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 _____	03/05/2020

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

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C 000	INITIAL COMMENTS The State Survey agency (SA) performed an unannounced recertification survey at the Critical Access Hospital from 03/2/2020 to 03/5/2020. The SA survey team identified the CAH was operating in compliance with the Conditions of Participation for Critical Access Hospitals. The survey team identified the following standard level deficiencies.	C 000	POC Accepted 3/16/20 cmp Date of Correction 3/26/20	
C 914	MAINTENANCE CFR(s): 485.623(b) , 485.623(b)(1) The CAH has housekeeping and preventive maintenance programs to ensure that-- (1) 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, document review, and staff interviews, the Critical Access Hospital's (CAH) administrative staff failed to ensure staff inventoried and performed preventative maintenance on 4 of 4 BrewerAccess High-Low electric exam tables located in 4 of 4 exam rooms (Exam room #1, Exam room #2, Exam Room #3, and Exam Room #4) in the Visiting Physicians Clinic. Failure to inventory equipment and perform preventative maintenance could potentially result in the equipment failing to function when needed for the care and treatment of a patient, and may result in delayed care, treatment, and patient harm The CAH's administrative staff identified an average of 245 patients treated per month in the Visiting Physicians Clinic. Findings include:	C 914	C 914 Maintenance Corrective Action CFR(s): 485.623(b) , 485.623(b)(1) Process: 1. Process going forward is that all equipment will be held in purchasing department until it has been checked and labeled by BioMed 2. All required equipment will be inventoried and inspected by BioMed. Inventory list will be kept in department. 3. VPC Manger and BioMed tech walked through the VPC department and inventoried equipment. Date corrected was 3/10/2020 4. VPC manager will do monthly inventory checks with biomed and track on QI for equipment variances between department and BioMed list. Person Responsible: VPC Patient Care Manager	03/10/2020

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

Andrew Mitchell | CEO | 03-13-2020

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 914	Continued From page 1 1. Observations during a tour of the Visiting Physicians Clinic (VPC) on 03/04/2020 at 10:45 AM with the Visiting Physicians Clinic/Cardiac Rehab Manager revealed the following items lacked a biomedical or maintenance sticker to identify when the equipment was checked for electrical safety: Exam Room 1 electric BrewerAccess High-Low exam table Serial number (SN) HL018708 Exam Room 2 electric BrewerAccess High-Low exam table SN HL018724 Exam Room 3 electric BrewerAccess High-Low exam table SN HL018726 Exam Room 4 electric BrewerAccess High-Low exam table SN HL018709 2. Review of documentation from the Visiting Physicians Clinic/Cardiac Rehab Manager on 3/4/2020 reveals the BrewerAccess High-Low exam tables were purchased 2/12/2018 and received in the clinic 2/23/2020. 3. Review of manufacture's recommendations for preventive maintenance revealed in part: "Failure to perform periodic inspections of the table could result in equipment damage. Inspect tables every 6 months ..." 4. Review of the Biomedical Service report from 02/24/2020 revealed the CAH staff failed to include the above mentioned exam tables in the biomedical inventory list and safety checks. The report lacked documentation the Biomedical Services staff checked the equipment for electrical safety.	C 914		

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C 914	Continued From page 2 5. During an interview at the time of the tour, the Visiting Physicians Clinic (VPC)/Cardiac Rehab Manager acknowledged the CAH staff and the contracted bio-medical equipment service failed to inventory the equipment and document preventive maintenance on the equipment. 6. During an interview on 03/02/2020 at approximately 2:00 PM, the Director of Support Services reported they identify the pieces of equipment the Facilities Services department must check for patient safety, and reports the department does not do the preventive maintenance checks on the patient beds or the exam tables. The contracted bio-medical equipment service performs the safety checks on the patient beds and exam tables. 7. During an interview on 03/05/2020 at 9:40 AM, the Chief Nursing Officer verified the Biomedical Services staff had not inventoried or checked the BrewerAccess High-Low exam tables in Visiting Physicians Clinic for electrical safety.	C 914		
C1016	PATIENT CARE POLICIES CFR(s): 485.635(a)(3)(iv) [The policies include the following:] (iv) 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 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:	C1016		

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C1016	Continued From page 3 I. Based on observation, document review, and interviews, the Critical Access Hospital's (CAH) administrative staff failed to ensure the surgery staff changed the sterile water flush bottles after endoscopy procedures for each patient, in accordance with the manufacturer's directions. Failure to change the flush bottle of sterile water after each patient could potentially result in bacteria growing in the sterile water and potentially causing an infection in the next patient The Surgical Services Manager identified that the surgery staff performed an average of 379 endoscopy procedures from 03/01/2019 to 03/01/2020. Findings include: 1. Observations during a tour of the surgery department on 03/03/2020 at approximately 1:45 PM in the Endoscopy Room in the Operating Room (OR) revealed 2 of 2 B. Braun Medical 500 mL bottles and 1 of 1 B. Braun Medical 1000 mL bottle of sterile water for irrigation connected to the endoscopy equipment (a nonsurgical procedure where a physician inserts a flexible camera into a patient's body to examine the digestive tract). Review of the manufacturer's instructions revealed in part, "Sterile Water for Irrigation USP is indicated for use as an irrigating fluid .. single unit container . . discard unused portion of irrigating solution since it contains no preservative." 2. During an interview at the time of the tour, Registered Nurse (RN) F, Licensed Practical Nurse (LPN) G, and the Surgical Services	C1016	C1016 Sterile Water & Succinylcholine Corrective Action CFR(s): 485.635(a)(3)(iv) Sterile Water Process: 1. The surgical services manager added two 500ML bottles of sterile water to the colonoscopy and esophagogastroduodenoscopy case cards on 3/10/2020 to be implemented immediately. 2. CS will change the 500ML bottle of sterile water out between each patient and as needed during endocsopy cases , and discard any unused portion of irrigation solution when each case is completed. 3 The circulator will confirm that the CS has changed out the 500ML bottles of Sterile water and assure they have been charged accordingly per case. 4. Monitoring compliance for the above will be implemented via Surgery QI tracking monthly. Succinycholine Process: 5. Process to Date Succinycholine when removed from Refrigerator will be dated and placed in OR Extra Kit The OR Extra Kit is stored in locked Pyxis cabinet when not in use by CRNA. 6. Central supply, CRNA, and Pharmacy will monitor out dates of medication and put any outdated medication in cactus box for pharmacy disposal. 7 Monitoring compliance for the above will be implemented through Surgery QI tracking monthly 8. Person Responsible: Surgical Services Manager	3/20/2020

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C1016	Continued From page 4	C1016		

Manager revealed the surgery staff opened the bottles of sterile water for irrigation each day endoscopy procedures are scheduled and connected it to the equipment. The equipment contained a one-way valve to prevent backflow between patients to prevent contamination of the source bottle. The surgery staff changed the flush tubing between the patient and the one-way valve after each endoscopy procedure, but did not change the tubing between the one-way valve and the bottle of sterile water for irrigation or replace the bottle of sterile water for irrigation between endoscopy procedures. The surgery staff would only discard the bottles of sterile water for irrigation once they completed all of the endoscopy procedures for the day or if the bottle ran empty

3. During an interview on 03/03/2020 at approximately 2:40 PM, the Surgical Services Manager stated she reviewed and confirmed the manufacturer's directions for the B. Braun Medical 500mL and 1000 mL bottles of sterile water for irrigation. The Surgical Services Manager acknowledged the manufacturer did not support using the bottles of sterile water for irrigation for more than one patient.

II. Based on observation, document review and staff interview, the Critical Access Hospital (CAH) staff failed to store "Quellcine"-succinycholine (medication used to relax muscles during surgery) according to manufacturer's recommendations. Failure to ensure succinycholine is stored according to manufacturer's recommendations could

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C1016	Continued From page 5 potentially result in patients receiving a medication that does not work in the body as expected resulting in unintended consequences or side effects The CAH's administrative staff identified the surgical services staff performed 887 surgical procedures for fiscal year 2019. Findings include: 1. Observations on 03/03/2020, at 10:20 AM, during a tour of the Operating Room (OR), an interview with Registered Nurse (RN) F, Licensed Practical Nurse (LPN) G, and the Surgical Services Manager stated the succinycholine was kept in a monitored, secured refrigerator, has a shorter expiration date once removed from the refrigerator, is returned to the refrigerator everyday after surgeries are completed but may be kept at room temperature for 30 days. During further observation of the succinycholine, no date of the initial removal from the refigerator was identified on the bottles. 2 During an interview at the time of the tour, the Pharmacy Director stated the CAH practice was that the succinycholine is stable outside the refrigerator for up to 3 months at temperatures up to 25 degrees C [Celsius] degrees (77 degrees F [Fahrenheit]). 3. Review of manufacturer's recommendations for the storage of succinycholine revealed, in part: "Refrigeration of the undiluted agent will assure full potency until expiration date...Store in refrigerator 2 degrees - 8 degrees C [Celsius] (35.6-46.4 degrees F)...the multi-dose vials are stable for up to 14 days at room temperature without significant loss of potency."	C1016		

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C1028 C1028	Continued From page 6 LABORATORY SERVICES CFR(s): 485.635(b)(2) The CAH provides basic laboratory services essential to the immediate diagnosis and treatment of the patient that meet the standards imposed under section 353 of the Public Health Service Act (42 U.S.C. 236a). (See the laboratory requirements specified in part 493 of this chapter.) The services provided include the following: (i) Chemical examination of urine by stick or tablet method or both (including urine ketones). (ii) Hemoglobin or hematocrit. (iii) Blood glucose. (iv) Examination of stool specimens for occult blood. (v) Pregnancy tests. (vi) Primary culturing for transmittal to a certified laboratory. This STANDARD is not met as evidenced by. I Based on observation, document review and staff interviews, Critical Access Hospital (CAH) administration failed to ensure 3 of 3 reviewed laboratory staff members (Medical Technologist B, Medical Technologist C and Medical Technologist D), 2 of 2 reviewed registered nurses (RN A and RN E), 1 of 1 Acute Patient Care Manager (Medical/Surgical Emergency), 1 of 1 Advanced Registered Nurse Practitioner (ARNP B), 1 of 1 Physician Assistant (PA A), and 2 of 2 CAH physicians (Physician C Physician D) had color vision proficiency prior to interpreting	C1028 C1028	C1028 LABORATORY SERVICES CFR(s) 485.635(b)(2) Process: Employee Color Blind Testing 1. Upon hire MD, DO, PA, ARNP, Lab technicians, RN, LPN's will receive color blind test upon hire. Pre Placement Post Offer Health Screen Policy has been revised to include color blind testing for applicable employees. 2. By March 26, 2020 MD, DO, PA, ARNP, Lab technicians, RN, LPN's will receive color blind test 3. Will monitor through QI Compliance quarterly. 4. Person Responsible: Chief Nursing Officer	3/26/ 2020

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C1028	Continued From page 7	C1028		

the results of fecal occult blood (blood in stool) tests for all laboratory, nursing and medical staff who read the results of the test. Failure to test all laboratory, nursing and medical staff for color blindness before performing this test may result in staff misreading the results of the fecal occult blood test which could potentially adversely affect the diagnosis and treatment plan for patients. The CAH performed 256 fecal occult blood tests from March 2019 to February 2020.

Findings include:

1. Observation on 03/02/2020 at 11:15 AM, during a tour of the Medical Surgical Unit (Med/Surg) revealed the Med/Surg staff utilized Beckman Coulter Hemoccult slides to check stool for occult blood

2. Observation on 03/02/2020 at 1:20 PM, during a tour of the Laboratory Department (Lab), revealed staff utilized Beckman Coulter Hemoccult slides to check stool for occult blood.

3. During an interview at the time of the laboratory tour, Laboratory Manager reported the staff are not color blind tested upon hire to identify a positive Hemoccult test and to interpret the test would require the ability to identify the color blue.

4. During an interview on 3/3/2020 at 11:05 AM, the Acute Patient Care Manager reported the staff are not color blind tested to interpret a positive Hemoocult test, which would require the ability to identify the color blue

5. Review of manufacturer's recommendations from June 2015 for Beckman Coulter Hemoccult slides revealed, in part: "Because the test is

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C1028	Continued From page 8 visually read and requires color differentiation, it should not be interpreted by individuals with blue color deficiency (blindness)." 6. Review of personnel files revealed the following: a. Medical Technologist B started working at the CAH on 02/27/2017. Medical Technologist B's personnel file lacked documentation the CAH staff tested Medical Technologist B for blue color vision proficiency upon hire or at any time after hire. b. Medical Technologist C started working at the CAH on 11/12/2014. Medical Technologist C's personnel file lacked documentation the CAH staff tested Medical Technologist C for blue color vision proficiency upon hire or at any time after hire. c. Medical Technologist D started working at the CAH on 01/13/2020. Medical Technologist D's personnel file lacked documentation the CAH staff tested Medical Technologist D for blue color vision proficiency upon hire or at any time after hire. d. Registered Nurse (RN) A started working at the CAH on 01/8/2018. RN A's personnel file lacked documentation the CAH staff tested RN A for blue color vision proficiency upon hire or at any time after hire. e. Registered Nurse (RN) E started working at the CAH on 02/01/2016. RN E's personnel file lacked documentation the CAH staff tested RN E for blue color vision proficiency upon hire or at any time after hire.	C1028		

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C1028	Continued From page 9 f. Acute Patient Care Manager (Medical/Surgical Emergency) started working at the CAH on 07/07/2014. Acute Patient Care Manager (Medical/Surgical Emergency)'s personnel file lacked documentation the CAH staff tested Acute Patient Care Manager (Medical/Surgical Emergency) for blue color proficiency upon hire or any time after hire. g. Advanced Registered Nurse Practitioner (ARNP) B started working at the CAH on 10/21/2016. ARNP B's personnel file lacked documentation the CAH staff tested ARNP B for blue color vision proficiency upon hire or at any time after hire. h. Physician Assistant (PA) A started working at the CAH on 12/18/2017. PA A's personnel file lacked documentation the CAH staff tested PA A for blue color vision proficiency upon hire or at any time after hire. i. CAH Physician C started working at the CAH on 10/21/2016. Physician C's personnel file lacked documentation the CAH staff tested Physician's C for blue color vision proficiency upon hire or at any time after hire. j. CAH Physician D started working at the CAH on 01/14/1997. Physician D's personnel file lacked documentation the CAH staff tested Physician's D for blue color vision proficiency upon hire or at any time after hire. 7. During an interview on 03/02/2020 at 12:20 PM, the Chief Nursing Officer (CNO) confirmed CAH staff did not perform color vision proficiency testing on any CAH employees, including the	C1028		

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C1028	Continued From page 10 CAH physicians, Advanced Registered Nurse Practitoner (ARNP), and Physician Assistant (PA) upon hire to interpret the results of fecal blood tests.	C1028		
C1622	SPECIALIZED REHABILITATIVE SERVICES CFR(s): 485.645(d)(6) Specialized Rehabilitative Services (§483.65 of this chapter). " §483.65 (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for a mental disorder and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act (b) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel. This STANDARD is not met as evidenced by: Based document review and staff interviews, the Critical Access Hospital (CAH) administrative staff failed to ensure physicians ordered specialized rehabilitation services for 2 of 5 reviewed closed swing bed patients (Patient #1	C1622	C1622 Specialized Rehabilitative Services Corrective Action CFR(s): 485.645(d)(6) 3/26/ 2020 Process: Skilled Patient Rehabilitation Orders 1. SNF patients needing Rehabilitation Services will be order by physician only. 2. When a PA or ARNP are admitting a skilled patient they will contact MD or DO requesting them to either call a verbal order or enter an order for Rehabilitative services. 3 Rehab Services will only accept SNF patient orders by a physician. 4. Rehab Services will monitor compliance for the above through their Quality Improvement metrics quarterly. Person Responsible: Rehabilitation Services Manager	

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C1622	Continued From page 11 and Patient #3). Failure to ensure a physician ordered specialized rehabilitation services could result in swing bed patients not receiving specialized rehabilitation services appropriate to their medical condition. The CAH administrative staff identified 32 swing bed admissions in fiscal year 2019. Findings included: 1. Review of swing bed policy, "Swing Bed Form: Services Provided," effective 10/2019, revealed in part, " ...Specialized Rehabilitation Services must be provided under the written order of a Physician ...." 2. Review of Patient #1's closed medical record revealed the CAH staff admitted Patient #1 for swing bed level care on 12/24/2019 The CAH staff discharged Patient #1 on 12/29/2019. Physician Assistant (PA) A wrote an order on 12/25/2019 at 11:44 AM for the Physical Therapist to evaluate and treat Patient #1 and for the Occupational Therapist to evaluate and treat Patient #1. 3 Review of Patient #3's closed medical record revealed the CAH staff admitted Patient #3 for swing bed level care on 12/05/2019. The CAH staff discharged Patient #3 on 12/19/2019. Advanced Registered Nurse Practitioner (ARNP) B wrote an order on 12/05/2019 at 01:08 PM for the Physical Therapist to evaluate and treat Patient #3 and for the Occupational Therapist to evaluate and treat Patient #3. ARNP B wrote an order on 12/05/2019 at 03:45 PM for the Speech Therapist to evaluate and treat Patient #3. 4. During an interview on 03/03/2020 at 09:00	C1622		

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C1622	Continued From page 12 AM, the Patient Care Manager Acute Care/Emergency Room confirmed that PA A wrote the therapy orders for Patient #1 and ARNP B wrote the therapy orders for Patient #3 when the patients received swing bed services.	C1622		