

C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

May 27, 2014

Wade Johnson, Administrator Walter Knox Memorial Hospital 1202 East Locust Street Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear . Johnson:

This is to advise you of the findings of the Medicare/Licensure survey at Walter Knox Memorial Hospital, which was concluded on May 12, 2014.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567 and State Form 2567.

Wade Johnson, Administrator May 27, 2014 Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by <u>June 9, 2014</u>, and keep a copy for your records.

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

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

PRINTED: 05/27/2014 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
						С	
		131318	B. WING	i		05/	12/2014
NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
   WALTER	KNOX MEMORIAL H	OSPITAL			202 EAST LOCUST STREET		
				E	EMMETT, ID83617		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
C 000	INITIAL COMMENT	S	c	000	Walter Knox Memorial Hospital Plan of Correction for deficiencies cited during complaint investigation survey conducted 5/08/14 through 5/12/14.	from	
		iencies were cited during			Deficiency C 302 485.638(a) (2)		
		ion survey of your hospital			RECORD SYSTEMS		
		8/14 through 5/12/14.			The records are legible, complete, accurat	ely	
	Surveyors conducting	ng the investigation were:	7 m		documented, readily accessible, and systematically organized.		
	Gary Guiles, RN, H	FS, Team Leader RECEIVERN, HFS	ar struck		systematically organized.		J
	Don Sylvester, BSN	RN, HFS	Mary Control		Corrective Action:		
	Susan Costa, RN, I	HFS	£ 9 5 6		Authentication, date and time omission Medical Record Documentation policy wi		
-	Nancy Bax, RN, BS	N, HFS	MOAR	08	drafted by the Director of Quality Improve		
	Acronyms used inth	Nancy Bax, RN, BSN, HFS			and the Health Information Manager, to incl the procedure of authenticating each entry ir medical record with a signature, date and tin		
	CAH - Critical Acces	ss Hospital			Additions to the record (i.e. date): A M		
	C-Section - caesare				Record Documentation policy will be draft	fted by	
	D&C - dilation and c	-			the Director of Quality Improvement and		
	PACU - Post Anesth				Health Information Manager, to include; of time and initials be provided when an add		
0.000	RN - Registered Nu		0.5	200	made to the medical record.	ition is	
C 302	485.638(a){2) REC	UKD2 2121FIN2	U s	302	Time and content discrepancies in		
	The records are leg	ible, complete, accurately			documentation: A Medical Record Cont		
	documented, readily				Policy will be drafted by the Director of Q Improvement and the Health Information	uanty	
	systematically organ				Manager to include; accurate and chronolo	ogical	
					documentation requirements be entered in		
		not met as evidenced by:			medical record by qualified care providers addition the current Code Blue Policy will		
		view and review of medical			reviewed and revised by the Director of Pa		
	•	rmined the hospital failed to on was complete for 2 of 8			Care Services, to include; a designated		
		atients (#1 and #2), whose			"Recorder" be assigned to all code blue pa	tients.	
		red. This had the potential to			The Recorder is charged with accurately		
		of information related to the			recording the events of the code, including of interventions and patient response to	times	
	course of treatment	and completeness of the			interventions.		
	medical record. Fin	dings include:			Patient Inter-facility Transfer		
	4 B. (1				Documentation: A patient Inter-facility		
		ical record documented a 36			Transfer Policy will be drafted, to include documentation of unit patient is being	j	
		was admitted to the CAH on or. She was transferred to an			transferred from/to, as well as, the date and	d	
		ater that day. Patient #1's			time transfer is initiated and completed.		
	acute care mospital	alei mai vay. Taliem #15			,		

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.

Ππε

(X6) DATE

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

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

PRINTED: 05/27/2014 FORM APPROVED OMS NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	JILDINGCOM		E SURVEY IPLETED	
•		131318	B. WING	ì			12/2014
	PROVIDER OR SUPPLIER KNOX MEMORIAL H	OSPITAL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST LOCUST STREET EMMETT, ID 83617		
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
C 302	record included "P/ notes, which were a separate "Patient of completed by the Fincluded documents or ORDER SHEET PI "OPERATIVE CAR signed. The record on 4/23/14, were not a. RN "PATIENT of documented Patient dropped beginning the fetal heart rate taken to the operate emergency caesard. RN "Patient Care Noted a baby be breathing and was mother's head of bowas potentially hap and transported to "RN "PATIENT CAR 4/23/14 at 8:40 AM C-Section was star "non-viable baby bowere] expelled with A "PHYSICIAN'S ONOTE" documented delivery and Patier was handwritten in timed. Someone had a separate or	ATIENT CARE ACTIVITIES" completed by the RNs and care Notes," which were also RNs. Patient #1's record also ation on "PHYSICIAN'S ROGRESS NOTE" and an E RECORD" which were not its, all which were documented of complete as follows:  AREACTIVITIES," notes at 7:53 AM. The notes stated declined and Patient #1 was ing room in preparation for an ean section at 8:38 AM.  Intes" on 4/23/14 at 8:34 AM, as "on surgery table just by [Patient #2] that was not without a heart rate. Stood at ed to comfort and explain what expening. Mother was stabilized PACU via bed."  REACTIVITIES" notes on a documented before the ted, Patient #1 delivered a by, copious amount of blood and delivery of baby."  REDER SHEET/PROGRESS of Patient #1's care during at #2's resuscitation. The note black ink. The note was not and written the date, 4/23/14, in date column. The note did not	C	302	Continued from page 1 Omitted Pre-anesthesia evaluation: The Prc and Post Anesthesia Policy will be reviewed and updated as appropriate by the Certified Registered Nurse Anesthetist (or designee) to ensure all preoperative patien receive an evaluation by a Certified Regist Nurse Anesthetist (CRNA). CRNA's and Periperative nursing staff will review the upolicy. Blood Gas Analyzer Time Discrepancy: The Laboratory Manager (or designee) will ensure the Blood Gas Analyzer is set to the accurate time. The Lab Manager (or designed will develop an interdepartmental procedu which a weekly check of the accurate anal time is verified and documented on the lab Quality Control log.  Staff Education: a) All nursing staff and medical providers will receive initial training on documentative requirements for revised/new policies by the Director of Patient Care Services (DPCS) designee) by no later than July 30, 2014. b) Nursing staff and medical providers will review policies and provide verification of understanding to the DPCS by no later than 30, 2014. c) All staff that may be assigned to the coeteam will participate in education coordinathe DPCS (or designee) on the process of recording the events of a code blue event blater than July 30, 2014. Code blue events drills will be evaluated to ensure a recorde assigned and documentation appropriate. d) Laboratory staff will receive training on addition of the blood gas analyzer weekly verification and recording on the QC log b Laboratory Manager	e Lead  ts tered  pdated  li e gnee) re by yzer coratory  ion he (or  i fi n July de ated by yy no and r is i the time	

#### DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		СОМ	TE SURVEY MPLETED				
		131318	B. WING			1	C 12/2014
NAME OF PROVIDER OR SUPPLIER WALTER KNOX MEMORIAL HOSPITAL				12	TREET ADDRESS, CITY, STATE, ZIP CODE 202 EAST LOCUST STREET MMETT, ID 83617		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
C 302	Patient #1 was stab were stable. The in blood following the at 10:45 AM, the RI continues to be extra the "Patient Care in the "Patient Care in the "Patient Care in Patient #1 was stabler in PACU. RN "AM, documented Physician at that tim Patient #1's medical she left PACU after in the "Patient #1's medical she left PACU after in the "Patient #1's blood in became "unrespoole. Patient #1's blood in became "unrespoole. Patient #1 return was performed relating the "OPERATIVE (1/23/14 and untime the person who wro patient #1's surgery 1/23/14 at 10:50 AM physician's signature evaluation of Patient administering anesit in the "OPERATIV untimed, document in the person who wro patient #1's surgery 1/23/14 at 10:50 AM physician's signature evaluation of Patient administering anesit in the "OPERATIV untimed, document in the person who wro patient #1's surgery 1/23/14 at 10:50 AM physician's signature evaluation of Patient administering anesit in the person who wro patient #1's document in the person who wro patient #1's surgery 1/23/14 at 10:50 AM physician's signature evaluation of Patient administering anesit in the person who wro patient #1's blood in the person who wro patient #1's surgery 1/23/14 at 10:50 AM physician's signature evaluation of Patient #1's person who wro patient #1's blood in the person who wro patient #1's bl	e Notes" at 9:05 AM, stated le, alert, and her vital signs ote stated Patient #1's flow of delivery was "mild." However, N documented "Bleeding reme."  Notes" notes following Patient 4 AM and 9:05 AM did not partum blood flow.  Notes" at 10:10 AM, stated le and her husband was with Patient Care Notes" at 10:25 atient #1 was seen by the ne.  If record did not state whether her delivery.  Notes" at 11:02, stated pressure dropped and she nsive for about 10 [seconds]."  ed to the OR where a D&C ted to her heavy bleeding. CARE RECORD," dated d, was not authenticated by the it. The consent form for and anesthesia, dated M, contained a line for the e. It was not signed. An ant #1 by the anesthetist prior to thesia was not documented.  E REPORT," dated 4/23/14 ted Patient #1 required a D&C "Postpartum hemorrhage with	C 3	602	Continued from page 2  How actions will improve the process the to the deficiency: Medical record documentation is required to record perting facts, findings and observations about an individual's health history, including past and present illness, examinations, tests, treatments and outcomes. The medical record rechronologically documents the care of the patients and is an important element contrito high quality care.  The medical record facilitates the ability of physician and other healthcare professional evaluate and plan the patient's immediate treatment as well as monitor his/her health over time. Accurate documentation enhance communication and continuity of care and physicians and other healthcare profession involved in the patient's care. Through the corrective actions outlined in this PoC, the documentation standards will be met.  Monitoring and tracking procedures: A minimum of three patient records per week be audited by the Director of Quality Improvement (or designee) for accurate documentation, date and time of entries an appropriate authentication. A minimum of patient records per week will be audited by Director of Quality Improvement (or designee) for accurate documentation, date and time of entries and appropriate authentication. A minimum of three patient records per week will be audited by the Director of Quality Improvement (or designee) for accurate the patient records per week will be audited by the Director of Quality Improvement for appropriate documentation entered in their-facility Transfers to include; the patient is being transferred from/to, as as, the date and time transfer is initiated an completed. A minimum of three surgical precords per week will be audited by the Director of Quality Improvement (or designee) for appropriate documentation of pre-anesthes evaluation.	ord buting f the ls to care ces ong als c will d three the cord records f curate in the cek on of he unit well id atient rector	
ODN CHE SE	67/02-99) Previous Versions	Dhsolete Event 10:2Ell11		Fa		aaaon sa	eet Page 3 of 6

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

PRINTED: 05/27/2014 FORM APPROVED OMB NO 0938-0391

		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		131318	B. WING	i		l	C 1 <b>2/2014</b>
NAME OF	PROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		12,2014
WALTER KNOX MEMORIAL HOSPITAL					202 EAST LOCUST STREET EMMETT, ID 83617		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLANOF CORRECTION (EACHCORRECTIVEACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
C 302	Patient #1's "OPER dated 4/23/14, untir operating room at a "Anesthesia Record "Recovery Notes," serient #1's vital signulse 102, respiration Patient #1 was give blood pressure. Addocumented as bloorespirations 20. Netimed.  g. RN "Patient Care noon, stated Patient Vital signs stable," a included. The notes happened to Patient 12:00 noon. Vital signs stable," a included. The notes happened to Patient 12:00 noon. Vital signs stable, and a RN "PATIENT CARIPM on 4/23/14 documents and acute care hospital to patient #1 was an acute care hospital to patient #1 was acute care hospital #1	ATIVE CARE RECORD," med, stated she was left the l1:38 AM. The corresponding d," under the heading stated "To PACU" and listed ins as blood pressure 67/36, ons 20. The note stated in Phenlyphrine to raise her ditional vital signs were od pressure 103/61, pulse 98, ither set of vital signs were  Notes," 4/23/14 at 12:00 t #1 was "returned to PACU, and her vital signs were did not explain what t #1 between 11:38 AM and igns were not documented and 12:00 noon.  E ACTIVITIES" notes at 1:12 umented a medication was ient #1.  ote, at 1:15 PM on 4/23/14, as transported by helicopter to	C3	802	Continued from page 3 A weekly audit of the laboratory Quality Clog will be completed by the Director of Q Improvement (or designee) to ensure week verification has been completed on the Blo analyzer. Audits will continue until 100% compliance is reached and sustained for not than 1 month.  Education of nursing staff and providers w verified through signed attendance rosters.  The corrective actions outlined in this of Correction will be completed and implemented by no later than August 7 2014.	uality ly time od Gas less ill be	

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

PRINTED: 05/27/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		131318	B. WING	i e			C 12/2014
NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL			THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPER	STREET ADDRESS, CITY. STATE. ZIP 1202 EAST LOCUST STREET EMMETT, ID 83617	CODE	100,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C	ON SHOULD EAPPROPR	BE	(XS) COMPLETION DATE
C 302	2. Patient #2's menewborn male who 8:35 AM. He was thospital for higher! Patient #2's record a. The "DELIVERY Patient #2 was delivexceedingly tight naround the baby's baby had Apgar so minutes of age indipulse, blue in color, tone or muscle movey "aggressive resuscundertaken includin administration." The Patient #2's heart results to the progress notes included orders for fluids, lab work, and intubated. The orderindicate the time or c. Patient #2's med consistent timing of print out from the Fanalyzer indicated that consistent the consistent that consistent that consistent that consistent that consistent that consistent the consi	dical record documented a was delivered on 4/23/14 at transferred to an acute care evel of care later that day. was not complete as follows:  NOTE," dated 4/23/14, stated vered spontaneously "with an uchal cord [cord wrapped neck]" The note stated the bres of O at birth and 0 at 5 cating the baby was without a not breathing, and had no vernent. The note stated itation measures were ag intubation and epinephrine e note did not state when atte was established.  And included a form titled DER SHEET PROGRESS dated. The 2 page form the right column. The form medications, intravenous did indicated Patient #2 was ers and progress notes did not date they were written.  Itical record did not have fractivities. For example, the coint of Care blood gas the test was performed at 8:17 breachest wa	C3	302			

Facility ID: IDH71J

# DEPARTMENT OF HEALTHAND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/27/2014 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION A. BUILDING.		N	(X3) DATE SURVEY COMPLETED				
		131318	8. WING				C 12/2014
NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL				STREET ADDRESS, 1202 EAST LOCU EMMETT, ID 83		00.	12/24/14
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPR DEFICIENCY)	₿E	(XS) COMPLETION DATE
C 302	dated 8/23/14, state AM. However, the 'SHEET PROGRESS the baby was born a During an interview Director of the Eme Risk Manager revier record and confirme complete.	ed the baby was born at 8:40 "PHYSICIAN'S ORDER S NOTE," not dated, stated	C	02			
			<del> </del>				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	<b>1</b> `	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	IDH71J	B. WING		C 05/12/2014	
	PROVIDER OR SUPPLIER	STREET AD 1202 FAS	DRESS, CITY:	STATE, ZIP CODE STREET	The second secon	
1012121			Г, ID 83617			
(X4) 10 PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLANOF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 85 COMPLETE	
	were cited during the survey of your hosp through 5/12/14. So investigation were:  Gary Guiles, RN, H Don Sylvester, BSN Susan Costa, RN, BSN Nancy Bax, RN, BSN 16.03.14.360.12 Record Content contain sufficient in	o state licensure deficiencies the complaint investigation that conducted from 5/08/14 turveyors conducting the TFS, Team Leader I, RN, HFS BN, HFS accord Content the medical records shall formation to justify the	BB283	Walter Knox Memorial Hospital Plan of Correction for deficiencies cited during complaint investigation survey conducted 5/08/14 through 5/12/14.  Deficiency BB283 16.03.14.360.12 RECORD CONTENT The medical records shall contain su information to justify the diagnosis, the treatment and end results. The mercord shall also be legible, shall be with ink or typed, and shall contain to further time one BB283 (a. through Corrective Action: Authentication, date and time omission Medical Record Documentation policy drafted by the Director of Quality Improand the Health Information Manager, to	ed from  fficient warrant edical written he gh i.)]  ons: A will be ovement include;	
	The medical record written with ink or ty following information a. Admission date; b. Identification date; b. Identification date; c. History, including illness, inventory of history, social history physical examination that was completed before or within fortiadmission; and (5-3 d. Diagnostic, there and (10-14-88)	and (10-14-88)  a and consent forms; and  chief complaint, present systems, past history, family y and record of results of n and provisional diagnosis no more than seven (7) days y-eight (48) hours after 3-03) peutic and standing orders; rvations, which shall include	JUN 17 2014 DIV OF LIC & CERT	the procedure of authenticating each ent medical record with a signature, date an Additions to the record (i.e. date): A Record Documentation policy will be different to include the Director of Quality Improvement and Health Information Manager, to include time and initials be provided when an admade to the medical record.  Time and content discrepancies in documentation: A Medical Record Composition will be drafted by the Director of Manager to include; accurate and chroned documentation requirements be entered medical record by qualified core provides addition the current Code Blue Policy were viewed and revised by the Director of Care Services, to include; a designated "Recorder" be assigned to all code blue. The Recorder is charged with accurately recording the events of the code, includity of interventions and patient response to interventions.	d time. Medical rafted by d the ; date, idition is  ntent Quality n plogical in the ers, In ill be Patient patlents.	

Bureau of Facility Standards

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR BROWDER/SUPPLIES REPRESENTATIVE'S SIGNATURE

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STATE FORM

Bureau of Facility Standards (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING:-C B, WING 05/12/2014 IDH71J STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1202 EAST LOCUST STREET WALTER KNOX MEMORIAL HOSPITAL **EMMETT, ID 83617** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING NFORMATION) TAG. TAG DEFICIENCY) Continued from page 1 Continued From page 1 **BB283** BB283 Patient Inter-facility Transfer i. Consultation written and signed by consultant Documentation: A patient Inter-facility which includes his findings; and (10-14-88) Transfer Policy will be drafted, to include; documentation of unit patient is being transferred from/to, as well as, the date and ii. Progress notes written by the attending time transfer is initiated and completed. physician; and (10-14-88) Omitted Pre-anesthesia evaluation: The Pre and Post Anesthesia Policy will be iii. Progress notes written by the nursing reviewed and updated as appropriate by the Lead personnel; and (10-14-88) Certified Registered Nurse Anesthetist (or designee) to ensure all preoperative patients iv. Progress notes written by allied health receive an evaluation by a Certified Registered personnel. (10-14-88) Nurse Anesthetist (CRNA). CRNA's and Periperative nursing staff will review the updated policy. f. Reports of special examinations including but Blood Gas Analyzer Time Discrepancy: not limited to: (10-14-88) The Laboratory Manager (or designee) will ensure the Blood Gas Analyzer is set to the i. Clinical and pathological laboratory findings; accurate time. The Lab Manager (or designee) and (10-14-88) will develop an interdepartmental procedure by which a weekly check of the accurate analyzer ii. X-ray interpretations; and (10-14-88) time is verified and documented on the Iaboratory Quality Control log. iii, E.K.G. interpretations. (10-14-88) Staff Education: a) All nursing staff and medical providers will receive initial training on documentation g. Conclusions which include the following: requirements for revised/new policies by the (10-14-88)Director of Patient Care Services (DPCS) (or designee) by no later than July 30, 2014. i. Final diagnosis; and (10-14-88) b) Nursing staff and medical providers will review policies and provide verification of ii. Condition on discharge; and (10-14-88) understanding to the DPCS by no later than July 30, 2014. iii. Clinical resume and discharge summary; and c) All staff that may be assigned to the code team will participate in education coordinated by (10-14-88)the DPCS (or designee) on the process of recording the events of a code blue event by no iv. Autopsy findings when applicable. (10-14-88) later than July 30, 2014. Code blue events and drills will be evaluated to ensure a recorder is h. Informed consent forms. (10-14-88) assigned and documentation appropriate. d) Laboratory staff will receive training on the i. Anatomical donation request record (for those addition of the blood gas analyzer weekly time patients who are at or near the time of death) verification and recording on the QC log by the containing: (3-1-90) Laboratory Manager

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Bureau of Facility Standards

NAME OF PROVIDER OR SUPPLIER  WALTER KNOX MEMORIAL HOSPITAL  STREET ADDRESS, CITY, STATE, ZIPCODE 1202 EAST LOCUST STREET EMMETT. ID 33917  PROVIDER SUMMARY STATEMENT OF DEPICIPACIES (EACH DEPICIPACY MUST BE PRECEDED BY PULL TAG  CONTINUED TO PROVIDER STATEMENT OF DEPICIPACIES (EACH DEPICIPACY MUST BE PRECEDED BY PULL TAG  CONTINUED TO PROVIDER SPLANOF CORRECTION SHOULD BE (EACH DEPICIPACY MUST BE PRECEDED BY PULL TAG  CONTINUED TO PROPORTION SHOULD BE (EACH DEPICIPACY MUST BE PRECEDED BY PULL TAG  I. Name and affiliation of requestor; and (3-1-90) II. Name and affiliation of requestee; and (3-1-90) III. Response to request, and (3-1-90) IV. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records being incomplete.  This Rule is not met as evidenced by: Refer to C302 as it relates to medical records by the Director of Quality Improvement (or designe) for accurate and chronological documentation entered in the medical record by the Director of Quality Improvement (or designe) for accurate and chronological documentation of pre-accurate and complete.  Refer to C302 as it relates to medical records being the de		NT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED	
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C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Ekder Street P.O. Box 83720 Bolse, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

May 28, 2014

Wade Johnson, Administrator Walter Knox Memorial Hospital 1202 East Locust Street Emmett, ID 83617

RE: Walter Knox Memorial Hospital, Provider #131318

Dear Mr. Johnson:

On May 12, 2014, a complaint survey was conducted at Walter Knox Memorial Hospital. The complaint allegation, findings, and conclusion are as follows:

#### Complaint #ID00006475

Allegation: Emergency equipment, medications, and qualified medical staff were not available when needed.

**Findings:** An unannounced complaint investigation was performed at the Critical Access Hospital from 5/08/14 to 5/12/14. Medical records of 28 patients were reviewed. Physicians and nursing staff were interviewed. Tours of the hospital were conducted, including labor and delivery, nursery, emergency, surgery departments, and the nursing unit with the following results:

During a tour of the hospital on 5/08/14 beginning at 9:15 AM, emergency carts and equipment were inspected. Emergency carts were in the process of being consolidated to make equipment and medications more convenient for staff use. The carts were either open or utilized plastic break-away locks so the contents would be immediately accessible to staff during an emergency. The carts included emergency equipment and medications for adults, pediatrics, and newborns, were stocked and available for use at the time of the tour.

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Emergency call buttons were tested in rooms on the medical/surgical unit and on the obstetrical unit during the tour. All emergency call systems functioned appropriately. However, facility records included an email, dated 3/14/14, that documented emergency call lights were repaired on 3/14/14. When asked about the email on 5/08/14 at 9:25 AM, The Director of the Emergency Department stated the emergency call lights had been fixed and were functional since that time.

Additionally, medical records of 28 patients, including emergency patients, women in labor, and 1 neonate, were reviewed. Physicians were documented as present at deliveries. A qualified member of the medical staff examined all Emergency Department patients. Most were present when the emergency patient arrived at the hospital. The longest delay in medical staff arrival to the Emergency Department was less than 10 minutes.

Further, the "as-worked" nursing staffing schedules were reviewed for the past 3 months. At least 2 Registered Nurses (RNs) were noted to be on duty at all times, one in the Emergency Department and one on the nursing unit. Other RNs were on duty "as needed" for procedures and when the in-patient census increased. Further, the hospital schedule included 4 nurses that were qualified and accepted by the medical staff as competent to work in the OB (obstetrics) department. The four OB qualified nurses shared on-call duties for around the clock coverage, and were included in the staffing schedules.

No delays in the availability of medical staff in an emergency were identified based on the as-worked schedules or in the 28 patient records which were reviewed. For example, one patient's medical record documented a 36 year old female that delivered a baby on 4/23/14 at 8:40 AM. The patient's record documented an OB qualified nurse cared for the patient prior to delivery. The baby was in full arrest when delivered and cardiopulmonary resuscitation was promptly initiated by 2 physicians and an OB qualified nurse. Hospital staff provided critical care to the baby for 1 hour before a neonatal transport team from a larger hospital arrived and assumed care. The physician was present during this time.

Two physicians and an RN who participated in the resuscitation were interviewed about the above event. All three staff members stated emergency equipment and medications were readily available. They said there were no delays during the resuscitation.

The Director of the Emergency Department, an RN, stated the nurse grabbed a laryngoscope handle and the blade for a different type of laryngoscope that did not connect. She stated a correct blade was quickly obtained and had not delayed the resuscitation. She stated a system had since been developed to ensure all emergency equipment were compatible. Surveyors observed that the current resuscitation equipment available for use were compatible.

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A second RN who was present for the delivery on 4/23/14 was interviewed. She stated she arrived just as the baby was born. She stated she asked what she could do and was directed to care for the mother. She stated she had "Adult Cardiac Life Support" certification. She stated she was not an obstetrical nurse but she said she provided care for the patient and performed nursing duties such as massaging the patient's uterus to prevent bleeding.

The patient's medical record documented she experienced excessive bleeding at 10:45 AM on 4/23/14. She was taken to surgery where dilation and curettage surgery was performed for postpartum hemorrhage with a suspected retained placenta. Following the procedure, the same nurse recovered the patient and continued to care for her. The patient received a blood transfusion, and was transferred to an acute care hospital for further treatment at 1:15 PM on 4/23/14.

It could not be established that emergency equipment, medications, and medical staff were unavailable when needed. Therefore, the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES

Health Facility Surveyor

Non-Long Term Care

SYLVIA CREŚWELL

Mission bot

Co-Supervisor

Non-Long Term Care

GG/pmt