient events.	A 287		
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 record review and staff interview it was determined the hospital failed to ensure nursing staff supervised the care for 2 of 2 bone marrow biopsy patients (#21 and #52), and 2 of 4 blood transfusion patients (#22 and #23), and 1 of 5 patients (#22) whose procedures were observed. The lack of nursing supervision and failure to follow physicians' orders had the potential to compromise patients' health and recovery. Findings include: 1. The hospital failed to ensure nursing staff had	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 395	Continued From page 15 assessed post procedural/post surgical bone marrow biopsy and aspiration patients. Examples include: a. Patient #21 was a 60 year old male who was a current patient on the hospital's Oncology Unit as of 9/21/10. Patient #21's medical record contained a consent for a bone marrow biopsy, dated 9/20/10 that was not timed. Patient #21's "Operative Times - Operative Data" sheet, dated 9/20/10, noted the procedure ended at 11:08 AM. Patient #21 was taken directly to the "medical floor," by-passing the hospital's Post Anesthesia Care Unit. Patient #21 was given general anesthesia as noted on the "Consent for Anesthesia" dated 9/19/10. Patient #21 was discharged with the following physician orders, "Status post bone marrow core Bx + Asp [Bone marrow biopsy and aspiration]. Right post iliac crest. Pressure dressing in place. Check for bleeding q [every] 15 minutes for 1 hour, and then every 1 hour for 6 hours. If no bleeding after 8 hours replace dressing ..." Patient #21's nursing notes, dated 9/20/10, were reviewed. A nursing note, dated 9/20/10 at 11:20 AM, written by a student nurse was the only documented physical assessment of Patient #21 after the procedure. This note did not include an assessment of the surgical dressing or site. Patient #21's vital signs sheet, dated 9/20/10, documented his vital signs were taken by the student nurse at 11:55 AM and then repeated at 4:30 PM. The registered nurse who was in charge of Patient #21's post-operative care on 9/20/10 was interviewed on 9/21/10 starting at 3:00 PM. She stated post-operative patients that were intubated	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 395	Continued From page 16 were to have vital signs every 15 minutes for 1 hour, every 30 minutes for 2 hours, and then every hour for 4 hours. She stated that if a patient was not intubated, the vital signs were to be taken every 15 minutes for ½ hour and then every 30 minutes for 1 hour. She also stated patients were to have a head to toe assessment by a registered nurse upon arrival to the unit. None of the above nursing assessments or vital signs were documented in Patient #21's medical record, including dressing checks as ordered by the physician. The registered nurse stated she did do the assessments and vital signs for Patient #21 but the information had been written on a napkin that she could not find. b. Patient #52 was a 33 year old female who was admitted to the hospital on 8/27/10. Patient #52 had a bone marrow biopsy and aspiration on 9/01/10. Patient #52's 9/01/10 "Operative Times - Operative Data" sheet stated the procedure ended at 11:06 AM, and he was taken directly to the surgical floor, by-passing the hospital's Post Anesthesia Care Unit. Patient #52's 9/01/10 nursing notes documented that vital signs were not obtained until 4:00 PM (almost 5 hours post procedure), and there was no nursing assessment of the patient's surgical site. An interview was conducted with the Director of the Medical/Surgical/Oncology floor on 9/23/10 starting at 12:00 PM. She reviewed Patient #52's record. She confirmed that vital signs were not obtained until 4:00 PM, and that nursing did not document an assessment of the patient's procedural site. She stated that her expectations of post procedural/surgical patients were that vital signs were obtained upon the patient's arrival from surgery, and that a head to toe assessment	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 395	Continued From page 17 would be done by a registered nurse which included an assessment of the surgical/procedural site. The hospital failed to ensure nursing staff had assessed patients after bone marrow biopsy and aspiration. 2. The hospital failed to ensure nursing staff followed physician's orders. Examples include: a. Patient #23 was a 56 year old female who was a current patient in the hospital's ICU as of 9/21/10. Patient #23's record contained a physician's order, dated 9/11/10 at 7:00 AM. The order was to infuse 2 units of blood. The order specified that each unit was to be infused over 2 hours. Patient #23's "Transfusion Record," dated 9/11/10 documented the first unit of blood was infused from 10:30 AM to 11:15 AM (45 minutes). The second unit of blood was documented as being given from 10:30 AM (during the first infusion) to 1:30 PM (2 ½ hours). The ICU's Department Manager reviewed Patient #23's record and was interviewed on 9/21/10 starting at 2:26 PM. He confirmed the nurse did not follow the physician's orders. Additionally, Patient #23's record contained a physician's order, dated 9/17/10 that was not timed. The order was to infuse 2 unit of blood. Patient #23's medical record did not contain documented evidence that the blood was administered. The ICU's Department Manager reviewed Patient #23's record and was interviewed on 9/21/10 starting at 2:26 PM. He stated nursing staff should have filled out the hospital's "Transfusion	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 395	Continued From page 18 Record" for the units of blood ordered on 9/17/10. He stated he could not find documented evidence that the nurse gave the units of blood as ordered on 9/17/10. b. Patient #22 was a 60 year old female who was a current patient in the hospital's ICU as of 9/21/10. A physician's order, dated 8/29/10 at 4:00 AM, requested Patient #22 be administered 2 units of blood. Patient #22's "Transfusion Record" documented that 1 single unit of blood was given on 8/29/10 from 6:05 AM to 7:38 AM. The ICU's Department Manager and the Director of Rehabilitation researched the missing unit on 9/21/10 at 10:46 AM. They found the laboratory had only released 1 unit of blood during that time. They stated they were unable to explain why Patient #22 had not received the second unit of blood as ordered. However, a "Transfusion Record," dated 9/01/10 at 2:30 PM, documented Patient #22 had received a unit of blood. The ICU's Department Manager and the Director of Rehabilitation, during an interview starting on 9/21/10 at 10:46 AM, stated the 9/01/10 2:30 PM blood could have been the second unit that was ordered on 8/29/10 at 4:00 AM. Additionally, consent for blood products was not obtained by nursing staff until 9/01/10 at 6:45 PM, after the blood products had been administered. This was also confirmed by the ICU's Department Manager and the Director of Rehabilitation during an interview starting on 9/21/10 at 10:46 AM. The ICU's Department Manager and the Director of Rehabilitation, were interviewed on 9/21/10 starting at 10:46 AM. They reviewed the medical record and were unable to find an order for the units of blood that were transfused on 9/22/10. The only order that was located was dated	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 395	Continued From page 19 9/03/10 at 7:10 PM. However, they confirmed no blood had been released from the laboratory at that time. The blood was transfused on 9/01/10 without a physician's order. The hospital failed to ensure nursing staff had followed physician's orders. 3. The hospital failed to ensure patient safety. The example includes: Patient #22 was a 60 year old female who was a current patient in the hospital's ICU as of 9/21/10. An observation of a procedure was conducted on 9/21/10 from 8:30 AM to 9:51 AM. Patient #22 was on an air mattress, intubated and semi responsive. The registered nurse was observed preparing Patient #22 for the procedure. This included, but was not limited to, raising the bed to approximately 3 feet off the ground and lowering the right side rails to the down position. At 8:37 AM, the registered nurse left the room with the patient in the above described position. The ICU's Department Manager came into the room shortly after the registered nurse had left. He asked if everything was ok. The issue of the patient's safety was pointed out and he stated the nurse should have put the side rails up before leaving Patient #22's bedside. He then placed the side rails in an up position. The hospital failed to ensure nursing staff supervised the care of bone marrow biopsy and aspiration patients, blood transfusion patients, and the safety of an observed patient.	A 395		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 438	Continued From page 20 each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the hospital failed to ensure accurate and promptly completed medical records were maintained for 4 of 14 patients (#2, #13, #25, and #55) whose records were reviewed for completeness of documentation. This resulted in a lack of clarity related to the actual course of patient events and had the potential to interfere with quality and coordination of patient care. Findings include: 1. Patient #2 was a 72 year old male admitted to the hospital on 8/08/10 with a diagnosis of "right subdural hematoma" (a collection of blood on the surface of the brain). A surgical consent form, dated 8/08/10 at 1:30 PM, stated Patient #2 was consenting to "left craniotomy and removal of blood clot." There was a line drawn through the word "left." The word "right" was handwritten above the crossed out word. There was no date or time for the change. It could not be determined if the change had been made before or after Patient #2's representative signed the consent for surgery. A physician's consultation report, dated 8/08/10 at 8:31 PM, referenced Patient #2's left subdural hematoma. Two of the references in the report to "left" subdural hematoma had lines drawn through	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 438	Continued From page 21 the word "left." The word "right" was handwritten above the crossed out area. One reference to a left acute subdural hematoma, under the section of the report "REASON FOR CONSULTATION," was not corrected. During an interview on 9/21/10 at 10:30 AM, the Nurse Educator for ICU reviewed Patient #2's record. She confirmed the crossed out areas in the record and replacement of the word "left" with the word "right." During an interview on 9/21/10 at 11:30 AM, the Director of Quality Management was asked for the hospital's policy for correction of errors in documentation in the medical record. After looking for the policy, he stated he did not believe the hospital had such a policy. The hospital failed to have a procedure to ensure consistent documentation of correction of documentation errors. 2. Patient #25 was a 42 year old male who was admitted to the hospital on 7/16/10 after sustaining a head injury. A physician's consultation report, dictated 7/19/10 at 7:56 AM, had a notation on the first page "*Dictation is garbled from this point forward, unable to transcribe.* BLANKS WITHIN REPORT, PLEASE CLARIFY*." There was no documentation to indicate the dictation had been clarified to finish the consultation report. During an interview on 9/23/10 at 3:45 PM the Director of Clinical Quality and Patient Safety reviewed the record and stated she would check with the Medical Record Department and see if the consultation was ever completed. At 9/24/10	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 438	Continued From page 22 at 8:35 AM, she stated the consultation was not completed or clarified. The medical record was incomplete. 3. Patient #55 was a newborn infant transferred to the facility on 8/27/10 for evaluation of seizures. Patient #55 underwent a lumbar puncture on 8/27/10 at approximately 9:30 PM. The admission note, dictated by the Neonatal Nurse Practitioner at 9:20 PM on 8/27/10, and signed by the physician, indicated the father was updated at the bedside regarding the plan for care (including the lumbar puncture). In addition, nursing notes from 8/27/10 at 9:00 PM, documented the physician discussed the plan of care with the father prior to performing the lumbar puncture. However, a signed consent for the lumbar puncture was not located in Patient #55's medical record. The Director of Women's and Children's Services reviewed Patient #55's record and stated she could not locate a signed consent. She stated that even if the procedure was completed in an urgent manner, she would still expect to see a completed consent form for the lumbar puncture in the medical record. The medical record did not contain all appropriate consent forms and was therefore incomplete. 4. Patient #13 was an 11 year old girl admitted to the pediatric unit on 9/15/10 for evaluation of diarrhea and dehydration. As a precaution, she was placed in contact isolation which indicated the need to don a gown and gloves for interactions that involved contact with Patient #13 or potentially contaminated areas in her room.	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 438	Continued From page 23 The pediatric unit was toured on 9/21/10 at approximately 11:30 AM. While waiting at the nurses' station, the surveyor, and the RN caring for Patient #13 on 9/21/10, observed Patient #13's mother approach the nurses' station with bare feet and without a gown or gloves. Patient #13's mother was interviewed on 9/21/10 at 1:50 PM. She stated that she was aware of the recommendation to observe isolation precautions, including wearing a gown and gloves while caring for her daughter, however she chose not to. She explained that she did not believe an infectious disease was causing her daughter's diarrhea and therefore saw no need for isolation precautions. She did confirm that nursing staff had on various occasions educated her on the proper protective equipment. The RN, who cared for Patient #13 on 9/21/10, was interviewed on 9/22/10 at 2:45 PM. The RN confirmed the family was educated about the importance of following isolation precautions. The RN stated she, and other nurses caring for Patient #13, had addressed this issue with the family on numerous occasions during the hospitalization. She stated the family was encouraged to wear a gown and gloves while caring for Patient #13. The RN specifically stated she repeatedly addressed the issue of the mother's insistence on not wearing socks and shoes. She did acknowledge the lack of family compliance with proper isolation precautions and admitted she did not always document her conversations with the family regarding the need to follow these precautions. The Director of Women's and Children's Services	A 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 438	Continued From page 24 reviewed Patient #13's medical record for documentation related to nursing management of the isolation precautions in relation to family members. She was interviewed on 9/23/10 at 9:50 AM. She reported that she was not able to locate nursing documentation related to the noncompliance of Patient #13's family with isolation precautions. Patient #13's medical record lacked documentation addressing the noncompliance to isolation precautions and the response of staff to this noncompliance. The facility failed to ensure complete and accurate medical records were maintained for all patients.	A 438		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on medical record review, review of hospital policies, and staff interview it was determined the facility failed to ensure all patient medical records were completed with date, time, and/or physician signature for 6 of 14 patients (#2, #4, #5, #6, #53, and #54) whose inpatient records were reviewed for completeness of physician order documentation. Failure to ensure physician orders were dated, timed, and signed had the potential to interfere with the clarity of when orders were given and/or authentication of the orders. Findings include:	A 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 450	Continued From page 25 The facility policy, "Physicians Orders," dated 5/27/09, specified that medication orders would contain the time and date of the order and the prescriber's signature. It was unclear whether or not other types of orders, such as diagnostic and non-medicinal therapeutic orders, were to contain the date and time of the order along with the physician's signature as required by federal regulations. In addition, the policy addressed the protocol for verbal orders, including who could give and receive orders, the need for repeat verification of the verbal order, and what documentation was to be included when the verbal order was transferred into the medical record. The policy failed to address the physician co-signature of orders to verify accuracy, and the need to date and time this co-signature. 1. Patient #53 was a 33 year old female admitted to the facility on 6/28/10 to deliver her baby. The following orders were incomplete: - Patient #53's medical record contained a "STANDARDIZED POST-PARTUM ORDERS" form. The top of the form was dated 6/28/10, 7:20 AM. The bottom of the form contained a line for the physician's signature, date, and time. The physician had signed on the line, but failed to include the date and time the orders were signed. - A physician's verbal order was documented in the medical record by an RN on 6/28/10 at 11:55 AM. Beneath the orders was a space for the physician's signature and the date and time. The physician signed the order but failed to document the date and time. - The Physician Assistant wrote discharge orders,	A 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 450	Continued From page 26 including a prescription for a narcotic, on 6/30/10 at 8:00 AM. There was a space beneath the written orders for the physician's signature and the date and time. The physician signed the order but failed to document the date and time. The Director of Clinical Quality and Patient Safety reviewed Patient #53's medical record on 9/23/10 at 8:45 AM. She confirmed that the date and time the physician signed, or co-signed, his orders was not clear. 2. Patient #2 was a 72 year old male admitted to the hospital on 8/08/10 with a diagnosis of "right subdural hematoma" (a collection of blood on the surface of the brain). The following physician orders were incomplete: - A physician's verbal order, dated 8/08/10 at 5:55 PM, was not co-signed by the physician. - Preprinted physician's orders for "INPATIENT ADMISSION," dated 8/08/10 at 5:00 PM, were signed by a physician on 8/09/10. The time the physician signed the order was not documented. - Pre-printed physician's orders on a form titled "POST ANESTHESIA" were signed by a physician. However, the date and time of the orders was not documented. During an interview on 9/21/10 at 11:40 AM, the Nurse Educator for ICU reviewed the record and confirmed the incomplete physician orders. She stated physician orders should be signed, dated, and timed. 3. Patient #6 was a 14 year old male admitted to	A 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 450	Continued From page 27 the hospital on 8/07/10 after a head injury. The following physician orders were incomplete: - An untimed "ED TRAUMA ORDER FORM," dated 8/07/10, was not signed by the physician. - Physician orders, dated 8/15/10 at 10:00 AM, were not signed by the physician. - A physician's verbal order, noted by an RN on 8/16/10, was signed by the physician but not dated or timed. - Physician orders, dated 8/16/10 at 11:30 AM, were not signed by the physician. - Physician orders, noted by an RN on 8/22/10, were not signed by the physician. During an interview on 9/21/10 at 4:00 PM, the Nurse Educator for ICU reviewed the record and stated physician orders should be signed, dated, and timed. 4. Patient #54 was a 49 year old female admitted to the hospital on 6/17/10 for surgery. The following physician orders were incomplete: - Physician's pre-printed orders on a form titled "POST ANESTHESIA," page 1, failed to include Patient #54's name, the date or time of the orders or the date or time the orders were noted. - Physician's pre-printed orders on a form titled "PRE-OP VAGINAL or ABDOMINAL HYSTERECTOMY, LAPAROTOMY..." were signed by the physician. There was no date or time for the orders or when the physician signed the orders.	A 450		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 450	Continued From page 28 During an interview on 9/24/10 at 10:00 AM, the Director of Clinical Quality and Patient Safety reviewed the record and confirmed the physician's orders were incomplete. 5. Patient #4's medical record documented a 50 year old male who was admitted to the Rehabilitation Unit on 8/20/10 and was discharged to a Surgical Unit on 9/04/10. His diagnosis was stroke. Daily orders for an enclosed net bed restraint were documented from 8/20/10 through 8/29/10. The orders on 8/20/10, 8/23/10, 8/26/10, 8/27/10, 8/28/10, and 8/29/10 were not timed. The Director of the Rehabilitation Center was interviewed on 9/29/10 at 3:40 PM. She stated the orders for Patient #4 were not timed. Staff failed to time restraint orders for Patient #4. 6. Patient #5's medical record documented a 67 year old male who was admitted to the Rehabilitation Unit on 5/28/10 and was discharged on 6/18/10. His diagnosis was stroke. A physician order, dated 5/28/10 at 1:30 PM, stated Patient #5 was to have an Enclosed Bed restraint. Daily orders for an enclosed net bed were documented from 5/29/10 through 6/02/10. None of these orders included the time the order was written. The Director of the Rehabilitation Center was interviewed on 9/29/10 at 3:40 PM. She stated the orders for Patient #5 were not timed. Staff failed to time restraint orders for Patient #5.	A 450		

STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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 450	Continued From page 29 The hospital failed to ensure medical records were complete and included physician orders that contained the physician's signature along with the date and time the order was signed.	A 450		
A9999	CLOSING COMMENTS M63 42 CFR 412.29(f) Excluded rehabilitation units: In order to be excluded from the prospective payment systems described in 412.1(a)(1) and to be paid under the prospective payment system in 412.1(a)(2), a rehabilitation unit must meet the following requirements: Have a Director of Rehabilitation.	A9999		
	This requirement is not met as evidenced by: Based on review of contracts and staff interview, it was determined the hospital failed to ensure an overall Medical Director Director of Rehabilitation had been appointed to oversee the operation of the Rehabilitation Unit. This resulted in the lack of one individual who assumed responsibility for medical direction for the Rehabilitation Unit. Findings include: A contract with 2 physicians, titled "PROFESSIONAL SERVICES AGREEMENT FORM," dated 5/01/2009, stated the 2 physicians would provide the services of "Co-Medical Director, Rehab Services." A separate "PROFESSIONAL SERVICES AGREEMENT FORM," dated 5/01/2009, stated a third physician would also serve as "Co-Medical Director, Rehab Services." The Director of Rehabilitation Services was interviewed on 9/21/10 beginning at 2:00 PM. she confirmed the 3 physicians were all Co-Medical Directors of the Rehabilitation Unit		Our CEO in collaboration with our Director for the Rehab Unit will identify one physician to be designated as the Rehab Unit's Medical Director.	1/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTER	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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
A9999	Continued From page 30 and no 1 person was actually the overall Medical Director. The hospital failed to appoint a Medical Director for the PPS Excluded Rehabilitation Unit.	A9999		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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 state licensure survey of your hospital. The surveyors conducting the inspection were: Gary Guiles, RN, HFS, Team Leader Patrick Hendrickson, RN, HFS Aimee Hastriter, RN, HFS Gary Banister, RN, HFS Teresa Hamblin, RN, MS, HFS Acronyms used in this report include the following: ED - Emergency Department ICU - Intensive Care Unit L&D - Labor and Delivery LPN - Licensed Practical Nurse RN - Registered Nurse VAC - Vacuum Assistive Closure device	B 000	RECEIVED NOV 01 2010 FACILITY STANDARDS	
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days	BB283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB283	Continued From page 1 before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88)	BB283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB283	Continued From page 2 iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Based on staff interview, observation, and record review, it was determined the hospital failed to ensure accurate and promptly completed medical records were maintained for 4 of 14 patients (#2, #13, #25, and #55) whose records were reviewed for completeness of documentation. This resulted in a lack of clarity related to the actual course of patient events and had the potential to interfere with quality and coordination of patient care. Findings include: Refer to A438 as it relates to the lack of complete medical records.	BB283	The Director of Health Information Management will develop and implement an error correction policy. Unit staff currently flag active records requiring completion (e.g., verbal order authentication) and Health Information Management conducts monitoring of discharge records for documentation completeness and flags records for completion. Physician-specific documentation data is reviewed by the Medical Executive Committee with appropriate follow-up when documentation is incomplete.	12/1/2010
BB556	16.03.14.550.06 Storage,Transport,Treatment & Disposal of Inf 06. Storage, Transportation, Treatment and Disposal of Infectious Waste. (1-13-90)	BB556		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 3 a. For purposes of this section, the following definitions shall apply: (1-13-90) i. Storage shall mean the containment of infectious waste in such a manner as not to constitute treatment of such waste. (1-13-90) ii. Transport shall mean the movement of infectious waste from the point of generation to any intermediate point and finally to the point of treatment and such waste must be transported by haulers knowledgeable in handling of infectious waste. (1-13-90) iii. Treatment shall mean any method, technique or process used to change the character or composition of any infectious waste so as to render such waste noninfectious. Effective treatment may include, but is not limited to, one (1) of the following methods: (1-13-90) (1) Incineration in an incineration facility approved and permitted in accordance with the current requirements of the Idaho Air Quality Bureau. Incinerators shall be capable of providing proper temperatures and residence time to ensure destruction of all pathogenic organisms. (1-13-90) (2) Sterilization by heating in a steam sterilizer utilizing saturated steam within a pressure vessel (known as a steam sterilizer, autoclave or retort) at time lengths and temperatures sufficient to kill infectious agents within the waste. Operating procedures shall include, but are not limited to, standards for temperature settings, residence times, recording or operational procedures and results, and periodic testing by treatment indicators. (1-13-90)	BB556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 4 (3) Discharge of liquid or semi-solid waste into a sanitary sewer that provides secondary treatment of waste. (1-13-90) (4) One (1) of several less commonly used methods such as chemical disinfection, thermal inactivation, gas/vapor sterilization or irradiation. Efficacy of the method shall be demonstrated by the development of a biological testing program, e.g., spore strips. Monitoring shall be conducted on a periodic basis using appropriate indicators. (1-13-90) iv. Disposal shall mean the final placement of treated waste in a properly permitted landfill. (1-13-90) b. Storage and transport of infectious waste. The following shall apply: (1-13-90) i. Containment of infectious waste shall be in a manner and location which affords protection from animals, rain and wind; does not provide a breeding place or a food source for insects and rodents; and minimizes exposure to the waste by the public. Enclosures used for containment of infectious waste shall be secured so as to deny access by unauthorized persons and shall be marked with prominent warning signs. (1-13-90) ii. Infectious waste, except for sharps, shall be contained in disposable containers/bags which are impervious to moisture and have a strength sufficient to preclude ripping, tearing or busting under normal conditions of use. The bags shall be securely tied so as to prevent leakage or expulsion of solid or liquid waste during storage, handling or transport. The containment system shall have a tight-fitting cover and be kept clean and in good repair. (1-13-90)	BB556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	130018		09/28/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN IDAHO REGIONAL MEDICAL CENTE	3100 CHANNING WAY IDAHO FALLS, ID 83404

(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
BB556	Continued From page 5 iii. Sharps shall be disposed of in impervious, rigid, puncture-resistant containers immediately after use. Needles shall not be bent, clipped or broken by hand. (1-13-90) iv. All bags used for containment of infectious waste shall be clearly identified by label or color, or both. Rigid containers of discarded sharps shall be labeled in the same way or placed in the disposable bags used for other infectious waste. (1-13-90) v. Reusable containers for infectious waste shall be thoroughly washed and decontaminated each time they are emptied by an approved method for decontamination as described in Subsection 550.06.b.v.(1), unless the surfaces of the containers have been protected from contamination by disposable liners, bags or other devices removed with the waste except for that waste outlined in Subsection 550.06.b.ii. (12-31-91) (1) Approved methods of decontamination include, but are not limited to, agitation to remove visible soil combined with exposure to hot water of at least one hundred eighty (180) degrees Fahrenheit for a minimum of fifteen (15) seconds; or exposure to a chemical sanitizer by rinsing with or immersion in one (1) of the following for a minimum of three (3) minutes: hypochlorite solution (five hundred (500) ppm available chlorine), phenolic solution (five hundred (500) ppm active agent), iodophor solution (one hundred (100) ppm available iodine), or quaternary ammonium solution (four hundred (400) ppm active agent). (12-31-91) (2) Reusable pails, drums, dumpsters or bins	BB556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 6 used for containment of infectious waste shall not be used for containment of waste to be disposed of as noninfectious waste or for other purposes except after being decontaminated by procedures as described in Subsection 550.06. (12-31-91) vi. Trash chutes shall not be used to transfer infectious waste between locations where the waste is contained. (1-13-90) vii. Storage of infectious waste shall not exceed seven (7) days unless stored at a temperature below thirty-two (32) degrees Fahrenheit, but no longer than ninety (90) days. (12-31-91) c. Treatment and disposal of infectious waste. Except as otherwise provided in these rules, infectious waste shall be treated prior to disposal using a process defined in Subsection 550.06. (12-31-91) d. Alternate Methods. Where on-site treatment of infectious waste is demonstrated to be economically or technically unfeasible, by petition to the licensing agency, alternate methods of on-site or off-site treatment or disposal may be used with the approval of the licensing agency. (1-13-90) This Rule is not met as evidenced by: Based on staff interview, observation, and review of hospital policies, it was determined the hospital failed to ensure potentially infectious waste was properly contained and/or disposed properly. This had the potential to result in an infection control hazard for staff, patients, or visitors encountering biohazardous waste in patient rooms. This directly impacted 1 of 1 patient (#34) whose procedure was observed on the Surgical Floor. It had the potential to impact	BB556	**Unit Director in collaboration with Infection Control will relocate biohazard bags to be more convenient for unit staff to access prior to or during procedures where infectious waste needs to be properly contained and disposed of.**	12/1/2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 7 patients/staff/visitors in all rooms on the Surgical Floor where biohazardous waste was handled. Findings include: 1. Patient #34 was a 70 year old female admitted on 9/20/10 for right leg surgery. On 9/22/10 at 9:15 AM, two surveyors observed an RN (with the assistance of an LPN and a physician) change Patient #34's right leg dressing and remove a Hemovac (a portable wound suction device containing blood) from the right knee area. Surveyors observed nursing staff place a soiled dressing and Hemovac (containing visible blood) directly into the sink in the room. There were no red biohazard canisters or red bags observed in the room. The RN was observed to use the call light and request someone bring a red biohazard bag to Patient #34's room so he could transfer the soiled items into the red bag prior to removing the items from the room. Someone brought a red biohazard bag to the room. The RN was observed to place the soiled equipment and dressing that had been stored in the sink into the red biohazard bag before removing it from the room. The LPN stated she needed to get a Saniwipe to bring back into the room to clean the sink where the soiled items had been placed. Surveyors did not observe the sink cleaned. During an interview on 9/22/10 at 9:30 AM, the Director of the Surgical Floor was asked about the location of red biohazard bags and canisters. She stated they were kept in the utility room (down the hall). During an interview at 9:40 AM, the RN (who performed the dressing change on Patient #34) stated the LPN planned to go back in the room and clean the sink after surveyors left. He stated, "We probably should have biohazard containers	BB556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 8 in the rooms." He stated it was necessary for nursing staff to remember ahead of time to get a red bag out of the utility room prior to doing a procedure that might require disposal of biohazard waste. The Assistant Supervisor of Housekeeping was interviewed on 9/22/10 at 10:10 AM. He stated that ICU, ED, L&D, and the Women's Center all kept red biohazard containers in their rooms. However, the Surgical Floor did not keep biohazard containers in patient rooms. A hospital policy, "Dress Change Technique for All Wounds," dated 11/21/08, stated old dressing should be discarded into an appropriate container. A hospital policy, "Infection Prevention & Control," dated 8/13/09, stated that tubing visibly contaminated with blood or bodily fluids should be placed in a "RED BAG." During an interview on 9/23/10 at 10:30 AM with the Infection Control Coordination, she stated that wound VACs (Vacuum Assistive Closure device, such as a Hemovac) should be disposed of directly into biohazard bags, not placed in sinks. Biohazardous waste was improperly stored prior to disposal in appropriate biohazard waste containers. 2. On 9/22/10 at 10:00 AM, a Housekeeper who emptied the trash for the Surgical Floor was interviewed. When asked if she noticed anything being disposed of in the regular trash containers that she thought did not belong there, she stated she did not find urine bags or anything bloody in the trash anymore, but she noticed that suction	BB556		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130018	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER EASTERN IDAHO REGIONAL MEDICAL CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CHANNING WAY IDAHO FALLS, ID 83404		

(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
BB556	Continued From page 9 canisters were being put in the trash. She explained she thought they were supposed to go in the red biohazard bags. During an interview on 9/23/10 at 3:55 PM, the Infection Control Coordinator explained that suction canisters would be handled as biohazardous waste and she expected them to be disposed of in red biohazard bags. The hospital failed to ensure appropriate disposal of potentially biohazardous waste.	BB556		