IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
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.

After you have completed your Plan of Correction, return the original to this office by **June 9, 2014**, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	131318	A. BUILDING _____ B. WING	C 05/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALTER KNOX MEMORIAL HOSPITAL	1202 EAST LOCUST STREET EMMETT, ID 83617

(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
C 000	INITIAL COMMENTS The following deficiencies were cited during complaint investigation survey of your hospital conducted from 5/08/14 through 5/12/14. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Don Sylvester, BSN, RN, HFS Susan Costa, RN, HFS Nancy Bax, RN, BSN, HFS Acronyms used in this report include: CAH - Critical Access Hospital C-Section - caesarean section D&C - dilation and curettage PACU - Post Anesthesia Care Unit RN - Registered Nurse	C 000	Walter Knox Memorial Hospital Plan of Correction for deficiencies cited during complaint investigation survey conducted from 5/08/14 through 5/12/14. Deficiency C 302 485.638(a) (2) RECORD SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized.	
C 302	485.638(a)(2) RECORDS SYSTEMS The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure documentation was complete for 2 of 8 obstetric/newborn patients (#1 and #2), whose records were reviewed. This had the potential to interfere with clarity of information related to the course of treatment and completeness of the medical record. Findings include: 1. Patient #1's medical record documented a 36 year old female who was admitted to the CAH on 4/23/14 in active labor. She was transferred to an acute care hospital later that day. Patient #1's	C 302	**Corrective Action:** **Authentication, date and time omissions:** A Medical Record Documentation policy will be drafted by the Director of Quality Improvement and the Health Information Manager, to include; the procedure of authenticating each entry in the medical record with a signature, date and time. **Additions to the record (i.e. date):** A Medical Record Documentation policy will be drafted by the Director of Quality Improvement and the Health Information Manager, to include; date, time and initials be provided when an addition is made to the medical record. **Time and content discrepancies in documentation:** A Medical Record Content Policy will be drafted by the Director of Quality Improvement and the Health Information Manager to include; accurate and chronological documentation requirements be entered in the medical record by qualified care providers. In addition the current Code Blue Policy will be reviewed and revised by the Director of Patient Care Services, to include; a designated "Recorder" be assigned to all code blue patients. The Recorder is charged with accurately recording the events of the code, including times of interventions and patient response to interventions. **Patient Inter-facility Transfer Documentation:** A patient Inter-facility Transfer Policy will be drafted, to include; documentation of unit patient is being transferred from/to, as well as, the date and time transfer is initiated and completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 6/9/14

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C 302	Continued From page 1 record included "PATIENT CARE ACTIVITIES" notes, which were completed by the RNs and separate "Patient Care Notes," which were also completed by the RNs. Patient #1's record also included documentation on "PHYSICIAN'S ORDER SHEET PROGRESS NOTE" and an "OPERATIVE CARE RECORD" which were not signed. The records, all which were documented on 4/23/14, were not complete as follows: a. RN "PATIENT CARE ACTIVITIES," notes documented Patient #1's fetal heart tones dropped beginning at 7:53 AM. The notes stated the fetal heart rate declined and Patient #1 was taken to the operating room in preparation for an emergency caesarean section at 8:38 AM. RN "Patient Care Notes" on 4/23/14 at 8:34 AM, siated Patient #1 was "on surgery table just delivered a baby boy [Patient #2] that was not breathing and was without a heart rate. Stood at mother's head of bed to comfort and explain what was potentially happening. Mother was stabilized and transported to PACU via bed." RN "PATIENT CARE ACTIVITIES" notes on 4/23/14 at 8:40 AM, documented before the C-Section was started, Patient #1 delivered a "non-viable baby boy, copious amount of blood [were] expelled with delivery of baby." A "PHYSICIAN'S ORDER SHEET/PROGRESS NOTE" documented Patient #1's care during delivery and Patient #2's resuscitation. The note was handwritten in black ink. The note was not timed. Someone had written the date, 4/23/14, in blue ink under the date column. The note did not indicate who wrote the date.	C 302	Continued from page 1 **Omitted Pre-anesthesia evaluation:** The Pre and Post Anesthesia Policy will be reviewed and updated as appropriate by the Lead Certified Registered Nurse Anesthetist (or designee) to ensure all preoperative patients receive an evaluation by a Certified Registered Nurse Anesthetist (CRNA). CRNA's and Periperative nursing staff will review the updated policy. **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 designee) will develop an interdepartmental procedure by which a weekly check of the accurate analyzer time is verified and documented on the laboratory Quality Control log. **Staff Education:** a) All nursing staff and medical providers will receive initial training on documentation requirements for revised/new policies by the Director of Patient Care Services (DPCS) (or 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 July 30, 2014. c) All staff that may be assigned to the code team will participate in education coordinated by the DPCS (or designee) on the process of recording the events of a code blue event by no later than July 30, 2014. Code blue events and drills will be evaluated to ensure a recorder is assigned and documentation appropriate. d) Laboratory staff will receive training on the addition of the blood gas analyzer weekly time verification and recording on the QC log by the Laboratory Manager	

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C 302	Continued From page 2 b. RN "Patient Care Notes" at 9:05 AM, stated Patient #1 was stable, alert, and her vital signs were stable. The note stated Patient #1's flow of blood following the delivery was "mild." However, at 10:45 AM, the RN documented "Bleeding continues to be extreme." The "Patient Care Notes" notes following Patient #1's delivery at 8:34 AM and 9:05 AM did not document her post partum blood flow. c. RN "Patient Care Notes" at 10:10 AM, stated Patient #1 was stable and her husband was with her in PACU. RN "Patient Care Notes" at 10:25 AM, documented Patient #1 was seen by the physician at that time. Patient #1's medical record did not state whether she left PACU after her delivery. d. RN "Patient Care Notes" at 11:02, stated Patient #1's blood pressure dropped and she became "...unresponsive for about 10 [seconds]." e. Patient #1 returned to the OR where a D&C was performed related to her heavy bleeding. The "OPERATIVE CARE RECORD," dated 4/23/14 and untimed, was not authenticated by the person who wrote it. The consent form for Patient #1's surgery and anesthesia, dated 4/23/14 at 10:50 AM, contained a line for the physician's signature. It was not signed. An evaluation of Patient #1 by the anesthetist prior to administering anesthesia was not documented. f. "The "OPERATIVE REPORT," dated 4/23/14 untimed, documented Patient #1 required a D&C with a diagnosis of "Postpartum hemorrhage with suspected retained placenta."	C 302	Continued from page 2 **How actions will improve the process that led to the deficiency:** Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history, including past and present illness, examinations, tests, treatments and outcomes. The medical record chronologically documents the care of the patients and is an important element contributing to high quality care. The medical record facilitates the ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment as well as monitor his/her healthcare over time. Accurate documentation enhances communication and continuity of care among physicians and other healthcare professionals involved in the patient's care. Through the corrective actions outlined in this PoC, these documentation standards will be met. **Monitoring and tracking procedures:** A minimum of three patient records per week will be audited by the 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 inclusion of date, time and initials for record amendments. A minimum of three patient records per week will be audited by the Director of Quality Improvement (or designee) for accurate and chronological documentation entered in the medical record by qualified care providers. A minimum of three patient records per week will be audited by the Director of Quality Improvement for appropriate documentation of patient Inter-facility Transfers to include; the unit the patient is being transferred from/to, as well as, the date and time transfer is initiated and completed. A minimum of three surgical patient records per week will be audited by the Director of Quality Improvement (or designee) for appropriate documentation of pre-anesthesia evaluation.	

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C 302	Continued From page 3 Patient #1's "OPERATIVE CARE RECORD," dated 4/23/14, untimed, stated she was left the operating room at 11:38AM. The corresponding "Anesthesia Record," under the heading "Recovery Notes," stated "To PACU" and listed Patient #1's vital signs as blood pressure 67/36, pulse 102, respirations 20. The note stated Patient #1 was given Phenlyphrine to raise her blood pressure. Additional vital signs were documented as blood pressure 103/61, pulse 98, respirations 20. Neither set of vital signs were timed. g. RN "Patient Care Notes," 4/23/14 at 12:00 noon, stated Patient #1 was "...returned to PACU. Vital signs stable," and her vital signs were included. The notes did not explain what happened to Patient #1 between 11:38 AM and 12:00 noon. Vital signs were not documented between 11:38 AM and 12:00 noon. RN "PATIENT CARE ACTIVITIES" notes at 1:12 PM on 4/23/14 documented a medication was administered to Patient #1. The final nursing note, at 1:15 PM on 4/23/14, stated Patient #1 was transported by helicopter to an acute care hospital. During an interview on on 5/14/14 at 10:45 AM, the Director of the Emergency Department and the Risk Manager reviewed Patient #1's medical record with the surveyor. Both staff members confirmed the documentation in the record was not complete. Patient #1's medical record was incomplete.	C 302	Continued from page 3 A weekly audit of the laboratory Quality Control log will be completed by the Director of Quality Improvement (or designee) to ensure weekly time verification has been completed on the Blood Gas analyzer. Audits will continue until 100% compliance is reached and sustained for no less than 1 month. Education of nursing staff and providers will be verified through signed attendance rosters. The corrective actions outlined in this Plan of Correction will be completed and implemented by no later than August 7, 2014.	

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C 302	Continued From page 4 2. Patient #2's medical record documented a newborn male who was delivered on 4/23/14 at 8:35 AM. He was transferred to an acute care hospital for higher level of care later that day. Patient #2's record was not complete as follows: a. The "DELIVERY NOTE," dated 4/23/14, stated Patient #2 was delivered spontaneously "with an exceedingly tight nuchal cord [cord wrapped around the baby's neck]..." The note stated the baby had Apgar scores of O at birth and 0 at 5 minutes of age indicating the baby was without a pulse, blue in color, not breathing, and had no tone or muscle movement. The note stated "aggressive resuscitation measures were undertaken including intubation and epinephrine administration." The note did not state when Patient #2's heart rate was established. b. Patient #2's record included a form titled "PHYSICIAN'S ORDER SHEET PROGRESS NOTE" that was undated. The 2 page form contained hand written orders in the left column and progress notes in the right column. The form included orders for medications, intravenous fluids, lab work, and indicated Patient #2 was intubated. The orders and progress notes did not indicate the time or date they were written. c. Patient #2's medical record did not have consistent timing of activities. For example, the print out from the Point of Care blood gas analyzer indicated the test was performed at 8:17 AM on 4/23/14. However, the printed laboratory report sheet that corresponded to the blood gas analyzer results noted the test was performed at 9:34 AM. Further, the "Clinical Documentation Report,"	C 302		

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C 302	Continued From page 5 dated 8/23/14, stated the baby was born at 8:40 AM. However, the "PHYSICIAN'S ORDER SHEET PROGRESS NOTE," not dated, stated the baby was born at 8:35 AM. During an interview on 5/14/14 at 10:45 AM, the Director of the Emergency Department and the Risk Manager reviewed Patient #2's medical record and confirmed the documentation was not complete. Patient #2's medical record was not complete.	C 302		

Bureau of Facility Standards

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B0001	16.03.14 Initial Comments The following Idaho state licensure deficiencies were cited during the complaint investigation survey of your hospital conducted from 5/08/14 through 5/12/14. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Don Sylvester, BSN, RN, HFS Susan Costa, RN, HFS Nancy Bax, RN, BSN, HFS	B0D0	Walter Knox Memorial Hospital Plan of Correction for deficiencies cited during complaint investigation survey conducted from 5/08/14 through 5/12/14. Deficiency BB283 16.03.14.360.12 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 [Information as described in column one BB283 (a. through i.)]	
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 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)	BB283	Corrective Action: **Authentication, date and time omissions:** A Medical Record Documentation policy will be drafted by the Director of Quality Improvement and the Health Information Manager, to include; the procedure of authenticating each entry in the medical record with a signature, date and time. **Additions to the record (i.e. date):** A Medical Record Documentation policy will be drafted by the Director of Quality Improvement and the Health Information Manager, to include; date, time and initials be provided when an addition is made to the medical record. **Time and content discrepancies in documentation:** A Medical Record Content Policy will be drafted by the Director of Quality Improvement and the Health Information Manager to include; accurate and chronological documentation requirements be entered in the medical record by qualified care providers. In addition the current Code Blue Policy will be reviewed and revised by the Director of Patient Care Services, to include; a designated "Recorder" be assigned to all code blue patients. The Recorder is charged with accurately recording the events of the code, including times of interventions and patient response to interventions.	

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

CEO 6/9/14

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BB283	Continued From page 1 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) 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)	BB283	Continued from page 1 **Patient Inter-facility Transfer Documentation:** A patient Inter-facility Transfer Policy will be drafted, to include; documentation of unit patient is being transferred from/to, as well as, the date and time transfer is initiated and completed. **Omitted Pre-anesthesia evaluation:** The Pre and Post Anesthesia Policy will be reviewed and updated as appropriate by the Lead Certified Registered Nurse Anesthetist (or designee) to ensure all preoperative patients receive an evaluation by a Certified Registered Nurse Anesthetist (CRNA). CRNA's and Periperative nursing staff will review the updated policy. **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 designee) will develop an interdepartmental procedure by which a weekly check of the accurate analyzer time is verified and documented on the laboratory Quality Control log. **Staff Education:** a) All nursing staff and medical providers will receive initial training on documentation requirements for revised/new policies by the Director of Patient Care Services (DPCS) (or 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 July 30, 2014. c) All staff that may be assigned to the code team will participate in education coordinated by the DPCS (or designee) on the process of recording the events of a code blue event by no later than July 30, 2014. Code blue events and drills will be evaluated to ensure a recorder is assigned and documentation appropriate. d) Laboratory staff will receive training on the addition of the blood gas analyzer weekly time verification and recording on the QC log by the Laboratory Manager	

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BB283	Continued From page 2 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: Refer to C302 as it relates to medical records being incomplete.	BB283	Continued from page 2 **Monitoring and tracking procedures:** A minimum of 5 patient records per week will be audited by the Director of Quality Improvement (or designee) for accurate documentation, date and time of entries and appropriate authentication. A minimum of five patient records per week will be audited by the Director of Quality Improvement (or designee) for inclusion of date, time and initials for record amendments. A minimum of five patient records per week will be audited by the Director of Quality Improvement (or designee) for accurate and chronological documentation entered in the medical record by qualified care providers. A minimum of three patient records per week will be audited by the Director of Quality Improvement for appropriate documentation of patient Inter-facility Transfers to include the unit the patient is being transferred from/to as well as the date and time transfer is initiated and completed. A minimum of three surgical patient records per week will be audited by the Director of Quality Improvement (or designee) for appropriate documentation of pre-anesthesia evaluation. **How actions will improve the process that led to the deficiency:** Medical record documentation is required to record pertinent facts, findings and observations about an individual's health history, including past and present illness, examinations, tests, patients and is an important element contributing to high quality care. Accurate documentation enhances communication and continuity of care among physicians and other healthcare professionals involved in the patient's care. Through the corrective actions outlined in this PoC, these documentation standards will be met. The corrective actions outlined in this Plan of Correction will be completed and implemented by no later than August 7, 2014.	

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RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
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Boise, ID 83720-0009
PHONE 208-334-6626
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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.

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.

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 CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt