Dear Administrator:

IMPORTANT
PLEASE READ CAREFULLY

The Centers for Medicare and Medicaid Services (CMS) has determined that Vibra Hospital of Boise 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 Vibra Hospital of Boise participation in the Medicare program. The projected date on which the agreement will terminate is December 17, 2018.

On September 6, 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 Vibra Hospital of Boise to
furnish services of an adequate level and quality. The details of the above deficiency are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS-2567).

The finding that Vibra Hospital of Boise is not in compliance with the Conditions of Participation does not affect your facility's 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 The 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 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 at 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
We thank you for your cooperation and 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

This is an official notice sent electronically or facsimile, pursuant to 42 C.F.R. Part 488, no hard copy to follow
The following deficiencies were cited during the Federal complaint investigation at your hospital, conducted from 8/30/18 to 9/06/18. Surveyors conducting the investigation were:

Brian Osborn, RN, HFS - Team Leader
James Brown, RN, HFS
Gary Gulles, RN, HFS
Nancy Bax, RN, BSN, HFS

Acronyms used in this report include:

- ACLS - Advanced Cardiac Life Support
- ADL - Activities of Daily Living
- ASAP - As Soon As Possible
- CCO - Chief Clinical Officer
- CEO - Chief Executive Officer
- CNA - Certified Nursing Assistant
- C/O - complaints of
- CPR - Cardiopulmonary Resuscitation
- CVA - Cerebrovascular Accident
- DBD - Director of Business Development
- DON - Director of Nursing
- ECG - Electrocardiogram
- HR - Human Resources
- HS - House Supervisor
- I & O - Intake and Output
- ICU - Intensive Care Unit
- IV - Intravenous
- LLC - Limited Liability Corporation
- LPN - Licensed Practical Nurse
- LTAC - Long Term Acute Care
- LTACH - Long Term Acute Care Hospital
- MAR - Medication Administration Record
- mg - milligram
- MT - Monitor Technician
- NP - Nurse Practitioner

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 patient. (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.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: Vibra Hospital of Boise

A. GOVERNING BODY

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body...

This CONDITION is not met as evidenced by:

- Based on staff interview and review of medical records, hospital policies, organizational chart, personnel records, incident reports, Medical Staff Bylaws, QAPI documents, and meeting minutes, it was determined the hospital's Governing Board failed to assume responsibility for determining, implementing, and monitoring policies, and failed to oversee the hospital's nursing services. This resulted in a lack of leadership and guidance to hospital staff.

Findings include:

1. The Governing Body failed to utilize a DON to

Plan of Action

- A 043: Governing Body has met evidence by:

  - Vibra Hospital of Boise has a Governing Body in place that oversees the following: hospital policies, organizational chart, personnel records, contracts, incident reports, Medical Staff Bylaws, Quality Assessment and Performance Improvement (QAPI) Program documents and meeting minutes. The oversight of nursing services has been amended to comply with Idaho Administrative Procedure Act (IDAPA) codes. As well as the Conditions of Participation with Governing Board oversight, a Director of Nursing (DON) has been hired and the organizational chart reflects the leadership of Nursing services under the Director of Nursing.

  - Organizational Chart noting the delineation of Director of Nursing overseeing Nursing services.

  - Reviewed and approved by Governing Board.

- A 000: Continued From page 1

  - PEA - Pulseless Electrical Activity
  - PO - By Mouth
  - Pt - Patient
  - QAPI - Quality Assessment Performance Improvement
  - QIO - Quality Improvement Organization
  - RCA - Root Cause Analysis
  - RN - Registered Nurse
  - RT - Respiratory Therapist
  - RRT - Rapid Response Team
  - SNF - Skilled Nursing Facility
  - S/P - status post
  - VP - Vice President

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  - SNF - Skilled Nursing Facility
  - S/P - status post
  - VP - Vice President

  - The Governing Body failed to utilize a DON to
DON and Nursing Practice Council will ensure safe and effective delivery of nursing services.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>A043</td>
<td>Continued From page 2 oversee nursing services.</td>
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An organization chart, not dated, showed various departments of the hospital and listed the name of the department director. The box for Nursing Services did not list a director.

The Division President for the Mid-Mountain Region was listed directly under the Governing Board on the organization chart. He was a corporate vice-president who lived in another state. He was interviewed by telephone on 9/05/18 beginning at 11:00 AM. He stated he was Chairman of the Board for the hospital.

The Division President stated the hospital did not have a DON and said it was not the hospital's model to employ a DON. He stated the hospital had a Chief Clinical Officer who was a respiratory therapist. He stated she had oversight of the nursing services in the hospital.

The CEO was interviewed on 9/05/18 at 2:05 PM. She stated the hospital did not have a DON.

The Governing Body did not employ a DON.

2. The Governing Body failed to ensure guidelines were developed for Medical Staff call.

Vibra Hospital is a 40 bed long term acute care hospital. It accepts patients who are often very ill and fragile, such as patients on ventilators.

The hospital did not have onsite 24 hour physician coverage. The hospital maintained a practitioner call schedule in case patients had care needs after hours.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier Identification Number:** 132002

**Name of Provider or Supplier:** VIBRA HOSPITAL OF BOISE

**Address:**
- **Street Address, City, State, Zip Code:** 6651 W FRANKLIN ROAD, BOISE, ID 83709

**ID PREFIX TAG:**
- **A. BUILDING:**
- **B. WING:**

### Summary Statement of Deficiencies

(Each deficiency must be preceded by full regulatory or LSC identifying information)

1. **A 043** Continued from page 3

   Medical Staff rules and regulations did not provide direction to practitioners who were on call, including the expectations and availability of practitioners to come to the hospital to evaluate patients.

   The past President of the Medical Staff was interviewed on 9/05/18 beginning at 12:20 PM. He stated he was not aware of a rule or policy that defined the duties of practitioners on call.

   The Governing Body did not develop guidance for the Medical Staff.

   3. Refer to A84 as it relates to the failure of the Governing Body to ensure contracted nursing services were provided in an effective manner.

   4. Refer to A115 as it relates to the failure of the Governing Body to ensure the rights of patients were protected and promoted.

   5. Refer to A385 as it relates to the failure of the hospital to ensure nursing services were organized and supervised to effectively meet the health care needs of patients.

### A 084 Contracted Services

**CFR(s):** 482.12(e)(1)

The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.

This STANDARD is not met as evidenced by:

Based on review of contracts, hospital policy, hospital documents, personnel records, and staff interview, it was determined the hospital failed to ensure contracted nursing services were provided in an effective manner.

**Plan of Action**

Medical Staff has met evidenced by:

Medical Staff on call policy has been presented to Medical Staff and has been implemented to reflect the placement of the on call schedule, how to reach the on call provider, when call schedule starts, and escalation protocol if unable to reach on call provider.

Monitoring and Tracking and Person Responsible

Any inability in reaching an on call provider will be escalated per protocol and documented in an incident report to be reviewed by the Medical Director.

Process Improvement

The policy was reviewed with Medical Staff to assure all aspects of the process were addressed.

Outcomes will be reported to MEC and GB.

**Completion Date:** 9/26/2018

### Plan of Action

**Contracted Services Standard is met by evidence:**

Vibra Hospital of Boise has a Governing Body in place that oversees the following: hospital policies, organizational chart, personnel records, contracts, incident reports, Medical Staff Bylaws, Quality Assessment and...
Performance Improvement (QAPI) Program documents and meeting minutes. The oversight of nursing services has been amended to comply with Idaho Administrative Procedure Act (IDAPA) codes. As well as the Conditions of Participation with Governing Board oversight, a Director of Nursing (DON) has been hired and the organizational chart reflects the leadership of Nursing services under the Director of Nursing.

- Director of Nursing, Educator, HR, and Scheduler will ensure that all current agency/travel nurses have completed orientation packet.
- Process in place for future agency/travel staff to complete the Fast Track orientation packet with competency check off.
- Orientation of location of current policies and procedures will be provided to all contracted staff during the Fast Track orientation process.

Monitoring and Tracking and Person Responsible

- Tracking tool will be utilized to ensure 100% compliance of this process. This will be tracked for 90 days to ensure compliance and will be reported to (QAPI).
- After 90 days random audits will be completed and reported to (QAPI).
- The scheduler/HR will complete 5 random audits monthly. The audits will include ensuring the following documents are complete - quick start for competency, - 3 day evaluation, - 90 day evaluation.

Process Improvement

- A tracking tool was put in place in order to be able to review any complaints or grievances.
- Outcomes will be reported to QAPI, MEC and GB
In an effective manner. This resulted in the inability of the hospital to ensure contracted nurses were competent to perform their jobs. Findings include:

The hospital's policy, "Volunteer, Student Observers, Interns, Externs, Per Diem, and Contracted Services," revised 3/12/18, stated "Contracted Services...Orientation"

a. All contracted personnel are required to complete the Hospital orientation packet to ensure a thorough [sic] understanding of expectations, hospital policies, safety and infection control.

b. Department orientation will address patient care issues and departmental policies and procedures.

c. The Department Director remains responsible for the oversight of the contracted personnel.

The hospital's "Daily Staffing Assignment" sheets for 7 days, from 8/30/18 to 9/05/18, were reviewed for the number of RNs on the night shift (7:00 PM to 7:30 AM) who were hospital employees verses contracted staff. On 6 of the 7 nights, the RN supervisor was a contracted RN. Ten of 40 RN shifts, or 25%, were completed by contracted RN staff.

A contract titled "Travel Personnel Staffing Agreement" signed by the hospital's CEO on 1/26/17, stated "Hospital shall orientate all Nurses to Hospital's internal policies and practices. Such orientation shall include information necessary to orientate each Nurse to the particular unit he/she has been assigned."

The personnel files of 2 RNs contracted through...
A 084 Continued From page 5

the travel agency were reviewed, with start dates of 4/30/18 and 5/28/18. They did not include documentation of an orientation to the hospital's policies and procedures, or a department orientation.

A contract titled "STAFFING AGREEMENT" signed by the hospital's CEO on 6/17/16, stated "Facility shall provide such orientation and non-job specific training (such as training regarding Facility's employment policies) as is reasonably required by facility."

The personnel files of 2 RNs contracted through the staffing agency were reviewed, with start dates of 5/09/17 and 12/07/17. They did not include documentation of an orientation to the hospital's policies and procedures, or a department orientation.

During an interview on 9/05/18 at 4:05 PM, the VP of Clinical Development and Operations reviewed the personnel files of the 4 contracted RNs. She confirmed the 4 files did not include documentation of an orientation to the hospital's policies and procedures, or a department orientation.

The hospital failed to ensure RNs working in the hospital under contract received education on the hospital's policies and procedures, or orientation to the department.

A 115 PATIENT RIGHTS

Planned Action

Patient Rights standard is met by evidence:

A 115 All staff has been educated on Grievance vs. Complaint.

- Vibra Hospital of Boise has posted the statement of how to file a complaint and reviewed at each town hall.
- Additionally the employee newsletter
distinguishing between complaints and grievance was explained
- Also, education provided in huddle on 9/18

- Documentation of education will be complete through meeting minutes, employee sign in. Proper complaint and grievance forms have been uploaded to appropriate forms library.
- Grievance committee has met and meeting minutes completed
- Process to address patient care concerns to QIO has been implemented.
- Revision of Grievance form to match the policy has been completed.
- QIO notice has been updated with the correct information and has been posted in highly visible locations.
- Grievance letter process to be completed by the CEO has been implemented.
- Orientation and evaluation of agency travelers will be completed.

Monitoring and Tracking and Person Responsible
Monitoring will be completed for 100% completion for 90 days by the CCO and then randomly to ensure continued compliance. After review of all complaints and grievances, # of appropriate submission and f/u of identified grievances/# of grievances will be audited.

Process Improvement
A grievance tracking sheet was put in place so the process of completing the forms can be monitored and be audited.
- Outcomes of the audits will be reported to QAPI, MEC, GB
- Grievance minutes will be reported to QAPI and Medical Executive Committee (MEC).

Vibra Hospital of Boise policy education for Abuse and Harassment has been completed.
Education of incident reporting process has been completed for all staff.
**STATEMENT OF DEFICIENCIES**
**AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
VIBRA HOSPITAL OF BOISE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
6651 W FRANKLIN ROAD
BOISE, ID 83709

**SUMMARY STATEMENT OF DEFICIENCIES**

Each deficiency must be preceded by full regulatory or LSC identifying information.

**A 115** Continued From page 6

This CONDITION is not met as evidenced by:

Based on staff interview and review of hospital policy, Governing Body meeting minutes, grievance log, patients rights information, incident report, grievance response letter, Idaho Statutes, medical record, observation, personnel file, and quality improvement document, it was determined the hospital failed to ensure patients' rights were protected and promoted. This resulted in an incomplete investigation, analysis, and recommendations following a patient death and had the potential to affect all patients receiving care at the hospital. Additionally, this resulted in a lack of an effective grievance process and Governing Body oversight, the identification of potential patient abuse, and the accuracy of a QIO for patients and/or their representatives to submit concerns regarding care rendered.

Findings include:

1. Refer to A 119 as it relates to the failure of the hospital to ensure the effective operation and oversight of the grievance process by the Governing Body.

2. Refer to A 120 as it relates to the failure of the hospital to ensure an accurate process for referral of patient care concerns to a QIO.

3. Refer to A 123 as it relates to the failure of the hospital to ensure written grievance resolutions which included all results of the grievance process.

4. Refer to A 144 as it relates to the failure of the hospital to ensure care was provided in a safe manner.

5. Refer to A 145 as it relates to the failure of the hospital to ensure patients' rights were protected and promoted.
A 115
Hospital to ensure patients were free from abuse or harassment.

The cumulative effects of these systemic practices seriously impeded the ability of the hospital to protect patient rights and provide services in a safe setting.

A 119
PATIENT RIGHTS: REVIEW OF GRIEVANCES
CFR(s): 482.13(a)(2)
[The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.

This STANDARD is not met as evidenced by:
Based on staff interview and review of hospital policy, grievance log, and Governing Body meeting minutes, it was determined the hospital failed to ensure the effective operation and oversight of the grievance process by the Governing Body for 6 of 9 patient grievances reviewed. This resulted in a lack of an effective grievance process and had the potential to affect all patients who received care in the hospital.

Findings include:

1. The hospital "Complaint/Grievance Log 2018," dated 2/20/17 to 7/19/18, was reviewed. The log included 9 grievances, however, 6 of these were

Plan of Action
Grievance committee has established a process for prompt resolution for patient grievances.

Grievance Process has been added to patient admission information.

Grievance Process has been posted in lobby for all visitors and staff for review.

Monitoring and Tracking and Person Responsible
- Grievance log will be maintained by the Chief Clinical Officer.

Process Improvement
- The Grievance Committee was put in place in order to more efficiently monitor the grievance process. If any part of the process is ineffective, the Grievance committee will review and discuss in the next meeting.

- Grievance log will be reviewed at QAPI and MEC for compliance
| Event ID: 128111 | Facility ID: 132002 | Grievance log review will be added to Governing Body on an annual basis for compliance. |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
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<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
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<tbody>
<tr>
<td>VIBRA HOSPITAL OF BOISE</td>
<td>6651 W FRANKLIN ROAD BOISE, ID 83709</td>
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<tr>
<th>(X4) ID PREFIX</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<tr>
<td>A 119</td>
<td>Continued From page 8 documented as complaints:</td>
<td>A 119</td>
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<td></td>
<td>- Allegation of patient abuse dated 4/18/17 [incident 15277]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<td>- Multiple patient family issues dated 5/10/17 [incident 3801336]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<td>- Allegation of patient abuse dated 2/20/18 [incident 15584]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<td>- Multiple patient family issues dated 3/09/18 [incident 15263]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<td>- Multiple patient family issues dated 3/14/18 [incident &quot;Pt. Spouse&quot;]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<tr>
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<td>- Multiple patient issues dated 7/19/18 [incident 15745]. Required further investigation and actions for a postponed resolution. Documented as a patient complaint.</td>
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<tr>
<td></td>
<td>A hospital policy &quot;Patient Complaint and Grievance Process,&quot; reviewed January 2018, stated &quot;Patient complaint: Concern/Dissatisfaction - A verbal expression of concern or dissatisfaction with a service or department within Vibra Hospital, that is more substantive than a minor request, and is resolved</td>
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**Facility ID:** 132002  
**Event ID:** 122011  
**If continuation sheet Page 19 of 47**
### Summary Statement of Deficiencies

**A 119** Continued From page 9

By the staff present, to the satisfaction of the complainant, on the departmental level at the point of the complaint. Patient complaint: Grievance - Any expression of dissatisfaction (written or verbal) related to an occurrence within Vibia Hospital of Boise which is of such severity that it is not able to be resolved to the satisfaction of the complainant at a departmental level by the staff present. Complaints that require further investigation, further actions for resolution, or are postponed for later resolution are considered grievances. Hospital staff were unable to differentiate the difference between a patient complaint and a patient grievance. Examples include:

- **a.** RN A was interviewed on 8/31/18, beginning at 8:51 AM. When asked for her definition of a patient complaint, she stated "complaints can be resolved in-house; if a complaint is still in-house and works its way up the chain-of-command, it is still a complaint." When asked for her definition of a patient grievance, RN A stated "a complaint with no resolution after the patient discharges or is unhappy; the grievance must be formal."

- **b.** RN B was interviewed on 8/31/18, beginning at 9:13 AM. When asked for her definition of a patient complaint, she stated "something a patient would say to me for me to fix; if I can't resolve, it would go to the House Supervisor, but would still remain a complaint." When asked for her definition of a patient grievance, RN B stated "it's a formal process that would go up the chain-of-command."

- **c.** HS A was interviewed on 8/31/18, beginning at 9:21 AM. When asked for his definition of a patient complaint, he stated "something that is..."
### Statement of Deficiencies and Plan of Correction

**NAME OF PROVIDER OR SUPPLIER:** Vibra Hospital of Boise

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6651 W Franklin Road, Boise, ID 83709

**A 119 Continued From page 10**

addressed right away; a written complaint is still a complaint." When asked for his definition of a patient grievance, HS A was unsure. He stated "unsure if a grievance can be verbal, but it would be documented in the patient's chart and an incident report would be done." HS A stated he could not think of an example of a patient grievance.

d. The CCO was interviewed on 8/31/18, beginning at 9:32 AM. When asked for her definition of a patient complaint, she stated "it's dealt with internally, during the same shift, or something longer." When asked for her definition of a patient grievance, the CCO stated "something that is a long formal process."

e. The NP was interviewed on 9/04/18, beginning at 11:12 AM. When asked for his definition of a patient complaint, he stated "I would talk to the House Supervisor about it or go to the appropriate Department if there was a complaint; a complaint can still be something another department handles." When asked for his definition of a patient grievance, the NP stated "a grievance is an official written report."

f. MT B was interviewed on 9/05/18, beginning at 9:26 AM. When asked for her definition of a patient complaint, she stated "a complaint is something that is escalated." When asked for her definition of a patient grievance, MT B stated "a grievance is something I can fix."

The Director of Quality Management was interviewed on 9/05/18, beginning at 2:03 PM, and the hospital's grievance log was reviewed in her presence. She confirmed staff did not have a consistent understanding or ability to identify...
A 119 Continued From page 11

Continued From page 11

patient grievances. The Director of Quality
Management confirmed the hospital failed to
recognize documented patient complaints as
patient grievances.

Hospital staff were unable to differentiate and
identify patient complaints from patient
grievances.

2. The hospital’s “Annual Governing Body
Meeting Minutes,” dated 4/05/18, were reviewed.
The meeting minutes did not include documented
review or resolution of patient grievances.
Additionally, the meeting minutes did not
document if the hospital had a grievance
committee, delegated by the Governing Body, to
review and resolve patient grievances. It was
unclear how the Governing Body was providing
oversight of the hospital’s grievance process.

The Director of Quality Management was
interviewed on 9/05/18, beginning at 2:03 P.M.
She confirmed the hospital did not have a
Governing Body delegated grievance committee.
The Director of Quality Management stated the
hospital’s grievance data was presented to the
Governing Body by way of QAPI reporting. She
confirmed the Governing Body did not review and
resolve patient grievances.

The Governing Body failed to review and resolve
patient grievances.

A 120 PATIENT RIGHTS: TIMELY REFERRAL OF
GRIEVANCES

A 120 Grievance committee has established a process
for prompt resolution for patient Grievances.

<table>
<thead>
<tr>
<th>A 120</th>
<th>Grievance committee has established a process for prompt resolution for patient Grievances.</th>
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<tbody>
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<td>9/25/2018</td>
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<tr>
<td>Grievance Process has been added to patient admission information.</td>
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<tr>
<td>o Grievance Process has been posted in lobby for all visitors and staff for</td>
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</table>

The hospital must establish a process for prompt
resolution of patient grievances and must inform...
Monitoring and Tracking and Person Responsible

- Grievance log will be maintained by the Chief Clinical Officer
- Any deficiencies will be corrected by one-on-one training.

Process Improvement

- The Grievance Committee was put in place in order to more efficiently monitor the grievance process. If any part of the process is ineffective, the Grievance committee will review and discuss in the next meeting.

- Grievance log will be reviewed and any deficiencies noted will be reported at QAPI and MEC for compliance.

- Grievance log review will be added to Governing Body on an annual basis for compliance.

Please refer to Elements listed in A 115
### A 120

Continued From page 12

Each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum:

This STANDARD is not met as evidenced by:

- Based on hospital policy review, patients rights information review, and staff interview, it was determined the hospital failed to ensure an accurate process for referral of patient care concerns to a QIO for 8 of 8 patients (#'s 1 - 8) whose patients rights information was reviewed. This had the potential for unresolved patient issues regarding patients' quality of care and/or premature discharge. Findings include:

A hospital policy "Patient Complaint and Grievance Process," reviewed January 2018, stated "In the event the grievance is related to quality of care or premature discharge, the patient/family is advised they may contact Qualis Health, the Quality Improvement Organization for Idaho as per information provided on admission to the facility."

The patients rights form, "AN IMPORTANT MESSAGE FROM MEDICARE About Your Rights," included in Patient #'s 1 - 8's admission packets, stated "Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here: Livanta, LLC." The QIO listed in the...
A 120 Continued From page 13

patients rights information was not the same as
the QIO listed on hospital policy. It was unclear
who patients or their representatives should
contact in the event they had concerns about their
hospital care and/or premature discharge.

The Director of Quality Management was
interviewed on 9/05/18, beginning at 2:03 PM,
and patients rights were reviewed in her
presence. She confirmed the QIO listed on
hospital policy did not match the QIO given to
patients in their admission packets.

The hospital failed to ensure an accurate process
for referral of patient care concerns to a QIO.

A 123 PATIENT RIGHTS: NOTICE OF GRIEVANCE
DECISION

At a minimum:

In its resolution of the grievance, the hospital
must provide the patient with written notice of its
decision that contains the name of the hospital
contact person, the steps taken on behalf of the
patient to investigate the grievance, the results of
the grievance process, and the date of
completion.

This STANDARD is not met as evidenced by:

Based on staff interview and review of hospital
policy, incident report, and grievance response
letter, it was determined the hospital failed to
provide written grievance resolutions which
included all results of the grievance process for 1
of 1 grievance resolution letters reviewed. This
had the potential for incomplete grievance
investigations and resolutions to patient/family
concerns. Findings include:

Plan of Action

Grievance Letter template has been
implemented to address name of the hospital,
contact person, steps taken to investigate, the
results of each concern, and date of
completion.

- Education to all staff regarding
  Grievance process and timeline for
  completion.
  9/25/2018

Monitoring and Tracking and Person
Responsible

- Timely resolution will be monitored
  by the Grievance Committee. The
  Chief Clinical Officer will audit # of
timely responses to grievances / #
of grievances will be audited.

Process Improvement

- A Grievance worksheet was put in
  place and is turned into the
  chair of the Grievance Committee
  -Chief Clinical Officer for review.
  - Outcomes will be submitted to
Please refer to Elements listed in A 286 specifically Code Blue/Death Record

Please refer to Element A 084 Specifically monitoring and tracking of competency.
A hospital policy "Patient Complaint and Grievance Process," reviewed January 2018, stated: "Written notice of grievance resolution and decisions made is provided to complainants and contains the following: Steps taken on behalf of the patient to investigate the grievance...Results of the grievance process." This policy was not followed.

Incident report 45626, dated 1/02/18, included 7 patient grievance issues:

- "Spouse reports the nebulizer hose that was attaches [sic] to the vent tubing popped off several times and the spouse has to place it back on and no one checks to make sure it was done correctly."
- "He [spouse] reported the hose fell on the floor last week and the attending nurse/RT (he was unable to identify) picked it up off the floor and reattached it without cleaning it."
- "He [spouse] said his wife is scared and feels unsafe."
- "They [patient and spouse] reported the patient was left alone with no call light in her reach this morning rather it was placed on top of the ventilator machine out of her reach."
- "He [spouse] reports the patient is turned and the lines are pulled tight and tubes sometimes get detached—he [sic] states the alarms are always going off and it is frightening and no one comes urgently to help."
- "The spouse reported the staff argue with him..."
and the patient rather than try to help."

- "The patient is concerned she now has ecoli [sic] in the urine and feels it is because she does not get good hygiene care around her foley."

A written grievance response letter to incident report 45526, dated 1/05/18, did not include an investigation and results for 3 of the 7 identified issues:

- "Spouse Reports the nebulizer hose that was attaches [sic] to the vent tubing popped off several times and the spouse has to place it back on and no one checks to make sure it was done correctly."

- "Spouse reported the hose fell on the floor last week and the attending nurse/RT (he was unable to identify) picked it up off the floor and reattached it without cleaning it."

- "He [spouse] said his wife is scared and feels unsafe."

The Director of Quality Management was interviewed on 9/05/18, beginning at 2:03 PM, and the grievance response letter was reviewed in her presence. She confirmed the written grievance response to the patient did not address all the identified issues. Additional grievance response letters were requested from the Director of Quality Management, however, she stated there "were no others." She stated she had not kept records of any other grievance response letters.

The hospital failed to provide written grievance resolutions which included all results of the
A 123 Continued From page 16 grievance resolution.

A 144 PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:

Based on medical record review, observation, incident report review, personnel file review, hospital policy review, quality improvement document review, and staff interview it was determined the hospital failed to ensure care was provided in a safe setting. This directly impacted the safety of 1 of 1 patient (Patient #2) who experienced cardiopulmonary arrest and whose record was reviewed. This resulted in fragmented patient care, poor clinical outcomes, and had the potential to affect all patients receiving care at the hospital. Findings include:

The hospital failed to ensure patients received care in a safe setting. Examples include:

1. Patient #2 was a 32 year old female who was admitted to the hospital on 6/08/18, with a diagnosis of acute respiratory failure. Additional diagnoses included confusion, high fall risk, and intracranial hemorrhage. She was scheduled to discharge to a SNF on 6/29/18; however she expired in the hospital on 6/28/18.

A hospital policy "Fall Prevention & Management Program," reviewed March 2018, stated "High Risk Fall Prevention Interventions...Bed and chair alarm...Seat belt alarm...Low Bed with defined perimeter mattress/nonskid floor mat...Alarms at exits...Nurse CALL and communication systems..."
A hospital policy "Clinical Alarms," reviewed March 2018, stated:

- "Clinical staff will manually set off alarms during operational assessment of all medical devices/equipment to assure proper functioning of the equipment and associated alarms prior to use on a patient."

- "Clinical staff will immediately report any device malfunctions or concerns to the Plant Operations and/or Biomedical Staff. Tag and remove the device from operation according to the hospital's policies and procedures until it has been evaluated."

Patient #2's medical record included a "Nursing ICU Shift Assessment-Flowsheet," dated 6/27/18 at 9:07 PM, signed by RN D, which stated "Morse Fall Risk...55.0" and "45 or Greater = High Fall Risk...Action...Implement High Risk Fall Precautions."

Patient #2's medical record included a "Patient Care Notes," dated 6/27/18 at 9:07 PM, signed by RN D, which stated "bed alarm on."

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 12:14 AM, signed by RN D, which stated "bed alarm on."

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 4:00 AM, signed by RN D, which stated "bed alarm on."

Patient #2's medical record included a "Nursing ICU Shift Assessment-Flowsheet," dated 6/28/18 at 9:30 AM, signed by RN C, which stated "Morse Fall Risk...55.0" and "45 or Greater = High Fall Risk...Action...Implement High Risk Fall Precautions."

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 9:30 AM, signed by RN C, which stated "bed alarm on."

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 9:30 AM, signed by RN C, which stated "bed alarm on."
A144 Continued From page 18

Risk...Action-Implement High Risk Fall Precautions.*

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 9:45 AM, signed by RN C, which stated "bed alarm on."

Patient #2's medical record included a "INTERDISCIPLINARY TEAM MEETING/CARE CONFERENCE" note, dated 6/28/18, signed by Patient #2's physician, which stated Patient #2 had "Safety Issues," "Fall Risk," "Alteration in Mobility," and "Orientation x 2."

Patient #2's medical record included a "Nursing LTAC ADL Flowsheet," dated 6/28/18 at 12:15 PM, signed by RN C, which stated "Bed exit alarm in use."

Patient #2's medical record included a "CODE BLUE RECORD," dated 6/28/18 at 6:03 PM, signed by the NP, which stated "patient was found face down on the floor. patient [sic] was rolled over and CPR started." The form stated CPR was stopped at 6:26 PM, and Patient #2 was pronounced dead. Additionally, the form stated "Events Leading up to Code...in bed 30 min with bed alarm on prior to finding on floor face down."

Patient #2's medical record included a "Patient Care Notes," dated 6/28/18 at 6:12 PM, signed by RN C, which stated "Patient was discovered laying on left side prone position on left side of the bed approximately 1805. Tube feeding still attached and running, Foley intact. Patient rolled onto back, discovered not breathing or palpable pulse. Code called and compressions initiated immediately by discovering nurse."
An RCA, provided by the Director of Quality Management, titled “A Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event or Had the Potential For,” undated, and unsigned, stated:

- “This patient was admitted to VIB Boise [sic] on 06/08/2018 S/P Cranial Bleed.

The patient struggled with each level of improvement but after 20 plus days of intense respiratory/pulmonary and work with therapies the patient was nearly ready for referral to acute rehab services.

On 06/28/2018 Case Management had one accepting facility and one potentially pending. The patient had been ambulating with therapies in the afternoon. At approximately 18:00 on the 28th the patient was found face down on the floor next to the bed in full arrest.

She was turned and CPR was immediately initiated. Airway was patent as she still had her trach in. The resuscitation efforts were unsuccessful and the code was called at 18:26.”

The RCA did not identify, analyze, or investigate Patient #2’s fall directly preceding her death. The potentially faulty hospital bed and alarm system used for Patient #2 was not identified, analyzed, or investigated.

On 08/31/18 at approximately 6:30 AM, the CEO provided 2 HR Investigative notes regarding Patient #2’s death, however, these notes were not included in the hospital’s RCA. The first HR investigative note, dated 08/30/18, was a recalled
A 144 Continued From page 20

series of events by RN C to the Regional HR Director, which stated:

- "4:00 PM • Went in for a reassessment. Patient [Patient #2] was fidgety and trying to get out of bed. RN C and CNA A raised the right lower side rail up and double checked to make sure the bed alarm was on. It was and she knew it was working because it had sounded earlier in the day."

- "5:00 PM • [CNA A] and CCO repositioned patient."  

- "6:05 PM - [RN C] went into [room number] to get I's and O's and found patient unresponsive, facedown on the floor on the left side of the bed. She could not find a pulse, so he [sic] called a 'code' and started compressions. The left side rails on the bed were still up, she [Patient #2] was still connected to her tube feeding and the tele box. The bed alarm was not going off. RN C did not know how long this patient had been on the floor."

The second HR investigative note, dated 7/03/18, was a recalled series of events by CNA A to the Regional HR Director, which stated "Around 4:00 PM, [CNA A] and [RN C] went into [room number] and the patient [Patient #2] was trying to get out of bed. They put the right railing up (alternating side railings) and double checked to make sure the bed alarm was working."

The Director of Quality Management was interviewed on 8/31/18, beginning at 10:16 AM, and Patient #2's RCA was reviewed in her presence. She confirmed Patient #2's potentially faulty hospital equipment and fall were not
<table>
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<th>A 144</th>
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<tbody>
<tr>
<td>Identified, analyzed, or investigated as part of the hospital's RCA. The Director of Quality Management stated Patient #2's fall and potentially faulty hospital equipment should have been investigated.</td>
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<tr>
<td>The HR Regional Director was interviewed on 8/31/18 at 11:41 AM. When asked if she was part of the RCA regarding Patient #2's death, she stated no. The HR Regional Director stated she did not share information with RCAs unless requested.</td>
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<tr>
<td>The Medical Director, and Patient #2's physician, was interviewed on 8/31/18, beginning at 2:46 PM, and Patient #2's RCA was reviewed in his presence. He stated he was not asked to be part of Patient #2's RCA and stated he believed he should be involved. The Medical Director stated all medical records of patients who expired in the hospital would be sent for peer review. He stated Patient #2's medical record had not been sent to peer review yet.</td>
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<tr>
<td>CNA A was interviewed on 9/01/18, beginning at 9:20 AM, and Patient #2's RCA and medical record was reviewed in his presence. He stated Patient #2 tried to get out of bed &quot;a few times that shift&quot; and &quot;bed alarm was on.&quot; CNA A stated he was unsure why Patient #2's bed and/or bed alarm was not working.</td>
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<td>RN C was interviewed on 9/04/18, beginning at 10:31 AM, and Patient #2's RCA and medical record was reviewed in her presence. She stated Patient #2 attempted to get out of bed during her shift, was difficult to reorient, and would try to &quot;get up.&quot; RN C stated Patient #2's bed alarm was on. She stated Patient #2's bed was not given to...</td>
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</table>
### Statement of Deficiencies

**Identification Number:**

132002

**Provider/Supplier:**

VIBRA HOSPITAL OF BOISE

**Street Address:**

6651 W FRANKLIN ROAD

**City, State, Zip Code:**

BOISE, ID 83709

**Date Survey Completed:**

09/06/2018

**Summary Statement of Deficiencies**

<table>
<thead>
<tr>
<th>ID Prefix</th>
<th>TAG</th>
<th>Summary of Deficiency</th>
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<td>A 144</td>
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<td>Continued From page 22</td>
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Biomedical Services to be inspected.

The NP, who ran Patient #2's code blue on 6/28/18, was interviewed on 8/04/18, beginning at 11:12 AM. He stated he was not a part of Patient #2's RCA. When asked if he had ever been asked to participate in a hospital RCA, the NP stated no.

The Director of Plant Operations was interviewed on 9/05/18, beginning at 8:30 AM. When asked if Patient #2’s potentially faulty bed/bed alarm was turned over to him or to Biomedical Services, he stated no. The Director of Plant Operations stated he did not participate in Patient #2’s RCA.

An incident report regarding Patient #2’s death, updated 7/18/18, stated "RCA completed, scored 5 awaiting case closure by the Coroner’s Office to obtain the outcome of Cause of Death.”

The CEO was interviewed on 9/05/18, beginning at 4:37 PM. She confirmed Patient #2’s RCA was not complete and did not identify her fall and hospital equipment issues.

The hospital investigation following Patient #2’s death failed to identify, analyze, and investigate her fall, and potentially faulty hospital equipment.

2. Hospital staff did not follow ACLS guidelines during Patient #2’s CPR.

The NP who ran Patient #2’s code blue on 6/28/18, was interviewed on 8/04/18, beginning at 11:12 AM. He stated he responded to the code blue alert at 6:03 PM and, when he arrived, CPR was already in progress. The NP stated Patient #2 had no pulse and “was in PEA.” He stated
A 144 Continued From page 23

Patient #2 did not have a heart rhythm for the duration of code blue and expired at 6:26 PM.

The NP's personnel file was reviewed on 9/05/18, beginning at 12:30 PM, and current ACLS certification was confirmed.

The ACLS Medical Training website, accessed 9/12/18, included the following algorithm for PEA:

- "Continue CPR, Airway; Oxygen; Connect monitors"

- "Epinephrine 1 mg ASAP and every 3 -5 minutes"

- "Evaluate rhythm..."

- "Evaluate and treat reversible causes"

Patient #2's medical record included a "CODE BLUE RECORD," dated 6/28/18, signed by the NP. The form documented a series of events not covered under the ACLS PEA algorithm:

a. From start of CPR at 6:03 PM, to

b. From start of CPR at 6:03 PM, to

  a) pronouncement of death at 6:26 PM, Patient #2 did not have a "Monitored Rhythm" or identified cardiac waveform.

  b) pronouncement of death at 6:26 PM, Patient #2 did not have a monitored oxygen saturation level. The form documented "O2 @ flushed % via trach." It was unclear what percent of supplemental oxygen, or the flow rate, "flushed" was.

  c. Patient #2 was manually defibrillated (the
A 144

Continued from page 24

stopping of fibrillation of the heart by administering a controlled electric shock in order to allow restoration of the normal rhythm) at 6:03 PM, 6:05 PM, 6:07 PM, 6:09 PM, 6:11 PM, 6:13 PM, 6:14 PM, 6:16 PM, 6:18 PM, 6:20 PM, 6:22 PM, and 6:24 PM. The form did not indicate what joules were used for defibrillation.

d. Patient #2 was defibrillated via an AED at 6:07 PM, 6:09 PM, 6:11 PM, 6:13 PM, 6:14 PM, 6:16 PM, 6:18 PM, 6:20 PM, 6:22 PM, and 6:24 PM. The form did not indicate what joules were used for defibrillation.

e. From start of CPR at 6:03 PM, to pronouncement of death at 6:26 PM, Patient #2 did not receive initial, or subsequent, Epinephrine 1 mg IV push.

f. Patient #2 received an unknown infusion [drip] quantity of Epinephrine at 6:10 PM (7 minutes after the initiation of CPR), 6:13 PM, 6:16 PM, and 6:23 PM.

It was unclear if these CPR interventions occurred as documented, or if they were recorded in error.

The CEO was interviewed on 8/31/18, beginning at 1:56 PM, and Patient #2's code blue form was reviewed in her presence. When asked if staff retained Patient #2's cardiac waveforms, printed by the crash-cart defibrillator used during her CPR, the CEO stated "staff cannot locate them."

The VP of Clinical Development and Operations was interviewed on 9/04/18, beginning at 2:00 PM. She stated "post code huddle documentation was not done" for Patient #2.
The Director of Quality Management was interviewed on 9/04/18, beginning at 2:17 PM, and Patient #2's code blue form was reviewed in her presence. She confirmed Patient #2's documented CPR did not follow ACLS guidelines. The Director of Quality Management stated Patient #2's code blue form was not reviewed for accuracy or appropriateness.

Hospital staff did not follow ACLS guidelines during Patient #2's CPR.

3. The hospital provided a form titled "LTACH EDUCATION PLAN 2018," undated. The section titled "EDUCATION PLAN 2018" included a list of trainings to happen each month; including "Mock Code/RRT." This training was marked with an asterisk that denoted "Mandatory Education."

The last documented mock code was November 2017.

The CEO was interviewed on 8/31/18 beginning at 1:00 PM, and stated her expectation was for mock codes to be done 2 times a month.

The CCO was interviewed on 8/31/18 beginning at 9:30 AM, and stated her expectation is for mock codes to be done at least every 90 days. She did not remember the last time the facility performed a mock code.

The VP of Clinical Development and Operations was interviewed 9/05/18 beginning at 4:20 PM. She stated the "Mandatory Education" was a suggestion and each hospital created their own education plan for the year and sent it to corporate. When asked if the hospital had...
A 144. Continued From page 26

submitted an education plan for 2018 to corporate for approval she stated no. The VP of Clinical Development and Operations confirmed the last documented mock code was completed in November 2017.

The hospital failed to follow their education plan.

4. Patient #2's death record did not include accurate documentation.

Patient #2's medical record included a "Record of Death," dated 6/30/18. The form included 2 main sections: "NOTIFICATION" and "EYE/TISSUE/ORGAN DONATION." These 2 sections appeared to be completed by 2 different sets of handwriting. The bottom of the form included a section titled "TO BE COMPLETED BY HOSPITAL PERSONNEL." This section included the printed name of HS B next to "Funeral Home called by" and "Body of Decedent released by" dated 6/29/18 at 2:20 AM. Additionally, the bottom of the form included an illegible signature, dated 6/30/18 at 8:00 AM.

HS B was interviewed on 9/04/18, beginning at 3:19 PM, and Patient #2's death record was reviewed in his presence. When asked if he filled out any portions of the form, he stated no. HS B stated he was not working on 6/29/18 at 2:20 AM. He stated he did not recognize either of the 2 handwritings on the form, nor was he able to identify the unknown signature at the bottom of the form. HS B confirmed Patient #2 death record was not accurate.

Patient #2's death record did not include accurate documentation.
<table>
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<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>
</table>
| A 144 | | | Continued From page 27  
5. A hospital Telemetry Monitor Technician was unable to perform job duties.  
A hospital policy "Clinical Alarms," reviewed March 2018, stated:  
- "All staff that utilize or maintain equipment/devices with clinical alarm systems will be properly oriented to the equipment/device, the alarm and trained on its use."  
- "All staff using and/or maintaining medical equipment/devices with related alarm systems must be assessed and proven competent to operate the equipment/device and manage its associated alarm mechanism prior to use of that equipment/device."  
- "For all equipment/devices with clinical alarms, staff competency assessment will be conducted prior to Initial use of equipment/device and annually thereafter."  
This policy was not followed.  
An observation of the hospital's ICU was conducted with the VP of Licensing and Accreditation on 9/04/18, beginning at 11:40 AM, and MT B was observed executing her job duties at that time. MT B was located at the ICU nurses station and was responsible for monitoring patients' ECG waveforms remotely. During the observation, 9 of 13 patients on MT B's computer screen displayed "ECG ALARMS OFF." When asked why these 9 patients had their alarms turned off, MT B stated she did not know and "I'm new to this; I guess I need education." When asked how long she had been performing the duties of a Telemetry Monitor Technician, MT B | | | | | 09/06/2018 |
MT B's personnel file was reviewed on 9/04/18, beginning at 1:30 PM. MT B had a signed job competency; however, it was dated 9/02/18; 3 days after the start of the survey and several weeks after performing her job duties as a Telemetry Monitor Technician. MT B's personnel file did not include a documented orientation to her job duties.

MT B was interviewed on 9/05/18, beginning at 9:26 AM. She stated she was new to her role as a Telemetry Monitor Technician and had been "on my own for about 3 weeks." MT B stated she had no previous experience in telemetry monitoring or education prior to accepting her new role. She confirmed her competency was performed and documented after the start of the survey.

A hospital Telemetry Monitor Technician was unable to perform job duties.

6. The hospital provided a form titled "LTACH EDUCATION PLAN 2018," undated. It stated "New nursing and clinical employees will continue their orientation to each specific department ... An orientation checklist will be completed with a goal to sign off the initial core competencies within the first 90 days of hire." This was not followed. Examples include:

The personnel file of CNA A was requested. CNA A's personnel file included a date of hire 2/16/18. The file included a skills checklist titled "CORE COMPETENCY / DEMONSTRATION CNA Skills Checklist." The checklist included multiple skills that were signed off as "met" by the educator, and was completed on 8/30/18. There was no other
### Summary Statement of Deficiencies

A 144 Continued From page 29

Documentation CNA A had completed his skills checklist prior to 8/30/18. CNA A's personnel file also included a form titled "CORE COMPETENCY / DEMONSTRATION NURSING ASSISTANT." The form included multiple components, some examples included:

- Treats patient with respect.
- Involves patient in care decisions.
- Communicates effectively with patient.
- Understands the hospital's patient complaint grievance process.
- Follows safe hospital practices and protective services.
- Performs job ethically.
- Restraints.

The form documented the components were signed off by the Educator on 8/30/18. There was no other documentation these components were completed prior to 8/30/18.

During an interview with the VP of Clinical Development and Operations on 9/05/18 beginning at 4:30 PM, she confirmed CNA A's skills checklist and core competency were completed on 8/30/18, 6 months after his date of hire. She stated she contacted CNA A and he stated he must have lost the original checklist and competency form. The VP of Clinical Development and Operations stated the expectation is the CNA skills checklist and core competency should be completed and signed off within 90 days of date of hire. She confirmed CNA A did not have a documented skills checklist or core competency prior to 8/30/18.

The Hospital failed to ensure CNA A was...
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

#### PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

<table>
<thead>
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<td>A 144</td>
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</table>

#### NAME OF PROVIDER OR SUPPLIER

VIBRA HOSPITAL OF BOISE

#### ADDRESS

6651 W FRANKLIN ROAD
BOISE, ID 83709

#### ID PREFIX | TAG

| A 144 |        |     |
| A 145 |        |     |

### SUMMARY STATEMENT OF DEFICIENCIES

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>A 144</td>
<td></td>
<td></td>
<td>Patient Rights: Free from Abuse/ Harassment will be evidenced by:</td>
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<tr>
<td>A 145</td>
<td></td>
<td></td>
<td>VIBRA Hospital of Boise policy education for Abuse and Harassment has been completed by DNO for nursing staff, CEO for senior leadership and DQM for hospital orientation. Education of incident reporting process has been completed for all staff as above. This education was presented in New Employee Orientation by DQM and in huddles with the staff by DNO</td>
</tr>
</tbody>
</table>

#### CFM(s): 482.13(c)(3)

The patient has the right to be free from all forms of abuse or harassment.

This STANDARD is not met as evidenced by:

Based on hospital policy review, Idaho Statutes review, grievance log review, and staff interview, it was determined the hospital failed to ensure patients were free from abuse or harassment for 2 of 2 grievances reviewed which documented potential abuse. This had the potential for unsafe conditions for all patients receiving care at the hospital. Findings include:

"IDAHO STATUTES TITLE 39 HEALTH AND SAFETY CHAPTER 53 ADULT ABUSE, NEGLECT AND EXPLOITATION ACT," updated 7/01/18, states "39-6303. Duty to report cases of abuse, neglect or exploitation of vulnerable adults. (1) Any physician, nurse, employee of a public or private health facility, or a state licensed or certified residential facility serving vulnerable adults, medical examiner, dentist, osteopath, optometrist, chiropractor, podiatrist, social worker, police officer, pharmacist, physical therapist, or home care worker who has reasonable cause to believe that a vulnerable adult is being or has been abused, neglected or exploited shall immediately report such information to the commission. Provided however, that nursing facilities defined in section 39-130(1)(b), Idaho Code, and employees of such facilities shall make reports required under this chapter to the department. When there is
Reasonable cause to believe that abuse or sexual assault has resulted in death or serious physical injury jeopardizing the life, health or safety of a vulnerable adult, any person required to report under this section shall also report such information within four (4) hours to the appropriate law enforcement agency. This Statute was not followed.

A hospital policy "Suspected Patient Abuse/Neglect," reviewed March 2018, stated:

- "The Hospital maintains a strict policy to prevent or respond to allegations of abuse, neglect or mistreatment, including prompt reporting of any alleged abuse incident to hospital leaders and applicable state agencies."

- "Patient Abuse, Neglect, and/or Mistreatment is defined as any incident of physical, sexual, or verbal abuse, neglect, and/or mistreatment that is reported by patient or family, or is witnessed, reported, or suspected by an employee."

- "If the suspected abuse, neglect, mistreatment and/or exploitation involves an employee, the Hospital Chief Executive Officer will determine the action to be taken based on the investigation performed by appropriate Administration/Management. The employee may be suspended during the investigation, and if abuse is confirmed, termination of employment will result."

- "All investigation and resulting action documentation will be maintained in the Administrative office. This policy was not followed."
A second hospital policy "Reporting Issues of Concern," reviewed March 2018, stated "As required by state-specific laws, issues of non-compliance must be reported to appropriate state agencies. In certain states, health-care employees are designated as 'mandated reporters'. This designation requires that employees who have knowledge of or observed known or suspected abuse incidents must report such an event to an outside agency. The report, either written or oral, must be made as required by state law." This policy was not followed.

The hospital's "Complaint/Grievance Log 2018," included 2 potential patient abuse grievances:

1. Incident 15584, dated 1/29/18, stated "The patient told the CCO while writing on her whiteboard that 'My Nurse Hit Me' and then walks by giving me dirty looks. The patient stated she [sic] couldn't remember when it happened or where the event took place. No obvious signs of injury. Patient is somewhat confused with a history of CVA."

The investigation of Incident 15584, dated 2/20/18, stated "The communication with the CCO occurred at 15:00 on 01/29/18. Spoke with the nurse involved who outlined everything that had been happening for the first 3 hours of the shift. CCO spoke to the nursing supervisors and made arrangements for someone else to be assigned to [patient name]."

The investigation did not include which nurse was spoken to, when, about what, or what conclusions were made. The investigation did not identify which nursing supervisors were interviewed, when, about what, or what conclusions were
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: VIBRA HOSPITAL OF BOISE
STREET ADDRESS, CITY, STATE, ZIP CODE: 6651 W FRANKLIN ROAD, BOISE, ID 83709

A 145 Continued From page 33
made. The investigation did not include the date and time the nurse was removed from the patient's care and what steps were taken to ensure the patient was kept safe. The investigation did not include an interview with the patient and, subsequently, what her concerns were. The investigation did not include a written grievance response letter to the patient regarding her concerns. It could not be determined what steps the hospital took to ensure similar issues did not occur in the future.

2. Incident 15277, dated 3/21/17, stated "Patient C/O nurse putting head between two pillows and leaving him, C.N.A. came in and 'saved' him. Patient told wife to call the State and she refused."

The investigation of incident 15277, dated 4/18/17, stated "CEO & DBD spoke with the patient and the wife. There is a history with the patient of confusion particularly at night and all was resolved at that point."

The investigation did not include if the nurse in question was spoken to, when, about what, and what conclusions were made. The investigation did not include if the nurse in question was removed from the patient's care and what steps were taken to ensure the patient was kept safe. The investigation did not include an interview with the patient, patient's spouse, or what their concerns were. The investigation did not resolve why the State was not contacted when requested by the patient and identified by hospital staff. The investigation did not include a written grievance response letter to the patient regarding his concerns. It could not be determined what steps the hospital took to ensure similar issues did not
**A 145** Continued From page 34

The Director of Quality Management was interviewed on 9/05/18, beginning at 2:03 PM, and the hospital's grievance log was reviewed in her presence. She stated she had not previously identified the 2 patient incidents as potential abuse and confirmed the hospital did not follow State statutes and/or hospital policy to ensure patients were free from abuse and kept safe.

The hospital failed to ensure patients were free from abuse or harassment.

**A 286** PATIENT SAFETY

CFR(s): 482.21(a), (c)(2), (e)(3)

(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...

(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: ...

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<tr>
<td>A 145</td>
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<td>Plan of Action</td>
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<td>A 286</td>
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<td>Patient Safety Program will be met as evidence by.</td>
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<td>Nursing staff will be educated on the Code Blue form</td>
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<td>Mock Codes will be completed each shift on a monthly basis. Code critique form will be completed during each mock session.</td>
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<td>Critical Care Committee will review all code blue, rapid responses and deaths.</td>
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<td>Monitoring and Tracking and Person Responsible</td>
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<td>Adverse events will be tracked on a log, analyzed and reported to QAPI, Pharmacy and Therapeutics (P&amp;T) and MEC monthly with action items by the Director of Pharmacy</td>
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<td>Adverse events will be reported to Governing Board with action plan and measurable targets for Performance Improvement by the Director of Pharmacy.</td>
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<td>Code blue forms will be reviewed for complete, accurate information. The</td>
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<td>Code Blue forms will be reviewed ongoing, with just in time training by</td>
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<td>the Director of Nursing</td>
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<td><strong>Process Improvement</strong></td>
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<td>- Analysis of events will be reported to the QAPI, MEC monthly and</td>
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<td>annually Performance improvement plans will be reviewed monthly at QAPI</td>
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<td>with a Plan Do Study Act process at Governing board.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** Vibra Hospital of Boise

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
6651 W Franklin Road
Boise, ID 83709

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<td>A286</td>
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(3) That clear expectations for safety are established.

This STANDARD is not met as evidenced by:

Based on staff interview and review of quality documents, it was determined the hospital failed to analyze 3 of 12 adverse patient events and recommend preventive actions. This resulted in incomplete information with which to make decisions regarding care systems. Findings include:

1. The form "CODE BLUE/RAPID RESPONSE MONITORING AND EVALUATION," not dated, stated a "Code" was started on 2/10/18 at 5:50 PM. The form did not state specifically what happened. It listed the events leading up to the code and who responded. It listed personnel involved and stated the time the "Resuscitation Event" ended. The form did not state what took place during the event. The form did not include an analysis of the event nor did it include a determination of how staff performed during the event and whether resources were sufficient to respond to the event effectively.

   The Director of Quality Management was interviewed on 9/05/18 beginning at 9:00 AM. She stated an analysis of the event was not documented.

2. The form "CODE BLUE/RAPID RESPONSE MONITORING AND EVALUATION," not dated, stated a "Code" was started on 8/07/18 at 10:14 PM. The form was blank.

   Another form, titled "Rapid Response Team Care Record," undated, listed the events leading up to the event. It did not list personnel involved. The form did not state what took place during the event.
SUMMARY STATEMENT OF DEFICIENCIES

A 286

Continued From page 36

The form did not include an analysis of the event nor did it include a determination of how staff performed during the event and whether resources were sufficient to respond to the event effectively.

The Director of Quality Management was interviewed on 9/05/18 beginning at 9:00 AM. She stated an analysis of the event was not documented.

3. Refer to A144 as it relates to the failure of the hospital to thoroughly analyze the causes of a patient death under unusual circumstances and implement preventive actions.

A 385

NURSING SERVICES

CFR(s): 482.23

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:

1. Refer to A386 as it relates to the failure of the facility to ensure nursing services were organized under the authority of a director of nursing services responsible for nursing staff and care
| with evidence of completed orientation/ # of agency/travelers | | |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** VIBRA HOSPITAL OF BOISE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
6651 W FRANKLIN ROAD
BOISE, ID 83709

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| A385 | Continued From page 37 provided in the hospital.  

2. Refer to A395 as it relates to the failure of the hospital to ensure nursing care provided by LPNs was evaluated and supervised by an RN.  

3. Refer to A398 as it relates to the failure of the hospital to ensure orientation and training of non-employee contracted nursing personnel.  

4. Refer to A405 as it relates to the failure of the hospital to ensure medications were administered in accordance with accepted standards of practice.  

The cumulative effects of these systemic failures significantly impeded the ability of the hospital to provide nursing services of sufficient scope and quality. |

**PLAN OF ACTION**  
Organization of Nursing Services will be met as evidenced by: Director of Nursing service will oversee all nursing operations.  

- Organizational Chart will note the Director of Nursing a Registered Nurse oversees all nursing operations.  
- Plan for Provision of Care will note that nursing services is oversees by Registered Nurse.  

This STANDARD is not met as evidenced by: Based on staff interviews, review of hospital documents, policies, and job descriptions, it was determined the hospital failed to ensure nursing services were organized under the authority of a director of nursing services responsible for
**A386** Continued From page 38

nursing staff and care provided in the hospital. This failure had the potential negatively impact the quality of care provided to patients. Findings include:

The hospital's organizational chart was requested and received on 8/30/18 at 12:20 PM. It included the position of CCO, who reported to the CEO. Five departments were listed as reporting to the CCO: Laboratory, Radiology, Rehabilitation, Nursing, and Infection Control/Education. The Laboratory, Radiology, Rehabilitation, and Infection Control/Education departments each included the name of the department manager or supervisor. The Nursing department, which included the RN, LPN, CNA, and Unit Clerk positions, did not include the name of a department manager.

The Division President for the Mid-Mountain Region was listed directly under the Governing Board on the hospital's organization chart. He was a corporate vice-president who lived in another state. He was interviewed by telephone on 9/05/18 beginning at 11:00 AM. He stated he was Chairman of the Board for the hospital.

The Division President stated the hospital did not have a DON and said it was not the hospital's model to employ a DON. He stated the hospital had a Chief Clinical Officer who was a respiratory therapist. He stated she had oversight of the nursing department of the hospital.

The hospital's policy, "Plan for Provision of Care," effective 3/2018, stated "The Department of Nursing is a distinct department. The Chief Clinical Officer ultimately oversees all nursing related issues."
The job description titled "Chief Clinical Officer - LTAC," revised May 2017, was reviewed. It stated "MINIMUM QUALIFICATIONS: Bachelor of Science Degree in Nursing required. Master's Degree in Health Administration, Nursing or related field required. Five (5) years experience in a Nursing Management position supervising the delivery of patient care required. Current, valid, and active license to practice as a Registered Nurse in the state of employment required." The job description included a handwritten notation, next to "MINIMUM QUALIFICATIONS," that stated "Corporate approved RRT [Registered Respiratory Therapist] degree/license in place of Nursing license." The handwritten notation was signed by the Director of Human Resources. The notation was not dated. The job description was signed by the current CCO, an RT, on 6/03/18.

The job descriptions for the positions of Nurse Supervisor, Registered Nurse, CNA, Telemetry Monitor Tech, and Unit Secretary/Unit Clerk each included "Position Reports to: Chief Clinical Officer/Chief Nursing Officer/Nurse Manager." The hospital's organizational chart did not include the positions Chief Nursing Officer or Nurse Manager. Nursing staff job descriptions directed the nursing staff to report to the CCO, an RT.

During an interview on 9/04/18 at 9:40 AM, CNAA was asked to identify his supervisor. He named the CCO, an RT, as his supervisor.

During an interview on 9/04/18 at 12:00 PM, HS B was asked to identify his supervisor. He named the CCO, an RT, as his supervisor.
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/Clinical Laboratory Identification Number:** 132002

**Name of Provider or Supplier:** Vibra Hospital of Boise

**Street Address, City, State, Zip Code:** 6651 W Franklin Road, Boise, ID 83709

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<td>A 395</td>
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<td>9/24/2018</td>
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#### A 386

Continued From page 40

On 8/31/18 at 8:48 AM, an RN was observed administering medications to a patient. She was asked to identify her supervisor. She named the CCO, an RT, as her supervisor.

On 9/05/18 at 3:34 PM, LPN B was interviewed in the presence of the CCO. When asked to identify her supervisor, she stated she was not sure. When asked who she would go to to request time off of work, she stated she was not sure. The CCO stated she was responsible for approving requests for time off from nursing staff.

The hospital failed to ensure an RN was responsible for the operation of nursing services.

#### A 395

RN Supervision of Nursing Care is met as evidenced by:

- Director of Nursing a registered nurse has oversight of the nursing operations.
- Registered Nurse will oversee LPNs this will be evidenced by the nursing schedule.
- The daily nursing assignments sheets that note RN supervisor.
- RN will be assigned to LPN each shift this will be evidenced by the daily nursing staff assignment.
- The nursing supervisor will be responsible to audit and monitor by the review of assignment sheets and nursing schedules and reported monthly or the next 3 months and reported in QAPI, MEC and GB.
- The scheduler will submit an incident report if a deficiency is noted.
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[X1] PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:** 132002

**[X2] MULTIPLE CONSTRUCTION**

A. **BUILDING**

B. **WING**

**[X3] DATE SURVEY COMPLETED:** C 09/06/2018

**NAME OF PROVIDER OR SUPPLIER:** VIBRA HOSPITAL OF BOISE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 6651 W FRANKLIN ROAD BOISE, ID 83709

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**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**A 398** Continued From page 42

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 interview, review of contracts, documents, policies, and personnel records, it was determined the hospital failed to ensure orientation and training of non-employee contracted nursing personnel. This had the potential for poor patient outcomes due to lack of orientation and training of contracted nurses.

Findings include:

- The hospital's policy, "Volunteer, Student Observers, Interns, Externs, Per Diem, and Contracted Services," revised 3/12/18, stated "Contracted Services...Orientation
  a. All contracted personnel are required to complete the Hospital orientation packet to ensure a through [sic] understanding of expectations, hospital policies, safety and infections.
  b. Department orientation will address patient care issues and departmental policies and procedures.
  c. The Department Director remains responsible for the oversight of the contracted personnel."

- The hospital's "Daily Staffing Assignment" sheets for 7 days, from 8/30/18 to 9/05/18, were reviewed for the number of RNs on the night shift (7:00 PM to 7:30 AM) who were hospital employees versus contracted staff. On 6 of the 7 nights, the RN supervisor was a contracted RN.

**[X4] ID PREFIX TAG**

**[X5] COMPLETION DATE**

**[X6] PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

All Agency/traveler staff will be oriented to the location of the policies and procedures by RN Educator. The scheduler (HR) will be responsible to monitor:

- # of agency/travelers with completed orientation
- # of agency/traveler staff

**COMPLETION DATE:** 9/25/2018

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

**Event ID:** 028111  **Facility ID:** 132002  **If continuation sheet Page 58 of 47**
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<td>A398</td>
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<td>Ten of 40 RN night shifts, or 25%, were completed by contracted RN staff.</td>
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A contract titled "Travel Personnel Staffing Agreement," signed by the hospital's CEO on 1/26/17, stated "Hospital shall orientate all Nurses to Hospital's internal policies and practices. Such orientation shall include information necessary to orientate each Nurse to the particular unit he/she has been assigned."

The personnel files of 2 RNs contracted through the travel agency were reviewed, with start dates of 4/30/18 and 5/28/18. They did not include documentation of an orientation to the hospital's policies and procedure, or a department orientation.

A contract titled "STAFFING AGREEMENT," signed by the hospital's CEO on 6/17/16, stated "Facility shall provide such orientation and non-job specific training (such as training regarding Facility's employment policies) as is reasonably required by facility."

The personnel files of 2 RNs contracted through the staffing agency were reviewed, with start dates of 5/09/17 and 12/07/17. They did not include documentation of an orientation to the hospital's policies and procedure, or a department orientation.

During an interview on 9/05/18 at 4:05 PM, the VP of Clinical Development and Operations reviewed the personnel files of the 4 contracted RNs. She confirmed the 4 files did not include documentation of an orientation to the hospital's policies and procedure, or a department orientation.
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<td>A 398</td>
<td>Continued From page 44</td>
<td>A 398</td>
<td>Administration of Drugs will be met of evidence by:</td>
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<td>The hospital failed to ensure RNs working in the hospital under contract received education on the hospital's policies and procedures, or orientation to the department.</td>
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<td>o Education of clinical staff on hospital policy of the Administration of Medications and the 5 Rights completed by the DNO</td>
<td>9/25/2018</td>
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<tr>
<td>A 405</td>
<td>ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(I) &amp; (c)(2)</td>
<td>A 405</td>
<td>o Medication administration will be audited by the audit tracking tool following process by DNO and House Supervisors. Any deficiency in practice will be corrected by on time training by the DNO and House Supervisors</td>
<td>9/18/2018</td>
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<td>(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.</td>
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<td>o Education on documentation when an incident occurs, notification of provider, noted orders, patient effect completed by the DNO</td>
<td>9/6/2018</td>
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<td>(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.</td>
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<td>o Pharmacy on call policy put in place and educated to clinical staff by the Director of Pharmacy</td>
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<td>(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 accordance with the approved medical staff policies and procedures.</td>
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<td>o Investigation and follow up incident reports completed by DNO and DPT</td>
<td>9/24/2018</td>
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<td>This STANDARD is not met as evidenced by: Based on staff interview and review of patient records, hospital policy, and hospital incident report, it was determined the hospital failed to ensure medications were administered in accordance with accepted standards of practice and hospital policy for 1 of 8 patients (Patient #2) whose records were reviewed. This resulted in</td>
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<td>o Outcomes/Incidences will be reported to P&amp;T by DPT, QAPI by DNO, MEC and GB by CEO</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER: VIBRA HOSPITAL OF BOISE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6651 W FRANKLIN ROAD, BOISE, ID 83709

ID: 132002

SUMMARY STATEMENT OF DEFICIENCIES

A 405 Continued From page 45
}

the administration of a medication ordered PO and given IV. Findings include:

Patient #2 was a 32 year old female who was admitted to the hospital on 6/08/18, with a diagnosis of acute respiratory failure. Additional diagnoses included confusion, high fall risk, and intracranial hemorrhage. She was scheduled to be discharged to a SNF on 6/29/18, however she expired in the hospital on 6/28/18.

The hospital's policy, "Administration of Medications," effective 6/2013, stated: "The six 'rights' of administering medications will be followed with each medication administration:

1. Right patient.
2. Right drug.
3. Right dose.
4. Right route.
5. Right time.
6. Right documentation."

The facility failed to follow their policy.

Patient #2's medical record included an order for Vancomycin 125 mg by mouth every 6 hours. The medical record documented that Vancomycin was given on 6/08/18 at 11:19 PM. The Vancomycin was documented in Patient #2's MAR as given by the correct route. However, there was an incident report that documented a medication error on 6/08/18 related to Patient #2's oral Vancomycin.

There was no additional documentation of the medication error in Patient #2's medical record.

An incident report was reviewed for Patient #2 that documented a medication error on 6/08/18.
A405 Continued From page 46

The incident report documented the oral Vancomycin ordered for Patient #2 was unavailable and that the on-call pharmacist was called for mixing instructions. The medication was mixed by the RN per instructions from the on-call pharmacist and Patient #2's nurse gave the Vancomycin IV push instead of PO as ordered.

The Director of Pharmacy was interviewed on 8/31/18, beginning at 10:55 AM, and Patient #2's incident report was reviewed in her presence. She stated the on-call pharmacist should have come in to the hospital to mix the Vancomycin.

The Director of Pharmacy was interviewed on 9/06/18 beginning at 1:30 PM, and confirmed Patient #2 received the Vancomycin 125 mg IV push instead of PO as ordered. She stated the RN who administered the Vancomycin had been reeducated on medication administration.

The hospital provided an RCA that identified the medication error. The RCA documented the nurse and on-call pharmacists were provided reeducation on medication mixing and administration.

Patient #2 did not receive her medication as ordered.
September 18, 2018

Cynthia Newsom, Administrator
Vibra Hospital Of Boise
6651 W Franklin Road
Boise, ID 83709

Provider #132002

Dear Ms. Newsom:

An unannounced on-site complaint investigation was conducted from August 30, 2018 to September 6, 2018 at Vibra Hospital Of Boise. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00007915

Allegation #1: Patients did not receive care in a safe setting.

Findings #1: An unannounced visit was made to the hospital on 8/30/18. Staff were interviewed. 8 medical records, hospital policies, administrative documents, patients' rights, grievance information, meeting minutes, personnel files, and education were reviewed.

The hospital failed to ensure patients received care in a safe setting. Examples include:

One example was a 32 year old female who was admitted to the hospital on 6/08/18, with a diagnosis of acute respiratory failure. Additional diagnoses included confusion, high fall risk, and intracranial hemorrhage. She was scheduled to discharge to a SNF on 6/29/18; however she expired in the hospital on 6/28/18.
A hospital policy "Fall Prevention & Management Program," reviewed March 2018, stated "High Risk Fall Prevention Interventions...Bed and chair alarm...Seat belt alarm...Low Bed with defined perimeter mattress/nonskid floor mat...Alarms at exits...Nurse Call and communication systems..."

A hospital policy "Clinical Alarms," reviewed March 2018, stated:

- "Clinical staff will manually set off alarms during operational assessment of all medical devices/equipment to assure proper functioning of the equipment and associated alarms prior to use on a patient."

- "Clinical staff will immediately report any device malfunctions or concerns to the Plant Operations and/or Biomedical Staff. Tag and remove the device from operation according to the hospital's policies and procedures until it has been evaluated."

The patient's medical record included a "Nursing ICU Shift Assessment-Flowsheet," dated 6/27/18 at 9:07 PM, signed by her RN, which stated "Morse Fall Risk...55.0" and "45 or Greater = High Fall Risk...Action-Implement High Risk Fall Precautions."

The patient's medical record included a "Patient Care Notes," dated 6/27/18 at 9:07 PM, signed by her RN, which stated "bed alarm on."

The patient's medical record included a "Patient Care Notes," dated 6/28/18 at 12:14 AM, signed by her RN, which stated "bed alarm on."

The patient's medical record included a "Patient Care Notes," dated 6/28/18 at 4:00 AM, signed by her RN, which stated "bed alarm on."

Her medical record included a "Nursing ICU Shift Assessment-Flowsheet," dated 6/28/18 at 9:30 AM, signed by her RN, which stated "Morse Fall Risk...55.0" and "45 or Greater = High Fall Risk...Action-Implement High Risk Fall Precautions."

Her medical record included a "Patient Care Notes," dated 6/28/18 at 9:45 AM, signed by her RN, which stated "bed alarm on."

Her medical record included a "INTERDISCIPLINARY TEAM MEETING/CARE CONFERENCE" note, dated 6/28/18, signed by her physician, which stated she had "Safety Issues," "Fall Risk," "Alteration in Mobility," and "Orientation x 2."

Her medical record included a "Nursing LTAC ADL Flowsheet," dated 6/28/18 at 12:15 PM, signed by her RN, which stated "Bed exit alarm in use."
Her medical record included a "CODE BLUE RECORD," dated 6/28/18 at 6:03 PM, signed by the NP, which stated "patient was found face down on the floor. patient (sic) was rolled over and CPR started." The form stated CPR was stopped at 6:26 PM, and the patient was pronounced dead. Additionally, the form stated "Events Leading up to Code...in bed 30 min with bed alarm on prior to finding on floor face down."

The patient's medical record included a "Patient Care Notes," dated 6/28/18 at 8:12 PM, signed by her RN, which stated "Patient was discovered laying on left side prone position on left side of the bed approximately 1805. Tube feeding still attached and running. Foley intact. Patient rolled onto back, discovered not breathing or palpable pulse. Code called and compressions initiated immediately by discovering nurse."

An RCA, provided by the Director of Quality Management, titled "A Framework for a Root Cause Analysis and Action Plan In Response to a Sentinel Event or Had the Potential For," undated, and unsigned, stated:

- "This patient was admitted to VHBoise (sic) on 06/08/2018 S/P Cranial Bleed.

The patient struggled with each level of improvement but after 20 plus days of intense respiratory/pulmonary and work with therapies the patient was nearly ready for referral to acute rehab services.

On 06/28/2018 Case Management had one accepting facility and one potentially pending. The patient had been ambulating with therapies in the afternoon. At approximately 18:00 on the 28th the patient was found face down on the floor next to the bed in full arrest.

She was turned and CPR was immediately initiated. Airway was patent as she still had her trach in. The resuscitation efforts were unsuccessful and the code was called at 18:26."

The RCA did not identify, analyze, or investigate her fall directly preceding the patient's death. The potentially faulty hospital bed and alarm system used for her was not identified, analyzed, or investigated.

On 8/31/18 at approximately 8:30 AM, the CEO provided 2 HR investigative notes regarding the patient's death, however, these notes were not included in the hospital's RCA. The first HR investigative note, dated 6/30/18, was a recalled series of events by the patient's RN to the Regional HR Director, which stated:

- "4:00 PM - Went in for a reassessment. Patient was fidgety and trying to get out of bed. (RN) and (CNA) raised the right lower side rail up and double checked to make sure the bed alarm was on. It was and she knew it was working because it had sounded earlier in the day."
"5:00 PM - (CNA) and CCO repositioned patient."

"6:05 PM - RN went into (room number) to get I's and O's and found patient unresponsive, facedown on the floor on the left side of the bed. She could not find a pulse, so he (sic) called a 'code' and started compressions. The left side rails on the bed were still up, she was still connected to her tube feeding and the tele box. The bed alarm was not going off. RN did not know how long this patient had been on the floor."

The second HR investigative note, dated 7/03/18, was a recalled series of events by CNA to the Regional HR Director, which stated "Around 4:00 PM, (CNA) and (RN) went into (room number) and the patient was trying to get out of bed. They put the right railing up (alternating side railings) and double checked to make sure the bed alarm was working."

The Director of Quality Management was interviewed on 8/31/18, beginning at 10:16 AM, and the patient's RCA was reviewed in her presence. She confirmed her potentially faulty hospital equipment and fall were not identified, analyzed, or investigated as part of the hospital's RCA. The Director of Quality Management stated the patient's fall and potentially faulty hospital equipment should have been investigated.

The HR Regional Director was interviewed on 8/31/18 at 11:41 AM. When asked if she was part of the RCA regarding the patient's death, she stated no. The HR Regional Director stated she does not share information with RCAs unless requested.

The Medical Director, who was also the patient's physician, was interviewed on 8/31/18, beginning at 2:46 PM, and the patient's RCA was reviewed in his presence. He stated he was not asked to be part of her RCA and stated he believed he should be involved. The Medical Director stated all medical records of patients who expired in the hospital would be sent for peer review. He stated the patient's medical record had not been sent to peer review yet.

The patient's CNA was interviewed on 9/01/18, beginning at 9:20 AM, and the patient's RCA and medical record was reviewed in his presence. He stated the patient had tried to get out of bed "a few times that shift" and "bed alarm was on." The CNA stated he was unsure why her bed and/or bed alarm was not working.

The patient's RN was interviewed on 9/04/18, beginning at 10:31 AM, and the patient's RCA and medical record was reviewed in her presence. She stated the patient attempted to get out of bed during her shift, was difficult to reorient, and would try to "get up." The RN stated the patient's bed alarm was on. She stated the patient's bed was not given to Biomedical Services to be inspected.
The NP, who ran the patient's code blue on 6/28/18, was interviewed on 9/04/18, beginning at 11:12 AM. He stated he was not a part of the patient's RCA. When asked if he had ever been asked to participate in a hospital RCA, the NP stated no.

The Director of Plant Operations was interviewed on 9/05/18, beginning at 8:30 AM. When asked if the patient's potentially faulty bed/bed alarm was turned over to him or to Biomedical Services, he stated no. The Director of Plant Operations stated he did not participate in the patient's RCA.

An incident report regarding the patient's death, updated 7/18/18, stated "RCA completed, scored 5 awaiting case closure by the Coroner's Office to obtain the outcome of Cause of Death."

The CEO was interviewed on 9/05/18, beginning at 4:37 PM. She confirmed the patient's RCA was not complete and did not identify her fall and hospital equipment issues.

The patient's RCA failed to identify, analyze, and investigate her fall, and her potentially faulty hospital equipment, directly preceding her death.

2. Hospital staff did not follow ACLS guidelines during the patient's CPR.

The NP who ran the patient's code blue on 6/28/18, was interviewed on 9/04/18, beginning at 11:12 AM. He stated he responded to the code blue alert at 6:03 PM and, when he arrived, CPR was already in progress. The NP stated the patient had no pulse and "was in PEA." He stated the patient did not have a heart rhythm for the duration of code blue and expired at 6:26 PM.

The NP's personnel file was reviewed on 9/05/18, beginning at 12:30 PM, and current ACLS certification was confirmed.

The ACLS Medical Training website, accessed 9/12/18, included the following algorithm for PEA:

- "Continue CPR; Airway; Oxygen; Connect monitors"
- "Epinephrine 1 mg ASAP and every 3 - 5 minutes"
- "Evaluate rhythm..."
- "Evaluate and treat reversible causes"

The patient's medical record included a "CODE BLUE RECORD," dated 6/28/18, signed by the NP. The form documented a series of events not covered under the ACLS PEA algorithm:
a. From start of CPR at 6:03 PM, to pronouncement of death at 6:26 PM, the patient did not have a "Monitored Rhythm" or identified cardiac waveform.

b. From start of CPR at 6:03 PM, to pronouncement of death at 6:26 PM, the patient did not have a monitored oxygen saturation level. The form documented "O2 @ flushed % via trach." It was unclear what percent of supplemental oxygen, or the flow rate, "flushed" was.

c. The patient was manually defibrillated (the stopping of fibrillation of the heart by administering a controlled electric shock in order to allow restoration of the normal rhythm) at 6:03 PM, 6:05 PM, 6:07 PM, 6:09 PM, 6:11 PM, 6:13 PM, 6:14 PM, 6:16 PM, 6:18 PM, 6:20 PM, 6:22 PM, and 6:24 PM. The form did not indicate what joules were used for defibrillation.

d. The patient was defibrillated via an AED at 6:07 PM, 6:09 PM, 6:11 PM, 6:13 PM, 6:14 PM, 6:16 PM, 6:18 PM, 6:20 PM, 6:22 PM, and 6:24 PM. The form did not indicate what joules were used for defibrillation.

e. From start of CPR at 6:03 PM, to pronouncement of death at 6:26 PM, the patient did not receive initial, or subsequent, Epinephrine 1 mg.

f. The patient received a unknown infusion quantity of Epinephrine at 6:10 PM (7 minutes after the initiation of CPR), 6:13 PM, 6:18 PM, and 6:23 PM.

It was unclear if these CPR interventions occurred as documented, or if they were recorded in error.

The CEO was interviewed on 8/31/18, beginning at 1:56 PM, and the patient's code blue form was reviewed in her presence. When asked if staff retained the patient's cardiac waveforms, printed by the crash-cart defibrillator used during her CPR, the CEO stated "staff cannot locate them."

The VP of Clinical Development and Operations was interviewed on 9/04/18, beginning at 2:00 PM. She stated "post code huddle documentation was not done" for the patient.

The Director of Quality Management was interviewed on 9/04/18, beginning at 2:17 PM, and the patient's code blue form was reviewed in her presence. She confirmed the patient's documented CPR did not follow ACLS guidelines. The Director of Quality Management stated the patient's code blue form had not been reviewed for accuracy or appropriateness.

Hospital staff did not follow ACLS guidelines during the patient's CPR.
3. The hospital provided a form titled "LTACH EDUCATION PLAN 2018," undated. The section titled "EDUCATION PLAN 2018" included a list of trainings to happen each month; including "Mock Code/RRT." This training was marked with an asterisk that denoted "Mandatory Education."

The last documented mock code was November 2017.

The CEO was interviewed on 8/31/18 beginning at 1:00 PM, and stated her expectation is for mock codes to be done 2 times a month.

The CCO was interviewed on 8/31/18 beginning at 9:30 AM, and stated her expectation is for mock codes to be done at least every 90 days. She did not remember the last time the facility performed a mock code.

The VP of Clinical Development and Operations was interviewed 9/05/18 beginning at 4:20 PM. She stated the "Mandatory Education" was a suggestion and each hospital would create their own education plan for the year and send it to corporate. When asked if the hospital had submitted an education plan for 2018 to corporate for approval she stated no. The VP of Clinic development and Operations confirmed the last documented mock code was completed in November 2017.

The hospital failed to follow their education plan.

4. The patient's death record did not reflect accurate documentation.

Her medical record included a "Record of Death," dated 6/30/18. The form included 2 main sections: "NOTIFICATION" and "EYE/TISSUE/ORGAN DONATION." These 2 sections appeared to be completed by 2 different sets of handwriting. The bottom of the form included a section titled "TO BE COMPLETED BY HOSPITAL PERSONNEL." This section included the printed name of HS B next to "Funeral Home called by" and "Body of Decedent released by" dated 6/29/18 at 2:20 AM. Additionally, the bottom of the form included an illegible signature, dated 6/30/18 at 8:00 AM.

The House Supervisor was interviewed on 9/04/18, beginning at 3:19 PM, and the patient's death record was reviewed in his presence. When asked if he filled out any portions of the form, he stated no. The House Supervisor stated he was not working on 6/29/18 at 2:20 AM. He stated he did not recognize either of the 2 handwritings on the form, nor was he able to identify the unknown signature at the bottom of the form. The House Supervisor confirmed the patient's death record was not accurate.

The patient's death record did not reflect accurate documentation.
5. Hospital Telemetry Monitor Technician was unable to perform job duties.

A hospital policy "Clinical Alarms," reviewed March 2018, stated:

- "All staff that utilize or maintain equipment/devices with clinical alarm systems will be properly oriented to the equipment/device, the alarm and trained on its use."

- "All staff using and/or maintaining medical equipment/devices with related alarm systems must be assessed and proven competent to operate the equipment/device and manage its associated alarm mechanism prior to use of that equipment/device."

- "For all equipment/devices with clinical alarms, staff competency assessment will be conducted prior to initial use of equipment/device and annually thereafter."

This policy was not followed.

An observation of the hospital's ICU was conducted with the VP of Licensing and Accreditation on 9/04/18, beginning at 11:40 AM, and a monitor tech was observed executing her job duties at that time. The monitor tech was located at the ICU nurses station and was responsible for monitoring patients' ECG waveforms remotely. During the observation, 9 of 13 patients on the monitor tech's computer screen displayed "ECG ALARMS OFF." When asked why these 9 patients had their alarms turned off, the monitor tech stated she did not know and "I'm new to this; I guess I need education." When asked how long she had been performing the duties of a Telemetry Monitor Technician, the monitor tech stated "3 weeks."

The monitor tech's personnel file was reviewed on 9/04/18, beginning at 1:30 PM. The monitor tech had a signed job competency; however, it was dated 9/02/18; 3 days after the start of the survey and several weeks after performing her job duties as a Telemetry Monitor Technician. The monitor tech's personnel file did not include a documented orientation to her job duties.

The monitor tech was interviewed on 9/05/18, beginning at 9:26 AM. She stated she was new to her role as a Telemetry Monitor Technician and had been "on my own for about 3 weeks." The monitor tech stated she had no previous experience in telemetry monitoring or education prior to accepting her new role. She confirmed her competency was performed and documented after the start of the survey.

Hospital Telemetry Monitor Technician was unable to perform job duties.

It was determined the hospital failed to ensure patients received care in a safe setting. Therefore, the allegation was substantiated and federal deficiencies were cited.
Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

Allegation #2: Patient medication administration did not follow physician orders.

Findings #2: Patient medication administration did not follow physician orders.

One example was a 32 year old female who was admitted to the hospital on 6/08/18, with a diagnosis of acute respiratory failure. Additional diagnoses included confusion, high fall risk, and intracranial hemorrhage. She was scheduled to discharge to a SNF on 6/29/18; however she expired in the hospital on 6/28/18.

The hospital's policy, "Administration of Medications," effective 6/2013, stated: "The six 'rights' of administering medications will be followed with each medication administration:

1. Right patient.
2. Right drug.
3. Right dose.
4. Right route.
5. Right time.
6. Right documentation."

The facility failed to follow their policy.

The patient's medical record included an order for Vancomycin 125 mg by mouth every 6 hours. The medical record documented that Vancomycin was given on 6/08/18 at 11:19 PM. The Vancomycin was documented in the patient's MAR as given by the correct route. However, there was an incident report that documented a medication error on 6/08/18 related to the patient's oral Vancomycin.

There was no additional documentation of the medication error in the patient's medical record.

An incident report was reviewed for the patient documented a medication error on 6/08/18. The incident report documented the oral Vancomycin ordered for the patient was unavailable and that the on-call pharmacist was called for mixing instructions. The medication was mixed by the RN per instructions from the on-call pharmacist and the patient's nurse gave the Vancomycin IV push instead of PO as ordered.

The Director of Pharmacy was interviewed on 8/31/18, beginning at 10:55 AM, and the patient's incident report was reviewed in her presence. She stated the on-call pharmacist should have come in to the hospital to mix the Vancomycin.
The Director of Pharmacy was interviewed on 9/06/18 beginning at 1:30 PM, and confirmed the patient received the Vancomycin 125 mg IV push instead of PO as ordered. She stated the RN who administered the Vancomycin had been reeducated on medication administration.

The hospital provided an RCA that identified the medication error. The RCA documented the nurse and on-call pharmacist were provided reeducation on medication mixing and administration.

It was determined the hospital failed to ensure patients received medications as ordered by their physician. Therefore, the allegation was substantiated and federal deficiencies were cited.

**Conclusion #2:** Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

Thank you for the courtesies extended to us during the survey. If you have any questions, comments or concerns, please contact Dennis Kelly, RN or Nicole Wisenor, Co-Supervisors, Non-Long Term Care at (208) 334-6626, option 4.

Sincerely,

DENNIS KELLY, RN, Supervisor
Non-Long Term Care

DK/pmt