STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	161373	A. BLDG. _____ B. WING _____	MS 7/27/15 06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RINGGOLD COUNTY HOSPITAL	504 NORTH CLEVELAND STREET MOUNT AYR, IA 50854

(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 An onsite, unannounced Critical Access Hospital recertification survey occurred from 6/15/15 to 6/17/15. The survey team identified the following standard-level deficiencies during the survey.	C 000	Plan of correction accepted on 7/20/15 Compliance date Aug 7, 2015 Trish Haskell	
C 152	485.608(b) COMPLIANCE W ST & LOC LAWS & REGULATIONS All patient care services are furnished in accordance with applicable State and local laws and regulations. This STANDARD is not met as evidenced by: Based on policy review and staff interview the Critical Access Hospital (CAH) failed to schedule patient meals in accordance with applicable state regulations. The Administrative Staff identified a census of 3 patients and the Dietary Manager reported an average of 15 to 18 patients meals served daily. Failure to avoid extensive lapses between meals could potentially result in failure to provide patients with adequate nutrition. Findings include: 1. Review of the Iowa Administrative Code for the Department of Inspections and Appeals, Chapter 51 titled, "Hospitals", last updated 12/10/14, revealed in part, "... 51.20(2)b.(2) Not more than 14 hours shall elapse between the evening meal and breakfast of the following day..." Review of a Dietary Department policy titled, "Meal Service and Preparation", effective on 3/15/15, revealed in part, "...Three meals are	C 152	Tag: C152 Not more than 14 hours shall pass between evening meal and breakfast of the following day. 1. Breakfast patient cart will be delivered at 7:30 AM. 2. Lunch patient cart will be delivered at 12:00 PM. 3. Supper patient cart will be delivered at 5:30 PM. Proper changes have been made and our policy was updated. I will also be monitoring compliance through Quality Improvement. Effective Date: July 14, 2015 Responsible: Dietary Manager	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	CEO	07/20/2015

Plan of Corrective
Acceptable Tolerance
Completion Date
Date 7/2015
Next Problem

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 _____	06117/2015

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C 152	Continued From page 1 served daily with no more than 14 hours between the evening meal and breakfast...Breakfast...will be delivered at 7:50 to 8:00...supper...will be delivered at 16:50..." 2. During an interview on 6/15/15, at 11:00 AM, Staff 0, Dietary Manager, reported the scheduled patient meal times as 7:50 AM (breakfast), 11:50 AM (lunch) and 4:50 PM (supper). During an interview on 6/16/15, at 8:10 AM, Staff 0 reported the meal service schedule had remained the same since her employment at the CAH. She reported she knew there was a 14 hour time span rule but did not realize the current scheduled meal times extended the time between supper and breakfast to 15 hours.	C 152		
C 222	485.623(b)(1) MAINTENANCE The CAH has housekeeping and preventive maintenance programs to ensure that-- all essential mechanical, electrical, and patient care equipment is maintained in safe operating condition; This STANDARD is not met as evidenced by: Based on observation, review of documents, and staff interviews the Critical Access Hospital (CAH) failed to date the Truetest glucose control solution bottles when opened and removed outdated Truetest control solution bottles from 2 of the 4 patient care areas where staff used Glucometers to test patient blood glucose levels. Failure to date the Truetest glucose control solution bottles when staff opened the bottles and/or removed outdated Truetest glucose	C 222	Tag 222 Med Surg All glucose testing control solution will be labeled with the date opened and discarded 3 months after the date on the label. This measure will be added to the Quality Improvement of the Med Surg department, and the Med Surg Patient Care Manager will be responsible for monitoring this measure on the Med Surg Floor. Date of correction July 1, 2015. continued	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER7SUPPLIEPJCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE LCONSTRUCTION	(X3) DATSURVEY COMPLETED
	161373	A BLDG: _____ B WING _____	06/17/2015

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C 222	Continued From page 2 control solution bottles from all patient care areas where staff used Glucometers to test patient blood glucose levels could potentially result inaccurate patient blood glucose test results. Findings include: 1. Review of the package insert for the True Test Glucose Control Instructions for Use stated in part, "... Discard bottle after Expiration Date printed on the bottle label or 3 months after date written on bottle..." 2. Review of policy titled, "Disposable Supplies, Multi-use Vials/Bottles, Ointments, and Topical Creams", dated May 2011, stated in part "...All disposable supplies, multi-use bottles, or multi-use tubes are labeled with date and time of initial use..." 3. Observation and interview on 6/15/15 at 12:05 PM, with Staff D, RN Patient Care Manager verified, the 2 of 2 Truetest glucose control solution bottles failed to display the date when staffed opened the bottles. date. Staff D reported the CAH had a high volume of diabetic patients that used the Glucometer frequently. Observation and interview on 6/16/15 at 1:45 PM, with Staff F, RN Patient Care Manager of the Clinics, verified 2 of 2 Truetest glucose control solution bottles were outdated. Staff F reported the clinic rarely used the Glucometer.	C 222	Tag 222 continued Clinic All glucose testing control solution will be labeled with the date opened and discarded 3 months after the date on the label. Controls will be conducted prior to each use. This measure will be added to the Quality Improvement of the clinic department, and the Clinic patient care manager will be responsible for monitoring this measure in the Clinic. Date of correction June 16, 2015	
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES {The policies include the following:] Rules for the storage, handling, dispensation, and	C 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE CONSTRUCTION	(X-5) DATE-SURVEY COMPLETED
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C 276	Continued From page 3 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 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: I. Based on observations, policy/procedure review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to ensure pharmacy oversight of manufacturer's medication samples in 1 of 2 outpatient clinic locations. (Visiting Physician Clinic) The clinic staff reported a census of approximately 2 to 3 patients a month seen at the clinic that could receive the sample medications. Failure of pharmacy staff to provide oversight of sample medications could result in inappropriate medications or doses of medications, outdated, recalled, or otherwise unusable medications being available for use to patients, as well as, the potential for diversion of medications by unauthorized persons. Findings include: During an observation on 6/16/15 at 2:05 PM with Staff G, Clinic Registered Nurse, Visiting Clinic Manager revealed 1 locked cabinet at the nurse's in the Visiting Physician Clinic containing sample medications available for patient usage. The following medications were located in the locked cabinet: a. Pradaxa 75 mg (milligram)- 8 boxes with 12 tablets in each box.	C 276	TAG C-276 1. Sample drugs stored in the Visiting Physician Clinic area will be kept in a locked cupboard. 2. All sample drugs stored in cupboard will be recorded in "Sample Drug Log Book" on "Visiting Physician Clinic Drug Sample Intake Form " with medication name, lot number, expiration date, date received and total number received. 3. All medication dispensed to patients will be recorded on "Visiting Physician Clinic Drug Sample Disposition Form" with patient name, date of birth, medication, dose, lot number, expiration date, and quantity. continued	

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	161373	IDENTIFICATION NUMBER:COMPLETED (X2) MDLTIPLE CONSTRUCTION	06/17/2015

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C 276	Continued From page 4 b. Pradaxa 150 mg- 27 boxes with 12 tablets in each box. c. Eliquis 5 mg- 6 boxes with 14 tablets in each box. d. Eliquis 2.5 mg- 10 boxes with 14 tablets in each box. e. Xarelto 15 mg- 6 bottles with 5 tablets in each bottle. f. Crestor 10 mg- 4 boxes with 42 tablets in each box. g. Crestor 5 mg- 2 boxes with 42 tablets in each box. h. Vascepa 1 gram- 6 boxes with 8 capsules per bottle. i. Ranexa 1000 mg- 8 packs with 14 tablets per pack. Review of CAH policy titled "Drug Procurement/Inventory Control", revised 2/2010, revealed, in part... "Inspection: All drug storage areas within Ringgold County Hospital will be inspected monthly by the Pharmacy Department" During an interview on 6/16/15 at 2:40 PM, Staff H, Director of Pharmacy, stated he was not aware of any sample medications kept in the Visiting Clinic Clinic, therefore had no oversight of those medication samples brought in by the Iowa Heart physicians. II. Based on observation, staff interview, and record review, the Critical Access Hospital (CAH) pharmacy staff failed to develop and maintain a system where sample drugs are controlled and distributed through the pharmacy or through a process developed in cooperation with the pharmacy, for pharmacy oversight in 1 of 2 outpatient clinics, (Visiting Physician Clinic). The clinic manager reported an average monthly	C 276	continued 1. Outdates will be checked monthly and completion will be documented on "Outdate Log" in "Sample Drug Log Book." 2. We will follow pharmacy policy on Drug Procurement/Inventory Control and Drug Samples. 3. We have added Completion of Sample Drug Log Book to our QI to monitor for completion monthly. 4. Our sample drug cabinet will be inspected monthly by a pharmacist and a signed report will be maintained by pharmacy department. Date of Correction was 6/16/2015 The Director of Pharmacy will assure that this process is being completed.	

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C 276	Continued From page 5 census of 2 to 3 patients receiving sample medications. Failure to provide oversight could potentially result in expired medications available to patients, the potential for theft of medications by unauthorized persons and patients receiving medications recalled by the manufacturer. During an observation on 6/16/15 at 2:05 PM with Staff G, Clinic Registered Nurse, Visiting Clinic Manager revealed 1 locked cabinet at the nurse's in the Visiting Physician Clinic containing sample medications available for patient usage. The cabinet did not contain a perpetual inventory log identifying the medication in the cabinet or medications provided to patients during clinic visits. The following medications were located in the locked cabinet: a. Pradaxa 75 mg (milligram)- 8 boxes with 12 tablets in each box. b. Pradaxa 150 mg- 27 boxes with 12 tablets in each box. c. Eliquis 5 mg- 6 boxes with 14 tablets in each box. d. Eliquis 2.5 mg- 10 boxes with 14 tablets in each box. e. Xarelto 15 mg- 6 bottles with 5 tablets in each bottle. f. Crestor 10 mg- 4 boxes with 42 tablets in each box. g. Crestor 5 mg- 2 boxes with 42 tablets in each box. h. Vascepa 1 gram- 6 boxes with 8 capsules per bottle. i. Ranexa 1000 mg- 8 packs with 14 tablets per pack.	C 276		

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C 276	Continued From page 6 Review of CAH policy titled "Drug Samples", effective 11/2006, revealed, in part... "3. All samples will be signed out with the patient's name, medication name, strength, date lot number, expiration date and quantity." During an interview on 6/16/15 at 2:05 PM, Staff G confirmed the clinic lacked a perpetual inventory log documenting the required information as stated in the CAH Drug Sample policy. The visiting physicians supply the medications in the clinic, but staff did not log the medications when received or document when patients received the medications. During an interview on 6/16/15 at 2:40 **PM,** Staff H stated the clinic should have a perpetual inventory log of the sample medications kept in the Visiting Clinic Clinic.	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: Based on personnel record review, policy review and staff interview the Critical Access Hospital (CAH) administrative staff failed to follow a consistent system to identify and prevent transmission of infections and communicable diseases among personnel, who provided services to patients. Problems were identified for 2 of 17 CAH employees (Staff T and U) and 3 of 4 contracted employees selected for review (Staff Q, R and S). The Administrative staff identified a census of 3 patients.	C 278		

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RINGGOLD COUNTY HOSPITAL	**$04 NORTH CLEVELAND STREET MOUNT AYR, IA 50854**

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C 278	Continued From page 7 Failure to identify infections and communicable diseases could potentially result in causing harm to patients through exposure and transmission of communicable diseases. Findings include: 1. Review of a personnel policy titled "Employee Physical Examinations", reviewed and revised in 12/2014, revealed in part ".. . All new employees of Ringgold County Hospital must successfully complete a complete physical exam prior to starting work .. . and Mantoux (a skin test for tuberculosis) 3. Every four (4) years, employees must undergo a complete physical assessment . . . 4. Complete employee assessments will be completed every four (4) years by the Employee Health Nurse .. . 5. Results of these tests are on file in the Chief Nursing Officer Assistant's Office . .." The policy failed to address the procedure to obtain and document health information for contracted employees, who provided services to patients. 2. Review of the personnel records showed the following: a. Staff T, Emergency Medical Technician (EMT), revealed it lacked documented evidence of a Tuberculosis (TB) test or health exam. b. Staff **U,** Lab Technician, revealed a document titled "Every 4 Years Physical Examination", dated 1/20/09, and identified as the most recent health exam contained in the record. c. Staff Q, Contracted Occupational	C 278	DIA Tag C-278 1. All potential employees of Ringgold County Hospital will have current proof of immunizations and pre-employment health screening completed prior to being hired (provisional employment). We have implemented a new process that Human Resources will not offer employment until current immunizations and a pre employment health assessment is on file. Every employee will have a health assessment completed every 4 years thereafter. This new indicator will be reported at QI quarterly for new employees by the Employee Health Nurse with a 100% compliance goal. Date of completion: July 17, 2015 2. One EMS employee has been removed from the schedule until he has completed the required health screenings and provides current immunizations. 3 of the 4 Contracted Employees now have health examinations and current immunizations on file and we are awaiting the 4th to have a health examination completed. Date of completion is July 30, 2015.	

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C 278	Continued From page 8 a health exam. d. Staff R, Contracted Speech Therapist (ST), revealed it lacked documented evidence of a health exam. e. Staff S, Contracted Registered Dietitian (RD), revealed it lacked documented evidence of a health exam. 3. During an interview on 6/16/15 at 4:00 PM, Staff B, Administrative Assistant, and Staff P, Human Resources/Administrative Assistant, confirmed they had no health information on Staff Q, R, S and T and acknowledged the physical exam on file for Staff U failed to fall within the past 4 years. Staff B and P reported they would attempt to contact the employees and request current health information. 4. During an interview on 6/17/15, at 9:00 AM, Staff B, reported new employees are required to have a physical exam and TB test prior to starting and the physical exam is required every 4 years after that. She reported the department managers are responsible to ensure contracted staff, within their departments, have the required physical exams and the information is kept within their department. During a follow-up interview on 6/17/15 at 10:35 AM and 11:30 AM, Staff B and P reported they remained unable to provide documented evidence of a TB test on Staff T or current health exams on Staff T and U and contracted Staff Q, R and S.	C 278		
C 308	485.638(b)(1) PROTECTION OF RECORD INFORMATION	C 308		

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C 308	Continued From page 9 The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use. This STANDARD is not met as evidenced by: Based on observations, policy review, and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to protect all confidential patient information from unauthorized access in 1 of 1 Health Information Management department. The Business Office Manager identified approximately 1,100 CAH patient records, 400 Mount Ayr Medical Clinic patient records and 3,000 radiology films stored in the Health Information Management department. Failure to secure medical records against unauthorized access could result in identity theft and/or unauthorized disclosure of personal medical information. Findings include: 1. Review of a Health Information management policy titled, "Security and Access of Medical Records", approved 1/12/14, stated in part, "...It is the hospital's responsibility to safeguard both the record and its information content against loss, defacement and tampering and from use by unauthorized individuals...5. Providers/Staff will have access to hard copy records on a "need to know" basis. 6. All paper records not scanned into the EHR [Electronic Health Record] will be maintained in patient files in the HIM [Health Information Management] Department behind locked doors when the department is not attended..."	C 308	Tag 308 HIM Director will work with Maintenance Director to install a lock on the door between the physicians' workroom and the HIM department. Key pad door on the physicians work room will be changed. Only HIM staff, physicians, transition coach and Patient Care Coordinator will have authorized access to physician's workroom. No patient charts will be kept in physician's workroom. The locks will be completed by July 24, 2015. HIM Director will work with HIPAA Privacy Officer on education and monitoring of the HIM Department access. Maintenance Director will work with HIM. Director to inform Housekeeping staff of schedule changes so cleaning will only be done when HIM Staff is present. HIM Director will follow-up to make sure the updates have been made. HIM Director will also monitor the access to the HIM Department with a Quality Improvement indicator and will report at the QI Meetings on a quarterly basis. Effective date July 24, 2015. Responsible: HIM Director	

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C 308	Continued From page 10 2. Observations on 6/16/15 at 10:10 AM during the tour of the Health Information Management (HIM) department, with Staff K, HIM Specialist and Staff L, Business Office Manager revealed the opened shelves held multiple radiology film jackets and CAH patient medical records. In addition, the tables and counter in the HIM area held multiple clinic patient records. 3. During an interview and observation of the HIM area Staff K and Staff L reported an unlocked door that entered into the physician's lounge remained unlocked at all times. Inside the physician lounge had an additional door with a keyless digital door lock, that exited into a hall. Staff K and Staff L agreed the housekeeping staff would have access to the HIM department, and the unsecured records, during unsupervised hours when they entered through the physician's lounge door to collect the trash from the HIM department. Staff K and Staff L reported physicians/providers and nursing staff, in addition to housekeeping, had the code to the keyless lock but were unaware if additional staff had the code. During an interview on 6/16/15 at 10:30 AM Staff C, Chief Nursing Officer, reported Registered Nurses (RN), physicians/providers and housekeeping had the keyless lock code to enter into the physicians lounge, but did not know the door between the physician lounge and the HIM department remained unlocked at all times. During an interview on 6/16/15 at 10:55 AM Staff N, Housekeeper, reported she had the keyless lock code to enter the physician's lounge. Staff N demonstrated she had the ability to enter the	C 308		

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C 308	Continued From page 11 area. She reported during the night shift the housekeeping staff entered through the physician's lounge door or used the badge reader key for the door to clean the HIM department. Staff N demonstrated the key unlocked the hall door that entered into the HIM department. She reported all housekeeping staff used the key at the hall door entrance or entered through the physician lounge to the HIM department. During an interview on 6/16/15 at 11:35 AM Staff M, Lead Housekeeper, confirmed housekeeping was scheduled to clean the HIM department at night and they had key access to the area. During an interview on 6/16/15 at 11:46 AM Staff 0, Dietary Manager, reported she and Staff S, Registered Dietitian, had the code to the keyless lock on the physician's lounge and confirmed this allowed access into the HIM department. During a follow-up interview on 6/16/15 at 4:30 PM Staff C reported she did not know housekeeping had key access to the HIM department and were scheduled to clean the HIM department at night. She acknowledged housekeeping staff should not have unsupervised access to patient medical records. Staff V, Director of Facilities/Housekeeping/Laundry verified, 4 laundry/housekeeping staff and 2 maintenance staff had a key to access the HIM department.	C 308		
C 321	485.639(a) DESIGNATION OF QUALIFIED PRACTITIONERS The CAH designates the practitioners who are allowed to perform surgery for CAH patients, in	C 321		

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C 321	Continued From page 12 accordance with its approved policies and procedures, and with State scope of practice laws. Surgery is performed only by (1) a doctor of medicine or osteopathy, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (2) a doctor of dental surgery or dental medicine; or a doctor of podiatric medicine; or (3) a doctor of podiatric medicine. This STANDARD is not met as evidenced by: Based on review of documents and Medical Staff Rules and Regulations, and staff interview, the Critical Access Hospital (CAH) failed to delineate privileges for 1 of 1 Orthopedic Technician, Staff A, who was not an employee of the hospital, to assist with orthopedic surgical procedures. The Chief Nursing Officer (CNO) identified Staff A assisted with 6 orthopedic surgical procedures a month provided by an associated practitioner, Practitioner A. Failure to privilege all assistants that accompany providers could result in patients receiving surgical intervention from unqualified professionals. Findings include: 1. Review of Operating Room (OR) Log on 6/16/15 at 8:00 AM with Staff I, Registered Nurse (RN)/Operating Room Manager revealed Staff A provided surgical assistance for Practitioner A during orthopedic surgical interventions for	C 321	Tag: C321 1. Development of policy for Persons Employed by Privilege Practitioner will have privileges documented and approved by credentialing department. 2. The person that had not been privileged was notified to complete the PEPP packet and the privileged practitioner signed approval along with Credentialing department and CEO. July 15, 2015. 3. The new policy for PEPP will be sent to Professional Advisory committee July 30, 2015 for final approval. 4. Credentialing department will quarterly monitor privileges for persons employed by a privileged practitioner have been defined and approved by credentialing department. 5. Responsible: Chief Nursing Officer Effective Date: July 30, 2015	

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	161373	A. BUILDING _____ B. WING _____	06/17/2015

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C 321	Continued From page 13 patients. Staff A assisted with 6 surgical procedures a month completed by Practitioner A. During an interview at the time of the OR log review, Staff I acknowledged Staff A lacked delineation of privileges to assist Practitioner A with orthopedic surgical procedures. Review of "Amended and Restated Rules and Regulations of the Medical Staff' dated 6/16/08 revealed the following in part, ..."the Governing Board has delegated responsibility and authority to the Medical Staff to assure the quality of medical professional services provided by individuals with approved clinical and practice privileges and the Medical Staff accepts accountability for those services...purpose: to assure...professional performance of all Allied Health Professionals (AHPs) authorized to practice in the Hospital, through the appropriate delineation of the clinical and practice privileges that each may exercise in the hospital...The Governing Board, in consultation with the Executive Committee, shall determine the services provided in the hospital and the categories of AHPs eligible to provide services...Medical and Surgical Assistants are persons who are not employees of the hospital, and who are not members of the Medical staff...but who work from time to time in the hospital...all...surgical assistants who request privileges **to** provide services in the hospital under the direction and supervision of a Medical Staff member shall do so on an appropriate form approved by the Governing Board. Applicants shall submit information pertaining to their educational background and their experience in the specialty in which the privileges are requested, providing dates, places and descriptions of duties performed and by whom	C 321		

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C 321	Continued From page 14 supervised." Review of Administrative and Operating Room policies and procedures failed to show a CAH policy for delineation of privileges for surgical technicians who assist Practitioners during surgical procedures. 2. During an interview on 6/16/15 at 11:20 AM, Staff B, Administrative Assistant/Credentialing Specialist acknowledged Staff A lacked privileges to assist Practitioner A with orthopedic surgical procedures at their hospital in accordance with the Medical Staff Rules and Regulations. Staff B stated she did not know Staff A required privileges by the hospital to assist with surgical procedures at the CAH. Review of credential files at the time of the interview revealed Staff A lacked delineation of privileges to assist with orthopedic surgical procedures since 2008. During an interview on 6/16/15 at 1:00 PM, the CNO acknowledged they failed to delineate surgical privileges to Staff A to provide assistance to Practitioner A during surgical procedures performed in their OR. The CNO stated she did not know Staff A required privileges by the hospital to assist with surgical procedures and she was unaware the hospitals Medical Staff Bylaws/Rules and Regulations directed credentialing staff to delineate privileges to surgical technicians at the CAR.	C 321		
C 337	485.641(b)(1) QUALITY ASSURANCE The CAR has an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAR and of the treatment	C 337		

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C 337	Continued From page 15 outcomes. The program requires thet- all patient care services and other services affecting patient health and safety are evaluated. This STANDARD is not met as evidenced by: Based on review of documents, the Continuous Quality Improvement Plan (CQI) and Board of Trustee meeting minutes, and staff interviews, the Critical Access Hospital (CAH) quality improvement staff failed to evaluate all patient care services provided for 3 of 19 patient care services. (Surgery, anesthesia and infusion). The Chief Nursing Officer identified an average daily census of patients for surgery, anesthesia and infusion as follows: Surgery: In-patient - year to date 11 patients monthly Out-patient - year to date 261 patients monthly. Anesthesia: The same number of patients as surgery Infusion: In-patient - year to date 1,591 patients monthly Out-patient - year to date 145 patients monthly Failure to monitor and evaluate all patient care services for quality of care could potentially expose patients to inappropriate and/or substandard care and services. Findings include:	C 337	Tag: C 337 Deficient QI reports will be made current and in compliance .The QI plan will be changed to include steps to ensure reporting compliance. QI manager will monitor compliance with scheduled reporting on a monthly basis. Date of correction July 30, 2015.	

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C 337	Continued From page 16 1. Review of CAH "Continuous Quality Improvement Plan", dated 8/28/14, revealed in part, ..."CQI is a dynamic process through which standards are set and actions are taken to ensure achievement of these standards...The purpose of the CQI program is to enhance patient care...through a continuing objective assessment of important aspects or patient care and the correction of identified problems...The Board has the final authority and ultimate responsibility for the overall CQI program...requiring and reviewing summary reports of all quality measurement and improvement activities as specified in the plan...the CQI committee is a coordinating advisory body for all plans and programs that relate to monitoring and evaluating the quality and appropriateness of patient care...the quality and appropriateness of patient care in the following services are monitored with improvements made as necessary. Reports are required from the following departments/services on a scheduled basis: anesthesia...medical/surgical nursing services (infusion)...surgery...each department reports to the CQI committee quarterly based on an established schedule...each department manager will evaluate the department's specific plan annually or more often if needed to determine its effectiveness, appropriateness and completeness in meeting its stated objectives. The revised indicators must focus on patient care problems areas. They are then presented to the CQI committee for approval." Review of "CAH Quality Assurance and Performance Improvement Program Fiscal Year (FY) 14", dated 6/30/14 revealed the following in part, ..."All patient care services and other services affecting patient health and safety are	C 337		

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C 337	Continued From page 17 evaluated and included the following components with clear evidence...defines who is responsible to evaluate the patient care services, how patient care services are evaluated...that a structure for and follow up of the Quality Assurance Performance Improvement (QAPI) data is provided to Medical staff and that a structure for and follow up of the QAPI data is being provided to the Governing Body." Review of CQI committee meeting minutes from October 2014 to May 2015 lacked Quality Improvement (Q1) reports and/or quality monitors from surgery, anesthesia and infusion services. Review of Board of Trustee meeting minutes from 10/20/14 to May 18, 2015 lacked QI reports and/or quality monitors from surgery, anesthesia and infusion services. 2. During an interview on 6/16/15 at 8:00 AM, Staff I, Nurse Manager for surgery, anesthesia and infusion services said she failed to provide an QI activities since she started the position six months ago. During an interview on 6/16/15 at 4:00 PM, the Chief Nursing Officer (CNO) said she was aware surgery, anesthesia, and infusion services failed to submit QI monitoring activities to the QI committee. The CNO acknowledged the committee failed to ensure Staff I followed the QI plan and they were in the process of correcting this problem. She stated she knew this would be a concern from a regulatory standpoint.	C 337		
C 340	485.641(b)(4) QUALITY ASSURANCE [The CAH has an effective quality assurance	C 340		

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C 340	Continued From page 18 program to evaluate the quality and appropriateness of the diagnosis and treatment furnished in the CAH and of the treatment outcomes. The program requires that--I (4) The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy at the CAH are evaluated by-- (i) One hospital that is a member of the network, when applicable; (ii) One QIO or equivalent entity; (i) One other appropriate and qualified entity identified in the State rural health care plan; (ii) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site hospital, the distant-site hospital; or (v) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, one of the entities listed in paragraphs (b)(4)(i) through (iii)of this section; and This STANDARD is not met as evidenced by: Based on review of document and staff interview, the Critical Access Hospital (CAH) failed to ensure 2 of 2 tele-radiologists, 1 of 1 Ears/Nose/Throat (ENT) specialist, 1 of 1 Orthopedic surgeon, 1 of 1 Oncologist, and 1 of 1 Emergency room (ER) physicians selected for review, received outside entity peer reviews performed by the Network Hospital to evaluate the appropriateness and diagnosis and treatment furnished by physicians at the CAH. (Physician's	C 340	Tag: C340 1. The quality and appropriateness of the diagnosis and treatment furnished by doctors of medicine or osteopathy will be evaluated by external peer review by an equivalent entity every 2 years during the re-credentialing process. 2. The practitioners that had been credentialed without a peer review were immediately sent for peer review. 3. Credentialing department will quarterly monitor physicians being re-credentialed will have a peer review completed. 4. Responsible: Chief Nursing Officer 5. Effective Date: Network facility states peer review will be completed by August 7, 2015	

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C 340	Continued From page 19 A, B, C, D, E, and F). The Chief Nursing Officer (CNO) identified patient census from 12/16/14 to 6/16/15 as follows: Physician A, Orthopedic surgeon, provided care to 38 patients Physician B, ENT physician, provided care to 15 patients Physician C, Oncology physician, provided care to 72 patients Physician D, ER physician provided, care to 239 patients Physician E read 54 radiology exams for the CAH patients Physician F read 84 radiology exams for the CAH patients Failure to ensure all medical staff members received outside entity peer reviews could potentially effect the CAH's ability to ensure all physicians provided quality of care to the patients at the CAH. Findings include: 1. Review of CAH administrative and Health Information Management (HIM) policies and procedures failed to show the CAH had policies for external peer review. 2. Review of the "Peer Review Services Agreement" dated 2/20/15, from the CAH's Network Hospital, revealed in part, ...[Network Hospital] shall assist the CAR...in evaluating the quality and appropriateness of diagnosis and treatments furnished by physicians at the CAR...evaluated periodically by an outside entity."	C 340		

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C 340	Continued From page 20 Review of "CAH Quality Assurance and Performance Improvement Program Fiscal Year (FY) 14", dated 6/30/14, revealed the following in part, ..."The Quality and Appropriateness of the diagnosis and treatment furnished by the doctors of medicine or osteopathy at the CAH are evaluated (External Peer Review) by one hospital that is a member of the network...this applies to any distant side physicians and practitioners providing tele-medicine services." Review of "Bylaws of the Board of Trustees", dated June 21, 2010, revealed the following in part, ..."The Board shall require the conduct of specific review and evaluation activities to assess, preserve and improve the overall quality, efficiency and safety of patient care...the Medical staff, health care professional staff, and administration shall conduct and be accountable to the Board for conducting review and evaluation activities...these activities shall include: a review and evaluation of the quality of patient care through a valid and reliable patient care audit procedure." 3. Review of CAH documentation on 6/16/15 at 1:25 PM, revealed the facility failed to ensure the CAH received completed peer reviewed by the Network Hospital specific for the services provided to patients at the CAH for Physicians A, B, C, D, E, and F. 4. During an interview on 6/17/15 at 8:05 AM, the CNO acknowledged the CAH had not received completed external peer review by the Network hospital specific for the services provided to patients at the CAH for Physicians A, B, C, ID, E, and F for the medical staff to use the	C 340		

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C 340	Continued From page 21 provider-specific results during the physician's credentialing and privileging process. The CNO said from an quality assurance standpoint process she knew they were not in regulatory compliance.	C 340		
C 385	485.645(d)(4) PATIENT ACTIVITIES [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Patient activities (§483.15(f) of this chapter), except that the services may be directed either by a qualified professional meeting the requirements of §485.15(f)(2), or by an individual on the facility staff who is designated as the activities director and who serves in consultation with a therapeutic recreation specialist, occupational therapist, or other professional with experience or education in recreational therapy. Quality of Life - activities (§483.15(f)) "(1) The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. (2) The activities program must be directed by a qualified professional who- (i) Is a qualified therapeutic recreation specialist or an activities professional who- (A) Is licensed or registered, if applicable, by the State in which practicing; and	C 385	Tag 385. 1. Ringgold County Hospital contracted with an Occupational Therapist to serve as Activity Coordinator for the SNF unit. 2. The Patient Care Manager of the SNF unit will assure that the Occupational Therapist is notified of all SNF admits. 3. The SNF Activity Assessment will be added to the New SNF department QI Effective July 1, 2015. 4. The SNF Patient Care Manager is responsible all SNF patients have a activities program directed by a qualified professional, which we have contracted with an Occupational Therapist. 5. Effective Date: July 1, 2015.	

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C 385	Continued From page 22 (B) Is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (ii) Has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or (iii) Is a qualified occupational therapist or occupational therapy assistant; or (iv) Has completed a training course approved by the State." This STANDARD is not met as evidenced by: Based on review of policies, procedures and staff interviews the administrative staff failed to ensure the Activity Coordinator completed a State approved training course and/or was supervised by a qualified activities professional. The CAH administrative staff reported a current census of 0 skilled patients and a daily average of 1 skilled patients. Failure to ensure the Activity Coordinator completed a State approved training course could potentially result in staff failure to employ activities meeting each patients individual interests, physical, and mental needs in order to improve their psychosocial well-being and enhance recovery. Findings include: 1. Review of the CAH Activity Coordinator job	C 385		

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C 385	Continued From page 23 description, stated in part, ..." Completion of the approved State Activities Director Certification course is required." 2. Review of the CAH policy, "Swing Bed, Activities Program" revised 3/2011 stated in part..."II. The activities program is directed by a qualified professional who: 1. Is a qualified therapeutic recreation specialist, 2. Is an activities professional who is licensed or registered in the state of Iowa, 3. Is eligible for certification as a therapeutic recreation specialist or an activities professional by a recognized accrediting body on or after October 1, 1990, 4. Has 2 years experience in social or recreational program within the last 5 years, 5. Is a qualified occupational therapist or occupational therapy assistant, or 6. Has completed a training course approved by the state of **Iowa."** 3. During an interview on 6/15/15 at 11:25 AM, Staff D, Acute Care Patient Manager stated the CAH did not have a qualified Activity Coordinator at this time. Staff D said she was aware a qualified professional did need to oversee the activities program for Swing Bed patients. 4. During an interview on 6/15/15 at 11:45 AM, Staff C, Chief Nursing Officer (CNO) confirmed the current Activity Coordinator had no formal training required for the position of Activity Coordinator. The CNO stated since the former Activity Coordinator left employment on 1/11/14, the CAH has not had a qualified Activity Coordinator. Staff C stated Staff E was in the process of completing an approved Activity Coordinator course, but had not completed the course yet.	C 385		

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C 385	Continued From page 24 5. During an interview on 6/15/15 at 12:00 PM, Staff E, Certified Nursing Assistant stated she was in the process of completing the Activity Coordinator course, but still needed to complete her practicum. Staff E said she did not have a certificate of completion to be qualified as the Activity Coordinator.	C 385		