Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	531310	05/03/2012
Name of Provider or Supplier	**Street Address, City, State**	
Powell Valley Hospital	777 Avenue H, Powell, WY	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
C0000	The following common abbreviations are used throughout this document. CDC - Centers for Disease Control & Prevention CEO - chief executive officer CNO - chief nursing officer CRNA - certified registered nurse anesthetist PACU - post anesthesia care unit RN - registered nurse Less commonly used abbreviations will be annotated in each deficiency.
C0151	COMPLIANCE WITH FEDERAL LAWS & REGULATIONS CFR(s): 485.608(a) The CAH is in compliance with applicable Federal laws and regulations related to the health and safety of patients. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to indicate whether additional information related to advance directives was offered and accepted or refused for 5 of 5 acute care patients (#2, #7, #8, #10, #22) documented as not having advance directives. The findings were: Review of the medical records for patients #2, #7, #8, #10 and #22 showed all indicated they did not have advance directives. Further review of each clinical record showed no evidence any patient was offered additional information about advance directives. On 5/1/12 at 10:10 AM RN #4 stated additional information would be provided and documented in the financial area of the computerized record system. On 5/3/12 at 9:55 AM RN #5 stated she had checked with financial services and there was no further information available. She further stated the process was the same for all, whether inpatients or outpatients. Review of the "Advance Directive Report" forms for patients #2, #7, #8, #10 and #22 verified there was no additional information related to advance directives. At 9:58 AM that day the medical/surgical director stated there was nothing in the current system to trigger staff to follow up on advance directives.

C0195	AGREEMENTS - CREDENTIALING & QA CFR(s): 485.616(b) Each CAH that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least - (1) one hospital that is a member of the network; (2) one QIO or equivalent entity; or (3) one other appropriate and qualified entity identified in the State rural health care plan. This STANDARD is not met as evidenced by: Based on review of contracts, credentialing files, and staff interview, the facility failed to have a credentialing services agreement with a qualified entity for credentialing any physician, midlevel practitioner, or certified registered nurse anesthetist. The findings were: Review of credential files revealed the credentialing process that resulted in approval for these professionals did not include the services of another qualified entity. Review of provided contracts showed no evidence there was an agreement for credentialing services by another qualified entity. Interview with the CEO on 5/3/12 at 8:30 AM revealed an agreement was in place with the Quality Improvement Organization for quality assurance, but he had not found an agreement with any entity for credentialing. At 10 AM that day, the CEO stated there was no agreement for credentialing services to be provided by an outside agency.
C0271	PATIENT CARE POLICIES CFR(s): 485.635(a)(1) 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 observation, review of policies and procedures and staff interview, the facility failed to ensure surgical services maintained and implemented policies and procedures that were consistent with national standards of care for that service. The findings were: 1. Review of the policy and procedure manual for surgical services revealed many necessary policies and procedures were lacking. These included, but were not limited to, alcohol-based skin preparations, flash sterilization, management of malignant hyperthermia, personnel designated as allowed to administer anesthesia, and "Do Not Resuscitate" orders. 2. In addition, policies and procedures were lacking for tracking pass/fail test results per individual endoscope and tracking individual patient usage of endoscopes. Interview with the interim surgical manager and the central processing technician on 5/2/12 at 10:10 AM revealed the test results were not documented even though the pass/fail tests were run. Furthermore, the manager and technician thought the computer system documented endoscope usage per each individual patient; however, immediate observation of the computer program with them showed either the information was not recorded or they did not know how to access it. 3. Several of the policies in the manual were also inaccurate. Some examples were: a. "Environmental Cleaning of the Surgical Area" reviewed/revised 6 /09: "After each surgical procedure, a safe, clean environment will be reestablished." However, further review showed it was only necessary to clean the floor around the surgical field "when it is visibly soiled." b. "Operating Room Sanitation" reviewed /revised 6/09: "Prior to the first schedule of the day; a) Areas contaminated by organic debris (such as blood) during the procedure will receive immediate attention..." This was contradictory to the statement "Floors will be mopped completely..." at the

	completion of each day's schedule. c. "Temperature and Humidity" reviewed /revised 1/12: "4. Humidity must fall between 20% and 60%. Further review showed the case would be cancelled, rescheduled, or delayed if the humidity was out of range "by greater than 5%." However, the 2010 Guidelines published by the American Society of Healthcare Engineers (ASHE) and American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE), endorsed by the Associate for Professionals in Infection Control & Epidemiology (APIC) establishes 20-60% relative humidity as an acceptable safety standard for operating rooms. 4. Review of information in "2010 Perioperative Standards and Recommended Practices" showed "Policies and procedures for environmental cleaning and disinfection should be written, reviewed annually, and readily available in surgical practice settings." 5. On 5 /2/12 at 9:20 AM the interim surgical manager confirmed the policy and procedure manual was incomplete and inaccurate.
C0278	PATIENT CARE POLICIES CFR(s): 485.635(a)(3)(vi) [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 observation, staff interview, and review of policies and procedures, the manufacturer's instructions, and information from the CDC, the facilty failed to ensure standards of practice were maintained related to infection control practices. This failure involved cleaning and disinfecting all glucometers and lack of proper disinfection of equipment in the clinic, emergency department, and rehabilitation /therapy department. In addition, monitoring of hand hygiene practices in all departments of the facility was not part of the surveillance program. The findings were: 1. According to the facility's policies and procedures "Waived Laboratory Testing" Policy:A.101, last reviewed/revised 5/11, staff were to follow the user manual for the "Accu-chek Blood Glucose Monitoring System." On 5/2/12 during interview at 2:30 PM, the laboratory director confirmed staff followed manufacturer's instructions for cleaning and disinfecting glucometers. Review of those instructions ("Accu-Chek Advantage Owner's Booklet") showed appropriate cleaning solutions were "70% alcohol, Mild dishwashing liquid mixed with water, 10% household bleach solution (1 part bleach in 9 parts water) made the same day." At 9 AM on 5/3/12 the laboratory director stated she had checked and staff used an alcohol pad to clean glucometers. She presented the surveyor with an individual package labeled "Alcohol Prep Pad" and the contents were described as "70% Isopropyl Alcohol." The surveyor called the manufacturer, Roche, on 5/3/12 at 1:30 PM and was informed that they would fax new information on cleaning and disinfecting Accu-Chek glucometers that met the CDC guidelines. Review of that information, dated 10/19/10, showed the CDC had revised their guidelines for "proper cleaning and disinfecting of blood glucose meters" and "this may require changes in your facility policies." Reference: The CDC publication "Guideline for Disinfection and Sterilization in Healthcare Facilities", 2008, does not recommend the use of alcohol to disinfect equipment when blood borne pathogens, such as hepatitis viruses, are a concern. The Association for Professionals in Infection Control & Epidemiology (APIC) recommendations for disinfecting point-of-care devices are published in the American Journal of Infection Control, April 2010. The APIC guideline recommends glucometers be disinfected with a dilute bleach solution or an Environmental Protection Agency (EPA)-registered disinfectant effective against hepatitis and human

	immunodeficiency viruses. Alcohol is not an EPA-registered disinfectant for blood borne pathogens. Both CDC and APIC further recommended that if a point-of-care device, such as a glucometer, cannot be effectively disinfected, then it should not be used to test multiple patients. 2. Observation on 5/1/12 during a tour of the clinic at 2: 15 PM showed staff used "SaniCloth Plus" wipes for disinfecting tables (patient beds) and chairs. Interview with RN #6 at that time revealed she allowed the surface to air dry for "approximately one minute" but had never timed the actual wet contact time of the disinfectant. Further, she was unaware a wet contact time was required. Cleaning of equipment in the emergency department showed "SaniCloth Plus" wipes were used. The ambulance staff used "Virex Tb" to clean their gurney. The unidentified ambulance member cleaning the gurney stated she was unaware of the required wet contact time. Interview with the rehabilitation director and tour of the department on 5 /2/12 at 3:38 PM showed "Virex Tb" was used to disinfect the equipment between patients. The director stated staff did wait, but he was not sure there was always a three minute wet contact time. References: Review of the manufacturer's instructions printed on the label of the container of "SaniCloth Plus" showed: "To disinfect nonfood contact surfaces only: Use a wipe to remove heavy soil. Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipes if needed to assure continuous three (3) minute wet contact time. Let air dry." Review of the label instructions for "Virex Tb" showed a three minute wet contact time was required for disinfecting equipment. 3. During an interview on 5/1/12 at 3:30 PM, the infection control practitioner (ICP) stated hand hygiene was discussed in orientation but was not monitored. He further stated demonstrations of hand hygiene would be added to the yearly competency /education fair, but he acknowledged that he did not currently monitor opportunities for hand hygiene among staff nor the overall compliance rate for hand hygiene at the facility.
C0279	PATIENT CARE POLICIES CFR(s): 485.635(a)(3)(vii) [The policies include the following:] If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of 485.25(i) is met with respect to inpatients receiving posthospital SNF care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to provide a nutritional consult, as ordered, for 1 of 3 sample obstetrical patients (#16). The findings were: According to orders dated 4/18/12 at 7:38 PM, the registered dietitian was to complete a nutritional consult for patient #16. The order was documented as received by the dietitian on 4/19/12 (a Thursday) at 12 PM. Review of the medical record showed no evidence the consult was completed. After reviewing the record on 5 /3/12 at 1:10 PM, RN #3 confirmed a nutritional consult was not provided. She further stated there was a routine order for a nutritional consult for all new mothers, but acknowledged it was not always done, especially if the patient was discharged over the weekend.
C0281	PATIENT SERVICES CFR(s): 485.635(b)(1)

	(1) General. The CAH provides those diagnostic and therapeutic services and supplies that are commonly furnished in a physician's office or at another entry point into the health care delivery system, such as a low intensity hospital outpatient department or emergency department. These CAH services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions. This STANDARD is not met as evidenced by: Based on staff interview and review of the organizational chart, the facility failed to ensure the outpatient services department was accountable to a single individual who knew s/he was responsible for the department and who directed the overall operation of the department. The findings were: During an interview on 5/1/12 at 11:08 AM, the interim CNO, the corporate compliance officer and the director of medical/surgical services all agreed they did not have a single person in charge of and accountable for outpatient services. These services were defined as consisting of physical, occupational, and speech rehabilitation therapy; laboratory and radiology services; cardiopulmonary rehabilitation; emergency services; and outpatient surgical services. On 5/2/12 during an interview at 1:50 PM, the director of rehabilitation services stated he thought the outpatient services were under the direction of the CNO. He further stated that as an interim, the CNO probably did not know she was the director of the services. Review of the organizational chart showed outpatient surgical services were not accountable to the CNO.
C0295	NURSING SERVICES CFR(s): 485.635(d)(1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on staff and resident interview, medical record review, and review of hospital policies and procedures, the hospital failed to ensure all necessary assessments, monitoring, and nursing measures were implemented for effective and consistent pain management for 1 of 21 sample residents (#5) who had pain. In addition, the hospital failed to thoroughly assess intermittent variances between normal and abnormal SPAO2 readings for 1 of 21 sample patients (#6). The findings were: 1. Review of the medical record for patient #5 showed s/he was admitted on 3/30/12 for rehabilitation after an open reduction and internal fixation of a fractured left femur. Review further revealed the resident had diagnoses including diabetes, chronic renal insufficiency, hypertension, and obstructive sleep apnea. Review of the physician's admission orders showed an order for Oxycodone IR 5 milligrams (mg) one to two tablets every four hours as needed for pain. Continued review of physician's orders showed the Oxycodone IR was increased to one to four tablets every four hours as needed on 4 /15/12. The following concerns with pain management were identified: a. Review of the 4/4/12 nursing notes timed at 10:11 PM showed the patient had pain rated between five and six on a pain scale of 0 to 10 with 10 being the worst (5-6/10). Review of the April 2012 MAR showed the resident received Oxycodone IR 5 mg at 9:56 PM. Continued review showed the next time the patient was assessed was five hours later (3:28 AM) at which time s/he still had pain. b. Review of the 4/9/12 nursing notes

timed at 11:43 AM showed the patient was tearful and in pain. The patient was administered Oxycodone IR 5 mg. Further review showed no evidence the patient's pain was re-assessed to determine the effectiveness of the medication in relieving the pain. The next notes were written at 4:55 PM (five hours later) by the PTA (physical therapy aide). Review of these PTA notes revealed the patient's ambulation was limited due to pain in the left lower extremity. c. Review of the nursing notes showed on 4/10/12 at 12:52 AM the patient complained of pain rated 8 /10 and received Oxycodone IR 5 mg. Review of the nursing notes showed the resident's pain was not re-assessed until 7:36 AM (six hours later) to determine the effectiveness of the pain medication administered. In addition, there was no evidence other non-pharmacological interventions were attempted to relieve the patient's pain. d. Review of the physical therapy notes written on 4/14/12 and timed at 8:10 AM showed the patient's pain continued to limit his/her mobility and ambulation. Interview with the patient on 5/1/12 at 9 AM verfied s/he had pain, especially with any mobility or walking. e. Interview with the director of medical /surgical services on 5/3/12 at 2 PM verified the above noted incidents were accurate and that no re-assessment was performed but it should have been. Review of the second page of the hospital's policy on pain, reviewed 4/2011, showed the following instructions: "....The patient's/resident's pain will be re-assessed after every pain control mechanism employed by the patient/resident care providers as per the appropriate care setting procedure. The timing of the re-assessment (patient's/resident's response) will be dependent upon the route of administration. The re-assessment will be ....2 hours for oral and will be documented in the appropriate portion of the medical record." 2. Review of the medical record for patient #6 showed s/he was admitted after a motor vehicle accident on 5/4/11. Review of the discharge summary showed "Patient had been having some decreased pulse oximetry after administration of narcotics and while lying flat falling asleep. This was suspected due to narcotic administration, sleep apnea secondary to obesity, and atelectasis. Review of the physician progress notes written on 5/6/11 at 1: 05 PM showed the patient's SPO2 (oxygen saturation level) dropped when his /her oxygen was removed and the oxygen had to be replaced. Review of the vital sign detail report showed the patient's SPO2 on 5/5/11 at 6:34 AM was 89% with 3 liters of oxygen per nasal cannula. At 6:49 AM the SPO2 was 96% with the 3 liters of oxygen and remained within normal limits (88% or above) until 12:38 PM on 5/6/11 at which point it was 85% on room air. After placing oxygen on at 2 liters the SPO2 rose to 93%. At 8 PM on that same day the SPO2 was 90% on 2 liters of oxygen. On 5 /7/11 at midnight, the patient's SPO2 was 83% with oxygen at 2 liters. The nurse turned the oxygen up to 4 liters at that time which brought the SPO2 level up to 90% within 46 minutes. On 5/7/11 at 7:55 AM the SPO2 was 91% on 4 liters of oxygen. Review of the 5/7/11 nursing notes timed at 1:45 PM showed the patient was placed on room air and his/her SPO2 was maintained in the high 80's . The PA-C documented the "pt is safe for discharge." The patient was discharged on 5/7/11 at 2 PM without oxygen. The following concerns were identified: a. Review of the emergency room (ER) records showed on 5/8/11 at 2:25 PM, the patient was seen in the ER with a history of having SPO2 readings in the 40's. Further review of the ER record showed the patient was pale and short of breath upon arrival and his/her SPO2 was 88%. Further review of the ER records showed the patient required transfer via ambulance to another acute care facility with a final diagnosis of pulmonary contusion secondary to a motor vehicle accident. The patient had a history of intermittent low SPO2 throughout his/her hospital stay and required high liters of oxygen (as high as 10 liters per minutes). Upon discharge the patient had SPO2 readings in the high 80s prior to discharge but was not discharged to home with oxygen. b. Review of the ER record of 5/8/11 showed "....today, when [s/he] came

	back to the hospital to have her dressings changed [s/he] was found to be hypoxic and tachycardic. Patient was brought [to] the emergency room for evaluation." Review of the record showed no evidence the patient was assessed or had an SPO2 reading taken upon arrival at the hospital for the dressing change that day. Interview with the director of medical/surgical services on 5/3/12 at 2 PM revealed she was unable to find any documentation or record of the patient's admission for a dressing change on 5/8/11 but that probably due to the patient's hypoxic state upon arrival staff sent him/her to the ER for immediate evaluation. She further stated, however, there should have been documentation of the assessment of the patient's condition and disposition after arrival for his/her dressing change.
C0298	NURSING SERVICES CFR(s): 485.635(d)(4) A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on staff interview and medical record review, the hospital failed to ensure care plans were comprehensive for 10 of 10 medical/surgical patients (#1, #6, #7, #8, #9, #10, #11, #12, #13, #14). The findings were: Review of the care plans for patients #1, #6, #7, #8, #9, #10, #11, #12, #13 and #14 showed not all problems identified were included, goals were not measureable, interventions were not individualized to meet the specific needs for each patient and discharge planning was not evident. Interview with the director of medical/surgical on 4/30/12 at 6 PM revealed the care plan software program was not working properly and nurses were not remembering to write everything in the care plans and were not updating them. She said the hospital was in the process of changing computer programs and she thought the new program would yield improved care plans. The director further said nurses did not use the care plans to direct or plan care anyway, they used a kardex instead. .
C0302	RECORDS SYSTEMS CFR(s): 485.638(a)(2) The records are legible, complete, accurately documented, readily accessible, and systematically organized. This STANDARD is not met as evidenced by: Based observation, staff interview and medical record review, the hospital failed to ensure the accuracy of the allergy history for 1 of 21 sample patients (#20). The findings were: Review of the medical record for patient #20 showed a bright red allergy sticker was placed on the outside cover. Observation of this sticker showed it was blank; indicating no allergies. However, review of the record on 5/1/12 at 9:48 AM revealed the physician's history and physical noted the patient was allergic to penicillin "causes hives" and "valium turns the patient red." Interview with RN #1 on 5/1/12 at 9:48 AM confirmed the patient had allergies and the cover sticker needed to be changed. Review of the medical record on 5/2/12 at 10:48 AM revealed the allergy sticker on the cover of the medical record had been changed but NKDA (no known drug allergies) was written on it. Interview with RN #2 at that time revealed the sticker was still incorrect.
C0304	RECORDS SYSTEMS

	CFR(s): 485.638(a)(4)(i) For each patient receiving health care services, the CAH maintains a record that includes, as applicable-- identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient; This STANDARD is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure informed consents were properly executed for 2 of 7 sample patients (#16, #20) who underwent procedures that required informed consent. The findings were: 1. Medical record review showed patient #16 signed a consent for epidural anesthesia, but neither the date nor the time of the signature of the patient, the CRNA, or the witness were indicated on the consent form. In addition, the space to write the name of the CRNA performing the procedure was blank. During an interview on 5/3/12 at 12:30 PM RN #3 confirmed the consent was incomplete; she stated the consent should be dated and timed when signed. 2. Review of the medical record for patient #20 showed s/he was admitted on 4/29/12 for acute lower back pain. Further review of the record revealed an "informed consent for medical, surgical and diagnostic procedures" was filled out on 11/26/11 allowing for a "left L4-5 transforaminal epidural injection." However, the informed consent form did not have the required patient's signature. Interview with RN #1 on 5/1/12 at 9:48 AM confirmed the consent form had not been signed by the patient.
C0308	PROTECTION OF RECORD INFORMATION CFR(s): 485.638(b)(1) 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 observation, staff interview, and review of policies and procedures, the facility failed to ensure all outpatient clinical records were secured from access by unauthorized personnel. The findings were: During interview on 5/1/12 at 1:55 PM, the clinic director and the vice president of physician services stated the main clinic area was locked with a separate key. Observation of the clinic at 2:15 PM showed all records were stored in revolving file cabinets that could be individually locked. However, the receptionist stated that she closed the files each evening but did not lock them. She further stated that housekeeping and maintenance had access to the area and that anyone with a key to the clinic could open the file cabinets. According to the facility's policy "Management of Information" last reviewed/revised 5/2011 "4. Patient records are maintained in a secure, confidential environment."
C0320	SURGICAL SERVICES CFR(s): 485.639 If a CAH provides surgical services, surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body, or responsible individual, of the CAH in accordance with the designation requirements under paragraph (a) of this section.

	This CONDITION is not met as evidenced by: Based on observation, medical record review, staff interview, review of policies and procedures, and review of credentialing files, the facility failed to ensure the necessary surgical policies and procedures were developed and implemented (C271), failed to obtain appropriate informed consents (C304), failed to provide evidence of appropriate post-anesthesia evaluations (C322) and failed to designate personnel allowed to administer anesthesia (C323). In addition, the facility failed to indicate which endoscope passed or failed the pass/fail test and to track individual patient usage of endoscopes (C271). The cumulative effect of these deficiencies resulted in a determination that the facility failed to promote a safe surgical environment and, therefore, failed to meet the requirements for the condition of participation for surgical services.
C0322	ANESTHETIC RISK & EVALUATION CFR(s): 485.639(b) (1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed. (2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia. (3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and review of policies and procedures, the facility failed to ensure post-anesthesia evaluations were completed appropriately for 3 of 5 sample patients (#1, #16, #31) undergoing surgical procedures. The findings were: 1. According to the medical record, patient #1 underwent a surgical procedure with general endotracheal anesthesia on 4/30/12. Review of the post-anesthesia evaluation showed it was completed on 4/30/12, but no time was indicated. Further, the CRNA only wrote "[No] anes (anesthesia) probs (problems)." The evaluation failed to address the patient's level of consciousness, respiratory function, cardiovascular function, vital signs, pain, and nausea and vomiting. 2. Review of the medical record showed patient #16 underwent epidural anesthesia on 4/18/12. Review of the post-anesthesia evaluation showed "[No] anes. comp (complications)". The CRNA failed to sign the evaluation or indicate the date and time it was completed. In addition, the evaluation did not include the patient's level of consciousness, respiratory function, cardiovascular function, vital signs, and pain. 3. Review of the anesthesia record for patient #31 revealed s/he received general endotracheal anesthesia for an outpatient surgical procedure on 4/30/12. Further review showed the post-anesthesia evaluation, conducted at some unknown time on 4/30/12, failed to address the patient's level of consciousness, respiratory function, cardiovascular function, vital signs, pain, and nausea and vomiting. Instead, the CRNA had documented "[No] anes probs." 4. Review of the surgical policies and procedures showed post-anesthesia evaluations were not included. During an interview with the interim surgical nurse manager and CRNA #1, the CRNA stated the post-anesthesia evaluation was completed just before the patient was transferred to PACU. He further stated the CRNAs signed all PACU sheets but did not include the date or time of their signature. Review of the PACU sheets for the three patients listed above showed none had been signed by a CRNA.

	Further, signing this sheet would not meet the requirements for completing the post-anesthesia evaluation as the PACU nurse was not a practitioner qualified to administer anesthesia. Additionally, per the Centers for Medicare & Medicaid Services survey and certification letter dated January 14, 2011, the post-anesthesia evaluation "generally should not be performed immediately at the point of movement from the operative area to the designated recovery area. Rather, accepted standards of anesthesia care indicate that the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc." There was no evidence the aforementioned patients could participate in the evaluation.
C0323	ADMINISTRATION OF ANESTHESIA CFR(s): 485.639(c)(1) The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and procedures and with State scope of practice laws. Anesthesia must be administered by only - (i) a qualified anesthesiologist; (ii) a doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (iii) a doctor of dental surgery or dental medicine; (iv) a doctor of podiatric medicine; (v) a certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter; (vi) an anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or (vii) a supervised trainee in an approved educational program, as described in 413.85 or 413.86 of this chapter. This STANDARD is not met as evidenced by: Based on staff interview, review of credentialing privileges for 4 physicians and 1 physician's assistant, and review of policies and procedures, the facility failed to develop policies and procedures that specified the physicians or physician assistants who could administer anesthesia, thus failing to meet the regulatory criteria for conducting post-anesthesia evaluations. This failure had the potential to affect any surgical patient whose post-anesthesia evaluation was conducted by a physician or physician's assistant. The findings were: During an interview with the interim nurse manager and CRNA #1 on 5/1/12 at 2:35 PM, the CRNA stated outpatients sometimes left the facility before a post-anesthesia evaluation could be performed. He further stated he was aware that a physician could perform the evaluation. However, he did not think there were policies and procedures specifying which physicians could administer anesthesia. Review of the credentialing files for physicians #1, #2, #3, #4, and physician assistant #1 verified they were not credentialed to provide anesthesia. Review of surgical policies and procedures confirmed the lack of those policies.
C0369	MAIL CFR(s): 485.645(d)(1) [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter:] Resident rights - mail (483.10(i)): "The resident has the right to privacy in written communications, including the right to- (1) Send and promptly receive mail that is unopened; and (2) Have access to stationery, postage, and writing implements at the resident's own expense."

	This STANDARD is not met as evidenced by: Based on resident and staff interview, the hospital failed to ensure mail was delivered on Saturdays to 4 of 4 swing-bed patients. The findings were: Interview with patient #5 on 5/1/12 at 9 AM revealed s/he had not received mail on Saturday while in the hospital as a swing bed patient. Interview with the compliance officer on 5/3/12 at 3 PM revealed mail was picked up by a staff member on Saturdays so residents in the attached care center received their mail. She further said, however, the staff member who delivered the mail to the care center did not deliver to the hospital which was where the swing-bed patients/residents resided.
C0395	COMPREHENSIVE CARE PLANS CFR(s): 485.645(d)(6) [The CAH is substantially in compliance with the following SNF requirements contained in subpart B of part 483 of this chapter: Comprehensive assessment, comprehensive care plan, and discharge planning (483.20(b), (k), and (l), except that the CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under 483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in 413.343(b)).] Comprehensive care plans (483.20(k)(1)) "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following- (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.25; and (ii) Any services that would otherwise be required under 483.25 but are not provided due to the resident's exercise of rights under 483. 10, including the right to refuse treatment under 483.10(b)(4)." This STANDARD is not met as evidenced by: Based on staff interview and medical record review, the hospital failed to ensure care plans were comprehensive for 5 of 5 swing-bed patients (#4, #5, #15, #20, #21). The findings were: Review of the care plans for swing-bed patients #4, #5, #15, #20 and #21 showed not all problems identified were included, goals were not measureable, and interventions were not individualized to meet the specific needs for each patient. Interview with the director of medical/surgical services on 4/30/12 at 6 PM revealed the care plan software program was not working properly and nurses were not remembering to write everything in the care plans and were not keeping them updated. She said the hospital was in the process of changing computer programs and she thought the new program would yield improved care plans. The director further said nurses did not use the care plans to direct or plan care anyway, they used a kardex instead.
K0000	This STANDARD is not met as evidenced by: The regulatory reference is 42CFR 485.623(b) except where a different regulation may be specifically referenced. K3: Building Type II (111) partially sprinkled single story Critical Access Hospital built in 1985. The facility is protected by a supervised automatic wet sprinkler system and an addressable fire alarm system. The facility is adjacent to the Powell Valley Care Center Nursing Home. K7: The facility must meet

	the applicable provisions of the 2000 edition of the Life Safety Code, New and Existing Health Care, of the National Fire Protection Association (NFPA). K8: Total beds=25. K9: The facility meets the Life Safety Code standard based on acceptance of a plan of correction. "NFPA" National Fire Protection Association
K0029	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101 One hour fire rated construction (with hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in 1 of 6 smoke compartments. The findings were: Observation on 5/1/12 at 12:30 PM revealed the door to the human resources storage room did not have a self closure device attached. The storage area contained over 20 boxes of paper and was greater than 50 square feet measuring 7ft x 8ft. In addition, observation on 5/1/12 at 12:48 pm revealed the door to the janitor's closet (room 128) and the door to the janitor's closet opposite the human resources office did not have a self closure devices attached. Maintenance staff acknowledged the finding at the time of the observations. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.2, 8.2.4.3.5
K0056	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure sprinkler heads in 2 of 6 smoke compartments were installed as required. The findings were: Observation on 5/1/12 between 11 AM and 3:30 PM revealed the following concerns: a. The laboratory electric room #120 did not have sprinkler coverage. The room was greater than 50 square feet and had a heat detector installed in the ceiling. b. The telephone equipment room in the basement did not have sprinkler coverage. The room was greater than 50 square feet and had a smoke detector installed in the ceiling. Interview with the maintenance staff at the time of the observations confirmed the findings. Reference: NFPA 101, Life Safety Code, 2000 edition. Sections 9.7.1.1; 19.3.5.1; 1999 NFPA 5-6.5.3.
K0062	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101

	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure the fire suppression (sprinkler) system was properly maintained in 2 of 6 smoke compartments. The findings were: Observation on 5/1/12 at 2:48 PM revealed a gap greater than one-half inch existed between the sprinkler head escutcheons and the ceiling in the mail room, in the soiled utility room in the surgical suite and in the purchasing supply room in the basement. In addition, a storage shelf in the housekeeping storage room by the mens' locker room had supplies stored less than 8 inches from the sprinkler head. Interview with maintenance staff at the time of the observation confirmed the findings. Ref: 2000 NFPA 101 Section 19.3.5.1 (existing). Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. 9.7.5 All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested and maintained in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of the Water-Based Fire Protection systems, 1992 edition.
K0064	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101 Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based upon observation and staff interview the facility failed to maintain 1 portable fire extinguisher in 1 of 6 smoke compartments as required. The findings were: Observation on 5/1/12 at 11:48 AM revealed an AC water mist type of fire extinguisher attached to the wall in the cardiac therapy room (old education section). The top of the fire extinguisher was approximately six feet from the floor exceeding the maximal 5 ft requirement for extinguishers weighing less than 40 pounds. The fire extinguisher weighed 21 lbs. Interview with maintenance staff at the time of the observation confirmed the above findings. Reference: NFPA 101, Life Safety Code, 2000 edition. Sections 19.3.5.6 Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for the Installation of Portable Fire Extinguishers, 1990 ed. 1-6.9. Extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of the extinguisher is not more than 5 ft above the floor. Extinguishers having a gross weight greater than 40 lb shall be installed so installed that the top of the extinguisher is not more than 3.5 ft above the floor. In no case shall the clearance between the bottom of the extinguisher and the floor be less than 4 in.
K0076	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101

	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure medical gas cylinders were securely fastened in 1 of 6 smoke compartments. The findings were: Observation on 5/1/12 at 1:23 PM showed two unsecured "E" sized oxygen tanks lying horizontally on the floor in the medical/surgical Pixus room. Interview with maintenance staff at the time of the observation confirmed the tanks needed to be secured. Reference: NFPA 101, Life Safety Code, 2000 edition. Section 19.3.2.4 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99 Standard for Health Care Facilities, Chapters 4 and 8. Stand Alone Cylinders and Containers Storage areas: General Considerations. Cylinders must be secured from falling or mechanical shock.
K0147	LIFE SAFETY CODE STANDARD CFR(s): NFPA 101 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure compliance with the National Electric Code in 1 of 6 smoke compartments. The findings were: Observation on 5/1/12 at 10:30 AM revealed a desk in the medical records section had an electrical cover plate that had come away from the wall. The electrical cord was still plugged into the outlet. In addition, a light switch cover plate in the soiled utility room was chipped. Interview with maintenance staff at the time of the observations confirmed the above findings. Reference: NFPA 70, National Electrical Code, 1999 Edition.