11/15/10 MS

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	161373	A. BUILDING _____ B. WING _____	08/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RINGGOLD COUNTY HOSPITAL	211 SHELLWAY DRIVE MOUNT AYR, IA 50854

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C 000	INITIAL COMMENTS The State Survey Agency completed a Medicare Recertification/Relocation survey from 8/16/10 to 8/18/10. The survey team identified the following deficiencies during the survey. DEFINITIONS: Automated Endoscope Reprocessor - A machine designed to automate part of the cleaning process for endoscopes. (C-0278) Dexamethasone - A medication used to reduce inflammation. (C-0277) Disinfecting solution - A chemical solution used to kill microorganisms potentially transmitted through medical instruments. (C-0278) Endoscope - A flexible camera designed to allow a physician to view the stomach or colon. (C-0278) Endoscopic Procedures - A procedure where the physician inserts an endoscope into the patient's stomach or colon to view the patient's colon or stomach. (C-0278) Iontophoresis - A process of delivering medication into the skin using a mild electrical current. (C-0277) Microorganisms - Bacteria, fungus, and viruses. (C-0278) Rapicide - A chemical disinfecting solution. (C-0278)	C 000	HEALTH FACILITIES AUG 31 2010 POC OK 8/31/10 Compliance date 10/31/10 PS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gordon Wilhelm — TITLE: Administrator/CEO — (X6) DATE: 08/25/2010

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

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C 000	Continued From page 1 Reprocessing - The manufacturer specified process for cleaning endoscopes, designed to eliminate disease causing microorganisms in the endoscope. (C-0278)	C 000		
C 271	485.635(a)(1) PATIENT CARE POLICIES The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. This STANDARD is not met as evidenced by: Based on document review and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to ensure nursing staff obtained a physician's order for the release of a deceased patient's body for 2 of 3 closed medical records (patient #3 and #4). The CAH administrative staff identified an average of 10 deaths per year. Failure to obtain a physician's order for the release of a deceased patient's body could potentially interfere with the CAH's medicolegal obligations, result in the release of body to an unauthorized individual, and interfere with appropriate after-life care. Findings included: 1. Review of the Rules and Regulations for the Medical Staff, approved 3/12/2001, revealed in part, "Release of body. The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the Medical Staff or a physician member of the Medical Staff has ordered release of the body." 2. Review of Patient #3's medical record	C 271	A review of Medical Staff Rules and Regulations Section 8.24 "Release of Body" will be included on the agenda for the Medical Staff meeting held 10/12/10 and the Nursing Department Meeting 09/22/10. Staff will be informed of the requirement that a body may not be released until an entry has been made and signed in the deceased's medical record identifying where and to whom the body is released. HIM Director will monitor compliance. Completion Date: 10/31/10	

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C 271	Continued From page 2 revealed: a. Nursing staff documented on 1/8/10 at 9:10 AM, "Body released to funeral home... exited to funeral home per cart." b. Patient #3's medical record lacked documented evidence of a physician's order for release of the body to the funeral home. 3. Review of Patient #4's medical record revealed: a. Nursing staff documented on 5/13/10 at 10:17 PM, "Patient unresponsive, negative respiration, negative heart beat... funeral home notified." b. Patient #4's medical record lacked documented evidence of a physician's order for release of the body to the funeral home. 4. During an interview on 8/18/10 at 9:50 AM, the Chief Nursing Officer (CNO) verified Patient #3 and #4's medical records lacked evidence of a physicians's order for the release of the body. The CNO reported the Medical Staff Rules and Regulations contained the requirement for nursing to obtain a physician order before releasing the body to a funeral home. The CNO also stated the CAH administrative staff needed to, "...follow this more carefully."	C 271		
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and	C 276		

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C 276	Continued From page 3 disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use. This STANDARD is not met as evidenced by: Based on observation, staff interview, and document review, the Critical Access Hospital (CAH) administrative staff failed to ensure Rehabilitation Services staff appropriately discarded single use medication vials after each use for 1 of 1 opened single use medication vial. The CAH identified an average of approximately 15 iontophoresis procedures per month. Failure to discard the unused portion of the Dexamethasone in a vial could potentially result in growth of microorganisms in the vial between patients. If microorganisms grew in the vial, patients could potentially receive a healthcare acquired infection. Findings include: 1. Observations during a tour on 8/16/10 at 2:30 PM of the Rehabilitation Therapy revealed 1 opened, single use, 1 mL vial of Dexamethasone. 2. During an interview at the time of the tour, the Director of Rehabilitation Services stated the iontophoresis equipment required 1.5 mL of Dexamethasone. The Rehabilitation Services staff removed 1 mL from a vial of Dexamethasone, and 0.5 mL from a second vial of Dexamethasone. The Rehabilitation Services staff then stored the opened vial of Dexamethasone with the unopened vials of Dexamethasone. The Rehabilitation Services	C 276	1. All rehabilitation staff were instructed that if single use medication vials are used & there is any remaining medication in the vial, the vial must be discarded. 2. The iontophoresis protocol was revised on 08/17/10 to require staff to discard the unused portion of single use medication vials. Protocol/policy will be presented to PAC for approval on 08/26/10. The Director of Rehab Services will be responsible for monitoring staff compliance by (1) observing staff. (2) Daily checks of locked medication storage area will be completed by Director or PTA to assure that only unused single use vials are available for patient use. Initiated 08/17/10. Will monitor through 09/17/10.	

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C 276	Continued From page 4 staff used the partial vial of Dexamethasone the next time a patient required ionophoresis. 3. During an interview on 8/17/10 at 3:30 PM, the Pharmacist stated they did not know the Rehabilitation Services staff failed to discard the unused portion of the Dexamethasone in the vials after withdrawing part of the medication in the vial. The vials of Dexamethasone used in Rehabilitation Services lacked a preservative, and staff should have discarded the unused Dexamethasone, to prevent bacteria from potentially growing in the unused Dexamethasone. 4. Review of the policy titled, "iontophoresis protocol", effective 7/1/05, revealed the policy lacked instructions to discard the partially filled Dexamethasone vial after withdrawing the required medication for one patient. 5. During an interview on 8/17/10 at 4:00 PM, the Director of Rehabilitation Services acknowledged the policy lacked instructions to discard the unused Dexamethasone after removing the medication from the vial, and stated the Director of Rehabilitation Services revised the policy to require staff to discard the unused portion of the Dexamethasone in the vial.	C 276		
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by:	C 278		

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C 278	Continued From page 5 Based on observation, document review, and staff interview, the Critical Access Hospital (CAH) Surgical Services administrative staff failed to ensure surgical staff tested the disinfecting solution in 2 of 2 Automated Endoscope Reprocessors before each use. Surgical Services administrative staff identified an average of approximately 40 endoscopy procedures per month. Failure to test the disinfecting solutions prior to each use could potentially result in the disinfecting solution lacking sufficient strength of the active ingredient to kill all microorganisms, resulting in the spread of infectious microorganisms between patients. Findings included: 1. Observations during a tour of the Dirty Side of the Cleaning Area on 8/16/10 at approximately 4:00 PM revealed 2 CER-1 Medivator Automated Endoscope Reprocessors. 2. Review of the "...Rapicide Testing Log" for both Automated Endoscope Reprocessors revealed surgical services staff tested the Rapicide once per day. 3. During an interview at the time of the tour, the Patient Care Manager of Surgery stated surgical staff tested the Rapicide once, at the start of the day, and did not test the Rapicide before each time staff reprocessed an endoscope. The Patient Care Manager of Surgery stated surgical staff reprocessed up to 5 endoscopes per day, and only tested the Rapicide for adequate levels of the active ingredient before staff reprocessed the first endoscope of the day.	C 278	Rapidcide policy changed to reflect the manufacturer's recommendation. Policy will be presented to PAC 08/26/10 for approval. Any changes of chemical disinfecting solutions will follow manufacturer's recommendation and change practice and policy accordingly. Responsible: OR/VPC Patient Care Manager Completion Date: 09/01/10	

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C 278	Continued From page 6 4. Review of the manufacturer's directions for the Medivator CER-1 revealed, in part, "...Medivators recommends ...testing before every reprocessing cycle, to ensure an adequate level of active ingredient." 5. During an interview on 8/17/10 at approximately 9:30 AM, the Patient Care Manager of Surgery acknowledged the manufacturer recommended testing the Rapicide before each reprocessing cycle, and stated surgical staff would test the Rapicide before each reprocessing cycle.	C 278		
C 307	485.638(a)(4)(iv) RECORDS SYSTEMS [For each patient receiving health care services, the CAH maintains a record that includes, as applicable-] dated signatures of the doctor of medicine or osteopathy or other health care professional. This STANDARD is not met as evidenced by: Based on medical record review, Critical Access Hospital (CAH) Medical Staff Rules and Regulations review, and staff interview, the CAH administrative staff failed to ensure emergency medical providers dated and/or timed all medical record entries in 3 of 8 closed emergency room medical records (Patient #1, #2 and #3) reviewed. The CAH administrative staff identified an average of 1,625 emergency room visits per month. Failure to date and time medical record entries potentially could cause harm to patients by a	C 307	Sent notification to EMCARE (Emergency Department Physician Coverage Company) that Ringgold County Hospital requires all EMCARE physicians to date and time medical record entries. At the 10/12/10 Medical Staff Meeting, will reinforce this requirement with our Medical Staff. CNO will monitor compliance through 100% review of ER records through December, 2010. Responsible: CNO Completion Date: 10/13/10	

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C 307	Continued From page 7 delay in treatment, actions, or assessments provided. Findings include: 1. Review of closed emergency room medical records, on 8/16/10 at 10:40 AM, showed the emergency medical providers failed to date and time anyl medical record entries in 3 of 8 closed emergency room medical records (Patients #1, #2, and #3). 2. Review of the Ringgold County Hospital Amended and Restated Rules and Regulations of the Medical Staff, approved 3/7/01, showed the attending practitioner must sign and date all standing orders. The Rules and Regulations did not require the physicians to date or time handwritten orders. 3. During an interview on 8/18/10 at 9:10 AM, the Patient Care Manager stated the emergency room physicians did not date and time all emergency room physician records. 4. During an interview on 8/18/10 at 9:20 AM, the Chief Nursing Officer reported physicians did not date and time all emergency room medical record entries. The contract physicians mainly did not date and time the entries. The Medical Staff Rules and Regulations state to date the orders only, but the federal regulation require date, time and signature for all practitioner entries. The physicians should have dated, timed, and signed all entries.	C 307		
C 339	485.641(b)(3) QUALITY ASSURANCE [The program requires that--] the quality and appropriateness of the diagnosis and treatment	C 339		

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C 339	Continued From page 8 furnished by nurse practitioners, clinical nurse specialists, and physician assistants at the CAH are evaluated by a member of the CAH staff who is a doctor of medicine or osteopathy or by another doctor of medicine or osteopathy under contract with the CAH; This STANDARD is not met as evidenced by: Based on review of credential files and staff interview, the Critical Access Hospital (CAH) administrative staff failed to perform peer review for 1 of 1 Certified Registered Nurse Anesthetist (CRNA). The CAH administrative staff identified an average of 14 surgical procedures involving anesthesia per month. Failure to perform peer review could potentially expose patients to inappropriate diagnosis and treatment. Findings included: 1. Review of credential files on 8/17/10 revealed Practitioner A's (CRNA) credential file lacked documented evidence of external peer review. 2. During an interview on 8/17/10 at 1:20 PM, the Health Information Management (HIM) Director verified Practitioner A's credential file lacked documented evidence of external peer review. The HIM Director stated, "I should be doing this. I'm not following our hospital's ... requirements for [external peer review] of [the] medical staff. We do not have a written policy, but everyone who provides care to [our] patients should [receive external peer review]." The HIM Director stated the CRNA "slipped through the cracks", and	C 339	CRNA external peer review will be done by 10/01/10. Will include CRNA's in peer review system to ensure an external peer review done a minimum of once a year. Will monitor compliance through HIM Quality Improvement quarterly. Responsible: HIM Director Completion Date: 10/01/10	

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C 339	Continued From page 9 should have received external peer review on the care provided to patients at the CAH.	C 339		