

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
701 Fifth Avenue, Suite 1600
Seattle, WA 98104



IMPORTANT NOTICE – PLEASE READ CAREFULLY

**THIS SERVES AS OFFICIAL NOTICE SENT VIA FACSIMILE PURSUANT TO 42 CFR §488.
NO HARD COPY TO FOLLOW.**

October 26, 2015

Mike Pinello, Administrator
St Luke's Magic Valley RMC
801 Pole Line Road West
Twin Falls, ID 83301

CMS Certification Number: 13-0002

**Re: Notice of Enforcement Action
Complaint survey completed on October 6, 2015
Condition of Participation Not Met
90-day termination track
Removed Deemed Status**

Dear Mr. Pinello:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that St Luke's Magic Valley RMC no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. The hospital is now placed on a **90-day termination track** based on the completion date of the survey. This letter serves as notification that effective **January 4, 2016**, the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with St Luke's Magic Valley RMC. Also, your deemed status with the Joint Commission (JC) is removed and you are placed under the State's jurisdiction. Your deemed status will be restored when you get back in substantial compliance with Medicare regulatory requirements.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a hospital is found to be out of compliance with the Medicare Condition of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a hospital's Medicare provider agreement if the hospital no longer meets the regulatory requirements for a hospital. 42 CFR § 489.53 authorizes the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider no longer meets the Condition of Participation.

On October 6, 2015, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility. The survey found that the following Medicare Condition of Participation (CoP) were not met:

42 CFR § 482.13	Patient Rights
42 CFR § 482.23	Nursing Services
42 CFR § 482.25	Pharmaceutical Services

These deficiencies limit the capacity of St Luke's Magic Valley RMC to furnish services of an adequate level and quality. The details of the above deficiencies are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS 2567).

II. PUBLIC NOTICE OF TERMINATION AND OPPORTUNITY TO CORRECT

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper 15 days before the termination date.

St Luke's Magic Valley RMC can avoid the 90-day termination action by correcting the deficiencies prior to the effective date of the termination. CMS must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the deficiencies have been corrected. **Complete your plan of correction in the space provided on the CMS-2567 within the next 10 calendar days.** An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

- Plan of Correction for each specific deficiency cited.
- Procedure/process for implementing the acceptable plan of correction for each deficiency cited.
- Monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements.
- Address process improvement and demonstrate how the hospital has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice.
- A completion date for correction of each deficiency cited.
- The plan must include the individual responsible for implementing the acceptable plan of correction with signature and title.

Please send your plan of correction to the State survey agency and to CMS:

CMS – Division of Survey and Certification
Attention: Aileen Renolayan
EFax: (443) 380-7328
Email: aileen.renolayan@cms.hhs.gov

III. APPEAL RIGHTS

If you disagree with the Centers for Medicare and Medicaid Services' determination, you or your legal representative may request a hearing before an Administrative Law Judge of the Department of Health and Human Services, Departmental Appeals Board (DAB).

The regulations governing this process are set out in 42 CFR § 498.40 et seq. You will find the DAB's e-filing procedures on the internet at the following URL:

<http://www.hhs.gov/dab/divisions/civil/procedures/filing-and-service.html>

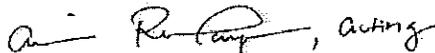
A request for a hearing should identify the specific issues, and the findings of fact, and conclusions of law with which you disagree. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense. **A hearing request must be filed not later than 60 days after the date you receive this letter.**

If you have no internet access and would prefer to file your appeal in writing, please contact the DAB office below:

Chief, Civil Remedies Division Departmental Appeals Board MS 6132 Cohen Building, Room 637-D 330 Independence Avenue, SW Washington, D.C. 20201	Please also send a copy to:	Chief Counsel, DHHS Office of General Counsel 701 Fifth Avenue, Suite 1620 M/S RX-10 Seattle, WA 98121-2500
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If you have any questions, please contact Aileen Renolayan of my staff at (206) 615-2041 or by email at aileen.renolayan@cms.hhs.gov.

Sincerely,



Patrick Thrift, Branch Manager
Division of Survey and Certification, Seattle

Enclosure: CMS 2567 Summary of Deficiencies

cc: Idaho Bureau of Facility Standards
Office of General Counsel, DHHS
The Joint Commission

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/08/2015
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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301
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(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
A 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey of your hospital from 9/30/15 through 10/08/15. The Conditions of Participation for Patient Rights, Nursing Services, Pharmacy Services, and Quality Assessment Performance Improvement were reviewed.</p> <p>Surveyors conducting the investigation were</p> <p>Teresa Hamblin, RN, MS, HFS, Team Lead Gary Guiles, RN, HFS Susan Costa, RN, HFS Dennis Kelly, RN-BC, CHPN, HFS</p> <p>Acronyms used in this report include.</p> <p>COPD - Chronic Obstructive Pulmonary Disease CPR - Cardiopulmonary Resuscitation Dr. - Doctor ED - Emergency Department EMAR - Electronic Medication Administration Record ER - Emergency Room HR - Human Resources HRS - Hours IV - Intravenous kg - kilogram LIP - Licensed Independent Practitioner LMS - Learning Management System MD - Medical Doctor mg - milligram ml - milliliter MQPS - Manager of Quality and Patient Safety NICU - Neonatal Intensive Care Unit Pt. - Patient Q - every</p>	A 000	<p>Please see attached corrective action plans.</p> <p style="text-align: center;">RECEIVED NOV 10 2015 FACILITY STANDARDS</p>	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mike Fenello* TITLE: *— Mike Fenello, MVRMC Administrator* (X6) DATE: *11/9/15*

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 60 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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PRINTED: 10/26/2015
FORM APPROVED
OMB NO. 0938-0391

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A 000	Continued From page 1 QAPI - Quality Assessment Performance Improvement RN - Registered Nurse SVT - Supraventricular Tachycardia TFPD - Twin Falls Police Department	A 000	Please see attached corrective action plans.	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by Based on staff interview, observation, and review of medical records, QAPI documents, pharmacy documents, hospital policies, meeting minutes, and nursing and medical staff educational material, it was determined the hospital failed to ensure patients' rights were protected and promoted. This resulted in a violation of each patient's right to 1) receive care in a safe setting, 2) be protected from abuse and intimidation, and 3) safe and appropriate initiation of restraints by qualified staff, only necessary to protect the patient or others from harm. Findings include 1. Refer to A-0144 as it relates to the failure of the hospital to ensure processes were established to ensure care was provided to patients in a safe setting. 2. Refer to A-0145 as it relates to failure of the hospital to ensure patients were protected from intimidation or abuse from staff. 3. Refer to A-0166 as it relates to the failure of the hospital to ensure a nursing care plan for restraints was updated. 4. Refer to A-0168 as it relates to the failure of	A 115		

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A 115	<p>Continued From page 2</p> <p>the hospital to ensure restraints were implemented in accordance with current, clear, and complete orders of physicians or other LIPs who were authorized to order restraints.</p> <p>5. Refer to A-0171 as it relates to the failure of the hospital to ensure orders for restraints used to manage violent or self-destructive behavior were renewed in accordance with hospital policy.</p> <p>6. Refer to A-0174 as it relates to the failure of the hospital to ensure restraints were discontinued at the earliest possible time.</p> <p>7. Refer to A-0176 as it relates to the failure of the hospital to ensure LIPs authorized to order restraints had a working knowledge of the hospital's restraint policy.</p> <p>8. Refer to A-0178 as it relates to the failure of the hospital to ensure a face-to-face meeting by an LIP was conducted within 1 hour of the application of restraints used to manage violent or self-destructive behavior.</p> <p>9. Refer to A-0184 as it relates to the failure of the hospital to ensure medical records included documentation of a face-to-face evaluation by qualified individuals within one hour of application of restraints used to manage violent or self-destructive behavior.</p> <p>10. Refer to A-0186 as it relates to the failure of the hospital to ensure medical records included documentation of a patient's response to restraints used and/or the rationale for continued use of restraints.</p> <p>11. Refer to A-0194 as it relates to the failure of</p>	A 115	Please see attached corrective action plans.	
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A 115	Continued From page 3 the hospital to ensure ED staff had education, training, and demonstrated knowledge to manage violent or aggressive patients in an ED setting. 12. Refer to A-0405 as it relates to the failure of the hospital to ensure nursing services provided safe administration of medications. 13. Refer to A-0490 as it relates to the failure of hospital to ensure pharmaceutical services provided safe medication delivery. The cumulative effects of these negative systemic practices seriously impeded the ability of the hospital to provide services of sufficient scope and quality.	A 115	Please see attached corrective action plans.	
A 144	482.13(c)(2) PATIENT RIGHTS CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by. Based on review of medical records, QAPI and pharmacy documentation, observation, review of nursing and medical staff educational material, and staff interview, it was determined the hospital failed to ensure processes were established to ensure care in a safe setting as they related to protection from abuse, use of spit masks and restraints, and safe medication administration. Unsafe practices affected 20 of 28 patients (#6, #7, #8, #9, #10, #11, #14, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27, and #28) whose medical records and/or incident reports were reviewed. These systemic negative practices resulted in unsafe patient care practices which resulted in the death of one patient, and	A 144		

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A 144	<p>Continued From page 4</p> <p>compromised the safety of all patients receiving services at the hospital. Findings include:</p> <p>1. In the following examples, spit masks/surgical masks were applied without a corresponding policy that addressed safe use of spit masks.</p> <p>a. Patient #11 was a 27 year old female who arrived with a police escort to the ED on 7/09/15 at 11.15 AM. She had threatened suicide and had a laceration to her wrist. She was diagnosed with severe depression, anxiety, and suicidal ideation. She was admitted to the medical floor around 6 30 PM on 7/09/15.</p> <p>An incident report that stated "Date Received, 7/09/15," contained an account of a restraint event by a security officer on the scene. The account stated Patient #11 became aggressive and was restrained by police and staff. The report stated after being handcuffed, the police officer "...and I helped [Patient #11] to her feet then to bed. Patient #11 continued to be verbally and physically aggressive towards staff. She was cursing at us and being demanding. A surgical mask was put on her face so she could not spit at staff. Her legs were put into leather restraints because she tried to kick staff. Her hands were uncuffed and recuffed to the bed."</p> <p>The use of a surgical mask as a spit mask was not approved for restraint use as the mask could not be removed by the patient who was otherwise restrained. Staff could not observe the patient's mouth for appropriate breathing and the mask created a risk of aspiration should the patient vomit.</p> <p>The Director of the Center for Learning and</p>	A 144	Please see attached corrective action plans.		

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A 144	<p>Continued From page 5</p> <p>Development was interviewed on 10/06/15 beginning at 9.00 AM. She stated the hospital's restraint policy did not address the use of spit masks. She stated it was the practice of the ED to use surgical masks as spit masks if needed.</p> <p>b. Patient #9 was a 62 year old male who arrived by ambulance to the ED on 9/05/15. He was described in a physician's note, dated 9/05/15 at 9.46 PM, as "combative, aggressive, and spitting behaviors" upon arrival to the ED. He was placed in 4 point restraints for violent self-destructive behavior 9/05/15 at 3.15 PM.</p> <p>A physician's note, dated 9/05/15, summarized the ED course of care. It stated "We put a mask over his head so he would spit into the mask and not over people. Paramedics had used a mask also but he had a better mask that fit over the whole head."</p> <p>A nursing note, dated 9/05/15 at 4.34 PM, included the following documentation. "Pt is cooperative, continues to spit to clear his mouth. Pt. denies that he is attempting to spit on staff, was cooperative with using tissues and waiting to spit into tissues. Mask was placed back over pt's face as he is still restrained and unable to use tissues on his own, continues to feel need to spit to clear his mouth."</p> <p>A policy was requested for use of a spit mask to determine what safety precautions had been established while using a spit mask, such as when to avoid or discontinue use (e.g. when patient is bleeding from the mouth, vomiting, or respiratory distress is observed). No policy was provided.</p>	A 144	Please see attached corrective action plans.	

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A 144	Continued From page 6 The manufacturer's instructions for use of a spit mask were requested. None were provided. RN M, an RN Educator, reviewed Patient #9's record during an interview on 10/01/15 at 3 55 PM. She confirmed the use of a spit mask. The hospital failed to develop policy or guidelines for safe use of a spit mask. 2. Refer to A-0145 as it relates to failure of the hospital to ensure patients were protected from intimidation or abuse from staff. 3. Refer to restraint tag deficiencies (A-0168, A-0171, A-0174, A-0176, A-0178, A-0184, A-0188, and A-0194) as they relate to the failure of the hospital to ensure restraint guidelines were followed to ensure safe use of restraints. 4. Refer to A-0286 as it relates to a failure of the hospital to analyze and/or take preventive actions on medication errors that were identified. 5. Refer to A-0398 as it relates to a failure of the hospital to ensure nursing services provided adequate supervision and evaluation of the clinical activities of non-employee nursing personnel. 6. Refer to A-0405 as it relates to the failure of the hospital to ensure nursing services provided safe administration of medications. 7. Refer to A-0490 as it relates to the failure of hospital to ensure pharmaceutical services provided safe medication delivery.	A 144	Please see attached corrective action plans.		
A 145	482.13(c)(3) PATIENT RIGHTS FREE FROM	A 145			

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A 145	<p>Continued From page 7 ABUSE/HARASSMENT</p> <p>The patient has the right to be free from all forms of abuse or harassment.</p> <p>This STANDARD is not met as evidenced by Based on staff interview and review of medical records, hospital policy, and incident reports, it was determined the hospital failed to ensure 1 of 6 patients (#11), who were restrained and whose records were reviewed, were protected from abuse. The failure to protect patients interfered with the ability of the hospital to ensure patients were not subjected to abuse. Findings include</p> <p>The hospital's abuse policy "SUSPECTED OR IDENTIFIED ABUSE, EXPLOITATION OR NEGLIGENCE OF AN ADULT," dated 7/10/12, was reviewed. The policy defined abuse as "The intentional or negligent infliction of physical pain, injury or mental injury. [Idaho Code 39-5302(1)."</p> <p>In the example that follows, the hospital failed to ensure nursing staff was appropriately trained to handle an aggressive patient in a way that did not result in increased physical pain and intimidation.</p> <p>Patient #11 was a 27 year old female who arrived with a police escort to the ED on 7/09/15 at 11 15 AM. She had threatened suicide and had a laceration to her wrist. She was diagnosed with severe depression, anxiety, and suicidal ideation. She was admitted to the medical floor around 6 30 PM on 7/09/15.</p> <p>The first Nursing Note, dated 7/09/15 at 11.15 AM, stated Patient #11 was belligerent, refused to go to her assigned ED room, refused to sit on a stretcher, and refused to change into paper</p>	A 145	Please see attached corrective action plans.	

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A 145	Continued From page 8 scrubs. A Nursing Note, on 7/09/15 at 11.25 AM, stated Patient #11 was being held by security personnel and police to assist with changing into paper scrubs. The note also stated Patient #11 attempted to leave the ED. The note stated police "...and security hands on to floor, [sic] pt lifted head off floor and then slammed it down, left forehead. No bruising or contusions noted." A Nursing Note, dated 7/09/15 at 11.30 AM, stated Patient #11 was placed in hard lower extremity restraints and soft upper extremity restraints. A Nursing Note, dated 7/09/15 at 11.35 AM, stated Patient #11 was given an intramuscular injection of Zyprexa, an antipsychotic medication with sedative effects. A Nursing Note, dated 7/09/15 at 11.40 AM, stated Patient #11 was in leather restraints and the physician was suturing her wrist. A Nursing Note, dated 7/09/15 at 11.50 AM, the RN stated, while she was setting up to suture Patient #11's arm, she grabbed the nurse's..."hand, yanked and squeezed it. I took her [left] 5th and 6th fingers [sic] and bent them back really hard. I told her that it was a felony to commit battery on a nurse and that she would not win. (TFPD and our security x2) were also in the room. She relaxed and I released her fingers. PI has been compliant ever since because she does not want to go to jail and or the Zyprexa is working." An incident report that stated "Date Received	A 145	Please see attached corrective action plans.		

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A 145	Continued From page 9 7/09/15," contained an account of the event by a security officer on the scene. The account stated Patient #11 "...was compliant until she changed her mind and became angry and refused to follow the staff's instructions. The (RN) asked her to change into the paper scrubs but she refused. She tried to go out the east badge swipe double doors which were locked. She threw the scrubs on the floor and was verbally abusive towards staff. (RN C) gave her a choice to change into the paper scrubs on her own or she would be helped into them. (Patient #11) continued to refuse and be defiant. (The police officer) told (Patient #11) that he was going to handcuff her. He took hold of her left arm and I took hold of her right arm. She was told that now her clothes would be cut off her. She began to scream that she did not want her clothes cut off. She tried to pull away from me and the officer. (Another security officer) took hold of her head with both hands because she tried to bite me and the officer. We took her to the ground to control her. (The other security officer and the police officer) handcuffed her hand behind back while I controlled her legs. After she was handcuffed (the police officer) and I helped (Patient #11) to her feet then to bed. (Patient #11) continued to be verbally and physically aggressive towards staff. She was cursing at us and being demanding. A surgical mask was put on her face so she could not spit at staff. Her legs were put into leather restraints because she tried to kick staff. Her hands were un-cuffed and re-cuffed to the bed. She continued to be aggressive and tried to grab our hands during the transition. She continued to be verbally and physically aggressive until (the RN) told her that she had two choices. She could go to (the hospital's psychiatric unit) or go to jail. (Patient #11) calmed	A 145	Please see attached corrective action plans.	

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A 145	<p>Continued From page 10</p> <p>down and apologized for her behavior. [Patient #11] had calmed down enough so her right arm was put into a leather restraint and attached to the top of her bed. Her left arm was put in a soft restraint and was put down by her side so the doctor could stitch up the cut. She was given a shot of medication which made her sleep."</p> <p>The incident report stated the incident was reviewed by the Security Team Lead on 7/20/15 and the Director of the ED on 8/26/15, 1 month and 16 days after the event. Under "Disposition," both persons documented "Review Complete." The incident report did not state what steps were taken to investigate the events. It did not determine whether staff acted appropriately or not.</p> <p>RN C, the RN who cared for Patient #11 in the ED, was interviewed on 10/02/15 beginning at 11:35 PM. RN C stated it was hospital policy to have mental health patients change into paper scrub garments. She stated the policy required she have Patient #11 change into scrubs immediately and she, RN C, could not allow the patient to wait until she calmed down. RN C stated if mental health patients refused to wear scrubs their clothes would be cut off and scrubs would be placed.</p> <p>RN C stated Patient #11 was handcuffed. RN C stated while she was preparing Patient #11 for suturing, the patient grabbed her hands and tried to yank and squeeze them. RN C stated she grabbed Patient #11's fingers and bent the last 3 fingers back so the patient would let go. RN C stated she told Patient #11 that grabbing an RN was a federal offense and the patient could go to jail. RN C stated she told Patient #11 that the</p>	A 145	Please see attached corrective action plans.	
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A 145	<p>Continued From page 11</p> <p>patient had 2 choices, to cooperate and be allowed to go to the hospital's psychiatric unit or to go to jail.</p> <p>RN C stated she had not received training for how to escape if a patient grabbed her or assaulted her. She said she thought such training would be very useful.</p> <p>The security officer who wrote the incident report was interviewed on 10/02/15 beginning at 10 40 AM. He stated Patient #11 was compliant until the RN told her to change into the paper scrubs and then the patient became aggressive. He stated he did not witness the nurse bending Patient #11's fingers.</p> <p>The Director of the ED was interviewed on 10/02/15 beginning at 1 05 PM. He confirmed he had reviewed the incident report. He stated he thought he had reviewed Patient #11's medical record as part of an investigation but was not sure. He stated he did not recall having any thoughts or recommendations regarding the care of Patient #11. He stated the Nursing Notes about bending Patient #11's fingers back and threatening her with jail if she did not cooperate could cause concern if taken out of context. He stated there was a fine line between the nurse protecting herself and abuse.</p> <p>The Director of the ED stated currently, nursing staff had no training on protecting themselves from assaultive patients. He stated he had asked for such training but it had not been implemented yet. He also stated the hospital had not adopted a behavior management system that staff could consistently use when interacting with aggressive patients.</p>	A 145	Please see attached corrective action plans.	

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A 145	Continued From page 12 The hospital failed to protect patients from abuse. Patient #11's medical record documented abusive and intimidating practices by nursing staff who were poorly trained. Witness accounts implied Patient #11 became aggressive when staff forced her into removing her clothing and putting on paper scrubs instead of negotiating with her and allowing her to calm down. The medical record indicated the RN bent Patient #11's fingers back in a way that was meant to inflict pain instead of simply to escape. The medical record and interviews indicated the nurse used threats of cutting her clothes off and jail to intimidate Patient #11 to comply with staff demands. Following the events, staff failed to conduct a thorough investigation in order to determine if abuse had occurred.	A 145	Please see attached corrective action plans.		
A 166	482.13(e)(4)(i) PATIENT RIGHTS, RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by. Based on staff interview and review of medical records and hospital policy, it was determined the nursing plan of care for restraints was not updated and did not accurately reflect the use of restraints for 1 of 2 inpatients (#11) whose restraint documentation was reviewed. This resulted in a lack of clarity as to the plan of care for restraint use and when the restraints were discontinued. Findings include. The hospital's "Restraint" policy, dated 8/13/13,	A 166			

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A 166	<p>Continued From page 13</p> <p>was reviewed. The policy included, but was not limited to the following information:</p> <ul style="list-style-type: none"> - "The patient's plan of care will be updated to reflect the use of restraints." - "Update the plan of care when restraints are discontinued and note the time restraints were discontinued." <p>Patient #11's plan of care did not accurately reflect the use of restraints, as follows:</p> <p>Patient #11 was a 27 year old female who was diabetic. She was admitted to the medical floor of the hospital on 7/09/15 after cutting her wrist in a suicidal gesture. There was documentation Patient #11 was physically restrained on the medical floor from 7/09/15 at 6.49 PM until 7/11/15 at 8.54 PM. She was discharged from the hospital on 7/13/15.</p> <p>The nursing care plan, dated 7/10/15, addressed restraint use as "RESTRAINTS AS NEEDED. MONITOR Q2 HRS" The care plan was not updated to reflect the restraints being discontinued on 7/11/15. The care plan incorrectly gave the impression that restraints could be used on an as-needed basis. Physician orders for restraints were written on a continuous, rather than PRN basis, and included the following orders:</p> <ul style="list-style-type: none"> - 7/09/15 at 6.42 PM. Wrist and ankle restraints for violent/self-destructive behavior for a maximum of 4 hours - 7/09/15 at 8.55 PM. Wrist and ankle restraints for non-violent/non-self-destructive behavior for 	A 166	Please see attached corrective action plans.		

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A 166	Continued From page 14 24 hours. - 7/10/15 at 10.35 AM. Alternate bilateral upper extremity for non-violent/non self-destructive behavior for 24 hours. RN J, who worked on the medical unit, was interviewed on 10/01/15 beginning at 2 55 PM. She stated "restraints as needed means get an order as needed." The Director of Center for Learning & Development and the Regional Director of Accreditation were interviewed together by telephone on 10/06/15 beginning at 9 00 AM. They stated the care plan was "worded poorly " She confirmed the care plan did not reflect discontinuation of restraints.	A 166	Please see attached corrective action plans.		
A 168	482.13(e)(5) PATIENT RIGHTS, RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by. Based on medical record review, policy review, and staff interview, it was determined the use of restraints was not implemented in accordance with current, clear, and complete orders of physicians or other LIPs for 6 of 6 patients who were restrained (#8, #9, #10, #11, #12 and #28) and whose medical records were reviewed. This resulted in missing or incomplete orders and	A 168			

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A 168	<p>Continued From page 15</p> <p>restraint use that was not consistent with the orders of a physician or other LIP. This had the potential to result in unsafe care of restrained patients. Findings include.</p> <p>The hospital's "Restraint" policy, dated 8/13/13, was reviewed. The policy included, but was not limited to, the following information</p> <ul style="list-style-type: none"> - "A physician order must be obtained as soon as possible upon initiation of restraints." - "A complete restraint order must include <ol style="list-style-type: none"> 1. Type of restraint. 2. Clinical justification for the restraints. 3. Order duration. 4. Signature, date, and time." - "All restraints are applied and continued pursuant to an order by the LIP who is responsible for the patient's ongoing care." - If an LIP is not available to issue such an order, an RN may initiate the use of restraints based on an assessment of the patient and patient's behavior. In that case, the LIP managing the patient's care is notified within minutes of the initiation of restraint, and a telephone or written order is obtained from the LIP and entered into the patient's medical record. <p>Restraint orders were incomplete or missing as follows</p> <ol style="list-style-type: none"> 1. Patient #11 was a 27 year old diabetic female who arrived at the ED with police escort on 7/09/15 at 11 14 AM after a suicidal gesture resulting in a laceration to her wrist. She was subsequently placed on a physician's protective 	A 168	Please see attached corrective action plans.	

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A 168	<p>Continued From page 16 hold and admitted to the medical floor.</p> <p>a. Patient #11's medical record included documentation of a physician's order in the ED, dated 7/09/15 at 11 54 AM. It stated "Violent/Self-Destructive Behavior Hard restraints Soft restraints Duration = 1 hr - violent behavior Aggressive/violent behavior Place patient on an involuntary mental health hold"</p> <p>The order did not specify the number of limbs to be restrained or which limbs would be restrained with hard restraints and which limbs would be restrained with soft restraints. This resulted in nursing staff making decisions about the use of restraints independent of a specific order. This was confirmed by RN M, an RN Educator, during interview on 10/01/15 at 2.55 PM.</p> <p>Restraint orders originating in the ED for Patient #11 were incomplete.</p> <p>b. Patient #11's medical record included documentation of a physician's verbal order on the inpatient medical unit, dated 7/09/15 at 6 42 PM, authenticated at 7/09/15 at 9 00 PM. The order specified wrist and ankle restraints for "violent/self-destructive behavior jeopardizes the safety of self and/or others."</p> <p>The order did not clarify number of limbs to be restrained or whether hard or soft restraints should be used. This resulted in nursing staff making decisions about the use of restraints independent of a specific order. This was confirmed by RN #13 during interview on 10/01/15 beginning at 2 55 PM.</p> <p>Restraint orders on a medical floor for Patient #11</p>	A 168	Please see attached corrective action plans.	
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A 168	Continued From page 17 were incomplete. c. Nursing notes included documentation of "bedrails up x 4," for example, on the following dates. 7/09/15 at 7.37 PM, 9.25 PM, 11.18 PM and 7/10/15 at 12.54 AM, 4.23 AM, 6 24 AM. There were no physician or LIP orders for 4 side rails. The policy, "Restraints," dated 8/13/13, was reviewed. It included a definition of physical restraints. "Raised hospital bed side rails x 4" was included in the description of physical restraints. It further described when the use of side rails was not considered a restraint - Side rails on a stretcher, - Due to developmental or physical limitations, patient is not able to get out of bed (including cribs), - Specialty bed which constantly moves to improve circulation or prevent skin breakdown. If the patient is actively experiencing involuntary movement, such as a seizure or is on acute seizure precautions, - Following surgery and until the patient is alert and stable, all four side rails will be utilized, - The use of the side rails to hold a medical device or equipment in place (e.g., Continuous Passive Motion (CPM) equipment, phone, etc.), - If side rails are segments, and all but one segment are raised (e.g., three of four side rails) - If the patient can easily lower the side rails by himself. There was no documentation to indicate exception criteria for 4 side rails had been met for Patient #11 to explain why an order was not obtained.	A 168	Please see attached corrective action plans.	

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A 168	Continued From page 18 RN J, who worked the medical floor, was interviewed on 10/01/15 beginning at 2:55 PM. She stated an order was not required for 4 side rails when a patient was otherwise restrained. This information was not consistent with the hospital's restraint policy. Patient #11's physician, a hospitalist, was interviewed on 10/02/15 at approximately 9:00 AM. He stated 4 side rails were a "fall precaution." There was no restraint order for Patient #11 for 4 side rails in accordance with hospital policy and regulatory requirements. 2. Patient #9 was a 62 year old male who arrived by ambulance to the ED on 9/05/15. He was described in a physician's note, dated 9/05/15 at 9:46 PM, as "combative, aggressive, and spitting behaviors" upon arrival to the ED. Patient #9's medical record included documentation of a physician's verbal order "Violent/Self-Destructive Behavior Soft restraints Four-point receiving sedation Aggressive/Violent behavior," dated 9/05/15 at 3:06 PM, and authenticated 9/05/15 at 3:21 PM. The duration of the restraints was not specified. RN M, Nursing Supervisor for the ED, reviewed the record during an interview on 10/01/15 at 3:55 PM. She confirmed the restraint order documentation for Patient #9. The restraint order was incomplete. 3. Patient #10 was a 35 year old female who was	A 168	Please see attached corrective action plans.		

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A 168	<p>Continued From page 19</p> <p>brought to the ED on 9/23/15 by police in handcuffs with acute psychosis.</p> <p>a. Restraint orders included a verbal order, dated 9/23/15 at 2.15 AM, and authenticated 2.30 AM, for "Violent/Self-Destructive Behavior Soft restraints Left ankle left wrist right wrist right ankle." The order did not specify duration or clinical justification for restraints as required in hospital policy.</p> <p>RN M, a Nursing Supervisor for the ED, reviewed the record during interview on 10/01/15 at 4 10 PM, and confirmed the findings.</p> <p>b. Nursing documentation indicated restraints were applied 9/23/15 at 1.16 AM, 59 minutes prior to receipt of a verbal order. There was no documentation to indicate the LIP managing the patient's care was notified within minutes of the initiation of restraint to obtain a telephone or written order.</p> <p>RN M reviewed the record during interview on 10/01/15 at 4 10 PM, and confirmed the findings.</p> <p>4. Patient #12 was a 68 year old female who was admitted to the hospital on 8/18/15 when she presented with altered mental status. Admitting diagnoses included, but were not limited to, possible seizures, metabolic encephalopathy, and COPD.</p> <p>Nursing documentation, dated 8/24/15 at 9 45 AM, described Patient #12 as "COMBATIVE SPITTING/HITTING/SCRATCHING/PUNCHING/KICKING STAFF. ALSO PT SCRATCHING SELF AND REMOVING 2 IVS WITHIN 2 HOUR TIME FRAME. PT TRYING TO DESTROY</p>	A 168	Please see attached corrective action plans.		

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A 168	<p>Continued From page 20</p> <p>EQUIPMENT. PT REMOVED GOWN SEVERAL TIMES. ALTERNATIVE INTERVENTIONS UNSUCCESSFUL. SITTER AT BEDSIDE." The nursing note further documented application of restraints, including "Four Side Rails Soft ankle bilateral soft wrist bilateral"</p> <p>Restraint orders for Patient #12, dated 8/24/15 at 9 50 AM, for wrist and ankle restraints were signed by the LIP on 8/24/15 at 9.45 AM. The orders were for a maximum of 4 hours for violent/self destructive behavior. They did not specify the number of limbs to be restrained. They did not include orders for four side rails.</p> <p>RN J, who worked the medical floor, was interviewed on 10/01/15 beginning at 2 55 PM. She stated an order was not required for 4 side rails when a patient was otherwise restrained. This information was not consistent with the hospital's restraint policy.</p> <p>5. Patient #8 was a 14 year old female who presented to the ED on 6/21/15 at 3.14 PM. Her chief complaints were suicidal ideation, threats to others, and acting out. She was transferred to a psychiatric hospital on 6/22/15 at 12.13 AM.</p> <p>A nursing triage assessment at 3 16 PM on 6/21/15, stated Patient #8 was alert, oriented, and speaking coherently. A physician progress note at 3 47 PM on 6/21/15, stated Patient #8 did not take antidepressant medication or see a psychiatrist. A drug screen, dated 6/21/15 at 4 25 PM, was negative.</p> <p>A Nursing Note, dated 6/21/15 at 5 30 PM, stated Patient #8 stripped out of scrubs and yelled at her mother. The note stated she was placed back in</p>	A 168	Please see attached corrective action plans.	
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A 168	<p>Continued From page 21 scrubs.</p> <p>A Nursing Note, dated 6/21/15 at 6 15 PM, stated Patient #8 took off her scrub bottoms.</p> <p>A Nursing Note, dated 6/21/15 at 8.42 PM, stated Patient #8 got out of the stretcher. The note stated she was told to stay in the stretcher or she would have a mattress on the floor. The note stated she then got on the stretcher and yelled at family members and staff.</p> <p>A Nursing Note, dated 6/21/15 at 10.01 PM, stated Patient #8 continued to take off her scrub pants. The note stated Patient #8 agreed to keep her pants on if allowed to wear her own pants. The note stated she was allowed to wear her own pants and was described as calm.</p> <p>A Nursing Note, dated 6/21/15 at 10 30 PM, stated Patient #8 "...was combative in room. Injection given by RN with 2 RN and 2 security officer support to hold [patient] for injection. [Patient #8] states that 'I should have just killed myself.' The note stated Patient #8's parents and 2 security officers were at the bedside.</p> <p>A Nursing Note, dated 6/21/15 at 10 56 PM, stated "MD notified of [Patient #8's] continued combative behavior. [Patient] slammed forehead into wall. Order for medication received and administered. Dr. in room to speak to [patient]."</p> <p>A Nursing Note, dated 6/21/15 at 11.17 PM, stated Patient #8 was sleeping.</p> <p>Subsequent Nursing Notes stated Patient #8 continued to sleep until she was transferred to another hospital at 12.13 AM on 6/22/15.</p>	A 168	Please see attached corrective action plans.	

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
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A 168	<p>Continued From page 22</p> <p>Patient #8 was physically restrained by 4 people who held her for the injection of the chemical restraint.</p> <p>Nursing notes stated the intramuscular Haldol and Ativan were administered on 6/21/15 at 10 28 PM. Nursing Notes also stated the intramuscular Haldol was administered again on 6/21/15 at 10.54 PM.</p> <p>An order for Haldol 5 mg (an antipsychotic medication) and Ativan 2 mg (an anti-anxiety medication) was written on 6/21/15 at 10 13 PM. A second order for Haldol was written on 6/21/15 at 10.44 PM. The specific reason for the orders was not documented.</p> <p>A physician note, dated 6/22/15 at 12.19 AM, stated Patient #8 "...became increasingly agitated throughout her emergency department stay she required 10 mg of [intramuscular] Haldol with 2 mg of [intramuscular] Ativan. With these treatments the patient calmed down and was noted to be sleeping for the remainder of her emergency department stay."</p> <p>The hospital provided surveyors with a copy of the online training module used for restraint training for nurses and other staff.</p> <p>The untitled and undated training by "Articulate Storyline" stated "Medication cocktails ARE generally considered restraints (haldol + lorazepam, thiorazine + diazepam). Always give one medication first, monitor effects and add second medication only if needed to control the patient's present behavior."</p>	A 168	Please see attached corrective action plans.		

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301
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(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
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A 168	<p>Continued From page 23</p> <p>The medications were given to control Patient #8's behavior. A physical restraint was required to administer the chemical restraint. Neither the order nor the progress notes stated the medications and physical hold were a restraint. They did not state the medications were ordered for a reason other than restraint.</p> <p>RN M, a Nursing Supervisor for the ED, reviewed Patient #8's medical record on 10/01/15 beginning at 4:25 PM. She agreed the orders for the Haldol and Alivan were not written as restraints. She stated the record did not contain an order for the physical restraint (the hold).</p> <p>Patient #8 was restrained without appropriate orders.</p> <p>6. Patient #28 was a 24 year old male who was brought to the ED by police on 8/10/15 at 3:14 PM. He told staff he was "crazy" and was having auditory hallucinations. He was admitted to the hospital's psychiatric unit the morning of 8/11/15. He was diagnosed with psychosis. Patient #28's legal status was not documented.</p> <p>A Nursing Note, on 8/11/15 at 1:29 AM, stated Patient #28 was informed he was being admitted to the hospital's psychiatric unit. The note stated he "...became verbally abusive and escalated rapidly." The next Nursing Note, dated 8/11/15 at 1:57 AM, stated Patient #28 "... attempted to leave at this time, restrained by security staff. Officers notified and en route at this time." The time Patient #28 was restrained and the time he was released were not documented.</p> <p>No order was present in Patient #28's medical record for physical restraint.</p>	A 168	Please see attached corrective action plans.	
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A 168	Continued From page 24	A 168	Please see attached corrective action plans.		
A 171	<p>RN M, a Nursing Supervisor for the ED, reviewed Patient #28's medical record on 10/01/15 beginning at 4.25 PM. She stated Patient #28 did not have an order for restraint.</p> <p>Patient #28 was restrained without appropriate orders.</p> <p>482.13(e)(8) PATIENT RIGHTS, RESTRAINT OR SECLUSION</p> <p>Unless superseded by State law that is more restrictive--</p> <p>(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours.</p> <p>(A) 4 hours for adults 18 years of age or older,</p> <p>(B) 2 hours for children and adolescents 9 to 17 years of age, or</p> <p>(C) 1-hour for children under 9 years of age.</p> <p>This STANDARD is not met as evidenced by. Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure orders for restraint used to manage violent or self-destructive behavior were renewed every 4 hours for 1 of 1 patient (#11) who was restrained for more than 4 hours to manage violent or self-destructive behavior and whose record was reviewed. This resulted in a lack of oversight by a qualified LIP and had the potential to interfere with patient safety. Findings include.</p> <p>The hospital's "Restraint" policy, dated 8/13/13,</p>	A 171			

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A 171	<p>Continued From page 25</p> <p>was reviewed. The policy included, but was not limited to, the following information related to violent/self-destructive physical restraints.</p> <ul style="list-style-type: none"> - "The initial restraint order is good for the following maximum time limits, unless a shorter time is otherwise specified, 4 hours for adults 18 years of age or older" - "The orders for restraints used for the management of violent or self-destructive behavior ... must be renewed by the LIP according to this time frame for the first 24 hours of restraint use, 4 hours for adults 18 years of age or older." - "After 24 hours, a new order for the use of restraint to manage violent/self destructive behavior is required." - DEFINITIONS: "Violent/Self Destructive Restraints. Used when a patient is exhibiting aggressive/violent behavior that jeopardizes the immediate physical safety of the patient, staff, or others." <p>The policy also offered a definition for "Nonviolent/Non-Self Destructive Restraint." It stated "Used when a patient is a danger to himself or others due to his underlying medical condition and is unable to consistently follow direction or there is a behavior consistent with the unplanned removal of life saving tubes/devices."</p> <p>In the example that follows, restraints used to manage violent and self-destructive behavior were not renewed every 4 hours, as required by hospital policy and regulatory requirements.</p>	A 171	Please see attached corrective action plans.		

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A 171	<p>Continued From page 26</p> <p>Patient #11 was a 27 year old female who arrived by police escort to the ED on 7/09/15 after a suicidal gesture resulting in a laceration to her wrist.</p> <p>A "Protective Custody Authorization," dated and signed by the physician on 7/09/15 at 4.45 PM, indicated Patient number #11 posed "an imminent danger to self as evidence by a threat of substantial physical harm."</p> <p>She was admitted to an inpatient medical unit on 7/09/15 at approximately 6.30 PM on the physician-authorized protective medical hold.</p> <p>She was also under police supervision due to "violence in ER."</p> <p>She had a 1.1 sitter due to suicidal ideation.</p> <p>On 7/10/15 at 4.30 PM, Patient #11 was evaluated by a designated examiner who recommended a continuation of protective custody due to a determination Patient #11 was a danger to herself and others. Patient #11's medical record documented she continued under police supervision, 1.1 sitter, and an involuntary hold until 7/13/15, the day she was discharged from the hospital.</p> <p>After admission to the inpatient unit, Patient #11's medical record included documentation of orders, dated 7/09/15 at 6.42 PM, for wrist and ankle restraints for 4 hours maximum for "Violent/Self-Destructive Behavior."</p> <p>Patient #11's medical record included documentation that bilateral soft wrist and ankle restraints were applied on 7/09/15 at 6 49 PM.</p>	A 171	Please see attached corrective action plans.	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2015
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
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A 171	Continued From page 27 Nursing notes included the following descriptions of Patient #11's behavior to justify restraints for violent/self destructive behavior 7/09/15 at 6.49 PM - "YELLING AND SCREAMING. PULLING AT HANDCUFFS, KICKING, THREATENING, AND SWINGING ARMS" and "PATIENT UNWILLING TO LISTEN OR COOPERATE AT THIS TIME." 7/09/15 at 7.00 PM - "PT ADMITTED WITH SUICIDE ATTEMPT. SHE IS THRASHING AROUND IN THE BED AND IS HAND CUFFED TO THE BED WITH AN OFFICER..." "EXPLAINED THE RESTRAINTS AND SITTER TO THE PATIENT." 7/09/15 at 8.00 PM - "SHE IS NOT AS AGITATED AS SHE WAS AN HOUR AGO BUT STILL RESTLESS AND UNSAFE." 7/09/15 at 8.49 PM - "GAVE PT ATIVAN TO HELP KEEP HER FROM PULLING ON HER RESTRAINTS AND HANDCUFFS." "PT IS VERY UPSET AND STATES THAT SHE JUST WANTED TO SEE HER GIRLFRIEND ONE MORE TIME BEFORE SHE LEFT FOR GOOD AND IS UPSET THAT WE WOULDN'T LET HER." "SHE IS IN BED SLEEPING OFF AND ON NOW SITTER AND OFFICER AT THE BEDSIDE." The physician's restraint order, dated 7/09/15 at 8:55 PM, were changed from wrist and ankle restraints for "Violent/Self-Destructive Behavior" to wrist and ankle restraints for "Non-Violent/Non-Self-Destructive Behavior." The boxes were checked for "Unable to consistently	A 171	Please see attached corrective action plans.		

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A 171	<p>Continued From page 28</p> <p>follow/understand direction" and "Prevent removal of medical equipment/therapeutic modalities" and "Other" - "Police Hold/Handcuffs."</p> <p>There was no documentation in Patient #11's medical record to indicate she was not able to follow directions or that her behavior was consistent with the unplanned removal of life saving tubes/devices. The police hold/handcuffs were used to manage violent behavior.</p> <p>RN K, who cared for Patient #11, was interviewed by telephone on 10/02/15 beginning at 10.00 AM. When asked why Patient #11 continued in restraints after the physician's order was changed to "non-violent/non-self-destructive behavior," she stated Patient #11 had been violent with a nurse in the ED, she had foul and threatening language, she threatened to rip her stitches out (of her arm), she might hurt herself, and she was detoxing from meth (methamphetamine).</p> <p>The restraint order was not appropriately classified as restraints for "Non-Violent/Non-Self-Destructive Behavior" as the restraints were being used to manage violent and self-destructive behavior.</p> <p>A renewal order for restraints was obtained 7/10/15 at 10.35 AM, more than 13 hours from the prior restraint order. The order directed staff to "alternate bilateral upper extremity" restraints. There was no other renewal orders written. She was discontinued from restraints over 22 hours later on 7/11/15 at 8.54 AM.</p> <p>Renewal orders were not obtained every 4 hours after initiation of restraints used to manage violent and self-destructive behavior.</p>	A 171	Please see attached corrective action plans.		

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A 171	Continued From page 29	A 171	Please see attached corrective action plans.		
A 174	<p>RN J was interviewed on 10/01/15 beginning at 2:55 PM. She reviewed Patient #11's record and confirmed the restraint orders.</p> <p>Orders for restraints used to manage Patient #11's violent or self-destructive behavior were not renewed at a minimum of every 4 hours.</p> <p>482.13(e)(9) PATIENT RIGHTS, RESTRAINT OR SECLUSION</p> <p>Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.</p> <p>This STANDARD is not met as evidenced by. Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 2 of 4 patients (#9 and #11) whose records documented restraint orders. This resulted in continued restraint use when patients were no longer a danger to themselves or others. Findings include:</p> <p>The hospital's "Restraint" policy, dated 8/13/13, was reviewed. The policy included, but was not limited to the following information:</p> <ul style="list-style-type: none"> - "Restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order. - "Restraints may only be imposed to ensure the immediate physical safety of the patient, staff member, or public and through the use of the least restrictive device for the shortest possible time when restraints are clinically appropriate and 	A 174			

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A 174	<p>Continued From page 30 adequately justified."</p> <p>- "The use of restraint or seclusion is limited to those situations for which there is adequate and appropriate clinical justification and based on the assessed needs of the patient."</p> <p>Restraints were not discontinued at the earliest possible time, as follows</p> <p>1. Patient #9 was a 62 year old male who arrived by ambulance to the ED on 9/05/15. He was described in a physician's note, dated 9/05/15 at 9 46 PM, as "combative, aggressive, and spitting behaviors" upon arrival to the ED.</p> <p>Patient #9's medical record included two restraint orders, including.</p> <p>- A physician's verbal order "Violent/Self-Destructive Behavior Soft restraints Four-point receiving sedation Aggressive/Violent behavior," dated 9/05/15 at 3:06 PM, and authenticated 9/05/15 at 3:21 PM. The duration of the restraint order was not specified.</p> <p>- A verbal order for renewal of the restraint order, was entered 9/05/15 at 3:59 PM, and authenticated 9/05/15 at 4:04 PM. It stated "Violent/Self-Destructive Behavior Soft restraints Four-point Duration = 1 hr - violent behavior receiving sedation. The clinical justification for renewal was not stated.</p> <p>Patient #9's medical record included nursing documentation of soft restraints of all extremities, from 9/05/15 at 3:15 PM, until restraints were discontinued 2 hours and 23 minutes later at 9/05/15 at 5:38 PM.</p>	A 174	Please see attached corrective action plans.	

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A 174	<p>Continued From page 31</p> <p>Nursing documentation did not include justification for the continued use of restraints after the initial description of Patient #9's violent behavior. Nursing notes described Patient #9 in the following manner.</p> <p>9/05/15 3.22 PM - "Alert, oriented to person, place and time, consistent with developmental age. Follows commands. Responds appropriately to questions. Speech clear."</p> <p>9/05/15 3.46 PM - "Alert - appropriate"</p> <p>9/05/15 4.34 PM - "Pt. is awake, alert. Pt. did not know where he is, re-oriented to place/situation. Pt. is cooperative, continues to spit to clear his mouth. Pt denies that he is attempting to spit on staff, was cooperative with using tissues and waiting to spit into tissues. Mask was placed back over pt's face as he is still restrained and unable to use tissues on his own, continues to feel need to spit to clear his mouth. Pt. did verbalize understand that he is remaining under restraint for continued safety of staff and for patient. Pt. was given sips of water, tolerated well. Repositioned for comfort. Pending mental health evaluation. Sitter in room with patient."</p> <p>9/05/15 5.00 PM - "Disoriented - confused"</p> <p>9/05/15 5.36 PM - "All restraints removed."</p> <p>RN M, an RN Educator, reviewed the record during interview on 10/01/15 at 3 55 PM. She confirmed the documentation.</p> <p>Restraints were continued on Patient #9 without sufficient evidence/documentation that restraints</p>	A 174	Please see attached corrective action plans.		

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A 174	<p>Continued From page 32</p> <p>continued to be necessary to ensure Patient #9's immediate physical safety or the safety of staff members or the public. Restraints were not discontinued at the earliest possible time.</p> <p>2. Patient #11 was a 27 year old female who arrived by police escort to the ED on 7/09/15, after a suicidal gesture resulting in a laceration to her wrist.</p> <p>A "Protective Custody Authorization," dated and signed by the physician on 7/09/15 at 4 45 PM, indicated Patient #11 posed "an imminent danger to self as evidence by a threat of substantial physical harm." She was admitted to an inpatient medical unit on 7/09/15 at approximately 6 30 PM on a physician-authorized protective medical hold.</p> <p>She was also under police supervision due to "violence in ER."</p> <p>She had a 1 1 sitter due to suicidal ideation.</p> <p>On 7/10/15 at 4 30 PM, Patient #11 was evaluated by a designated examiner who recommended a continuation of protective custody due to a determination Patient #11 was a danger to herself and others.</p> <p>Patient #11's medical record documented she continued under police supervision, 1 1 sitter, and an involuntary hold until 7/13/15, the day she was discharged from the hospital.</p> <p>After admission to the inpatient unit, Patient #11's medical record included documentation of wrist and ankle restraint orders, dated 7/09/15 at 6 42 PM, for "Violent/Self-Destructive Behavior" for 4</p>	A 174	Please see attached corrective action plans.	

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC	STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301
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A 174	<p>Continued From page 33 hours maximum.</p> <p>Patient #11's medical record included documentation of application of bilateral soft wrist and ankle restraints on 7/09/15 at 6.49 PM.</p> <p>Nursing notes included the following descriptions of Patient #11's behavior to justify restraints for violent/self destructive behavior.</p> <p>- 7/09/15 at 6.49 PM - "YELLING AND SCREAMING. PULLING AT HANDCUFFS, KICKING, THREATENING, AND SWINGING ARMS" and "PATIENT UNWILLING TO LISTEN OR COOPERATE AT THIS TIME."</p> <p>- 7/09/15 at 7.00 PM - "PT ADMITTED WITH SUICIDE ATTEMPT. SHE IS THRASHING AROUND IN THE BED AND IS HAND CUFFED TO THE BED WITH AN OFFICER." "EXPLAINED THE RESTRAINTS AND SITTER TO THE PATIENT."</p> <p>7/09/15 at 8.00 PM - "SHE IS NOT AS AGITATED AS SHE WAS AN HOUR AGO BUT STILL RESTLESS AND UNSAFE."</p> <p>7/09/15 at 8.49 PM - "GAVE PT ATIVAN TO HELP KEEP HER FROM PULLING ON HER RESTRAINTS AND HANDCUFFS." "PT IS VERY UPSET AND STATES THAT SHE JUST WANTED TO SEE HER GIRLFRIEND ONE MORE TIME BEFORE SHE LEFT FOR GOOD AND IS UPSET THAT WE WOULDN'T LET HER." "SHE IS IN BED SLEEPING OFF AND ON NOW SITTER AND OFFICER AT THE BEDSIDE."</p> <p>Physician's restraint orders, dated 7/09/15 at 8.55</p>	A 174	Please see attached corrective action plans.	
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A 174	<p>Continued From page 34</p> <p>PM, were changed from wrist and ankle restraints for "Violent/Self-Destructive Behavior" to wrist and ankle restraints for "Non-Violent/Non-Self-Destructive Behavior." The boxes were checked for "Unable to consistently follow/understand direction" and "Prevent removal of medical equipment/therapeutic modalities" and "Other" - "Police Hold/Handcuffs."</p> <p>There was no documentation in nursing notes to indicate Patient #11 was not able to follow or understand directions or was pulling at medical equipment.</p> <p>Nursing notes, after the restraint order changed, were as follows.</p> <p>- 7/09/15 at 9.00 PM - "PT IS SLEEPING RIGHT NOW, SHE IS VERY COOPERATIVE WHEN WOKEN UP AT THIS TIME AND STATES SHE IS VERY TIRED. WE REMOVED ONE RESTRAINT ON THE RIGHT HAND AND UNCUFFED THAT HAND FROM THE BED AND SHE IS DOING WELL WITH THAT AT THIS TIME." "SWITCHED PT FROM VIOLENT RESTRAINTS TO NONVIOLENT WILL TRIAL THIS AND A NEW ORDER WAS RECEIVED AND SIGNED BY THE PHYSICIAN."</p> <p>- 7/09/15 at 9.25 PM - "PT IN SOFT RESTRAINTS AT THIS TIME. SITTER AT BEDSIDE. PT HAS CALMED DOWN AND IS ABLE TO FOLLOW STAFF INSTRUCTIONS AT THIS TIME."</p> <p>- 7/09/15 at 10.00 PM - "PT IS SLEEPING STILL AND IS COOPERATIVE WHEN AWAKE AT THIS TIME. RIGHT HAND STILL UNRESTRAINED AT THIS TIME. SITTER AND OFFICER STILL AT</p>	A 174	Please see attached corrective action plans.		

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A 174	<p>Continued From page 35 THE BEDSIDE."</p> <p>- 7/09/15 at 11.18 PM - "PT IS SOFT RESTRAINTS AT THIS TIME SITTER AT BEDSIDE PT WAS CALMED DOWN AND IS ABLE TO FOLLOW STAFF INSTRUCTIONS."</p> <p>RN J, who worked on the medical floor, was interviewed on 10/01/15 beginning at 2.55 PM, at which time she reviewed Patient #11's medical record. She explained Patient #11 was switched to "non-violent restraints" because she was "sleeping and cooperative."</p> <p>RN#11, who provided care for Patient #11, was interviewed by telephone on 10/02/15 beginning at 10.00 AM. When asked why Patient #11 continued in restraints, she stated Patient #11 had been violent with a nurse in the ED, she had foul and threatening language, she threatened to rip her stitches out (of her arm), she might hurt herself, and she was detoxing.</p> <p>Restraints were continued on Patient #11 when there was no longer sufficient evidence/documentation after 7/09/15 at 9.00 PM, that restraints were necessary to ensure the immediate physical safety of the patient, staff member, or public.</p> <p>Restraints were not discontinued at the earliest possible time.</p>	A 174	Please see attached corrective action plans.	
A 176	<p>482.13(e)(11) PATIENT RIGHTS RESTRAINT OR SECLUSION</p> <p>Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum,</p>	A 176		

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A 176	<p>Continued From page 36</p> <p>physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.</p> <p>This STANDARD is not met as evidenced by. Based on staff interview, and review of medical records, hospital policy, and medical staff educational material, it was determined the hospital failed to ensure LIPs who were authorized to order restraints had a working knowledge of hospital policy regarding the use of restraints. This affected 6 of 6 patients (#8, #9, #10, #11, #12, and #28) who were restrained, and whose records were reviewed. This resulted in incomplete, missing, or miscategorized restraint orders, missing face-to-face evaluations, and missing documentation as to the course of care. Findings include:</p> <p>1. A hospitalist, who ordered restraints on the inpatient medical unit for Patient #11, was interviewed on 10/02/15 at 9.00 AM.</p> <p>When asked about training he received related to restraints, he stated he received training during his residency. He stated he was not sure of any training from the hospital.</p> <p>The hospitalist was asked what his understanding was of the one hour face-to-face requirement. He stated he was required to sign a stamp verifying the restraint was appropriate. He was not able to state what components were required in the face-to-face evaluation.</p> <p>When asked regarding the use of 4 side rails for</p>	A 176	Please see attached corrective action plans.	
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A 176	<p>Continued From page 37</p> <p>Patient #11, he stated that 4 side rails were for fall precautions. He was not aware that 4 side rails were considered restraints, unless exception criteria applied.</p> <p>The physician did not have a working knowledge of the hospital's restraint policy.</p> <p>2. Documentation of restraint training was requested for the physician who cared for Patient #11 in the ED, a patient who was restrained both physically and chemically.</p> <p>A packet, titled "Medical Staff Education Packet 2015" was provided. The packet included 13 separate items such as "ROLE IN EMERGENCY MANAGEMENT, INFECTION PREVENTION, MEDICATION SAFETY, DISCHARGE PLANNING, [and] USE OF RESTRAINT."</p> <p>The section titled "USE OF RESTRAINT," stated "All providers that manage patients placed in restraint will have a working knowledge of the hospital policy." The section included the policy number which physicians could find on the hospital's intranet. The education packet did not state how the working knowledge would be ensured and verified or whether an attestation was required.</p> <p>The hospital's policy, "Restraints," dated 8/13/13, was consistent with the medical staff education packet. It stated "LIPs authorized to order restraints must have a working knowledge of hospital policy regarding the use of restraints." The policy did not state how the working knowledge would be ensured and verified or whether an attestation would be required.</p>	A 176	Please see attached corrective action plans.	

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A 176	<p>Continued From page 38</p> <p>The Director of the Center for Learning and Development was interviewed on 10/06/15 beginning at 9:00 AM. She stated the physicians were given an annual packet of training documents. When asked how the hospital knew if physicians had reviewed the training and had knowledge of the policy, she stated records were not kept to determine if physicians had reviewed the material or met the restraint training requirements.</p> <p>The hospital did not have an active system to ensure physicians met restraint training requirements.</p> <p>3. There was lack of evidence that LIPs authorized to order restraints had a working knowledge of hospital policy, as follows.</p> <p>a. Refer to A-0168 as it relates to a failure to ensure restraint orders were current, clear, or complete for Patients #8, #9, #10, #11, #12, and #28.</p> <p>b. Refer to A-0171 as it relates to a failure to ensure timeliness of renewal orders in accordance with hospital policy for restraint used to manage violent or self-destructive behavior for Patient #11.</p> <p>c. Refer to A-0178 as it relates to a failure to ensure a face to face meeting by a LIP was conducted within 1 hour of the application of behavioral restraints for Patient #28.</p> <p>d. Refer to A-0184 as it relates to the failure to ensure documentation of a face-to-face evaluation by a qualified individual within one hour of application of restraints for Patients #8,</p>	A 176	Please see attached corrective action plans.		

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A 176	Continued From page 39 #9, #10, #11, and #12.	A 176	Please see attached corrective action plans.	
A 178	<p>482.13(e)(12) PATIENT RIGHTS, RESTRAINT OR SECLUSION</p> <p>When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention --</p> <ul style="list-style-type: none"> o By a-- <ul style="list-style-type: none"> - Physician or other licensed independent practitioner, or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure a face-to-face meeting by an LIP was conducted within 1 hour of the application of behavioral restraints for 1 of 6 patients (#28) who were restrained and whose records were reviewed. This prevented the hospital from evaluating the causes and appropriateness of the need for restraint. Findings include</p> <p>Patient #28 was a 24 year old male who was brought to the ED by police on 8/10/15 at 3.14</p>	A 178		

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A 178	Continued From page 40 PM. He told staff he was "crazy" and was having auditory hallucinations. He was admitted to the hospital's psychiatric unit the morning of 8/11/15. He was diagnosed with psychosis. Patient #28's legal status was not documented. A Nursing Note, on 8/11/15 at 1.29 AM, stated Patient #28 was informed he was being admitted to the hospital's psychiatric unit. The note stated he "...became verbally abusive and escalated rapidly." The next Nursing Note, dated 8/11/15 at 1.57 AM, stated Patient #28 "...attempted to leave at this time, restrained by security staff. Officers notified and en route at this time." The time Patient #28 was restrained and the time he was released were not documented. An order was not present in Patient #28's medical record for physical restraint. A physician progress note was written on 8/10/15 at 11.09 PM. The physician's progress note and Nursing Note did not include documentation Patient #28 was seen by an LIP following the restraint episode. RN M, a Nursing Supervisor for the ED, reviewed Patient #28's medical record on 10/01/15 beginning at 4.25 PM. She stated Patient #28 did not have documentation that a face-to-face encounter by an LIP was conducted. Patient #28 did not receive a face-to-face evaluation after being restrained.	A 178	Please see attached corrective action plans.		
A 184	482.13(e)(16)(i) PATIENT RIGHTS, RESTRAINT OR SECLUSION When restraint or seclusion is used, there must be documentation in the patient's medical record	A 184			

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A 184	<p>Continued From page 41 of the following</p> <p>The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.</p> <p>This STANDARD is not met as evidenced by Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure medical records included documentation of a face-to-face evaluation by a qualified individual within one hour of application of restraints for 5 of 6 patients (#8, #9, #10, #11, and #12) who were restrained to manage violent or self-destructive behavior, and whose medical records were reviewed. This resulted in a lack of LIP assessment of patients' physical and mental status, and created the potential for unsafe or unnecessary use of restraints. Findings include</p> <p>The hospital's "Restraint" policy, dated 8/13/13, was reviewed. The policy included, but was not limited to the following information.</p> <p>- "Restraints used to manage violent/self-destructive behavior require an LIP in-person examination of the restrained patient within one hour of initiation to include</p> <ol style="list-style-type: none"> An evaluation of the patient's immediate situation The patient's reaction to the intervention The patient's medical and behavioral condition The need to continue or terminate the restraint Authentication of the verbal order, if applicable" <p>Documentation was missing in the medical records, as follows.</p>	A 184	Please see attached corrective action plans.	

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A 184	<p>Continued From page 42</p> <p>1. Patient #9 was a 62 year old male who arrived by ambulance to the ED on 9/05/15. He was described in a physician's note, dated 9/05/15 at 9:46 PM, as "combative, aggressive, and spitting behaviors" upon arrival to the ED.</p> <p>Patient #9's medical record included a physician's verbal order "Violent/Self-Destructive Behavior Soft restraints Four-point receiving sedation Aggressive/Violent behavior," dated 9/05/15 at 3:06 PM, and authenticated 9/05/15 at 3:21 PM.</p> <p>Patient #9's medical record included nursing documentation of "Continuation of Violent Soft All extremities" on 9/05/15 at 3:15 PM. It could not be determined the exact time restraints were initiated as there was no documentation of initial application of restraints.</p> <p>There was no documentation to indicate Patient #9 was seen face-to-face by an LIP within 1 hour after the application of restraints. Patient #9's immediate situation, reaction to the restraint, medical and behavioral condition and need to continue or terminate the restraint, was not assessed by a qualified LIP.</p> <p>This was confirmed by RN M, an RN Educator, during record review and interview on 10/01/15 at 3:55 PM.</p> <p>Patient # 9's medical record did not include documentation of a face-to-face evaluation within one hour of initiation of behavioral restraints.</p> <p>2. Patient #10 was a 35 year old female who was brought to the ED on 9/23/15, by police in handcuffs, with acute psychosis.</p>	A 184	Please see attached corrective action plans.	
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A 184	<p>Continued From page 43</p> <p>Restraint orders included a verbal order, dated 9/23/15 at 2 15 AM, and authenticated 2.30 AM, for "Violent/Self-Destructive Behavior Soft restraints Left ankle left wrist right wright right ankle."</p> <p>Nursing documentation indicated restraints were applied 9/23/15 at 1.16 AM, and discontinued at 2.27 AM.</p> <p>Physician documentation as to the course of ED care for Patient #10 was dated 9/23/15 at 6.40 AM. There was no documentation to indicate the patient was seen face-to-face by a physician or LIP within 1 hour after initiation of restraints to evaluate the patients' immediate situation, reaction to the restraint, medical and behavioral condition and need to continue or terminate the restraint.</p> <p>This was confirmed by RN M, an RN Educator and Nursing Supervisor for the ED, during record review and interview on 10/01/15 at 4.00 PM.</p> <p>Patient #10's medical record did not include documentation of a face-to-face evaluation within one hour of initiation of behavioral restraints.</p> <p>3. Patient #12 was a 68 year old female who was admitted to the hospital on 8/18/15, when she presented with altered mental status. Admitting diagnoses included, but were not limited to, possible seizures, metabolic encephalopathy and COPD.</p> <p>Nursing documentation, dated 8/24/15 at 9 45 AM, described Patient #12 as "COMBATIVE SPITTING/HITTING/SCRATCHING/PUNCHING/ KICKING STAFF. ALSO PT SCRATCHING SELF</p>	A 184	Please see attached corrective action plans.	
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A 184	<p>Continued From page 44</p> <p>AND REMOVING 2 IVS WITHIN 2 HOUR TIME FRAME. PT TRYING TO DESTROY EQUIPMENT. PT REMOVED GOWN SEVERAL TIMES. ALTERNATIVE INTERVENTIONS UNSUCCESSFUL. SITTING AT BEDSIDE." The nursing note further documented application of restraints, including "Four Side Rails Soft ankle bilateral soft wrist bilateral"</p> <p>Restraint orders, dated 8/24/15 at 9:50 AM, for wrist and ankle restraints for a maximum of 4 hours for violent/self destructive behavior, were signed by the LIP on 8/24/15 at 9:45 AM. The LIP signature certified "I have examined the patient and certify the above restraint order is appropriate."</p> <p>Nursing documentation, dated 8/24/15 at 10:00 AM, documented "DR ROUNDING ON PT..." A physician's progress note, dated 8/24/15, dictated at 7:37 PM, was reviewed. It included an evaluation of Patient #12's medical and behavioral condition. It did not include an evaluation of Patient #12's reaction to being restrained or include a reference to whether restraints needed to be continued or terminated. It could not be determined if the evaluation was conducted during the face-to-face encounter referenced in nursing documentation on 8/24/15 at 10:00 AM.</p> <p>The Director of the Center for Learning & Development and the Regional Director of Accreditation were interviewed together on the telephone on 10/06/15 beginning at 9:00 AM. The Director of the Center for Learning & Development stated she reviewed Patient #12's record and confirmed documentation was missing regarding the physician's face-to-face</p>	A 184	Please see attached corrective action plans.	

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A 184	<p>Continued From page 45</p> <p>assessment that must be completed within an hour.</p> <p>Patient #12's medical record did not include documentation of a face-to-face evaluation within one hour of initiation of behavioral restraints that included all required components of the evaluation.</p> <p>4. Patient #11 was a 27 year old female who arrived by police escort to the ED on 7/09/15, after a suicidal gesture resulting in a laceration to her wrist.</p> <p>After admission to the inpatient unit, Patient #11's medical record included documentation of wrist and ankle restraint orders, dated 7/09/15 at 6.42 PM, for "Violent/Self-Destructive Behavior" for 4 hours maximum.</p> <p>Patient #11's medical record included documentation of application of bilateral soft wrist and ankle restraints on 7/09/15 at 6.49 PM.</p> <p>A stamped statement was signed by a physician on 7/09/15 at 9.00 PM. It stated "I have examined the patient and certify the above restraint order is appropriate." The statement was signed 2 hours and 11 minutes after application of restraints for violent/self-destructive behavior.</p> <p>The physician's progress note related to Patient #11 was dictated on 7/09/15 at 8.45 PM, 1 hour and 58 minutes after application of restraints.</p> <p>The physician who examined Patient #11 was interviewed on 10/02/15 beginning at 9.00 AM. When asked about face-to-face evaluation for</p>	A 184	Please see attached corrective action plans.		

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
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A 184	<p>Continued From page 46</p> <p>restraints used to manage Patient #11's violent/self-destructive behavior, he stated he was required to sign a stamp verifying the patient needed restraints.</p> <p>There was no documentation to indicate the patient was seen face-to-face by a physician or LIP within 1 hour after initiation of restraints to evaluate the patients' immediate situation, reaction to the restraint, medical and behavioral condition and need to continue or terminate the restraint.</p> <p>This was confirmed by RN J, an RN on the medical unit, during an interview on 10/01/15 beginning on 2:55 PM. She stated "it should be in the progress notes."</p> <p>Patient #11's medical record did not include documentation of a face-to-face evaluation within one hour of initiation of behavioral restraints that included all required components of the evaluation.</p> <p>5. Patient #8 was a 14 year old female who presented to the ED on 6/21/15 at 3:14 PM. Her chief complaints were suicidal ideation, threats to others, and acting out. She was transferred to a psychiatric hospital on 6/22/15 at 12:13 AM.</p> <p>Nursing progress notes, dated 6/21/15, stated Patient #8's behavior was erratic and belligerent. A nursing progress note, dated 6/21/15 at 10:30 PM, stated Patient #8 "...was combative in room. Injection given by RN with 2 RN and 2 security officer support to hold [patient] for injection. [Patient #8] states that 'I should have just killed</p>	A 184	Please see attached corrective action plans.		

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A 184	<p>Continued From page 47</p> <p>myself." The note stated the parents and 2 security officers were at the bedside.</p> <p>A nursing progress note, dated 6/21/15 at 10.56 PM, stated "MD notified of [Patient #8's] continued combative behavior. [Patient] slammed forehead into wall. Order for medication received and administered. Dr. in room to speak to [patient]." Subsequent nursing progress notes stated Patient #8 behaved more calmly.</p> <p>An order for Haldol 5 mg (an antipsychotic medication) and Ativan 2 mg (an anti-anxiety medication) was written on 6/21/15 at 10.13 PM. A second order for Haldol was written on 6/21/15 at 10.44 PM. The specific reason for the medications ordered were not documented.</p> <p>A physician note, dated 6/22/15 at 12.19 AM, stated Patient #8 "...became increasingly agitated throughout her emergency department stay she required 10 mg of [intramuscular] Haldol with 2 mg of [intramuscular] Ativan. With these treatments the patient calmed down and was noted to be sleeping."</p> <p>A face-to-face encounter with Patient #8, including the items required by the restraint policy, was not documented.</p> <p>RN M, a Nursing Supervisor for the ED, reviewed Patient #8's medical record on 10/01/15 beginning at 4.25 PM. She stated a face-to-face encounter by an LIP was not documented.</p> <p>Patient #8's medical record did not document a face-to-face encounter following restraints.</p>	A 184	Please see attached corrective action plans.		

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A 188 A 188	Continued From page 48 482.13(e)(16)(v) PATIENT RIGHTS, RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following.] The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. This STANDARD is not met as evidenced by: Based on medical record review, policy review, and staff interview, it was determined the hospital failed to ensure medical records included documentation of the patient's response to restraints used and/or the rationale for continued use of restraints for 2 of 6 patients who were restrained (#9 and #11) and whose medical records were reviewed. This resulted in patients being restrained without evidence they were an imminent danger to themselves or others. Findings include: The hospital's "Restraint" policy, dated 8/13/13, was reviewed. The policy did not specifically address the requirement to document in the patient's medical record the patient's response to the intervention(s) used, including the rationale for continued use of the intervention. 1. Patient #9 was a 62 year old male who arrived by ambulance to the ED on 9/05/15. He was described in a physician's note, dated 9/05/15 at 9:46 PM, as "combative, aggressive, and spilling behaviors" upon arrival to the ED. Patient #9's medical record included a physician's verbal order "Violent/Self-Destructive Behavior Soft restraints Four-point receiving sedation	A 188 A 188	Please see attached corrective action plans.		

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A 188	<p>Continued From page 49</p> <p>Aggressive/violent behavior," dated 9/05/15 at 3.06 PM, and authenticated 9/05/15 at 3.21 PM</p> <p>Patient #9's medical record included nursing restraint documentation "Continuation of Violent Soft All extremities" on 9/05/15 at 3.15 PM. It could not be determined when restraints were initiated, as all documentation indicated "continuation." Nursing restraint documentation indicated restraints were removed 9/05/15 at 5.38 PM, due to a discontinuation of violent behavior.</p> <p>Nursing documentation did not include the patient's response to restraints or offer a rationale for continued use. Nursing notes described Patient #9 in the following manner.</p> <p>9/05/15 3.22 PM - "Alert, oriented to person, place and time, consistent with developmental age. Follows commands. Responds appropriately to questions. Speech clear."</p> <p>9/05/15 3.46 PM - "Alert - appropriate"</p> <p>9/05/15 4.34 PM - "Pt. is awake, alert. Pt. did not know where he is, re-oriented to place/situation. Pt. is cooperative, continues to spit to clear his mouth. Pt denies that he is attempting to spit on staff, was cooperative with using tissues and waiting to spit into tissues. Mask was placed back over pt's face as he is still restrained and unable to use tissues on his own, continues to feel need to spit to clear his mouth. Pt. did verbalize understand that he is remaining under restraint for continued safety of staff and for patient. Pt. was given sips of water, tolerated well. Repositioned for comfort. Pending mental health evaluation. Sitter in room with patient."</p>	A 188	Please see attached corrective action plans.	

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A 188	<p>Continued From page 50</p> <p>9/05/15 5 00 PM - "Disoriented - confused"</p> <p>9/05/15 5 36 PM - "All restraints removed."</p> <p>RN M, an RN Educator, reviewed the record during interview on 10/01/15 at 3.55 PM. She confirmed the documentation.</p> <p>2. Patient #11 was a 27 year old female who arrived by police escort to the ED on 7/09/15, after a suicidal gesture resulting in a laceration to her wrist.</p> <p>A "Protective Custody Authorization," dated and signed by the physician on 7/09/15 at 4.45 PM, indicated Patient number #11 posed "an imminent danger to self as evidence by a threat of substantial physical harm."</p> <p>She was admitted to an inpatient medical unit on 7/09/15 at approximately 6 30 PM, on a physician-authorized protective medical hold. She was also under police supervision due to "violence in ER."</p> <p>She had a 1.1 sitter due to suicidal ideation.</p> <p>On 7/10/15 at 4.30 PM, Patient #11 was evaluated by a designated examiner who recommended a continuation of protective custody due to a determination Patient #11 was a danger to herself and others.</p> <p>Patient #11's medical record documented she continued under police supervision, 1.1 sitter, and an involuntary hold until 7/13/15, the day she was discharged from the hospital.</p> <p>After admission to the inpatient unit, Patient #11's</p>	A 188	Please see attached corrective action plans.	

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A 188	<p>Continued From page 51</p> <p>medical record included documentation of wrist and ankle restraint orders, dated 7/09/15 at 6 42 PM, for "Violent/Self-Destructive Behavior" for 4 hours maximum.</p> <p>Patient #11's medical record included documentation of application of bilateral soft wrist and ankle restraints on 7/09/15 at 6 49 PM.</p> <p>The physician's restraint orders, dated 7/09/15 at 8 55 PM, were changed from wrist and ankle restraints for "Violent/Self-Destructive Behavior" to wrist and ankle restraints for "Non-Violent/Non-Self-Destructive Behavior."</p> <p>Nursing documentation did not include a rationale or plan for continued use based on a nursing assessment. Nursing notes, after the restraint order changed, were as follows:</p> <p>- 7/09/15 at 9.00 PM - "PT IS SLEEPING RIGHT NOW, SHE IS VERY COOPERATIVE WHEN WOKEN UP AT THIS TIME AND STATES SHE IS VERY TIRED. WE REMOVED ONE RESTRAINT ON THE RIGHT HAND AND UNCUFFED THAT HAND FROM THE BED AND SHE IS DOING WELL WITH THAT AT THIS TIME." "SWITCHED PT FROM VIOLENT RESTRAINTS TO NONVIOLENT WILL TRIAL THIS AND A NEW ORDER WAS RECEIVED AND SIGNED BY THE PHYSICIAN."</p> <p>- 7/09/15 at 9.25 PM - "PT IN SOFT RESTRAINTS AT THIS TIME. SITTER AT BEDSIDE. PT HAS CALMED DOWN AND IS ABLE TO FOLLOW STAFF INSTRUCTIONS AT THIS TIME."</p> <p>- 7/09/15 at 10.00 PM - "PT IS SLEEPING STILL</p>	A 188	Please see attached corrective action plans.		

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A 188	Continued From page 52 AND IS COOPERATIVE WHEN AWAKE AT THIS TIME. RIGHT HAND STILL UNRESTRAINED AT THIS TIME. SITTER AND OFFICER STILL AT THE BEDSIDE." - 7/09/15 at 11 18 PM - "PT IS SOFT RESTRAINTS AT THIS TIME SITTER AT BEDSIDE PT WAS CALMED DOWN AND IS ABLE TO FOLLOW STAFF INSTRUCTIONS." RN J, an RN who worked on the medical floor, was interviewed on 10/01/15 beginning at 2:55 PM. She reviewed Patient #11's medical record. She explained Patient #11 was switched to "non-violent restraints" because she was "sleeping and cooperative." RN K, who provided care for Patient #11, was interviewed by telephone on 10/02/15 beginning at 10:00 AM. When asked why Patient #11 continued in restraints, she stated Patient #11 had been violent with a nurse in the ED (prior to admission), she had foul and threatening language, she threatened to rip her stitches out (of her arm), she might hurt herself, and she was detoxing. This information was not included in nursing notes.	A 188	Please see attached corrective action plans.		
A 194	Restraints were continued on Patient #11 without documented rationale for continued use. 482.13(f) PATIENT RIGHTS. RESTRAINT OR SECLUSION Restraint or Seclusion. Staff Training Requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.	A 194			

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A 194	<p>Continued From page 53</p> <p>This STANDARD is not met as evidenced by. Based on review of restraint education information, medical record review, and staff interview, it was determined the hospital failed to ensure ED staff had education, training, and demonstrated knowledge to manage patients exhibiting out-of-control and/or aggressive behavior. This resulted in inappropriate use of physical force and intimidation to manage the aggressive out-of-control behavior of 1 of 6 patients (#11) who were restrained to protect the safety of self and others. This failure also place all ED patients experiencing behavioral and psychiatric challenges at risk of physical and/or mental harm. Findings include</p> <p>1. Restraint education material was requested for hospital staff on the main campus. A copy of online training documentation was provided for review. The restraint education content did not include specific training related to the use of non-physical intervention skills for managing volatile patients, avoidance and escape techniques, and types of physical restraints and safe use of them.</p> <p>The RN Director of the ED was interviewed on 10/02/15 at 1.05 PM. He stated his staff had not received training on management of assaultive behavior or de-escalation techniques. He stated his staff was "unprepared and "they need it" to help them know how to deal appropriately with violent patients. He stated he had asked for such training but it had not been implemented yet. He also stated the hospital had not adopted a behavior management system that staff could consistently use when interacting with aggressive patients.</p>	A 194	Please see attached corrective action plans.		

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A 194	<p>Continued From page 54</p> <p>The Regional Director of Accreditation and the Director of the Center for Learning & Development were interviewed together by telephone on 10/06/15 at 9 00 AM. The Director of the Center for Learning & Development stated the hospital had plans to provide training to staff on management of psychiatric patients. The Regional Director of Accreditation stated they were aware that the ED staff needed to receive training and there were plans to provide the training.</p> <p>The following example illustrates an aggressive response to an out-of-control patient in the ED setting and the need for additional training of ED staff.</p> <p>Patient #11 was a 27 year old female who arrived with a police escort to the ED on 7/09/15 at 11 15 AM. She had threatened suicide and had a laceration to her wrist. She was diagnosed with severe depression, anxiety, and suicidal ideation. She was admitted to the medical floor around 6 30 PM on 7/09/15.</p> <p>The first Nursing Note, dated 7/09/15 at 11 15 AM, stated Patient #11 was belligerent, refused to go to her assigned ED room, refused to sit on a stretcher, and refused to change into paper scrubs.</p> <p>A Nursing Note, on 7/09/15 at 11 25 AM, stated Patient #11 was being held by security personnel and police to assist with changing into paper scrubs. The note also stated Patient #11 attempted to leave the ED. The note stated police "...and security hands on to floor, [sic] pt. lifted head off floor and then slammed it down, left forehead. No bruising or contusions noted."</p>	A 194	Please see attached corrective action plans.	

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A 194	Continued From page 55 A Nursing Note, dated 7/09/15 at 11.30 AM, stated Patient #11 was placed in hard lower extremity restraints and soft upper extremity restraints. A Nursing Note, dated 7/09/15 at 11.35 AM, stated Patient #11 was given an intramuscular injection of Zyprexa, an antipsychotic medication with sedative effects. A Nursing Note, dated 7/09/15 at 11.40 AM stated Patient #11 was in leather restraints and the physician was suturing her. A Nursing Note, dated 7/09/15 at 11.50 AM, stated, while setting up to suture Patient #11's arm, she grabbed the nurse's..."hand, yanked and squeezed it. I took her [left] 5th and 6th fingers [sic] and bent them back really hard. I told her that it was a felony to commit battery on a nurse and that she would not win. (TFPD and our security x2) were also in the room. She relaxed and I released her fingers. Pt has been compliant ever since because she does not want to go to jail and or the Zyprexa is working." An incident report, received 7/09/15, contained an account of the event by a security officer on the scene. The account stated Patient #11 "...was compliant until she changed her mind and became angry and refused to follow the staff's instructions. The [RN] asked her to change into the paper scrubs but she refused. She tried to go out the east badge swipe double doors which were locked. She threw the scrubs on the floor and was verbally abusive towards staff. [RN C] gave her a choice to change into the paper scrubs on her own or she would be helped into	A 194	Please see attached corrective action plans.		

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A 194	Continued From page 56 them. [Patient #11] continued to refuse and be defiant. [The police officer] told [Patient #11] that he was going to handcuff her. He took hold of her left arm and I took hold of her right arm. She was told that now her clothes would be cut off her. She began to scream that she did not want her clothes cut off. She tried to pull away from me and the officer. [Another security officer] took hold of her head with both hands because she tried to bite me and the officer. We took her to the ground to control her. [The other security officer and the police officer] handcuffed her hand behind back while I controlled her legs. After she was handcuffed [the police officer] and I helped [Patient #11] to her feet then to bed. Patient #11 continued to be verbally and physically aggressive towards staff. She was cursing at us and being demanding. A surgical mask was put on her face so she could not spit at staff. Her legs were put into leather restraints because she tried to kick staff. Her hands were uncuffed and recuffed to the bed. She continued to be aggressive and tried to grab our hands during the transition. She continued to be verbally and physically aggressive until [RN C] told her that she had two choices. She could go to [the hospital's psychiatric unit] or go to jail. [Patient #11] calmed down and apologized for her behavior. [Patient #11] had calmed down enough so her right arm was put into a leather restraint and attached to the top of her bed. Her left arm was put in a soft restraint and was put down by her side so the doctor could stitch up the cut. She was given a shot of medication which made her sleep. The incident report included documentation it was reviewed by the Security Team Lead on 7/20/15, and the Director of the ED on 8/26/15, 1 month	A 194	Please see attached corrective action plans.	

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A 194	<p>Continued From page 57</p> <p>and 16 days after the event. Under "Disposition," both persons documented "Review Complete." The incident report did not include documentation of what steps were taken to investigate the events.</p> <p>RN C, the RN who provided care for Patient #11 in the ED, was interviewed on 10/02/15 beginning at 11:35 PM. RN C stated it was hospital policy to make mental health patients change into paper scrub garments. She stated the policy required she make Patient #11 change into scrubs immediately and she could not allow the patient to wait until she calmed down. RN C stated if mental health patients refused to wear scrubs their clothes would be cut off and scrubs would be placed.</p> <p>RN C stated Patient #11 was handcuffed. RN C stated while she was preparing Patient #11 for suturing, the patient grabbed her hands and tried to yank and squeeze them. RN C stated she grabbed Patient #11's fingers and bent the last 3 fingers back so the patient would let go. RN C stated she told Patient #11 that grabbing the RN was a federal offense and the patient could go to jail. RN C stated she told Patient #11 that she had 2 choices, to cooperate and be allowed to go to the hospital's psychiatric unit or to go go jail.</p> <p>RN C stated she had not received training in how to escape if a patient grabbed her or assaulted her. RN C stated she thought such training would be very useful.</p> <p>The hospital failed to ensure staff were trained and demonstrated competency in managing patients with behavioral symptoms.</p>	A 194	Please see attached corrective action plans.		

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A 194	Continued From page 58 2. Restraint training records were reviewed for the RN who cared for Patient #11 in the ED. Her education records documented training back to November 2007. Between then and 10/01/15, 5 instances of restraint training were documented. These occurred on 2/18/14, 1/10/13, 2/08/12, 3/09/11, and 2/22/10. Each training in the record simply stated "Restraints" and included the time spent for each training. The record documented 18 minutes of restraint training on 2/18/14. The other sessions of restraint training each documented 30 minutes spent on the activity. The training for nursing staff was an online course that nurses could take on their own. It included a post test. The training module stated nurses could either view the training or simply take the test. No written description of hands on training for nurses was documented by the hospital. The Director of the Center for Learning & Development was interviewed on 10/06/15 beginning at 9:00 AM. She confirmed restraint training was done online. She stated nurses needed a score of 80% to pass the online test. She stated during core orientation, nurses tied a restraint and demonstrated the use of hard restraints but this was not documented. The hospital did not provide hands-on restraint training for ED nursing staff.	A 194	Please see attached corrective action plans.		

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<p>A 286 A 286</p>	<p>Continued From page 59 482.21(a), (c)(2), (e)(3) PATIENT SAFETY</p> <p>(a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ...</p> <p>(c) Program Activities (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital.</p> <p>(e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following ... (3) That clear expectations for safety are established.</p> <p>This STANDARD is not met as evidenced by Based on staff interview and review of incident reports, it was determined the hospital failed to ensure the causes of 11 of 21 adverse patient events involving medications (Patients #17-27) were analyzed and/or preventative actions were implemented. This interfered with the hospital's ability to identify problems and make improvements in the medication delivery system.</p>	<p>A 286 A 286</p>	<p>Please see attached corrective action plans.</p>	
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A 286	<p>Continued From page 60 Findings include:</p> <p>Incident reports did not include an analysis of adverse patient events related to medications and/or a description of actions taken to correct processes that led to the adverse events. Examples include:</p> <p>a. An incident report that stated "Date Received 9/03/15," stated Patient #17 was mistakenly administered Golytely, a bowel preparation drink, on 9/02/15. The report stated the Golytely was included on the EMAR, the list of medications assembled by pharmacy staff to direct nurses in medication administration. The report stated the medication had not been ordered for Patient #17 but had actually been ordered for a different patient. The report stated someone spoke to the parties involved. No other action was documented.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #17 on 10/01/15 beginning at 1.00 PM. They confirmed the documentation and stated no other action was taken.</p> <p>b. An incident report that stated "Date Received 8/03/15," stated IV Levofloxacin, an antibiotic, contained a handwritten label by pharmacy and was sent to the floor for administration to Patient #18. The report stated the medication was assigned to Patient #18 by mistake. It stated the wrong medication was the result of a miscommunication between the IV room and the main pharmacy. It stated the staff involved were notified. The report stated the event was followed up with a department meeting but no specific action was documented.</p>	A 286	Please see attached corrective action plans.	
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A 286	Continued From page 61 The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #18 on 10/01/15 beginning at 1.00 PM. They stated the pharmacy made the error. They confirmed no specific action was documented to prevent future occurrences. c. An incident report that stated "Date Received 7/02/15," stated an incorrect dose of Prednisolone, a steroid, was sent to the NICU for administration to Patient #19. The report stated the error was caught before it was administered. The report stated the error occurred 2 days in a row. The report stated the incident was followed up with a department meeting and a review was in process. No specific investigation or actions were documented. The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #19 on 10/01/15 beginning at 1.00 PM. They confirmed actions to correct the errors were not documented. They stated the pharmacy changed the way labels were written and a separate check was added to the process. However, they stated these actions were not documented. d. An incident report that stated "Date Received 5/21/15," stated on 5/19/15, Patient #20 received Vancomycin, an antibiotic. The report stated the medication was administered 3 times between 9.47 AM and 5.36 PM. The report stated the medication should have been given every 8 hours. The report stated the error was made by the pharmacist. The report stated the action taken was "Followed up with individual in (sic)." No other action was documented.	A 286	Please see attached corrective action plans.		

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A 286	<p>Continued From page 62</p> <p>The Vancomycin package insert, dated December 2010, stated large doses of Vancomycin could cause kidney failure and hearing loss.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #20 on 10/01/15 beginning at 1 00 PM. The Investigating Pharmacist stated the pharmacist who made the error was counseled. He confirmed no other action was documented.</p> <p>e. An incident report that stated "Date Received 6/21/15," stated on 6/21/15, Patient #21, a newborn baby, received Morphine which was labeled as the wrong dose. The report stated it was later determined the baby received the correct dose of the medication but the label was incorrect. The report stated the staff involved was reeducated. The report also stated the error led to a root cause analysis. The results of the root cause analysis were not documented.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #21 on 10/01/15 beginning at 1.00 PM. The Senior Pharmacy Manager stated he was not aware of a root cause analysis for this error.</p> <p>The Manager for Quality and Patient Safety was interviewed on 10/05/15 beginning at 1 PM. She stated a root cause analysis was not documented related to the medication error. She stated she did not know why the incident stated a root cause analysis had been requested.</p>	A 286	Please see attached corrective action plans.		

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A 286	Continued From page 63 f. An incident report that stated "Date Received 6/18/15," stated on 6/18/15, the pharmacy sent Patient #22 an incorrect dose of Insulin. The report stated the RN called a pharmacist and questioned the dose. The report stated the pharmacist double checked the order and said it was the correct dose. The report stated the nurse continued to question the pharmacist and it was eventually determined the insulin order was for a different patient. The report stated the Senior Pharmacy Manager discussed the event with the pharmacist and the Pharmacy Technician. No other investigation or actions were documented. The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He confirmed no other investigation or actions were documented related to the medication error. g. An incident report that stated "Date Received, 8/31/15," stated on 8/31/15, Patient #23 was given IV Nitroglycerine, a drug to treat chest pain, instead of the ordered IV Nitroprusside, a medication to lower blood pressure. The report stated the error was caused by a traveling nurse on her first night after orientation. The report stated the nurse was told Nitroprusside was not kept on the automated medication dispensing cabinet. Further investigation and actions taken were not documented. The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He confirmed no other investigation or actions were documented related to the medication error for Patient #23. h. An incident report that stated "Date Received.	A 286	Please see attached corrective action plans.	

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A 286	<p>Continued From page 64</p> <p>6/02/15, stated on 6/01/15, Patient #24 was given Abilify, a medication to treat psychosis instead of Aricept, a medication to treat dementia, which was ordered. The report stated Patient #24 developed a rash but did not attribute the rash to the medication error. The report stated the nurse was coached. The report stated the pharmacist and technician were notified of the error. No other investigation or action were documented.</p> <p>The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He stated the pharmacist and pharmacy technician both made errors. He confirmed no other investigation or actions were documented related to the medication error for Patient #24.</p> <p>i. An incident report that stated "Date Received, 6/04/15," stated on 6/03/15, Patient #25 was given Cefazolin, an antibiotic instead of the ordered Rocephin, another antibiotic. The report did not document an investigation or action taken in response to the incident.</p> <p>The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He stated the pharmacist and the technician both contributed to the error. He confirmed no other investigation or actions were documented related to the medication error for Patient #25.</p> <p>j. An incident report that stated "Date Received, 8/21/15," stated on 8/19/15, Patient #26 was given a 12 mcg Fentanyl pain patch instead of the ordered 125 mcg Fentanyl patch. The report did not document that an investigation or action was taken in response to the incident.</p> <p>The Senior Pharmacy Manager was interviewed</p>	A 286	Please see attached corrective action plans.		

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A 286	Continued From page 65 on 10/08/15 beginning at 2 05 PM. He stated the error was both a nursing and a pharmacy error. He confirmed no other investigation or actions were documented. k. An incident report that stated "Date Received 3/03/15," stated on 3/03/15, the pharmacy sent Ceftriaxone to the nursing unit for IV administration to Patient #27. The report stated the medication Ceftriaxone was the medication that was ordered. Both medications were antibiotics but were different medications. The report stated the nurse caught the error and Patient #27 did not receive the wrong medication. The report did not document an investigation or action was taken in response to the incident. The Senior Pharmacy Manager was interviewed on 10/08/15 beginning at 2.05 PM. He confirmed there was no documentation of an investigation or actions taken following Patient #27's medication error. The hospital failed to investigate adverse patient events regarding medications and failed to take corrective action.	A 286	Please see attached corrective action plans.		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by. Based on staff interview and review of policies and clinical records, it was determined the hospital failed to ensure RN's were appropriately assigned, trained, and evaluated to provide care	A 385			

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A 385	Continued From page 66 for patients to ensure safe delivery of nursing care. Nursing related medication administration errors were not fully investigated and analyzed and a patient death resulted from a medication administration error. Findings include: 1. Refer to A-0194 as it relates to a failure of the hospital to ensure appropriately trained ED nursing staff as it related to appropriate management of patients demonstrating out-of-control and/or aggressive behavior. 2. Refer to A-0398 as it relates to the failure of the facility to ensure contracted nursing staff were qualified, oriented, and supervised. 3. Refer to A-0405 as it relates to the failure of the facility to ensure safe administration of medications. These systemic failures significantly impede the ability of the hospital to provide safe nursing services by competent nursing staff.	A 385	Please see attached corrective action plans.		
A 398	482.23(b)(6) SUPERVISION OF CONTRACT STAFF Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by. Based on staff interviews, review of personnel records and training transcripts and staffing lists of RNs in the ED, the hospital failed to ensure	A 398			

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A 398	<p>Continued From page 67</p> <p>sufficient supervision and evaluation of the clinical activities of non-employee nursing personnel. Two of 2 patients cared for by travel nurses in the ED (#7 and #23), whose records were reviewed, experienced medication errors. This resulted in the death of one patient and had the potential to impact all patients in the hospital. Findings include.</p> <p>1. Patient #7 was a 7 month old male who was brought to the ED on 9/22/15, for treatment of SVT, (supraventricular tachycardia, an irregular and rapid heartbeat). As a result of a medication administration error, Patient #7 died on 9/23/15 at 4.12 AM.</p> <p>Patient #7's medical record was reviewed with hospital staff on 9/30/15 at 11.17 AM. They stated the RN who provided primary care for Patient #7 at the time of his code in the ED, was a travel nurse on assignment from a contracted agency.</p> <p>The HR Manager and the Senior Director of HR were interviewed together on 10/02/15 at 10 45 AM. They stated the hospital did not validate credentials, license(s) or competencies of non-employee clinical staff. They stated the evidence of credentials, license(s) and competencies were provided by a contracted agency that assigned the non-employee clinical staff and were assumed to be accurate and complete. They stated HR performed a preliminary review of qualifications of a prospective clinician and the information was sent to the unit manager for further review and interview.</p> <p>The HR Manager, HR specialist, ED Educator,</p>	A 398	Please see attached corrective action plans.	

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A 398	<p>Continued From page 68</p> <p>Supervisor, Director of Center for Learning & Development and an Educator were interviewed together on 10/01/15 beginning at 3.00 PM. They stated the hospital's practice for the orientation, evaluation and supervision of non-employee clinical staff included a general orientation that consisted of on-line modules through the hospital LMS (Learning Management System) and an orientation by an educator to the unit assigned. They stated that, following the unit specific orientation, the employee was assigned an RN preceptor to observe patient care and check-off tasks documented in a preceptor notebook.</p> <p>During the interview, they stated 13 RNs in the ED were designated as preceptors, however, they had not received training for the preceptor role.</p> <p>During the interview, the personnel record of RN H, a travel nurse, was reviewed with the HR Manager and Senior Manager. They confirmed RN H had started with the hospital on 8/27/15. The LMS transcript was reviewed and they confirmed that no on-line modules were recorded in the hospital LMS as completed by the RN since his hire date.</p> <p>During the same interview, the staff were unable to provide documentation of preceptor activities for RN H, which would have included a list of skills and tasks that preceptors would observed him perform and attest to his ability to perform independently. They stated they did not know the whereabouts of that book and were unable to state what skills had or had not been checked-off that attested to RN H's ability to provide patient care. They confirmed RN H had worked 13 shifts and had accepted patient assignments of 4 or more patients at a time for the shifts worked.</p>	A 398	Please see attached corrective action plans.	

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A 398	<p>Continued From page 69</p> <p>They confirmed the hospital did not have an adequate process to ensure orientation, supervision, and evaluation of non-employee clinicians' clinical activities.</p> <p>RN H and the contracted agency staff were unavailable for interview during the survey.</p> <p>2. An incident report that stated "Date Received. 8/31/15," stated on 8/31/15, Patient #23 was given IV Nitroglycerine, a drug to treat chest pain, instead of the ordered IV Nitroprusside, a medication to lower blood pressure. The report stated the error was caused by a traveling nurse on her first night after orientation. The report stated the nurse was told Nitroprusside was not kept on the automated medication dispensing cabinet. Further investigation and actions taken were not documented.</p> <p>RN I, identified by the hospital as the preceptor for the ED, was interviewed by telephone on 10/05/15 at 12:05 PM. He stated he was one of several RNs who participated in precepting the travel RN H. The RN preceptor stated he had preceptor responsibility for the travel RN H for approximately 6 hours because their shifts happened to overlap. He stated he had not received any hand-off or communication from other individuals who precepted RN H, thus he was unaware of any specific tasks to perform. He stated the process he followed as he precepted included his initials on items he observed in a checklist format contained in a book in the possession of the employee being precepted. He could not remember any specific tasks he was responsible for or that he performed during the 6 hour period.</p>	A 398	Please see attached corrective action plans.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/08/2015
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
(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	
A 398	Continued From page 70 Additionally, RN I, the RN Preceptor stated he had not received training for the role of preceptor and was scheduled for a class in November. He stated he had precepted RNs in the ED for 4 or 5 shifts and that in each instance he precepted, he did not receive a hand-off or communication from previous preceptors. He stated he followed the same process of initialing any observed activities on the employee's check list that had not previously been checked. The hospital failed to ensure adequate orientation, supervision and evaluation of non-employee clinical activities.	A 398	Please see attached corrective action plans.		
A 405	482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in	A 405			

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A 405	<p>Continued From page 71</p> <p>accordance with the approved medical staff policies and procedures.</p> <p>This STANDARD is not met as evidenced by Based on staff interview, record review, medication error reports, policy review and observation, it was determined the facility failed to ensure medication orders were properly clarified and administered for 12 of 28 patients (#6, #7, #14, #16, #17, #18, #20, #21, #23, #24, #25 and #26) whose records were reviewed. This failed practice resulted in errors in dosage, medication delivery and the death of a patient. Findings include.</p> <p>1. In a facility policy titled "Medications," revised 2/28/15, the section titled "Ordering," stated medication orders were to be clear, accurate and legible. The policy stated the required elements for ordering medications were to include date and time, patient name, drug name, dosage, route, frequency, rete (for IV fluids), and indications for use. The policy stated pediatric orders should be written on a weight basis. Additionally, the policy stated "Unclear/incomplete medication orders will be clarified with the prescriber prior to administration." However, the facility failed to implement the policy as follows:</p> <p>a. Patient #7 was a 7 month old male who was brought to the ED on 9/22/15, for treatment of SVT, (supraventricular tachycardia, an irregular and rapid heartbeat).</p> <p>The infant was brought directly back to a treatment room in the ED and assessed by a physician and an RN. His heart rate was documented as 280 beats per minute. According</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 72</p> <p>to Medline Plus, National Institutes of Health, an infant from 1 month to 11 months of age, the normal heart rate range is 80-160 beats per minute. The RN documented in his assessment that the infant had a fever earlier in the evening, and the mother noticed his rapid heart rate.</p> <p>i. The physician ordered a medication for treatment of Patient #7's SVT. However, the order was unclear and incomplete.</p> <p>The order was written as "Adenosine Intravenous 0.1 mg/kg IV maximum of 4 mg(s)." The amount of the medication to be administered was not included in the order, leaving the RN to calculate the actual dose.</p> <p>The physician's order included the maximum amount of 4 mg, which lacked clarity as to whether the dose was to be administered one time only or repeated up to a maximum of 4 mg. The initial assessment of the infant by the RN documented the infant's weight as 8.9 kg.</p> <p>The order did not include the dose calculation. The RN did not clarify the order with the prescribing physician to ensure appropriate dosage calculation.</p> <p>A complete medication order for the pediatric patient would have included the dosage amount of 0.1 mg Adenosine per kg of the infant (8.9 kg) for a total of 0.89 mg of Adenosine to be given. According to Nursing 2015 Drug Handbook, "Adenosine is supplied in vials of 3 mg/ml." Additional calculation would be required to determine the volume of the medication. The actual volume of medication to be delivered would be 0.29 ml which would equal 0.89 mg of</p>	A 405	Please see attached corrective action plans.	
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A 405	<p>Continued From page 73</p> <p>Adenosine.</p> <p>Additionally, the order did not indicate if it was a one time administration order or if the medication could be repeated for persistent SVT. The RN did not obtain clarification of the frequency of administration.</p> <p>ii. The physician ordered IV fluids for the infant. However, his order for the normal saline was unclear and incomplete.</p> <p>The order was written as "Normal Saline IV 20 ml/kg. Implement IV protocol as needed." The order lacked clarity as to the rate of infusion, or if it was to be a one time bolus (a large volume of fluid given intravenously and rapidly at one time).</p> <p>The RN did not ensure the order was complete and clarified before administration of IV fluids. Additionally, the RN did not implement IV protocol as the physician ordered. Patient #7's record did not include the protocol sheet.</p> <p>The RN C, who provided care for Patient #7 was unavailable for interview. However, the RN who was the charge nurse during the shift when Patient #7 was in the ED was available for interview on 10/01/15 at 2.50 PM. The Charge Nurse reviewed Patient #7's record and confirmed the orders for the Adenosine and normal saline were incomplete. He confirmed the IV protocol was not implemented. He stated he would interpret the order for the normal saline as a one time bolus and infuse it over an hour, unless the physician specified the rate of infusion.</p> <p>The physician did not include all the elements of writing medication orders as defined in the</p>	A 405	Please see attached corrective action plans.	

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A 405	<p>Continued From page 74</p> <p>hospital policy. The medication orders were incomplete and lacked clarity. The RN administered medications without clarification of the orders.</p> <p>b. Patient #6 was a 55 year old female admitted to the ED on 9/22/15, for care related to profound weakness. Additional diagnoses included anemia and electrolyte imbalance.</p> <p>i. The physician wrote an order for supplemental electrolytes to be administered intravenously, however the order was unclear and incomplete.</p> <p>The order was written as "Potassium Phosphate Intravenous, give 40 mEq." Additionally, the order specified "Run over 4 hours please." The RN did not clarify the order to include the volume/concentration of the medication in the IV fluid or the route of delivery.</p> <p>The RN who provided care for Patient #6 did not further clarify the order with the physician.</p> <p>2. The Medications policy section titled "Administration," stated when administering medications, the following rights of medication were to be followed.</p> <ol style="list-style-type: none"> 1. Right patient 2. Right medication 3. Right dose 4. Right time 5. Right route 6. Right Documentation. <p>However, the facility failed to ensure the policy was fully implemented as follows</p>	A 405	Please see attached corrective action plans.	
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A 405	<p>Continued From page 75</p> <p>a. Patient #7 was a 7 month old male who was brought to the ED on 9/22/15, for treatment of SVT, (supraventricular tachycardia, an irregular and rapid heartbeat).</p> <p>The physician wrote an order which read "Normal Saline IV 20 ml/kg. Implement IV protocol as needed."</p> <p>i. Patient #7's flowsheet included documentation of medication administration. "Ordered medication was given via an intravenous route, at the primary site peripheral catheter at this time. Patency of site is determined and the ordered medication is hung. IV fluid start time is recorded of fluid(s) connected to macro tubing and infusing per Alaris pump at 300 ml/hr." The entry was recorded by the RN, and was dated 9/22/15 at 12:05 AM.</p> <p>Patient #7's record included documentation at 12:16 AM, he became unresponsive, his heart rate stopped, and resuscitation efforts were initiated. At 12:29 AM, the infant remained unresponsive, and it was discovered the bag of IV normal saline was labeled for a different patient, it contained potassium phosphate and was mixed in a concentration intended for administration through a central line.</p> <p>Patient #7's record indicated the IV fluid was stopped at that time, and the resuscitative efforts changed direction to reverse the effects of the concentrated potassium phosphate infusion. Resuscitative efforts were unsuccessful, and at 4:12 AM CPR was stopped, and the infant was pronounced dead.</p> <p>ii. The RN did not follow the "6 Rights" as the</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 76 policy directed.</p> <ul style="list-style-type: none"> - The bag of normal saline included a patient label placed by the pharmacy that noted potassium phosphate was added, in a concentrated form, and was for another patient, not Patient #7. <p>The Right Patient and the Right Medication were not verified.</p> <ul style="list-style-type: none"> - The bag of normal saline included a label that stated the medication required infusion into a central line, not peripheral. Patient #7 did not have a central line. <p>The Right Dose and Right Route were not verified.</p> <ul style="list-style-type: none"> - The RN did not include in his documentation the name of the medication he administered to Patient #7 at 12 05 AM. <p>The Right Documentation was not completed.</p> <p>The RN who provided care for Patient #7 was unavailable to interview. During the entrance conference on 9/30/15 beginning at 11.17 AM, the incident related to the medication infusion to the infant was discussed. The Manager of Quality and Patient Safety (MQPS), an RN, discussed the events, and preliminary results of the facility's investigation. The MQPS stated an IV solution was ordered for another patient in the ED. The IV solution was in a small volume of normal saline, and contained potassium phosphate. According to the MQPS, an RN saw the IV solution that was sent by pharmacy, and connected the IV bag to the tubing in preparation for administration. She</p>	A 405	Please see attached corrective action plans.	

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A 405	<p>Continued From page 77</p> <p>then hung the IV bag and tubing on an IV pole with a pump, and set it aside for the patient's nurse. According to the MQPS, the RN that was taking care of Patient #7 saw the small volume IV bag of normal saline, and thought it was intended for Patient #7. She stated the RN took the IV fluid into Patient #7's room and started the infusion.</p> <p>During an interview on 10/01/15 at 2:50 PM, the Charge Nurse reviewed Patient #7's record and confirmed the "Rights of Medication Administration," were not followed before the normal saline infusion was initiated.</p> <p>The RN did not follow the correct procedure for administering medications which resulted in Patient #7's death.</p> <p>b. Patient #14 was a 3 year old female who was admitted to the Same Day Surgery department on 12/19/14, for removal of her tonsils, adenoids and placement of drainage tubes in her ears.</p> <p>Her record included a pre-printed order sheet titled "Post Anesthesia Recovery Orders," completed and signed by the CRNA. The orders were dated 12/19/14, at 10:00 AM, and included orders for Morphine 6.5 mg, IV every 10 minutes as needed for pain.</p> <p>The Post Anesthesia Care Nursing Record included documentation the RN administered 4 mg Morphine to Patient #14 at 10:10 AM. The patient did not receive the ordered dose of 6.5 mg of Morphine.</p> <p>Patient #14's record did not include documentation of the reason the RN</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 78</p> <p>administered a different dose from that which was ordered.</p> <p>The RN that provided care for Patient #14 was unavailable for interview. The Director of Peri-Anesthesia, an RN, was interviewed on 10/02/15 at 2.00 PM. She reviewed Patient #14's record, and confirmed the dose of Morphine that was administered was not the dose ordered. The Director of Peri-Anesthesia stated "The nurse can give less if she thinks the patient could tolerate a lower dose for pain meds." However, she was unable to find a policy or standing orders to support the statement.</p> <p>The Rights of Medication Administration were not followed.</p> <p>c. Patient #16 was a 3 year old female who was admitted to the Same Day Surgery department on 12/19/14, for removal of her tonsils, adenoids and placement of drainage tubes in her ears. Additionally, Patient #16 had a foreign body removed from her left ear.</p> <p>Her record included a pre-printed order sheet titled "Post Anesthesia Recovery Orders," completed and signed by the CRNA. The orders were dated 12/19/14, at 9.07 AM. The orders included for mild pain, Morphine 0.7 mg, IV every 10 minutes as needed for pain.</p> <p>The Post Anesthesia Care Nursing Record included documentation the RN administered 0.5 mg Morphine to Patient #16 at 9.31 AM and at 9.41 AM. The patient did not receive the ordered dose of 0.7 mg of Morphine.</p> <p>Patient #16's record did not include</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 79</p> <p>documentation of the reason the RN administered a different dose from that which was ordered.</p> <p>The RN that provided care for Patient #16 was unavailable for interview. The Director of Peri-Anesthesia, an RN, was interviewed on 10/02/15 at 2:45 PM. She reviewed Patient #16's record and confirmed the dose of Morphine that was administered was not the dose ordered. The Director of Peri-Anesthesia stated "The nurse can give less if she thinks the patient could tolerate a lower dose for pain meds." However, she was unable to find a policy or standing orders to support the statement.</p> <p>The Rights of Medication Administration were not followed.</p> <p>d. An incident report that stated "Date Received, 9/03/15," stated Patient #17 was mistakenly administered Golytely, a bowel preparation drink, on 9/02/15. The report stated the Golytely was included on the EMAR, the list of medications assembled by pharmacy staff to direct nurses in medication administration. The report stated the medication had not been ordered for Patient #17 but had actually been ordered for a different patient. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #17 on 10/01/15 beginning at 1:00 PM. They confirmed the documentation and stated the error was both a nursing and a pharmacy error.</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 80</p> <p>The nurse that administered the Golytely failed to follow the Rights of Medication Administration.</p> <p>e. An incident report that stated "Date Received 8/03/15," stated IV Levofloxacin, an antibiotic, contained a handwritten label by pharmacy and was sent to the floor for administration to Patient #18. The report stated the medication was assigned to Patient #18 by mistake. It stated the wrong medication was the result of a miscommunication between the IV room and the main pharmacy. It stated the staff involved were notified. The report stated the event was followed up with a department meeting but no specific action was documented. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #18 on 10/01/15 beginning at 1 00 PM. He stated the error was both a nursing and a pharmacy error.</p> <p>The nurse that administered the Levofloxacin failed to follow the Rights of Medication Administration.</p> <p>f. An incident report that stated "Date Received 5/21/15," stated on 5/19/15, Patient #20 received Vancomycin, an antibiotic. The report stated the medication was administered 3 times between 9.47 AM and 5.36 PM. The report stated the medication should have been given every 8 hours. The report stated the error was made by the pharmacist. The report stated the action taken was "Followed up with individual in (sic)."</p>	A 405	Please see attached corrective action plans.	
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A 405	<p>Continued From page 81</p> <p>No other action was documented. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Vancomycin package insert, dated December 2010, stated large doses of Vancomycin could cause kidney failure and hearing loss.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #20 on 10/01/15 beginning at 1.00 PM. He stated the error was both a nursing and a pharmacy error. He confirmed no other action was documented.</p> <p>The nurse that administered the three doses of Vancomycin failed to follow the Rights of Medication Administration.</p> <p>g. An incident report that stated "Date Received 6/21/15," stated on 6/21/15, Patient #21, a newborn baby, received Morphine which was labeled as the wrong dose. The report stated it was later determined the baby received the correct dose of the medication but the label was incorrect. The report stated the staff involved was reeducated. The report also stated the error led to a root cause analysis. The results of the root cause analysis were not documented. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager and the Investigating Pharmacist reviewed the incident report for Patient #21 on 10/01/15 beginning at 1.00 PM. He stated the error was both a nursing</p>	A 405	Please see attached corrective action plans.		

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A 405	<p>Continued From page 82 and a pharmacy error.</p> <p>The nurse that administered the Morphine failed to follow the Rights of Medication Administration.</p> <p>h. An incident report that stated "Date Received, 8/31/15," stated on 8/31/15, Patient #23 was given IV Nitroglycerine, a drug to treat chest pain, instead of the ordered IV Nitroprusside, a medication to lower blood pressure. The report stated the error was caused by a traveling nurse on her first night after orientation. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He stated the error was both a nursing and a pharmacy error. He confirmed no other investigation or actions were documented related to the medication error for Patient #23.</p> <p>The nurse that administered the IV Nitroglycerine failed to follow the Rights of Medication Administration.</p> <p>i. An incident report that stated "Date Received, 6/02/15, stated on 6/01/15, Patient #24 was given Abilify, a medication to treat psychosis instead of Aricept, a medication to treat dementia, which was ordered. The report stated Patient #24 developed a rash but did not attribute the rash to the medication error. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager was interviewed</p>	A 405	Please see attached corrective action plans.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/06/2015
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
(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	
A 405	<p>Continued From page 83 on 10/06/15 beginning at 2.05 PM. He stated the error was both a nursing and a pharmacy error.</p> <p>The nurse that administered the Abilify failed to follow the Rights of Medication Administration.</p> <p>j. An incident report that stated "Date Received 6/04/15," stated on 6/03/15, Patient #25 was given Cefazolin, an antibiotic instead of the ordered Rocephin, another antibiotic. The report did not document an investigation or action taken in response to the incident. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He stated the error was both a nursing and a pharmacy error. He confirmed no other investigation or actions were documented related to the medication error for Patient #25.</p> <p>The nurse that administered the Cefazolin failed to follow the Rights of Medication Administration.</p> <p>k. An incident report that stated "Date Received 8/21/15," stated on 8/19/15, Patient #26 was given a 12 mcg Fentanyl pain patch instead of the ordered 125 mcg Fentanyl patch. The report did not document that an investigation or action was taken in response to the incident. The nursing staff failed to verify the physician orders and the EMAR for accuracy, which resulted in the medication administration error.</p> <p>The Senior Pharmacy Manager was interviewed on 10/06/15 beginning at 2.05 PM. He stated the error was both a nursing and a pharmacy error.</p>	A 405	Please see attached corrective action plans.		

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A 405	Continued From page 84 He confirmed no other investigation or actions were documented.	A 405	Please see attached corrective action plans.		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service. This CONDITION is not met as evidenced by: Based on staff interview, record review, and policy review, it was determined the hospital failed to ensure pharmaceutical services were sufficiently developed to assure safe medication delivery for 13 of 21 patients (#6, #7, and #17-27) whose records and adverse patient events involving medications were reviewed. This resulted in deficient practices in medication ordering, order entry, dosage calculation, and medication delivery. These failures resulted in errors in medication orders, order entry, preparation, dispensing, and administration of medications and had the potential to result in negative patient outcomes for all patients receiving services at the facility. Findings include: 1. In a facility policy titled "Medications," revised 2/28/15, the section titled "Ordering," stated medication orders were to be clear, accurate and	A 490			

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301		
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A 490	<p>Continued From page 85</p> <p>legible. The policy stated the required elements for ordering medications were to include date and time, patient name, drug name, dosage, route, frequency, rate (for IV fluids), and indications for use. The policy stated pediatric orders should be written on a weight basis. Additionally, the policy stated "Unclear/incomplete medication orders will be clarified with the prescriber prior to administration." However, the pharmacy failed to implement the policy as follows.</p> <p>a. Patient #7 was a 7 month old male who was brought to the ED on 9/22/15, for treatment of SVT, (supraventricular tachycardia, an irregular and rapid heartbeat).</p> <p>The infant was brought directly back to a treatment room in the ED and assessed by a physician and an RN. His heart rate was documented as 280 beats per minute. According to Medline Plus, National Institutes of Health, an infant from 1 month to 11 months of age, the normal heart rate range is 80-160 beats per minute. The RN documented in his assessment that the infant had a fever earlier in the evening, and the mother noticed his rapid heart rate.</p> <p>i. The physician ordered a medication for treatment of Patient #7's SVT. However, the order was unclear and incomplete.</p> <p>The order was written as "Adenosine Intravenous 0.1 mg/kg IV maximum of 4 mg(s)." The amount of the medication to be administered was not included in the order, which required nursing staff to calculate the actual dosage to be administered.</p> <p>The physician's order included the maximum amount of 4 mg, which lacked clarity as to</p>	A 490	Please see attached corrective action plans.		

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NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301	
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A 490	<p>Continued From page 86</p> <p>whether the dose was to be administered one time only or repeated up to a maximum of 4 mg. The initial assessment of the infant by the RN documented the infant's weight as 8.9 kg.</p> <p>A complete medication order for the pediatric patient would have included the dosage amount of 0.1 mg Adenosine per kg of the infant (8.9 kg) for a total of 0.89 mg of Adenosine to be given. According to Nursing 2015 Drug Handbook, "Adenosine is supplied in vials of 3 mg/ml." Additional calculation would be required to determine the volume of the medication. The actual volume of medication to be delivered would be 0.29 ml which would equal 0.89 mg of Adenosine.</p> <p>The order was not sent to the pharmacy, the medication was obtained from an automated medication dispensing system located in the ED. The pharmacy did not provide oversight and direction to ensure an appropriate and accurate dose was dispensed for Patient #7.</p> <p>ii. The physician ordered IV fluids for the infant. However, his order for the normal saline was unclear and incomplete.</p> <p>The order was written as "Normal Saline IV 20 ml/kg. Implement IV protocol as needed." The order lacked clarity as to the rate of infusion, or if it was to be a one time bolus (a large volume of fluid given intravenously and rapidly at one time).</p> <p>During an interview on 10/01/15 beginning at 8.20 AM, the Senior Manager of Pharmacy Services stated the ED was one of three units in the hospital that did not have a scanning system for medication administration. He stated that most of</p>	A 490	Please see attached corrective action plans.	

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A 490	<p>Continued From page 87</p> <p>the medications were available to the ED through the automated medication dispensing system located in the department. He stated the small volume bags of normal saline were used for medication delivery, they came from the pharmacy, and they would all have a patient label attached. Additionally, he stated the only IV fluids that would not have a patient label attached, would be 1 liter bags that were stored on the individual nursing units.</p> <p>The pharmacy was not included in the review of the orders, clarification of the order by the pharmacist did not occur, which prevented the dispensing and safe delivery of medications for Patient #7.</p> <p>2. The Medications policy section titled "Dispensing," stated "All medication orders are reviewed by a pharmacist prior to dispensing." Additionally, "The pharmacist reviews each medication order for, ...appropriateness of drug, dose, route, and frequency..." However, the policy was not followed in the following example.</p> <p>a. Patient #6 was a 55 year old female admitted to the ED on 9/22/15, for care related to profound weakness. Additional diagnoses included anemia and electrolyte imbalance.</p> <p>The physician wrote an order for supplemental electrolytes to be administered intravenously, however the order was unclear and incomplete.</p> <p>The order was written as "Potassium Phosphate Intravenous, give 40 mEq." Additionally, the order specified "Run over 4 hours please."</p> <p>The physician documented in his dictated notes</p>	A 490	Please see attached corrective action plans.	

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A 490	<p>Continued From page 88</p> <p>that he spoke with the pharmacist when he ordered the IV medication. However, Patient #6's record did not indicate the order was clarified by the pharmacist to confirm the volume of IV fluid and concentration of the medication.</p> <p>During an interview on 10/01/15 beginning at 11:05 AM, the Physician who treated Patient #6 in the ED stated he spoke with the pharmacist about her need for the potassium and phosphate. He stated he left the decision to the pharmacist about the volume of the medication. He stated he never saw the bag of IV fluid, but thought it would have been at least in a 500 ml bag, not the 150 ml that was prepared by the pharmacist. The physician stated he was not aware the concentration was specific to infusion in a central line and not to be delivered peripherally.</p> <p>During an interview on 10/01/15 beginning at 3:15 PM, the Pharmacist that spoke with the ED physician regarding Patient #6 and her need for potassium phosphate confirmed he spoke with the physician the evening of 9/22/15. The Pharmacist stated he contacted the physician to clarify how the order was written and what the actual concentration of potassium he wanted. The Pharmacist stated the physician requested the medication to be delivered in as small amount as possible. The Pharmacist stated he then made a concentrated solution of the medication in a 150 ml bag of normal saline. He said the medication was concentrated, and could not be administered through a peripheral IV, and had to be administered into a central line. However, he stated he did not call the ED to alert the RN of the need for the IV medication to be infused through a central line.</p>	A 490	Please see attached corrective action plans.		

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A 490	<p>Continued From page 89</p> <p>The Pharmacist stated he was contacted by a nurse in the ED after midnight, and was asked to prepare another bag of the IV potassium phosphate. He stated he was told to send the medication to the nursing floor, as the patient was being admitted. The Pharmacist stated that when Patient #6 arrived on the nursing unit he was contacted by an RN that told him Patient #6 did not have a central line. He stated he then made another IV solution in a larger volume that could be delivered peripherally.</p> <p>The pharmacy failed to ensure the medication order was clarified for the concentration and volume of fluid to be delivered, which resulted in a concentration that was not appropriate for the method of delivery.</p> <p>2. Refer to A 286 as it relates to the hospital's failure to ensure medication errors were analyzed and corrective actions taken to prevent subsequent errors.</p> <p>These systemic negative practices seriously impeded the ability of the hospital to provide safe and effective pharmaceutical services.</p>	A 490	Please see attached corrective action plans.		

St. Luke's Magic Valley RMC Corrective Action Plan for CMS Report received 10/26/2015

CORRECTIVE ACTION PLAN for A-0115

The Governing Body of St. Luke's Magic Valley Regional Medical Center is accountable for immediate implementation of this Plan of Correction and has delegated direct oversight and responsibility to the St. Luke's Magic Valley Site Administrator. Supporting the implementation are the Interim Regional CEO, Medical Executive Committee (MEC) and related medical staff departments, and Hospital leadership. The MEC has direct physician oversight responsibility related to this plan and is assigned to review all results and direct further action to assure improvement and to sustain this action. The Leadership has delegated assignments and action to all appropriate clinical leadership to resolve, monitor, report, and sustain improvements documented in the Plan of Correction. The long-term goal for St. Luke's Magic Valley Regional Medical Center is to be a Highly Reliable Organization, to instill a Just Culture, and institute the TeamSTEPPS framework from AHRQ with communication and awareness of these initiatives having already taken place.

As evidenced by voluntarily reporting the 9/23/15 sentinel event to the Department of Health & Human Services which prompted the survey and subsequent findings, St. Luke's Magic Valley is committed to improving our care to our patients. Our Leadership team takes this report very seriously and is committed to do everything within our ability to ensure a successful implementation of the Plan of Correction.

See Corrective Action Plan for A-0144

See Corrective Action Plan for A-0145

See Corrective Action Plan for A-0166

See Corrective Action Plan for A-0168

See Corrective Action Plan for A-0171

See Corrective Action Plan for A-0174

See Corrective Action Plan for A-0176

See Corrective Action Plan for A-0178

See Corrective Action Plan for A-0184

See Corrective Action Plan for A-0188

See Corrective Action Plan for A-0194

See Corrective Action Plan for A-0405

See Corrective Action Plan for A-0490

CORRECTIVE ACTION PLAN for A-0144 (Jon Scallan, Regional Director of Accreditation, is responsible for the completion of this corrective action plan)

IMMEDIATE RESPONSE

Surgical masks will no longer be utilized as a spit mask for a patient in restraints. Audits will be conducted for all restraint patients with 100% compliance of this practice as the benchmark.

Completion Date: 10/15/2015

1. Began supervisor and educator communication in department safety huddles around abuse emphasizing patient and staff safety in the Emergency Department.

Completion Date: 10/27/15

2. Huddle discussions to include any issues related to Supply Chain's ability to fulfill orders for appropriate transport hoods. This will be built into safety huddle checklist.

Completion Date: 11/03/15

3. An Emergency Department education packet will be distributed November 9-20, 2015 covering appropriate use of transport hoods (spit masks) according to manufacturer's guidelines. This education will include the prohibition of the use of surgical masks as a substitute for a transport hood.

Completion Date: 11/20/15

4. Appropriate use of spit masks will be addressed in the updated restraint policy PC048MV to be approved by 11/30/15.

Completion Date: 11/30/15

5. This education will be tracked with the compliance rate reported to Magic Valley Quality Safety & Service Excellence (QSSEC).

Completion Date: 11/06/15

6. Compliance of the education to the staff will be reported to the Magic Valley QSSEC with an expectation of >90%.

Completion Date: 11/06/15

7. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application.

Completion Date: 11/06/15

8. Appropriate use of spit masks will be a review item for the Behavior Response Resource Team.

Completion Date: 11/06/15

CORRECTIVE ACTION PLAN for A-0145 (Jeremy Royal, Director of Case Management, is responsible for completion of this corrective action plan)

1. Began supervisor and educator communication around abuse emphasizing patient and staff safety in the Emergency Department.

Completion Date: 10/27/15

2. The policies, #4004 Abuse Exploitation Neglect Adult and #4003 Abuse Abandonment Neglect Children (Alleged) Safe Haven Act will be updated with content from #HR049TV Patient Abuse Prevention, cross-walked to CMS Conditions of Participation and adopted for Magic Valley to create alignment within the St. Luke's Health System.

Completion Date: 11/20/15

3. Situational Awareness training (see corrective action plan covering A-0194) will be given in the following phases:

Phase I – Behavior Response Resource Team (BRRT) training, create tool.

Completion of Phase I will occur by 11/20/15 with 90% completion as the target goal.

Phase II – Risk Stratified units training.

Phase III – Update computer learning Restraint Module and develop deployment plan to affected caregivers.

Completion of Phases II and III will occur by 12/18/15 with 90% completion as the target goal.

Completion rates for all training, which will be integrated into the restraint training/ education plan, will be tracked and reported to Magic Valley QSSEC until completion by all identified staff with target date of 12/18/15.

CORRECTIVE ACTION PLAN for A-0166 (Jeremy Royal, Director of Case Management, is responsible for completion of this corrective action plan)

1. The current restraint policy (Policy PC048MV) for St. Luke's Magic Valley excluding Canyon View Behavioral Health Services will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions. Develop a matrix that identifies all policies.

Completion Date: 11/20/15

2. In addition, our suicide protocol (Policy PE024MV), delirium protocol (Policy PC448PRO), and abuse/harassment policies (Policy 4004MV Abuse & Neglect Adult & Policy 4003MV (Abuse & Neglect Child)) will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.

Completion Date: 11/20/15

3. Our protective custody policy (Policy 4325MV) will be cross-walked to our new restraint policy.

Completion Date: 11/20/15

4. The current training program will be re-designed to cover the new policy, expectations for updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions. The training will also cover any modifications to the policies and practices listed in #s 2 and 3.

Completion Date: 12/18/15

5. A Behavior Response Resource Team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application

Completion Date: 11/06/15

6. Education and awareness applicable to level of practice will be disseminated to all staff with restraint responsibilities.

Completion Date: 12/18/15

Auditing will occur retrospectively for 100% of patients in any form of restraint from 10/01/15 forward. Results will be analyzed to identify trends and opportunities relating to deviations from standards and action plans will be implemented. The current restraint audit tool has been modified to include:

- Updated Care Plan.
- Clinical justification for continued restraint use to ensure earliest release was initiated.
- Documentation of 1 hour face-to-face meeting in the application of violent restraint.
- Evidence of patient response to restraint.

Completion Date: 11/04/15

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC. Completion Date: 12/02/15

The person responsible for completion, and the dates in the Corrective Action Plan for A-0166, are also applicable to the following tags:

A-0168

A-0171

A-0174

A-0176

A-0178

A-0184

A-0188

A-0194

CORRECTIVE ACTION PLAN for A-0168

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to the implementation of restraints being based on current, clear, and complete orders issued by a physician or other LIP.
2. The current training program will be re-designed to cover the new policy, including:
 - Expectations specific to physician and LIP workflows related to the ordering of restraints.
 - Address the use of 4x4 Bed rails, with clarification of when their use qualifies as a restraint.
3. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
4. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. Auditing of restraint orders and use of 4x4 Bed Rails when used as a restraint will occur retrospectively for 100% of patients in any form of restraint. Results will be analyzed to identify trends and opportunities relating to deviations from standards and action plans will be implemented. The current restraint audit tool has been modified to include the following audit fields:

- Updated care plan
- Documentation of Alternative de-escalation methods used prior to restraint use
- Clinical justification for restraint type (Non-violent/Violent/Chemical)
- Clinical justification for continued restraint use to ensure earliest release was initiated
- Documentation of 1 hour face-to-face meeting in the application of violent restraint
- Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN for A-0171

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions

applicable to the use of least restrictive measures for all restraints. More specifically the policy redesign will reflect the structure found in 482.13(e)(8) dictating that an order for restraint used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours and daily thereafter:

- (A) 4 hours for adults 18 years of age or older,
- (B) 2 hours for children and adolescents 9 to 17 years of age, or
- (C) 1-hour for children under 9 years of age

2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. Auditing for use of least restrictive measures will occur retrospectively for 100% of patients in any form of restraint. Results will be analyzed to identify trends and opportunities relating to deviations from standards and action plans will be implemented. The current restraint audit tool has been modified to include the following audit fields:

- Updated care plan
- Documentation of Alternative de-escalation methods used prior to restraint use
- Clinical justification for restraint type (Non-violent/Violent/Chemical)
- Clinical justification for continued restraint use to ensure earliest release was initiated
- Documentation of 1 hour face-to-face meeting in the application of violent restraint
- Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN for A-0174

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to the discontinuation of restraints at the earliest possible time, regardless of the length of time identified in the physician or LIP order.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, expectations for updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. Auditing will occur retrospectively for 100% of patients in any form of restraint. Results will analyzed to identify deviations from standards and action plan implemented. The current restraint audit tool has been modified to include the following audit fields:
 - Updated Care Plan

- Documentation of Alternative de-escalation methods used prior to restraint use
- Clinical justification for restraint type (Non-violent/Violent/Chemical)
- Clinical justification for continued restraint use to ensure earliest release was initiated
- Documentation of 1 hour face-to-face meeting in the application of violent restraint
- Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN for A-0176

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to the training requirements for all physicians and LIP's authorized to order restraint or seclusion.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, and give physician/LIP specific education/training on expectations for updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. A computer based learning module with knowledge testing will be required for risk stratified providers.

Required compliance for completion of computer based learning module and testing will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC

CORRECTIVE ACTION PLAN for A-0178

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to the requirement that a physician or LIP must conduct a face-to-face assessment of the patient within 1 hour, when restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient a staff member or others.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, and to specifically address the requirements for the ordering physician or LIP to conduct a face-to-face assessment within 1 hour of restraint initiation.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be

disseminated to staff with restraint responsibilities. Auditing will occur retrospectively for 100% of patients in any form of restraint. Results will be analyzed to identify deviations from standards and action plan implemented. The current restraint audit tool has been modified to include the following audit fields:

- Updated care plan
- Documentation of Alternative de-escalation methods used prior to restraint use
- Clinical justification for restraint type (Non-violent/Violent/Chemical)
- Clinical justification for continued restraint use to ensure earliest release was initiated
- Documentation of 1 hour face-to-face meeting in the application of violent restraint
- Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN for A-0184

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to the requirement that the patient's record must include documentation of the 1 hour physician or LIP face-to-face medical and behavioral evaluation, when restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member or others.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, expectations for updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. Auditing will occur retrospectively for 100% of patients in any form of restraint. Results will be analyzed to identify trends and opportunities relating to deviations from standards and action plans will be implemented. The current restraint audit tool has been modified to include the following audit fields:
 - Updated care plan
 - Documentation of Alternative de-escalation methods used prior to restraint use
 - Clinical justification for restraint type (Non-violent/Violent/Chemical)
 - Clinical justification for continued restraint use to ensure earliest release was initiated
 - Documentation of 1 hour face-to-face meeting in the application of violent restraint
 - Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC

CORRECTIVE ACTION PLAN for A-0188

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and

- other organizational restraint policies and re-designed to address all requirements and definitions applicable to documentation of patient response to restraint and rationale for continued restraint.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
 3. Our protective custody policy will be cross-walked to our new restraint policy.
 4. The current training program will be re-designed to cover the new policy, specifically focusing on the monitoring and consideration of the patient's response to an ongoing restraint events as that applies to updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
 5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
 6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities. Documentation of the monitoring and considerations of patient response to a restraint event will be audited retrospectively for 100% of patients in any form of restraint. Results will be analyzed to identify trends and opportunities relating to deviations from standards and action plans will be implemented.. The current restraint audit tool has been modified to include the following audit fields:
 - Updated care plan
 - Documentation of Alternative de-escalation methods used prior to restraint use
 - Clinical justification for restraint type (Non-violent/Violent/Chemical)
 - Clinical justification for continued restraint use to ensure earliest release was initiated
 - Documentation of 1 hour face-to-face meeting in the application of violent restraint
 - Documentation of patient response to restraint

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN for A-0194

1. The current restraint policy for St. Luke's Magic Valley Inpatient population, excluding Canyon View Behavioral Health Services, will be cross walked with the conditions of participation standards, and other organizational restraint policies and re-designed to address all requirements and definitions applicable to ensuring staff has education, training, and demonstrated knowledge to manage violent or aggressive patients.
2. In addition, our suicide protocol, delirium protocol, and abuse/harassment policies will be cross-walked with our restraint policy to ensure continuity of services to these patient populations.
3. Our protective custody policy will be cross-walked to our new restraint policy.
4. The current training program will be re-designed to cover the new policy, expectations for updating care plans, verbal de-escalation techniques, use of least restrictive alternatives, restraints-as-a-last-resort, safe restraint application, and appropriate documentation of restraint interventions.
5. A behavioral response resource team will be constituted to provide education, review, and oversight of verbal management of difficult patients and restraint application
6. Education and awareness applicable to level of practice and based on risk stratification will be disseminated to staff with restraint responsibilities.

Data collated from these audits will be reported to the hospital's Quality Management oversight group (MV QSSEC) on 12/02/15 and on an ongoing basis. A restraint resource expert has been identified who will oversee this audit program and coordinate reporting to MV QSSEC.

CORRECTIVE ACTION PLAN FOR A-0286 (Almita Nunnalee, Sr. Director of Quality, is responsible for completion of this corrective action plan)

Immediate/Containment

09/23/15 - Quality Director distributed a communication to staff on an immediate change to IV medication dispensing as an immediate containment measure

- IV admixture to which potassium was added will be labeled with a bright colored potassium alert messaging label referencing POTASSIUM. The label(s) will be visible from both sides of the IV bag. Compounded TPN solutions will be excluded. On 10/15/15, a single point lesson was distributed to all nursing and pharmacy staff units to be displayed and discussed during unit safety huddles.

Completion Date: 10/15/2015

- Implement placement of colored foil port cover on IV fluids manipulated (added to or taken away from) by pharmacy, in addition to normal pharmacy required product labeling on 10/02/15.

Completion Date: 10/02/2015

- 09/23/15 - Pharmacy Potassium Policy reviewed and updated to reflect immediate measures to include port covers and alert stickers. Policy refined and updated on 10/01/15, pharmacy specific single point lesson delivered to all staff with roster capturing 100% pharmacy education. (Senior Pharmacy Director)

Completion Date: 10/01/2015

- Re-education surrounding the 6 rights of medication administration was provided to clinicians who administer medication including contracted staff and nursing students. Education completed on 10/09/15 and rosters collected excluding physicians.

Completion Date: 10/09/2015

- 6 rights education and medication administration built into NECO Day 1, new provider and contractor orientation. (Senior Manager of Learning and Development)

Completion Date: 10/01/2015

- 10/01/15 - Implement requirement for double independent verification by qualified personnel on high risk medications administered to the pediatric populations (including IV fluids) in areas identified as highest risk within areas without Bedside Medication Verification. (Sr. Director of Nursing and Patient Care)

Completion Date: 10/01/2015

- 10/01/15 - Emergency Department implementation of 2 RNs performing 6 rights of medication administration at the bedside for pediatric medications on 10/01/15. (ED Director)

Completion Date: 10/01/2015

- Observational audits for pediatric population of high-risk areas will include compliance to standards of independent verification, weight based ordering and documentation. Sample size of this audit will be 30 per month for 3 months with >90% compliance as benchmark.

Completion Date: 11/20/2015

- Clinician Commitment reviewed with providers at Physician Leadership Committee (PLC) 10/09/2015 and Medical Executive Committee (MEC) 10/13/15 and general Medical Staff 10/29/15. (Administrator of Physician Services)

Completion Date: 10/29/2015

- 10/19/15 - Pharmacy Senior Director delivered email education to providers/prescribers that pharmacy would notify clinicians for incomplete orders for clarification. (Senior Pharmacy Director) will conduct retrospective auditing to ensure compliance.

Completion Date: 10/19/2015

CORRECTIVE ACTIONS

- A root cause analysis was immediately conducted which resulted in multiple areas of opportunity

pertaining to early identification and prevention of medication errors.

Completion Date: 10/02/2015

- In response to the RCA the following actions were taken:

- FMEA on medication administration in high-risk areas

Completion Date: 10/16/2015

- Medication Administration (6 rights, pediatric weight-based dosing/definition, pediatric double verification, patient education campaign, visual alerts on IV K+ K+bags);

Completion Date: 10/30/2015

- Review of Emergency Department master staffing plan; and

Completion Date: 12/18/2015

- Standardization of clinical contract staff orientation.

Completion Date: 10/30/2015

- Implementation of Medication Safety Committee & Medication Safety workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement for identified opportunities. (Senior Pharmacy Director, Medical Safety Coordinator)

Completion Date: 10/09/2015

- The Medication Policy MM0036 SLHS was reviewed by nursing and pharmacy leadership. The policy was modified and approved on 10/28/15 adding a St. Luke's Magic Valley specific addendum to include:

- Developed a definition of Pediatric High Risk medications which require an independent verification.

- Independent verification is defined as a redundant verification of verifying the order, dose, med, route, rate, and patient without any interference from the requesting person.

- Requirement for weight based dosing for medications ordered for pediatric patients except for those not usually ordered as a weight-based dose.

- Definition of a pediatric patient (under 13 or 40kg and under).

Completion Date: 10/28/2015

- The Pharmacy Director developed an SBAR communication tool to educate physicians and nurses on weight-based dosing including examples. Addendum development included SLHS key stakeholders for input and validation. A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)

Completion Date: 10/26/2015

- 10/21/15 - Pharmacy Commitment to Medication Safety was adopted. All pharmacists committed to not accepting or processing any incomplete orders. If orders are clarified by the

pharmacist, the clarified order will be recorded on a physician order sheet and added to the patient medical record.

Completion Date: 10/21/2015

- Phase I efforts are being concentrated in identified high-risk areas to ensure staff are trained in risk mitigation, 6 rights, independent double verification, and weight-based dosing. Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV. Phase II efforts will include analysis of remaining areas to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)

Completion Date:11/20/2015

QAPI

- RCA conducted on medication error resulting in a pediatric death on 09/23/15. Changes to our potassium labeling were immediately implemented. A comprehensive root cause analysis was developed.

Completion Date: 10/02/2015

- Implementation of Medication Safety Committee and Medication Safety multidisciplinary workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement. Reporting structure for this information will be: Medication events > Medication Safety Committee > MV QSSEC (and P & T) > East Region QSSEC > East Region Board & St. Luke's Health System QSSEC. In addition, Sr. Director Quality & Patient Safety reports Quality/PI data/issues to MEC. (Senior Pharmacy Director, Medical Safety Coordinator)

Completion Date: 10/09/2015

- A summary of all Medication errors, root causes, and interventions will be presented and reviewed by the Medical Executive Committee on a monthly basis. (Medical Chief of Staff)

Completion Date: 11/20/2015

- A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)

Completion Date: 10/26/2015

- Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV. Phase II efforts will include analysis of St. Luke's infusion pediatric medication administration process to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)

Completion Date: 11/06/2015

- Conducted FMEA analysis for Emergency Department, Surgery and Pharmacy to assess medication delivery system. Action items organized for implementation. (Patient Safety Officer)

Completion Date: 11/20/2015

- On 10/29/2015, identified weakness in current containment measures around weight-based dosing for pediatric patients.

Completion Date: 10/29/2015

- Additional education on independent verification provided to Emergency room nurses with a competency validation post education.

Completion Date: 11/20/2015

- Implement role of second independent verifier in the ED (ED Director)

Completion Date: 10/30/2015

The person responsible for completion, and the dates outlined in the Corrective Action Plan A-0286 are also applicable for Corrective Action Plans for A-0405 and A-0490.

CORRECTIVE ACTION PLAN for A-0385

The Governing Body of St. Luke's Magic Valley Regional Medical Center is accountable for immediate implementation of this Plan of Correction and has delegated direct oversight and responsibility to the St. Luke's Magic Valley Site Administrator. Supporting the implementation are the Interim Regional CEO, Medical Executive Committee (MEC) and related medical staff departments, and Hospital leadership. The MEC has direct physician oversight responsibility related to this plan and is assigned to review all results and direct further action to assure improvement and to sustain this action. The Leadership has delegated assignments and action to all appropriate clinical leadership to resolve, monitor, report, and sustain improvements documented in the Plan of Correction. The long-term goal for St. Luke's Magic Valley Regional Medical Center is to be a Highly Reliable Organization, to instill a Just Culture, and institute the TeamSTEPPS framework from AHRQ with communication and awareness of these initiatives having already taken place.

As evidenced by voluntarily reporting the 9/23/15 sentinel event to the Department of Health & Human Services which prompted the survey and subsequent findings, St. Luke's Magic Valley is committed to improving our care to our patients. Our Leadership team takes this report very seriously and is committed to do everything within our ability to ensure a successful implementation of the Plan of Correction.

The person responsible for completion of this corrective action plan is Danika Severe, Regional Manager of Education

See Corrective Action Plan for A-0194

See Corrective Action Plan for A-0398

See Corrective Action Plan for A-0405

CORRECTIVE ACTION PLAN FOR A-0398 (The person responsible for completion of this corrective action plan is Danika Severe, Regional Manager of Education)

1. All clinical contractor staff were given the 6 Rights of Medication Patient Safety document as part of the action plan response connected to the organization's Root Cause Analysis (See Attached).

Completion Date: 10/24/2015

2. Development of a standardized organizational process for onboarding clinical contract staff- with focus on patient safety expectations, service expectations, policies and procedures, and unit-specific high-

risk processes and performance improvement activities.

Completion Date: 10/18/2015

3. Standardized requirement for precepting shifts were defined by clinical role.

Completion Date: 10/18/2015

4. Preceptor expectations for onboarding clinical contract staff are standardized and have been communicated.

Completion Date: 10/18/2015

5. Implemented new process with existing clinical contractors starting from 10/18/15.

Completion Date: 10/18/2015

6. Trained unit-based educators on new standardized process and have oversight of implementation of onboarding requirements.

Completion Date: 10/30/2015

7. Updated Policy HR5005MV Clinical Contractor Orientation Requirements.

Completion Date: 10/30/2015

8. Created an organizational Contractor Orientation template currently in use at St. Luke's Magic Valley.

Completion Date: 10/18/2015

9. Created a unit-specific Contractor Orientation template in use at St. Luke's Magic Valley.

Completion Date: 10/18/2015

10. The Organization will conduct an audit of 100% clinical contracted staff to ensure compliance with an ongoing monthly audit of new staff.

Completion Date: 11/04/2015

CORRECTIVE ACTION PLAN FOR A-0405

IMMEDIATE/CONTAINMENT

09/23/15 - Quality Director distributed a communication to staff on an immediate change to IV medication dispensing as an immediate containment measure

- IV admixture to which potassium was added will be labeled with a bright colored potassium alert messaging label referencing POTASSIUM. The label(s) will be visible from both sides of the IV bag. Compounded TPN solutions will be excluded. On 10/15/15, a single point lesson was distributed to all nursing and pharmacy staff units to be displayed and discussed during unit safety huddles.
- Implement placement of colored port cover on IV fluids manipulated (added to or taken away from) by pharmacy, in addition to normal pharmacy required product labeling on 10/02/15.
- 09/23/15 - Pharmacy Potassium Policy reviewed and updated to reflect immediate measures to include port covers and alert stickers. Pharmacists instructed through daily safety huddles and reflected weekly written summaries. Policy refined and updated on 10/01/15, pharmacy specific single point lesson delivered to all staff with roster capturing 100% pharmacy education. (Senior Pharmacy Director)
- Re-education surrounding the 6 rights of medication administration was provided to clinicians who administer medication including contracted staff and nursing students. Education completed on 10/09/15 and rosters collected.
- 6 rights education and medication administration built into NECO Day 1, new provider and contractor

orientation. (Senior Manager of Learning and Development)

- 10/01/15 - Implement requirement for double independent verification by qualified personnel on high risk medications administered to the pediatric populations (including IV fluids) in areas identified as highest risk within areas without Bedside Medication Verification. (Sr. Director of Nursing and Patient Care)
- 10/01/15 - Emergency Department implementation of 2 RNs performing 6 rights of medication administration at the bedside for pediatric medications on 10/01/15. (ED Director)
- Observational audits for pediatric population of high-risk areas will include compliance to standards of independent verification, weight based ordering and documentation. Sample size of this audit will be 30 per month.
- Clinician Commitment reviewed with providers at Physician Leadership Committee (PLC) 10/09/2015 and Medical Executive Committee (MEC) 10/13/15 and general Medical Staff 10/29/15. (Administrator of Physician Services)
- 10/19/15 - Pharmacy Senior Director delivered email education to providers/prescribers that pharmacy would notify clinicians for incomplete orders for clarification. (Senior Pharmacy Director) will conduct retrospective auditing to ensure compliance.

CORRECTIVE ACTIONS

- A root cause analysis was immediately conducted which resulted in multiple areas of opportunity pertaining to early identification and prevention of medication errors.
- In response to the RCA the following actions were taken:
 - FMEA on medication administration in high-risk areas to include handoff communication;
 - Medication Administration (6 rights, pediatric weight-based dosing/definition, pediatric double verification, patient education campaign, visual alerts on IV K+ K+bags);
 - Review of Emergency Department master staffing plan; and
 - Standardization of clinical contract staff orientation.
- Implementation of Medication Safety Committee & Medication Safety workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement. (Senior Pharmacy Director, Medical Safety Coordinator)
- The Medication Policy MM0036 SLHS was reviewed by nursing and pharmacy leadership. The policy was modified and approved on 10/28/15 adding a St. Luke's Magic Valley specific addendum to include:
 - Developed a definition of Pediatric High Risk medications which require an independent verification.
 - Independent verification is defined as a redundant verification of verifying the order, dose, med, route and patient without any interference from the requesting person.
 - Requirement for weight based dosing for medications ordered for pediatric patients except for those not usually ordered as a weight-based dose.
 - Definition of a pediatric patient (under 13 or 40kg and under).

The Pharmacy Director developed an SBAR communication tool to educate physicians and nurses on weight-based dosing including examples. Addendum development included SLHS key stakeholders for input and validation. A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)

10/21/15 - Pharmacy Commitment to Medication Safety was adopted. All pharmacists committed to not accepting or processing any incomplete orders. If orders are clarified by the pharmacist, the clarified

order will be recorded on a physician order sheet and added to the patient medical record.

Phase I efforts are being concentrated in these areas to ensure staff are trained in risk mitigation, 6 rights, independent double verification, and weight-based dosing. Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV.

Phase II efforts will include analysis of remaining areas to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)

QAPI

- RCA conducted on medication error resulting in a pediatric death on 09/23/15. Changes to our potassium labeling were immediately implemented. A comprehensive root cause analysis was developed.

Implementation of Medication Safety Committee and Medication Safety multidisciplinary workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement. Reporting structure for this information will be: Medication events > Medication Safety Committee > MV QSSEC (and P & T) > East Region QSSEC > East Region Board & St. Luke's Health System QSSEC. In addition, Sr. Director Quality & Patient Safety reports Quality/PI data/issues to MEC. (Senior Pharmacy Director, Medical Safety Coordinator)

- A summary of all Medication errors, root causes, and interventions will be presented and reviewed by the Medical Executive Committee on a monthly basis. (Medical Chief of Staff)
- A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)
- Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV. Phase II efforts will include analysis of SL Clinic's infusion pediatric medication administration process to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)
- Conducted FMEA analysis for Emergency Department, Surgery and Pharmacy to assess medication delivery system. Action items organized for implementation. (Patient Safety Officer)
- On 10/29/2015, identified weakness in current containment measures around weight-based dosing for pediatric patients.
- Additional education on independent verification provided to Emergency room nurses with a competency validation post education.
- Implement role of second independent verifier in the ED (ED Director)

CORRECTIVE ACTION PLAN FOR A-0490

The Governing Body of St. Luke's Magic Valley Regional Medical Center is accountable for immediate implementation of this Plan of Correction and has delegated direct oversight and responsibility to the St. Luke's Magic Valley Site Administrator. Supporting the implementation are the Interim Regional CEO, Medical Executive Committee (MEC) and related medical staff departments, and Hospital leadership. The MEC has direct physician oversight responsibility related to this plan and is assigned to review all results and direct further action to assure improvement and to sustain this action. The Leadership has delegated assignments and action to all appropriate clinical leadership to resolve, monitor, report, and sustain improvements documented in the Plan of Correction. The long-term goal for St. Luke's Magic Valley Regional Medical Center is to be a Highly Reliable Organization, to instill a Just Culture, and institute the TeamSTEPPS framework from AHRQ with communication and awareness of these initiatives having already taken place.

As evidenced by voluntarily reporting the 9/23/15 sentinel event to the Department of Health & Human

Services which prompted the survey and subsequent findings, St. Luke's Magic Valley is committed to improving our care to our patients. Our Leadership team takes this report very seriously and is committed to do everything within our ability to ensure a successful implementation of the Plan of Correction.

IMMEDIATE/CONTAINMENT

09/23/15 - Quality Director distributed a communication to staff on an immediate change to IV medication dispensing as an immediate containment measure

- IV admixture to which potassium was added will be labeled with a bright colored potassium alert messaging label referencing POTASSIUM. The label(s) will be visible from both sides of the IV bag. Compounded TPN solutions will be excluded. On 10/15/15, a single point lesson was distributed to all nursing and pharmacy staff units to be displayed and discussed during unit safety huddles.
- Implement placement of colored port cover on IV fluids manipulated (added to or taken away from) by pharmacy, in addition to normal pharmacy required product labeling on 10/02/15.
- 09/23/15 - Pharmacy Potassium Policy reviewed and updated to reflect immediate measures to include port covers and alert stickers. Pharmacists instructed through daily safety huddles and reflected weekly written summaries. Policy refined and updated on 10/01/15, pharmacy specific single point lesson delivered to all staff with roster capturing 100% pharmacy education. (Senior Pharmacy Director)
- Re-education surrounding the 6 rights of medication administration was provided to clinicians who administer medication including contracted staff and nursing students. Education completed on 10/09/15 and rosters collected.
- 6 rights education and medication administration built into NECO Day 1, new provider and contractor orientation. (Senior Manager of Learning and Development)
- 10/01/15 - Implement requirement for double independent verification by qualified personnel on high risk medications administered to the pediatric populations (including IV fluids) in areas identified as highest risk within areas without Bedside Medication Verification. (Sr. Director of Nursing and Patient Care)

10/01/15 - Emergency Department implementation of 2 RNs performing 6 rights of medication administration at the bedside for pediatric medications on 10/01/15. (ED Director)

- Observational audits for pediatric population of high-risk areas will include compliance to standards of independent verification, weight based ordering and documentation. Sample size of this audit will be 30 per month.
- Clinician Commitment reviewed with providers at Physician Leadership Committee (PLC) 10/09/2015 and Medical Executive Committee (MEC) 10/13/15 and general Medical Staff 10/29/15. (Administrator of Physician Services)
- 10/19/15 - Pharmacy Senior Director delivered email education to providers/prescribers that pharmacy would notify clinicians for incomplete orders for clarification. (Senior Pharmacy Director) will conduct retrospective auditing to ensure compliance.

CORRECTIVE ACTIONS

- A root cause analysis was immediately conducted which resulted in multiple areas of opportunity pertaining to early identification and prevention of medication errors.
- In response to the RCA the following actions were taken:
 - FMEA on medication administration in high-risk areas to include handoff communication;
 - Medication Administration (6 rights, pediatric weight-based dosing/definition, pediatric double verification, patient education campaign, visual alerts on IV K+ K+bags);
 - Review of Emergency Department master staffing plan; and standardization of clinical contract staff orientation.

- Implementation of Medication Safety Committee & Medication Safety workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement. (Senior Pharmacy Director, Medical Safety Coordinator)
- The Medication Policy MM0036 SLHS was reviewed by nursing and pharmacy leadership. The policy was modified and approved on 10/28/15 adding a St. Luke's Magic Valley specific addendum to include:
 - Developed a definition of Pediatric High Risk medications which require an independent verification.
 - Independent verification is defined as a redundant verification of verifying the order, dose, med, route and patient without any interference from the requesting person.
 - Requirement for weight based dosing for medications ordered for pediatric patients except for those not usually ordered as a weight-based dose.
 - Definition of a pediatric patient (under 13 or 40kg and under).

The Pharmacy Director developed an SBAR communication tool to educate physicians and nurses on weight-based dosing including examples. Addendum development included SLHS key stakeholders for input and validation. A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)

10/21/15 - Pharmacy Commitment to Medication Safety was adopted. All pharmacists committed to not accepting or processing any incomplete orders. If orders are clarified by the pharmacist, the clarified order will be recorded on a physician order sheet and added to the patient medical record.

Phase I efforts are being concentrated in these areas to ensure staff are trained in risk mitigation, 6 rights, independent double verification, and weight-based dosing. Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV.

Phase II efforts will include analysis of remaining areas to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)

QAPI

- RCA conducted on medication error resulting in a pediatric death on 09/23/15. Changes to our potassium labeling were immediately implemented. A comprehensive root cause analysis was developed.
- Implementation of Medication Safety Committee and Medication Safety multidisciplinary workgroup to collect and analyze data on medication management, to identify risk points, trends, variations and to prioritize and initiate performance improvement. Reporting structure for this information will be: Medication events > Medication Safety Committee > MV QSSEC (and P & T) > East Region QSSEC > East Region Board & St. Luke's Health System QSSEC. In addition, Sr. Director Quality & Patient Safety reports Quality/PI data/issues to MEC. (Senior Pharmacy Director, Medical Safety Coordinator)
- A summary of all Medication errors, root causes, and interventions will be presented and reviewed by the Medical Executive Committee on a monthly basis. (Medical Chief of Staff)
- A stratification tool was developed to assess areas of highest risk for error with medication delivery. Identified Emergency Department, PACU, Same Day Surgery, Quick Care, and Medical Imaging-Nursing as areas with highest risk. (Senior Director of Nursing and Patient Care)
- Auditing of medical records to assure >90% compliance with double clinician verification of medication rights in areas identified as high risk without BMV. Phase II efforts will include analysis of SL Clinic's infusion pediatric medication administration process to evaluate current process for risk and for potential independent verification. (Administrator of Physician Services)

- Conducted FMEA analysis for Emergency Department, Surgery and Pharmacy to assess medication delivery system. Action items organized for implementation. (Patient Safety Officer)
- 10/29/2015 - Identified weakness in current containment measures around weight-based dosing for pediatric patients.
- Additional education on independent verification provided to Emergency room nurses with a competency validation post education.
- Implement role of second independent verifier in the ED. (ED Director)