Western Division of Survey & Certification

August 24, 2018

Eastern Idaho Regional Medical Center
3100 Channing Way
Idaho Falls, ID 83404

Dear Administrator:

Re: CMS Certification Number: 13-0018
Conditions of Participation Not Met
Removed Deemed Status
90-day Termination Track

IMPORTANT
PLEASE READ CAREFULLY

The Centers for Medicare and Medicaid Services (CMS) has determined that Eastern Idaho Regional Medical Center 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. Your deemed status with The Joint Commission 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.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a facility must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a facility is found to be out of compliance with the Medicare Condition of Participation, The Social Security Act Section 1866(b) authorizes the Secretary to terminate a facility’s Medicare provider agreement because the facility no longer meets the requirements for participation as a provider of services in the Medicare program. 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. Consequently, it is our intention to terminate Eastern Idaho Regional Medical Center participation in the Medicare program. The projected date on which the agreement will terminate is November 22, 2018.

On August 15, 2018, the Bureau Of Facility Standards (State survey agency) completed a complaint survey at your facility. The deficiencies identified are cited in the enclosed Statement of Deficiencies. The deficiencies limit the capacity of Eastern Idaho Regional Medical Center 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).

The finding that the Eastern Idaho Regional Medical Center is not in compliance with the Conditions of Participation does not affect your facility’s The Joint Commission accreditation, its Medicare payments, or its current status as a participating provider in the Medicare program. However, you are required to submit an acceptable plan of correction regarding these deficiencies. After the approved plan of correction has been implemented, and we have found that all of the Medicare Conditions of Participation are met, we will discontinue the state’s survey jurisdiction. A copy of this letter is being forwarded to Joint Commission and the Bureau Of Facility Standards.

POTENTIAL TERMINATION AND OPPORTUNITY TO CORRECT

To avoid potential termination action, CMS must receive and approve a credible allegation of compliance within 10 calendar days of the date of this letter. Complete your plan of correction in the space provided on the CMS-2567, or in the format of your choice. Compliance will be verified with an unannounced revisit by the State survey agency.

Please send your plan of correction to (1) the State Survey Agency and (2) to CMS to the attention of Karen Roe at:

CMS_RO10_CEB@cms.hhs.gov

Or, when not emailed, fax to (443) 380-7537

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 facility 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.

This is an official notice sent electronically or facsimile, pursuant to 42 C.F.R. Part 488, no hard copy to follow.
Thank you for your cooperation and I look forward to working with you on a continuing basis in the administration of the Medicare program. If you have any questions please contact my staff via e-mail at CMS_RO10_CEB@cms.hhs.gov. Attention: Karen Roe

Sincerely,

Julius P. Bunch Jr., Manager
(CQISCO) Seattle Regional Office
Certification & Enforcement Branch
Centers for Medicare & Medicaid Services

cc: Bureau Of Facility Standards
The Joint Commission
Office of General Counsel - DHHS
September 14, 2018

Administrator
Eastern Idaho Regional Medical Center
3100 Channing Way
Idaho Falls, ID 83404

Re: CMS Certification Number 13-0018
Plan of Correction Accepted
Termination Action Suspended

Dear Administrator:

After careful review of the plan of correction that you submitted on September 10, 2018, and the subsequent revisions, CMS and the Idaho Bureau of Facility Standards (State survey agency) determined that it is acceptable. You stated in your plan that you will implement corrective actions at the specified timeline. By this, CMS is accepting your Plan of Correction as your allegation of compliance. CMS will suspend its termination action pending result of a follow up survey to be conducted by the Bureau of Facility Standards. This will be an unannounced survey.

Thank you for your cooperation with this matter. If you have any questions, please contact me via email at CMS_RO10_CEB@cms.hhs.gov, attention Karen Roe.

Sincerely,

Karen W. Roe
Karen W. Roe, RN, MHA
Nurse Consultant
Division of Survey, Certification & Enforcement
Regional Office - Seattle

cc: Bureau of Facility Standards
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

[X1] PROVIDER/SUPPLIER CLIA IDENTIFICATION NUMBER: 130018

[X2] MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

[X3] DATE SURVEY COMPLETED: 08/15/2018

NAME OF PROVIDER OR SUPPLIER: EASTERN IDAHO REGIONAL MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 3100 CHANNING WAY, IDAHO FALLS, ID 83404

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<th>ID</th>
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<td>A000</td>
<td>INITIAL COMMENTS</td>
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<td>The following deficiencies were cited during the Federal Medicare complaint investigation conducted at your hospital on 8/13/18 to 8/15/18. The surveyors conducting the Federal Medicare complaint investigation were: Teresa Hamblin, RN, HFS, Team Lead Brian Osborn, RN, HFS</td>
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The following acronyms were used in this report:

- ALF - Assisted Living Facility
- CMS - Centers for Medicare & Medicaid Services
- DM - Diabetes Mellitus
- DNI - Do Not Intubate
- DNR - Do Not Resuscitate
- DPOA - Durable Power of Attorney for Healthcare
- ESLD - End Stage Liver Disease
- HHAs - Home Health Agencies
- HFS - Health Facility Surveyor
- IV - Intravenous
- LTC - Long Term Care
- PRBC - Packed Red Blood Cells
- QAPI - Quality Assessment Performance Improvement
- RN - Registered Nurse
- SNF - Skilled Nursing Facility

A263 QAPI

CFR(s): 482.21

The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.

The hospital's governing body must ensure that the program reflects the complexity of the

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE: [Signature]

TITLE: [Title]

[Signature]

[Date: 09/12/18]

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**A263** Continued From page 1

hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

This CONDITION is not met as evidenced by:

Based on medical record review, hospital policy review, hospital document review, review of incident reports, and staff interview, it was determined the hospital failed to ensure an effective, ongoing, hospital-wide, data-driven QAPI program focused on improved health outcomes. This resulted in the inability of the hospital to monitor the quality of patient care services and safety. Findings include:

1. Refer to A286 as it relates to the failure of the hospital to ensure adverse patient events were analyzed and actions were taken to prevent further incidents.

2. Refer to A843 as it relates to the failure of the hospital to ensure its discharge planning process was reassessed on an on-going basis.

The cumulative effect of these negative systemic practices prevented the hospital from evaluating the care and services it provided.

Refer to A286 and A843 tags for complete Plan of Correction and all corresponding elements.
A 286

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<td>A-286</td>
<td>Continued From page 2 (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 ... (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. (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. This STANDARD is not met as evidenced by: Based on medical record review, hospital policy review, hospital document review, review of incident reports, and staff interview, it was determined the hospital failed to ensure adverse patient events were identified, analyzed, and actions were taken to prevent further incidents for 1 of 1 patients (Patient #5) who had an adverse event and whose record was reviewed. This resulted in lack of analysis and evaluation of safe patient care and had the potential for unidentified adverse patient events for all patients receiving care at the hospital. Findings include: A hospital document &quot;Quality, Risk, and Safety Plan,&quot; effective 8/14/18, stated &quot;Duty to</td>
<td>A-286</td>
<td>Plan of Correction (POC): Revision of current Occurrence Reporting policy to include identification of key adverse events (i.e. unexpected mortalities, patient falls, medication errors, Code Blue, return to OR, readmission, SSI, inpatient stroke) recommended to trigger an occurrence report being completed. Education to all staff will occur directed at the importance of identifying adverse patient events, activation of an investigation and response to the event, and utilization of shared learning supporting care improvement. Outcomes and action plans of adverse events will be summarized and distributed to all staff for learning purposes. In regards to Patient #5, there was an occurrence report filed, however that report focused only on the unutilized units of blood, with none of the clinical event and actions being included. The revisions to the Occurrence Reporting policy, as outlined above, will provide the education needed to each nursing department regarding proper content of occurrence reporting going forward. There was a full mortality review completed by both the quality nurse reviewer, the Director of the Medical unit, the CNO, and the CMO. Opportunities identified from that review include a need for greater documentation of acute events prior to the mortality on the part of both the nursing staff on the Medical unit and the Hospitalist group.</td>
<td>9/23/18</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**ID (X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:** 130018

**NAME OF PROVIDER OR SUPPLIER:** EASTERN IDAHO REGIONAL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

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<td>Process for implementing POC: Revised policy will be assigned to all nursing staff as a required read. Education to all staff will occur through the use of an educational video assigned through Healthstream. Continue focal review of all key adverse events with each event being reported within 24 hours of occurrence, an initial quality review completed within 48 hours, with the intention of routling the event to the proper channel for further review. Education to the facility Directors and Managers regarding the expectation of investigating reported events will occur. This education will include the process for investigation and analysis of incident trends. Education will be published regarding the criteria and process of occurrence reporting through the available educational outlets to the medical staff. Distribution of outcome summaries occurs through a weekly safety 411 during safety huddle and a monthly newsletter on the Internal Intranet website will continue to occur. For the opportunity identified from the result of the case analysis of Patient #5, the education will be utilized for a re-focused initiative on the affected nursing department (Medical unit). This focus will be on the expectation of documentation of the nursing response to changes in patient condition via vital signs, critical labs, and physical findings. Our hospital will then continue with a phased roll-out after the 23rd to spread this education to Include all Inpatient nursing units. Education to the medical staff includes directives to the Hospitalist group being educated on the importance of thorough documentation in instences where mortalities occur while care is being escalated; also including the consideration of weighing actions that may be contrary or non-beneficial for DNR/DNI or hospice patients.</td>
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**DATE SURVEY COMPLETED:** 08/15/2018

**B. WING:**

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY):**

**PRINTED:** 08/24/2018

**FORM APPROVED OMB NO. 0938-0391**

**FORM CMS-2567(02-99) Previous Versions Obsolete**

**Event ID:** DS1011

**Facility ID:** IDLF0V

**If continuation sheet Page 4 of 22**
Continued From page 4

"...body, leading to a severe drop in blood pressure."

Further, the Mayo Clinic website, accessed 8/16/18, states "A low hemoglobin count is defined as less than...12 grams per deciliter of blood for women." "A low hemoglobin count can also be due to blood loss, which can occur because of...bleeding in your digestive tract..."

The Cleveland Clinic website, accessed 8/16/18, states "Esophageal varices are enlarged or swollen veins that occur on the lining of the esophagus. Varices can be life-threatening if the break open and bleed. They usually occur in people with cirrhosis of the liver."

Patient #5's medical record included the following nursing notes, dated 7/29/18, signed by her RN:

- 2:10 AM: "Blood pressure 70/35...PATIENT HAS BEEN REPORTING BLACK VOMIT. HOWEVER I HAVE YET TO SEE ANYTHING SINCE THE ONE EVENT OF RED BLOODY EMESIS [vomit] LAST NIGHT."
- 3:11 AM: "Blood pressure 70/41."
- 5:18 AM: "Blood pressure 71/34."
- 6:27 AM: "Hgb [hemoglobin] 4.9...order and transfuse [3 units] PRBC as ordered."

Patient #5's medical record included a discharge summary, dated 7/29/18, signed by the physician, which stated "However, during her stay the patient developed severe hematemesis [vomiting blood] likely secondary to esophageal variceal blood and passed away on 09/18 on 7/29/18."
### Summary Statement of Deficiencies

It was not documented if the RN contacted Patient #5's physician regarding her complaint of "black vomit" or her continuous low blood pressures. It could not be determined by the RN's documentation if Patient #5 received her ordered blood, as there was no blood administration forms in her medical record. Due to lack of RN documentation, it was unclear what events transpired on 7/29/18 between 6:27 AM and 9:18 AM.

The Director of Quality, Risk, and Patient Safety was interviewed on 8/14/18, beginning at 1:46 PM, and Patient #5's medical record was reviewed in her presence. She stated the missing blood administration documentation and subsequent death for Patient #5 had not been identified yet and did not warrant an incident/adverse event report. The Director of Quality, Risk, and Patient Safety stated there had not been a mortality review of Patient #5's chart yet. When asked why a mortality review had not been done, she stated the hospital only had one employee who would do the initial mortality reviews and it would take that person up to 30 days to complete. The Director of Quality, Risk, and Patient Safety stated "it takes time and resources and she [the mortality reviewer] has other duties and responsibilities." She stated there was no written policy or procedure for patient mortality reviews to identify potential adverse events in a timely manner. The Director of Quality, Risk, and Patient Safety confirmed Patient #5's RN failed to document physician notification of her complaints and low blood pressure, and blood administration. She confirmed it was unclear whether Patient #5 received her blood transfusion or not.
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<td>A 286</td>
<td>Continued From page 6</td>
<td>An incident/adverse event report regarding Patient #5's blood administration was requested from the Director of Quality, Risk, and Patient Safety on 8/14/18. The report provided, dated 8/01/18, referenced the wasting of unused blood for Patient #5 and stated &quot;Blood Administration...Omission.&quot;</td>
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<td>The RN who cared for Patient #5 during the night shift of 7/29/18 was interviewed by phone on 8/15/18, beginning at 9:02 AM. When asked if he notified Patient #5's physician regarding her complaint of &quot;black vomit&quot; and low blood pressure, he stated he did, but confirmed he did not document this. When asked if he administered the ordered blood for Patient #5, he stated he started a new peripheral IV in Patient #5's left arm and started the blood administration prior to leaving his shift, but confirmed he did not document this.</td>
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<td>The Blood Bank Supervisor was interviewed on 8/15/18, beginning at 9:50 AM. When asked if she could locate blood administration documentation for Patient #5, she stated there was none. She stated Patient #5 did not receive her ordered blood and the blood was returned to the hospital laboratory following her death. The Blood Bank Supervisor stated &quot;[name, Registered Medical Laboratory Scientist] told me the RN spiked the unit of blood, but [Patient #5's] IV was occluded. She [Patient #5] got no blood and died while they were trying to get a new IV.&quot;</td>
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| The Clinical Supervisor who was on shift and assisting when Patient #5 expired, and Director of Quality, Risk, and Patient Safety, were interviewed together on 8/15/18, beginning at 10:39 AM. When asked if Patient #5 received her...
Continued From page 7
ordered blood, the Clinical Supervisor stated "no."
The Clinical Supervisor stated Patient #5 did not
have a working IV to administer the ordered blood
and expired "hemorrhaging from the mouth."
When asked if she completed an adverse event
report regarding Patient #5's blood administration
complications and death, the Clinical Supervisor
stated "it wasn't needed." When asked what her
definition of an adverse event was, the Clinical
Supervisor stated "something outside the norm."
When asked if the situation preceding Patient
#5's death was outside normal expected
outcomes, the Clinical Supervisor stated "yes"
and confirmed an adverse event form should have
been completed. When asked how hospital staff
were trained on identifying and reporting adverse
events, the Director of Quality, Risk, and Patient
Safety stated "only during new-hire orientation."
When asked how long she had been an
employee of the hospital, the Clinical Supervisor
stated "20 years."

The Director of Quality, Risk, and Patient Safety
was interviewed on 8/15/18, beginning at 10:51
AM. She confirmed the conflicting stories of
events preceding Patient #5's death and
confirmed an adverse event form should have
been completed.

The hospital failed to ensure adverse patient
events were identified, analyzed, and actions
were taken to prevent further incidents.

The hospital must have in effect a discharge
planning process that applies to all patients. The
hospital's policies and procedures must be
This CONDITION is not met as evidenced by:

Based on review of policies, procedures, medical records, quality documents, and staff and caregiver interviews, it was determined the hospital failed to ensure the hospital's written policies and procedures addressed all the requirements of 42 CFR 482.43(a) - 482.43(e). The hospital also failed to ensure family members were adequately counseled to prepare them for post-hospital care, that lists of home health agencies were provided to patients/caregivers in accordance with hospital policy, that physicians received necessary medical information post-hospitalization, that a process was established to assess/reassess its discharge planning process. These failures interfered with the implementation of discharge planning and had the potential to result in unmet patient needs.

Findings include:

1. Surveyors requested policies and procedures related to discharge planning. The hospital policy "Assessment, Patient - Case Managers/Social Workers/Utilization Review," dated 5/04/15, stated "The hospital's policies and procedures must be specified in writing. This is a mandatory requirement of the Conditions of Participation for Hospitals."

Policies did not address all discharge planning requirements. Examples include:

a. Hospital policy did not address the requirements at 482.43(b)(6) (A-811) to discuss the results of the discharge planning evaluation with the patient or the patient's representative (and document the communication in the medical record).

Plan of Correction (POC): The Director of Case Management and Social Services will review the CMS conditions of participation and crosswalk with the hospital policies to ensure inclusion of all the discharge planning requirements and revise all pertinent policies.

Process for Implementing POC: The Assessment, Patient - Case Managers/Social Workers/Utilization Review policy will be retitled to "Discharge Planning" policy and updated to include the requirement of discussing the results of the discharge planning evaluation with the patient or the patient's representative with documentation of the communication in the medical record. The retitled "Discharge Planning" policy will also be updated to include the requirement specifying the patient's physician ability to request a discharge plan in the absence of one. The retitled "Discharge Planning" policy will also be revised to include the process that our hospital will follow to provide physician offices with necessary medical information post-hospitalization. The retitled "Discharge Planning" policy will be revised to include our hospital's process of reassessing the discharge planning process on an on-going basis, including a review of discharge plans.

Monitoring & tracking procedures ensuring the POC is effective: All policies will be revised and placed in Policy Manager with an annual review by the Director of Case Management and Social Services for ongoing monitoring purposes.

Process improvement actions incorporated into the QAPI program: The completion of the above listed policy updates will be reported to the Clinical Quality Committee.

Individual responsible: Teresa Pentz; Director of Case Management and Social Services
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<td>b. Hospital policy did not address the requirements at 482.43(c)(2) (A-819) specifying in the absence of a finding by the hospital that a patient needs a discharge plan, the patient’s physician may request a discharge plan, and in such a case, the hospital must develop a discharge plan for the patient.</td>
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<td>c. Hospital policy did not address the requirements at 482.43(d) (A-837) as it relates to providing physician offices with necessary medical information post-hospitalization.</td>
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<td>d. Hospital policy did not address the requirement at 482.43(e) (A-843) to have a process to reassess its discharge planning process on an on-going basis, including a review of discharge plans.</td>
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2. Refer to A-820 as it relates to the failure of the hospital to ensure family members were adequately counseled to prepare them for post-hospital care.

3. Refer to A-823 as it relates to the failure of the hospital to ensure home health agency lists were provided to patients/caregivers in accordance with hospital policy.

4. Refer to A-837 as it relates to the failure of the hospital to ensure a process was established to inform physicians of necessary medical information post-hospitalization.

5. Refer to A-843 as it relates to the failure of the hospital to ensure a process was established to assess/reassess its discharge planning process on an on-going basis as a part of the hospital’s...
The cumulative effect of these negative facility practices impeded the hospital's ability to provide adequate discharge planning services to patients. IMPLEMENTATION OF A DISCHARGE PLAN CFR(s): 482.43(c)(3), (5)

(3) The hospital must arrange for the initial implementation of the patient's discharge plan.

(5) As needed, the patient and family members or interested persons must be counseled to prepare them for post-hospital care.

This STANDARD is not met as evidenced by:

Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure family members were adequately counseled to prepare them for post-hospital care for 2 of 5 patients (#1 and #5) whose medical records were reviewed. This resulted in a lack of preparation and involvement of family members for patient discharges and had the potential to result in unmet patient needs. Findings include:

The hospital policy, "Skilled Nursing/Assisted Living Facility Referrals," dated 5/13/16, was reviewed. It stated "The Social Worker/Case Manager will meet with the patient, family/significant others to: a. Prepare the patient, family/significant others emotionally for the patient's transfer to the appropriate level of post-acute care as determined by the physician."

Family members were not counseled appropriately to prepare them for post-hospital care. Examples follow:

Plan of Correction (POC): Education to all case managers and social workers will occur regarding the hospital policy on including family members/representative in the discharge plan and the requirement of documenting those conversations in the medical record.

Process for implementing POC: Education will occur for 100% of the staff members.

Monitoring & tracking procedures ensuring the POC is effective: A random sample of 10% of discharged patients per month will be audited for a total of 6 months. The audits will be conducted weekly to verify documentation of communication with inclusion of family members/representatives.

Process improvement actions incorporated into the QAPI program: Audit results will be reported at the monthly Clinical Quality Committee by the Director of Case Management and Social Services.

Individual responsible: Teresa Pentz; Director of Case Management and Social Services.
1. Patient #1 was an 86 year old female admitted to the hospital on 7/06/18 for delirium in the setting of Alzheimer-type dementia with overlying urinary tract infection. Her daughter was listed on the initial nursing assessment, dated 7/06/18, as her decision-maker and DPOA. At admission, the daughter indicated a preference for a specific ALF after discharge.

PT daily notes for Patient #1, on 7/06/18, 7/07/18, and 7/08/18, included documentation that PT recommended Patient #1 be discharged to a SNF or LTC.

A physician note, dated 7/08/18, documented a plan for discharge to a SNF.

Patient #1 was discharged on 7/09/18 to the ALF with home health services.

Patient #1's DPOA was interviewed by telephone on 8/15/18 at 7:50 AM. The DPOA stated Patient #1's physician explained to her on 7/08/18 (the day prior to Patient #1's discharge) that the Physical Therapist had recommended Patient #1 be discharged to a SNF or rehabilitation unit due to her condition and he, the physician, agreed with those recommendations and proposed the plan. The DPOA stated she agreed to the plan and was willing to have Patient #1 go to any of 4 or 5 facilities that were presented to her as options. She stated she received a call later letting her know one of the SNFs was not available. She stated she assumed another one would have been arranged. On 7/09/18, the day of Patient #1's discharge, the DPOA arrived at the hospital, expecting to drive Patient #1 to a SNF or rehabilitation unit. Instead, the discharging nurse
Continued From page 12
told her, the DPOA, that Patient #1 was being discharged to the ALF that was initially discussed upon admit. She expressed surprise at hearing this change of plan but she signed the discharge paperwork anyway. She stated she should have protested. She stated no-one contacted her prior to her arrival at the hospital to inform her the plan for discharge had changed or to discuss it with her.

There were no clinical notes to indicate Patient #1's caregiver had been counseled as to the change in discharge plans.

Patient #1's Case Manager was interviewed. She reviewed Patient #1's medical record and stated she had not considered SNFs, otherwise there would have been a Patient Choice Form in the medical record, and there was not. She stated the family expressed an initial interest in the ALF at admission and she did not recall any other plan. She stated there was not a specific process to coordinate with physical therapy regarding the recommendations of the physical therapists.

During an interview on 8/14/18 at 8:20 PM, the Director of Case Management and Social Services stated that if there had been coordination of care it would have been documented in the Case Management notes.

The hospital did not prepare Patient #1's family ahead of time related to the discharge to the ALF after recommendations for SNF placement.

2. Patient #3 was a 74 year old female who was admitted to the hospital on 7/07/18 with diagnoses including encephalopathy, altered
Patient #3's medical record included a case management report, dated 7/09/18, signed by her case manager, which stated "Physicians asked that we discuss ALF placement with family. Message left for sister [name]."

Patient #3's medical record included a case management note, dated 7/09/18, signed by her case manager, which stated "Spoke with patient's sister on the phone regarding ALF planning and anticipated discharge tomorrow with [name of home health agency]."

Patient #3's medical record included a case management note, dated 7/10/18, signed by her case manager, which stated "Discharge orders sent to [name of home health agency]."

Patient #3's medical record included a discharge summary, dated 7/10/18, signed by her physician, which stated "At discharge she'll be sent home with home health care. The patient and her sister have been provided with information on pursuing placement at an assisted living facility."

It was not documented if Patient #3's sister was counseled to prepare her for post-hospital care at home.

The Director of Case Management and Social Services was interviewed on 8/14/18, beginning at 10:05 AM, and Patient #3's medical record was reviewed in her presence. She confirmed counseling for Patient #3's sister to prepare her for post-hospital care at home was not documented.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Eastern Idaho Regional Medical Center

<table>
<thead>
<tr>
<th>(K4) ID</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>(K5) Completion Date</th>
</tr>
</thead>
</table>
| A 820  | Continued From page 14  
The hospital failed to ensure Patient #3's sister was counseled to prepare her for post-hospital care at home. | A 820 |
| A 823  | HHAs and SNF Requirements  
**CFR(s):** 482.43(c)(6), (7), (8)  
The hospital must include in the discharge plan a list of (HHAs or) SNFs that are available to the patient, that are participating in the Medicare program, and (that serve the geographic area (as defined by the HHA) in which the patient resides, or) in the case of a SNF, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.  
  
(i) This list must only be presented to patients for whom home health care or post-hospital extended care services are indicated and appropriate as determined by the discharge planning evaluation.  

(ii) For patients enrolled in managed care organizations, the hospital must indicate the availability of home health and post-hospital extended care services through individuals and entities that have a contract with the managed care organizations.  

(iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf.  

(7) The hospital, as part of the discharge planning process, must inform the patient or the patient's family of their freedom to choose among participating Medicare providers of post-hospital... | A 823 |

**Address:** 3100 Channing Way, Idaho Falls, ID 83404

**ID Number:** 130018

**Survey Dates Completed:** 08/15/2018

**Surveyor:** [Signatures and Certifications]

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**Printed:** 08/24/2018

**Form Approved by:** OMB No. 0938-0391

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*Note: The document contains a table with rows for each deficiency and its corresponding corrective action, along with the provider's identification number and address information.*
Continued From page 15

care services and must, when possible, respect patient and family preferences when they are expressed. The hospital must not specify or otherwise limit the qualified providers that are available to the patient.

(8) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

Financial interests that are disclosable under Medicare are determined in accordance with the provisions of Part 420, Subpart C, of this chapter. This STANDARD is not met as evidenced by:

Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure home health agency lists were provided in accordance with hospital policy for 2 of 2 patients (#1 and #3) who were referred to home health services upon discharge. This had the potential to interfere with patient/caregiver understanding of options for home health services. Findings include:

The hospital policy "Discharge Planning and Referrals of Patients to Post-Discharge, dated 5/04/15, was reviewed. It stated "All patients who have orders to arrange post-hospital home health care ... will be presented with the available options. This includes patients who have come from a facility or who have previously had post hospital services in the home. The patient or patient's representative makes a selection and signs the Patient Choice Form. The form is placed in the chart and becomes a permanent part of the medical record." It also stated
"Medicare patients must be presented with a list of available providers, even if the physician or patient already has a preference." "The discharge planning documentation must include that the list was provided and the patient was able to choose their provider of care. (Patient Choice Form)."

The hospital did not provide lists of home health options, in accordance with hospital policy, to patients who had a prior relationship with a home health agency. Examples include:

1. Patient #1 was an 86 year old female admitted on 7/06/18 for delirium in the setting of Alzheimer-type dementia with overlying urinary tract infection. Her daughter was listed on the initial nursing assessment, dated 7/06/18, as her decision-maker and DPOA. She was discharged to an ALF with home health services on 7/09/18. There was no documentation a list of home health agencies had been provided to Patient #1 and her DPOA.

Patient #1's RN Case Manager was interviewed on 8/15/18 at 9:15 AM. She confirmed a list had not been provided and explained that Patient #1 wanted to return to the same home health agency, so a list was not necessary.

A list of home health agencies was not provided to Patient #1 in accordance with hospital policy, which required the list be presented to the patient/caregiver even if the patient had previous services in the home.

2. Patient #3 was a 74 year old female who was...
A623 Continued From page 17

admitted to the hospital on 7/07/18 with diagnoses including encephalopathy, altered mentation, and DM Type 2. She was discharged to her sister's home with home health services on 7/10/18.

Patient #3's medical record included a case management note, dated 7/08/18, signed by her Case Manager, which stated "Spoke with patient's sister on the phone regarding ALF planning and anticipated discharge tomorrow with [name of home health agency]."

Patient #3's medical record included a discharge summary, dated 7/10/18, signed by her physician, which stated "At discharge she'll be sent home with home health care. The patient and her sister have been provided with information on pursuing placement at an assisted living facility."

Patient #3's medical record did not include documentation the hospital presented Patient #3 with a list of home health agencies she could choose from in her geographic area.

The Director of Case Management and Social Services was interviewed on 8/14/18, beginning at 10:05 AM, and Patient #3's medical record was reviewed in her presence. She confirmed Patient #3's discharge plan did not include a list of home health agencies in her geographic area to choose from.

Patient #3's discharge plan did not include a list of home health agencies in her geographic area to choose from.

Patients who had prior relationships with home health agencies were not provided with lists of
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 130018

**NAME OF PROVIDER OR SUPPLIER:** EASTERN IDAHO REGIONAL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3100 CHANNING WAY, IDAHO FALLS, ID 83404

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A823</td>
<td>823</td>
<td>Continued From page 18 options in accordance with hospital policy, which required the list be presented to the patient/caregiver even if the patient had previous services in the home.</td>
<td>A823</td>
<td>837</td>
<td>Plan of Correction (POC): Develop a process to provide physician offices with necessary medical information post-hospitalization. The retitled &quot;Discharge Planning&quot; policy (refer to A-799) will be revised to include above articulated process. Process for implementing POC: The Health Information Management (HIM) department will develop a process in which they will provide the necessary medical information (i.e. discharge summary) to the physician offices. These physicians may include the attending physician, the primary care provider, and any consulted physician that the patient will see in follow-up after discharge. Monitoring &amp; tracking procedures ensuring the POC is effective: The HIM department will create a transactional log for record keeping and monitoring purposes. Process improvement actions incorporated into the QAPI program: The log will be reviewed and results reported at the monthly Clinical Quality Committee for 6 months by the Director of Health Information Management. Individual responsible: Marilyn Henry; Director of Health Information Management</td>
<td>9/23/18</td>
<td></td>
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<tr>
<td>A837</td>
<td>837</td>
<td>TRANSFER OR REFERRAL CFR(s): 482.43(d) The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care. This STANDARD is not met as evidenced by: Based on record review, policy review, and staff interview, it was determined the hospital failed to ensure a process was established to inform physicians of necessary medical information post-hospitalization. This impacted 2 of 2 patients (#3 and #4) who were referred to physicians for office follow-up and whose records were reviewed. This had the potential to result in patients' physicians being unaware of the outcome of hospital treatment or follow-up care needs and negatively impact the quality of follow-up patient care. Discharge policies were requested for review. Policies addressed the necessity to send necessary medical information when patients were transferred to another inpatient facility, and for discharge to a SNF, ALF, home health agency, and hospice. However, discharge policies did not address the necessity to send necessary medical information to physician offices on behalf of patients sent home or to an ALF and asked to follow-up with their physicians with appointments</td>
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</tbody>
</table>

**MULTIPLE CONSTRUCTION**

**DATE SURVEY COMPLETED:** C 08/15/2018
### Summary Statement of Deficiencies

**Prefix (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information):**

A837

**Continued From page 19**

Post-hospitalization.

Necessary medical information was not sent to physicians. Examples include:

1. **Patient #4** was a 62 year old male admitted to the hospital on 7/10/18 related to an unwitnessed seizure and soft tissue trauma. He was transferred to the inpatient rehabilitation unit on 7/13/18.

   A "Physician Discharge Summary" included instructions for discharge follow up: "He should follow up with his primary care provider in 1-2 weeks for further monitoring of his blood pressure. He should also follow up with urology and I would like to send him referral to [name of urologist] for further evaluation and management of his urinary retention as he is being discharged home with Foley catheter. He should also follow up with neurology in 2-4 weeks for stroke follow-up [sic] and continued evaluation and management of probable seizure."

   There was no documentation to indicate any clinical information was sent to Patient #4's physicians to inform them regarding the hospitalization.

2. **Patient #3** was a 74 year old female who was admitted to the hospital on 7/07/18 with diagnoses including encephalopathy, altered mentation, and DM Type 2. She was discharged to her sister's home with home health services on 7/10/18.

   Patient #3's medical record included discharge instructions, dated 7/10/18, signed by Patient #3, which stated "Primary Care Physician Follow
<table>
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<tr>
<th>A837</th>
<th>Continued From page 20</th>
</tr>
</thead>
</table>
|      | UP... [practitioner name] in 5 - 7 days [name] Gastroenterology in 1 - 2 weeks."
|      | There was no documentation to indicate any clinical information was sent to Patient #3's physicians to inform them regarding the hospitalization. |
|      | During an interview on 8/13/18 at 4:10 PM, The Director of Case Management and Social Services stated the hospital did not routinely send information to physicians when patients were sent home. She stated many physicians can access patient information using the electronic portal. When asked if physicians were alerted to patient discharges so they could access the electronic medical record, she stated, not to her knowledge. When asked how physicians accessed information who were out of the area, she stated there was not a process. |
|      | During an interview on 8/14/18 at 2:00 PM, a Social Worker for the Inpatient Rehabilitation Department, stated the nurses set up appointments for patients for post-hospital care. She stated she was not aware of any information sent to the physician offices. She stated many doctors can see the records electronically. |
|      | The hospital failed to ensure a process was established to inform physicians of necessary medical information post-hospitalization. |
| A843 | REASSESSMENT OF DISCHARGE PLANNING PROCESS |
|      | CFR(s): 482.43(e) |
|      | The hospital must reassess its discharge planning process on an on-going basis. The |
Continued From page 21

A 843

Reassessment must include a review of discharge plans to ensure that they are responsive to discharge needs. This STANDARD is not met as evidenced by:

Based on review of policies and quality data, and staff interview, it was determined the hospital did not have a process to reassess its discharge planning process on an on-going basis, including a review of discharge plans. This interfered with the identification of problem areas that could be addressed for process improvements. Findings include:

Discharge planning policies were requested. None of the policies provided addressed the necessity for the hospital to reassess its discharge planning processes on an ongoing basis.

The Director of Case Management and Social Services was interviewed on 8/13/18 4:10 PM. She stated she was not aware of any process to reassess the discharge planning processes. She stated the hospital monitored readmission rates, but she was not aware of how that information was used.

The Director of Quality, Risk & Patient Safety was interviewed on 8/14/18 at 11:00 AM. She stated Discharge Planning was not a part of the hospital's quality program.

The hospital did not have a policy or process to reassess its discharge planning process on an on-going basis.

Plan of Correction (POC): The retitled "Discharge Planning" policy (see reference A-799) will be revised to be reviewed and updated on an annual basis for the ongoing reassessment of the discharge planning process. Process of reviewing discharge plans on an on-going basis will be established through chart reviews and will be included in the above named policy.

Process for implementing POC: The retitled "Discharge Planning" policy will be assigned as an annual required read for all Case Management and Social Workers. Education to 100% of CM/SW staff members to the process of chart reviews will occur.

Monitoring & tracking procedures ensuring the POC is effective: A random sample of 10% of discharged patients per month will be audited for a total of 6 months. The audits will be conducted weekly to review the discharge plans and ensure that they are responsive to the corresponding patient's discharge needs.

Process improvement actions incorporated into the QAPI program: Audit results will be reported at the Clinical Quality Committee by the Director of Case Management and Social Services.

Individual responsible: Teresa Pentz;
Director of Case Management and Social Services