Dear Administrator:

IMPORTANT
PLEASE READ CAREFULLY

The Centers for Medicare and Medicaid Services (CMS) has determined that Saint Alphonsus Regional Medical Center no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. Your deemed status with The Joint Commission is removed and you are placed under the State's jurisdiction. Your deemed status will be restored when you get back in substantial compliance with Medicare regulatory requirements.

BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a facility must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a facility is found to be out of compliance with the Medicare Conditions 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 Saint Alphonsus Regional Medical Center's participation in the Medicare program. The projected date on which the agreement will terminate is **August 20, 2019**.

On May 16, 2019, 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 Saint Alphonsus Regional Medical Center to furnish services of an adequate level and quality. The details of the above
deficiencies are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS - 2567).

The finding that the Saint Alphonsus Regional Medical Center 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 to 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 to 443-380-7537

An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

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

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

Sincerely,

Renae Hill  Acting Manager

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

This is an official notice sent electronically or facsimile, pursuant to 42 C.F.R. Part 488, no hard copy to follow
Re: CMS Certification Number: 13000
Complaint #ID 00008078X

Dear Ms. Roe and Mr. Kelly:

Enclosed you will find Saint Alphonsus Regional Medical Center's Plan of Correction (POC) which is intended to address the deficiencies cited during the complaint investigation conducted from May 13, 2019 through May 16, 2019. Saint Alphonsus believes this POC meets the evidence of correction requirements of the cited deficiencies under Medicare Tags A123, A143, A216, A385, A395, A396, and A1133.

Saint Alphonsus takes these citations very seriously and is firmly committed to taking all actions outlined in this POC to enhance the hospital's compliance with regulations and improve the overall provision of patient care service and patient safety.

Please contact me at (208) 367-2902 for Amy.karsten@saintalphonsus.org if you have any questions or concerns regarding the enclosed document.

Respectfully submitted,

Amy Karsten, RN
Director of Patient Safety and Regulatory Compliance
Saint Alphonsus Health System

cc: Odette C. Bolano, President and CEO, Saint Alphonsus Health System:
   Andrew Cosentino, RHM President, Saint Alphonsus Regional Medical Center
   Shelley Harris, RHM CNO Oregon Idaho Region, Saint Alphonsus Regional Medical Center
   Jennifer Misajet, VP Operations, Saint Alphonsus Regional Medical Center

Enclosures: as stated
Grievance Findings
The hospital failed to provide written grievance resolutions which included the name of the contact person, steps taken to investigate, all results of the grievance process, and the date of completion for 2 of 6 patients (#2 and #7) whose grievances were reviewed. This had the potential for incomplete grievance investigations and resolutions communicated to patients.

Plan of Correction
The Patient Relations Department at Saint Alphonsus Regional Medical Center (SARMC) is accountable and responsible for all components of the grievance process; to reduce variation in grievance responses and to ensure each grievance response is timely, complete and accurate. The Patient Relations Department will also ensure that each grievance response contains all of the essential elements, including the name of the hospital contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion.

Procedure for Plan of Correction Implementation
• SARMC will revise the Concern and Grievance Management Program- SAHS Policy to clarify the Patient Relations Department's role in grievance management and to address the timeframe for resolution of grievances.
• The Patient Relations Department will be responsible to implement and follow the revised Concern and Grievance Management Program – SAHS Policy.
• The Patient Relations department will deploy mandatory education to grievance file managers. Grievance File Managers will attend a one-hour workshop to review...
## Provider Plan of Correction Form

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<thead>
<tr>
<th>Provider/Supplier Name</th>
<th>Survey Exit Date:</th>
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<tbody>
<tr>
<td>SAINT ALPHONSUS REGIONAL MEDICAL CENTER</td>
<td>5/16/2019</td>
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<tr>
<td>1055 NORTH CURTIS ROAD</td>
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<td>BOISE, ID 83706</td>
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### Monitoring Procedures for Plan of Correction

#### Effectiveness and Sustainability

- SARMC will audit 100% of all grievance responses to ensure all components of the grievance process are in place for 90 days. If compliant for 90 days, SARMC will move to auditing 50% of all grievances for 180 days. After 180 days of satisfactory compliance (as defined by the Quality and Patient Safety Council (QPSC)), SARMC will maintain their routine quality assurance audits at a rate of 30%.

- A sign-in roster will be maintained for the aforementioned mandatory education to track and ensure the 100% completion requirement. Grievance File Managers on a leave of absence during the education period will receive make-up education from the patient relations department on their return to work.

#### Quality Assessment and Performance Improvement

- The results of the grievance audits will be reported to the Grievance Committee and to the Quality and Patient Safety Council.

- A summary will also be reported to the Quality Care Professional Practice Committee (QCPPC) quarterly.

- If non-compliance occurs, the Grievance Committee and the Quality and Patient Safety Council will reassess the Plan of Correction and make any needed changes.

### Completion Date

- The Concern and Grievance Management Program – SAHS Policy will be revised and approved by SARMC Community Board by 6/6/2019.
### Provider Plan of Correction Form

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**Provider's Plan of Correction**

(Each Corrective Action should be Cross-Referenced to the appropriate cited deficient practice)

- The audit of 100% of all grievances will be initiated by 6/7/2019.
- The Patient Relations Department will implement the revised Concern and Grievance Management Program - SAHS Policy by 6/7/2019.
- The training of 100% of SARMC Grievance File Managers will be completed by 6/19/2019.
- The education will also be added to the next scheduled new leader orientation.

**Responsible Owner**

Adrianne Presnell, Director of Patient Experience

**Findings Patient Rights: Personal Privacy**

It was determined the hospital failed to ensure the patient/family was informed of video monitoring for 1 of 1 rehabilitation patient (Patient #1) for whom monitoring was implemented and whose record was reviewed. This resulted in a patient under video surveillance without his knowledge and had the potential for violation of his privacy.

**Plan of Correction**

SARMC will inform patients/patient representatives that patients may be monitored by video for safety reasons. Additionally, if video monitoring is implemented for any patient, the patient/patient representative will be informed of the video monitoring.

**Procedure for Plan of Correction Implementation**

- SARMC will revise the Consent to Medical Care and Patient Services Agreement (referred to as "Consent Form") to inform patients/patient representatives that patients may be monitored by video for safety reasons.
SAINT ALPHONSUS REGIONAL MEDICAL CENTER
1055 NORTH CURTIS ROAD
BOISE, ID 83706

5/16/2019

CMS Certification Number
130007

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<td>• SARMC will revise the Patient Safety Monitoring Policy to address the process for ensuring the patient/patient representative is informed of any video monitoring implemented for the patient and the process for documentation of such communication.</td>
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<td>• Mandatory education will be provided to all nursing staff on the process of informing the patient/patient representative of the video monitoring, including the documentation standards for the patient record. This education will also be added to the annual nursing staff competency and new colleague orientation.</td>
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**Monitoring Procedures for Plan of Correction**

**Effectiveness and Sustainability**

For 90 days, SARMC will audit 100% of charts for patients monitored by Remote Visual Monitoring Technician/Technology (VMT) for documentation of notification to patients/patient representatives of video monitoring. After 90 days of satisfactory compliance with documentation standards, SARMC will audit 50% of all charts for patients placed on VMT for 180 days. After 180 days of demonstrated satisfactory compliance with documentation standards, SARMC will audit 20 random charts of patients placed on VMT monthly.

• Learning Management System Healthstream (referred to as "Healthstream") Compliance Report will be generated to assess compliance with the mandatory education.

**Quality Assessment and Performance Improvement**

• The results of the audits and education will be reported to the Senior Leadership Team (SLT) and the Quality and Patient Safety Council.
Provider Plan of Correction
Form

Provider/Supplier Name
SAINT ALPHONSUS REGIONAL MEDICAL CENTER
1055 NORTH CURTIS ROAD
BOISE, ID 83706

Survey Exit Date:
5/16/2019

CMS Certification Number
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Provider's Plan of Correction
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<td>143</td>
<td>6/5/2019</td>
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<td>A 216</td>
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<td>7/5/2019</td>
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Findings Patient Rights: Visitation

This standard is not met as the facility failed to ensure that 6 of 6 patient records (#1-6) included documentation that patients or their representatives were informed of visitation rights. This had the potential to interfere with the exercise of patient visitation rights.

Plan of Correction

SARMC will implement a process to ensure each patient (or support person, where appropriate) is informed of the
### Provider Plan of Correction Form

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<td>A</td>
<td>216</td>
<td>Patient’s visitation rights, including any clinically necessary or reasonable restrictions on visitation. The process will also ensure each patient (or support person, where appropriate) is informed of: the right to receive visitors he/she designates, including but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or friend; and the right to withdraw or deny consent to receive specific visitors at any time.</td>
<td>(X5)</td>
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#### Procedure for Plan of Correction Implementation

- SARMC is revising the Visitation Policy to include language regarding how visitation rights, including any clinically necessary or reasonable restrictions on visitation, will be communicated to patients (or support person, where appropriate). The revisions will also address informing each patient (or support person, where appropriate) of: the right to receive visitors he/she designates, including but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or friend; and the right to withdraw or deny consent to receive specific visitors at any time.

- The "Your Rights and Responsibilities as a Patient" brochure is being revised to address the patient’s visitation rights, including any clinically necessary or reasonable restrictions on visitation. The revisions will also address informing each patient (or support person, where appropriate) of: the right to receive visitors he/she designates, including but not limited to, a spouse, a domestic partner (including same-sex domestic partner), another family member, or friend; and the right to withdraw or deny consent to receive specific visitors at any time. This brochure will be offered to patients at the time of registration.
Provider Plan of Correction Form

Provider/Supplier Name: SAINT ALPHONSUS REGIONAL MEDICAL CENTER
1055 NORTH CURTIS ROAD
BOISE, ID 83706

Survey Exit Date: 5/16/2019
CMS Certification Number: 130007

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| A 216             | • SARMC will revise the Consent Form so that patients can acknowledge in writing that they were offered a copy of the brochure at the time of registration.  
• Mandatory education regarding the Visitation Policy will be deployed in Healthstream to all nursing, registration and security staff. This education will also be added to new colleague orientation.  

**Monitoring Procedures for Plan of Correction**

**Effectiveness and Sustainability**

• SARMC will audit 100% of all Consent Forms for 90 days for documentation that all patients were offered the "Your Rights and Responsibilities as a Patient" brochure. After 90 days of satisfactory documentation compliance, SARMC will audit 50% of all Consent Forms for 180 days. After 180 days of satisfactory documentation compliance, SARMC will conduct 30 random audits of Consent Forms monthly.
• A Healthstream Compliance Report will be generated to assess compliance with the mandatory education of all nursing, registration and security staff.

**Quality Assessment and Performance Improvement**

• The results of the audits will be reported to the Quality and Patient Safety Council.
• If non-compliance occurs, the Quality and Patient Safety Council will reassess the Plan of Correction and make any needed changes.
• A summary will also be reported to the Quality Care Professional Practice Committee quarterly.

**Completion Date**

• The revision of the Visitation Policy will be revised and
Provider Plan of Correction Form

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<tr>
<td>A216</td>
<td></td>
<td>6/7/2019</td>
<td>approved by the regional CNO by 6/7/2019.</td>
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<td>7/5/2019</td>
<td>The changes to the Consent Form will be implemented by 7/5/2019.</td>
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<td>7/5/2019</td>
<td>Mandatory education will be 90% completed by 7/5/2019 for all nursing, registration staff and security staff who are available to work. For nursing, registration and security staff that were unavailable (FMLA, PTO) during the time of education, they will need to complete the education prior to their next workday.</td>
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<td>7/5/2019</td>
<td>The audit of 100% of all Consent Forms will be initiated by 7/5/2019.</td>
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<td>Responsible Owner</td>
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<td>Christin Doyle, Manager of Family Maternity Center</td>
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Findings Skin Assessment and Intervention

It was determined that the hospital failed to ensure nursing staff assessed skin in accordance with hospital policy and intervened to address skin needs for 5 of 6 patients (#1, #2, #3, #5, and #6) whose records were reviewed. This resulted in skin deterioration in 4 patients and had the potential to result in skin deterioration and unmet patient needs in all patients with identified skin care needs.

Plan of Correction

Nursing staff will assess skin in accordance with hospital policy and intervene to address skin care needs.

Procedure for Plan of Correction Implementation
Provider Plan of Correction
Form

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| A         | 395     | • Saint Alphonsus Regional Medical Center nursing leadership took immediate action by enhancing the shift to shift reports between caregivers to include skin assessment and devices.  
• Saint Alphonsus Regional Medical Center will consolidate its skin assessment policies and procedures into one "Braden Scale for Predicting Pressure Injury Risk and Skin Assessment Policy ("skin assessment and intervention policy") to reduce internal variation in skin assessment and optimize identification of patients' skin care needs.  
• A Healthstream Compliance Report will be generated to assess compliance with the mandatory education  
Monitoring Procedures for Plan of Correction  
Effectiveness and Sustainability  
• Audit of 100% of patient skin assessments for all new patient admissions and patients with a Braden score less than or equal to 12 for 90 days to insure satisfactory compliance with skin assessment and intervention policy. After 90 days of satisfactory compliance we will audit 50% of all charts for 180 days of satisfactory compliance. After 180 days of compliance, we will audit 70 random chart audits monthly. Audit results will be reported to the Quality and Patient Safety Council and if non-compliance occurs, the Council will review and assess appropriate modifications to this improvement plan.  
• Healthstream Compliance Report will be generated to assess nursing compliance with the mandatory training, with an expected a 90% education completion rate by all nursing staff who are available to work.  
Quality Assessment and Performance Improvement  
• Audit results will go to the pressure injury task force. |

CMS Certification Number  
130007

Survey Exit Date:  
5/16/2019

Provider/Supplier Name  
SAINT ALPHONSUS REGIONAL MEDICAL CENTER
1055 NORTH CURTIS ROAD
BOISE, ID 83706
Provider Plan of Correction
Form

Provider/Supplier Name: SAINT ALPHONSUS REGIONAL MEDICAL CENTER
1055 NORTH CURTIS ROAD
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Survey Exit Date: 5/16/2019

CMS Certification Number: 130007

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Provider's Plan of Correction
(Each Corrective Action should be Cross-Referenced to the appropriate cited deficient practice)

**Completion Date**

- The revision of the "Braden Scale for Predicting Pressure Injury Risk and Skin Assessment" policy will be revised and approved by the regional Chief Nursing Officer (CNO) by 6/15/2019.
- Mandatory education will be 90% complete by 7/5/2019 of all nursing staff who are available to work. Nursing staff who were out e.g. FMLA, PTO during the time of education, will need to complete education prior to their next workday.
- The review/audit of 100% of all patient charts will be initiated by 7/5/2019.

**Responsible Owner**

Ben Watland, Director of Nursing Operations

**Findings Development of Comprehensive Plan of Care**

*It was determined that the hospital failed to ensure that comprehensive Plans of Care were developed related to skin integrity for 3 of 3 patients (#1, #2, and #6) admitted to the rehabilitation unit and whose care plans were reviewed. This resulted in a lack of direction to staff caring for these patients and had the potential to contribute to skin breakdown.*

**Plan of Correction**

Saint Alphonsus Regional Medical Center will develop...
**Provider Plan of Correction Form**

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**Provider/Supplier Name**
SAINT ALPHONSSUS REGIONAL MEDICAL CENTER 1055 NORTH CURTIS ROAD BOISE, ID 83706

**Survey Exit Date:** 5/16/2019

**CMS Certification Number** 130007

**Provider's Plan of Correction**
(Each Corrective Action should be Cross-Referenced to the appropriate cited deficient practice)

- comprehensive individualized Plans of Care to address patients who have a Braden score less than or equal to 12.

**Procedure for Plan of Correction Implementation**
- Saint Alphonsus Regional Medical Center will revise the "Interprofessional Plan of Care- SAHS" policy to include definitions of the Plan of Care.
- Mandatory education will be provided to all nursing staff on the "Interprofessional Plan of Care- SAHS" through Healthstream. Education will be added to annual competency and new employee orientation.

**Monitoring Procedures for Plan of Correction Effectiveness and Sustainability**
- An audit of 100% of patients with a Braden score less than or equal to 12 verifying there is an open and individualized skin plan of care for 90 days. After 90 days of satisfactory compliance we will audit 50% of all charts for 180 days. After 180 days of satisfactory compliance, we will audit 50 random charts. Audit results will be reported to the Quality and Patient Safety Council and if non-compliance occurs, the Council will assess appropriate modifications to this improvement plan.
- Healthstream Compliance Report will be generated to assess compliance with the mandatory training with a 90% completion rate by all nursing staff who are available to work.

**Quality Assessment and Performance Improvement**
- Audit results will go to the pressure injury task force.
- Audit summary will be reported to the Quality and Patient Safety Council.
- Audit summary will also be reported to the Quality Care.
**Provider Plan of Correction Form**

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BOISE, ID 83706

**Survey Exit Date:**

5/16/2019

**CMS Certification Number:**

130007

**Provider's Plan of Correction**

(Each Corrective Action should be Cross-Referenced to the appropriate cited deficient practice)

**Completion Date**

- Revision of the "Interprofessional Plan of Care- SAHS" will be revised and improved by the regional Chief Nursing Officer (CNO) policy will be complete by 6/7/2019.

- Mandatory education will be 90% complete by 7/5/2019 of all nursing staff who are available to work. Nursing staff who were out, e.g. FMLA, PTO during the time of education, will need to complete education prior to their next workday.

- The review/audit of 100% of all patient charts will be initiated by 7/5/2019.

**Responsible Owner**

Claire Jones, Director of Critical Care

**Findings Obtaining Orders**

The standard was not met as evidenced by the hospital failed to ensure rehabilitation patients' records included orders or complete orders for all necessary care for 3 of 3 patients (#1, #2, and #6) admitted to the rehabilitation unit and whose records were reviewed. This resulted in lack of assessment and care provided to patients' skin.

**Plan of Correction**

The Medical Staff and the Advanced Practice Providers (APP) are accountable for providing orders that direct the patient's plan of care. Nursing and ancillary team members are responsible for the clarification and the
**Provider Plan of Correction Form**

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<td>implementation of the orders which direct the plan of care for the patient.</td>
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**Procedure for Plan of Correction Implementation**

- Saint Alphonsus Regional Medical Center took immediate action regarding order accuracy on 5/28/2019 by prompt discussion and email follow up with key medical directors (orthopedics, hospitalist and rehabilitation).
- Email regarding appropriate orders was sent to all Medical Staff and the Advanced Practice Providers (APP) 5/31/2019.
- The following education on appropriate orders will be provided to all department chairs by 6/7/2019 with instruction to cascade and reinforce in their departments through department meetings and additional communication:
  1. Ensure that all orders are up-to-date and accurate.
  2. Ensure that orders are in place for the care being provided.
  3. Ensure that all orders contain adequate detail for implementation.
- Non-physician practitioners education will be provided at the APP Council 6/19/2019.
- Updates from the department chairs related to communication efforts and reinforcement of above education at the Medical Executive Committee (MEC) on 6/24/2019.
- The detailed information will be included in the MEC summary that is sent out to all medical staff and APP's post MEC.

**Monitoring Procedure for Plan of Correction**
**Provider Plan of Correction Form**

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<th><strong>Effectiveness and Sustainability</strong></th>
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<tr>
<td>• Medical Staff and the Advanced Practice Providers (APP) orders education will be provided through email. Compliance will be tracked through &quot;email read&quot; receipts.</td>
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<tr>
<td>• Orders education to the APP Council on 6/19/2019 and compliance will be tracked through meeting minutes.</td>
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<tr>
<td>• Initial orders education reinforcement and updates will be presented at the 6/24/2019 Medical Executive Committee and tracked through corresponding meeting minutes.</td>
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<td>• Continued orders education will be provided at every Medical Staff Department meeting as evidenced by documentation in corresponding meeting minutes.</td>
</tr>
</tbody>
</table>

**Quality Assessment and Performance Improvement**

• The MEC summary will be reported to the Quality Care Professional Practice Committee quarterly.

**Completion Dates**

• Email to Medical Staff and the Advanced Practice Providers (APP) was sent 5/31/2019. 5/31/2019
• Focused medical director communication regarding the need to provide orders education throughout their departments (including department meetings) will be sent by 6/7/2019. 6/7/2019
• Non-physician practitioners orders education will be provided at the APP Council 6/19/2019. 6/19/2019
• Reinforcement and follow-up of orders education will be discussed at the Medical Executive Committee on 6/24/2019. 6/24/2019

**Responsible Owner**

Ryan Heyborne, CMO, SARMC
## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:** 130007

**(X2) MULTIPLE CONSTRUCTION**

- **A. BUILDING:**
- **B. WING:**

**(X3) DATE SURVEY COMPLETED:** 05/16/2019

### NAME OF PROVIDER OR SUPPLIER

**SAINT ALPHONSUS REGIONAL MEDICAL CENTER**

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

- **ADDRESS:** 1055 NORTH CURTIS ROAD
- **CITY:** BOISE
- **STATE:** ID
- **ZIP CODE:** 83706

### (X4) ID PREFIX TAG ID PREFIX TAG

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<tr>
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<tr>
<td>A000</td>
<td>A123</td>
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### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

**INITIAL COMMENTS**

The following deficiencies were cited during the complaint survey conducted at your hospital on 5/13/19 to 5/16/19. The surveyors conducting the complaint survey were:

- Teresa Hamblin, RN, MS, HFS, Team Lead
- Nancy Bax, RN, BSN, HFS

The following acronyms were used in this report:

- **ABD** - Abdominal pad (dressing)
- **ACE** - All Cotton Elastic (bandage)
- **BID** - Two times per day
- **CAM/CAM** - Controlled Ankle Movement (Walker Boot)
- **cm** - centimeter
- **CNO** - Chief Nursing Officer
- **ED** - Emergency Department
- **HFS** - Health Facility Surveyor
- **IPR** - Inpatient Rehabilitation Unit
- **IV** - Intravenous
- **LIP** - Licensed Independent Practitioner
- **MD** - Medical Doctor
- **NS** - Normal Saline
- **PA** - Physician Assistant
- **PIV** - Peripheral Intravenous
- **Pt** - Patient
- **RN** - Registered Nurse
- **SAHS** - Saint Alphonsus Hospital System
- **TKA** - Total Knee Arthroplasty

**PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION**

CFR(s): 482.13(a)(2)(iii)

At a minimum,

In its resolution of the grievance, the hospital must provide the patient with written notice of its

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**LABORATORY DIRECTOR'S OR PROVIDER/Supplier REPRESENTATIVE'S SIGNATURE**

**TITLE**

**DATE**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
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, record review, policy review, and review of hospital grievance documentation, it was determined the hospital failed to provide written grievance resolutions which included the name of the contact person, steps taken to investigate, all results of the grievance process, and the date of completion for 2 of 6 patients (#2 and #7) whose grievances were reviewed. This had the potential for incomplete grievance investigations and resolutions communicated to patients. Findings include:

Facility policy, "Concern and Grievance Management Program -- SAHS," approved 5/30/2018, was reviewed. The policy stated:

- "The resolution of a formal grievance should be completed within seven (7) days of receiving the grievance. If the grievance cannot be completed within 7 days, the patient will be contacted in writing within the initial 7 days and informed they will be contacted with additional information concerning the status of the review within thirty (30) days. If the investigation requires longer than 30 days, the patient will be provided a letter of extension indicating the circumstances and the date for final review, within 30 days."

- "Once the grievance investigation is completed, the patient will be contacted in writing, unless the complainant specifically states they do not want a
### Summary Statement of Deficiencies

This policy was not followed. Examples include:

1. Patient #7's grievance file was reviewed. It included a grievance, received by the hospital on 2/08/19. The file included an acknowledgement letter sent on 2/15/19, signed by the Patient Relations Coordinator, stating an investigation into the allegations would be completed, and Patient #7 would be contacted by letter no later than 3/15/19.

Patient #7's grievance file included a letter, dated 4/17/19, stating his case was closed. The letter did not meet regulations for grievance.
**SUMMARY STATEMENT OF DEFICIENCIES**

A 123 Continued From page 3 resolution, as follows:

a. The letter was sent 34 days after the date specified in the acknowledgement letter.

b. The letter did not state who Patient #7 should contact with additional information or questions.

c. The letter did not include the steps taken to investigate the grievance.

d. The letter did not state the date of completion of the investigation.

The Patient Relations Supervisor and the Risk Manager were interviewed on 5/15/19 at 8:45 AM. They reviewed Patient #7's grievance documentation and confirmed it was not sent by the date specified in the acknowledgement letter, and Patient #7 did not receive a letter informing him of the delay. Additionally, they confirmed the letter did not include the name and contact information of the hospital contact person, steps taken by the hospital to investigate the grievance, or the date the investigation was completed.

The hospital failed to ensure Patient #7 received all required information regarding the resolution of his grievance.

2. Patient #2's grievance file was reviewed. It included a grievance, received by the hospital on 3/04/19. It stated the complainant alleged Patient #2 complained of leg pain repeatedly, and staff dismissed his pain as normal and did not look at the site of his complaint, and that a large pressure ulcer was not found until he was being evaluated for discharge.
A letter of response, dated 4/03/19, documented sending the complainant's concerns to managers for the telemetry unit and the rehabilitation unit. The letter, addressed to Patient #2, acknowledged concerns, stating "Your wife voiced frustration that our staff seemed to dismiss your leg pain concerns and did not identify your pressure ulcer sooner."

The letter of response stated "In review of your Electronic Medical Record, it is documented that there were daily skin and wound assessments charted while on the telemetry floor. While on Rehab [rehabilitation unit], the pain you experienced was noted to be incisional pain not pain where the pressure ulcer was located."

The letter of response did not address skin assessment on Patient #2 while on the rehabilitation unit. There were no documented skin assessments of Patient #2's left leg under his CAM boot, ACE wrap, and dressing, included in his medical record from the time of admission to the rehabilitation unit on 2/18/19 until 10 days later, on 2/28/19.

The information in the hospital's letter of response, describing Patient #2's pain as incisional pain, did not match the information surveyors viewed in his record. Patient #2's record for the inpatient stay to the rehabilitation unit, beginning 2/16/19, included nursing documentation on the "Direct Charting Flowsheet" that Patient #2 reported "leg pain" one or more times on 2/19/19, 2/20/19, 2/21/19, 2/22/19, 2/23/19, 2/24/19, and 2/27/19. There was no documentation nursing staff (or medical staff) examined his left leg for 10 days, after admission to the rehabilitation unit on 2/16/19.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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<th>PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:</th>
<th>MULTIPLE CONSTRUCTION</th>
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NAME OF PROVIDER OR SUPPLIER
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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

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<th>ID</th>
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<th>Summary of Deficiency</th>
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<tr>
<td>A 123</td>
<td></td>
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<td>Continued From page 5 until 2/28/19, just prior to Patient #2's discharge on 3/01/19.</td>
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<td>The Patient Relations Coordinator was interviewed on 5/15/19 at approximately 9:55 AM.</td>
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<td>She stated the letter of response to the grievance was written based on information provided by unit managers and that it was her understanding Patient #2 had reported incisional pain (ankle area) instead of leg pain. She acknowledged the letter did not address whether Patient #2's skin had been assessed on the rehabilitation unit.</td>
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<td>The letter of response did not include complete or accurate information as to the steps taken on behalf of Patient #2 to investigate the grievance and the results of the investigation.</td>
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Note: A 143 PATIENT RIGHTS: PERSONAL PRIVACY

CFR(s): 482.13(c)(1)

The patient has the right to personal privacy.

This STANDARD is not met as evidenced by:

Based on medical record review, hospital policy review, and staff interview it was determined the hospital failed to ensure the patient/family was informed of video monitoring for 1 of 1 rehabilitation patient (Patient #1) for whom video monitoring was implemented and whose record was reviewed. This resulted in a patient under video surveillance without his knowledge and had the potential for violation of his privacy. Findings include:

The hospital's policy, "Patient Safety Monitoring--SAHS," approved 3/04/19, stated, "In an attempt to keep our patients safe who are most at risk from harm, a Patient Safety..."
Attendant or AvaSys Visual Monitoring Unit (where available) will be utilized as detailed in this Policy. The type of monitoring will be based on nurse assessment and recommendations. The policy included "Appendix A: Roles and Responsibilities Grid." The section of the grid titled "Staff RN" stated, "Notify patient, family, and LIP that continuous monitoring will be implemented to promote patient safety."

Patient #1 was an 85 year old male, admitted to the hospital's rehabilitation unit on 4/11/19, for care following a TKA. He was discharged on 4/24/19.

Patient #1's record included a "Handoff Form." An entry, dated 4/11/19 at 8:27 PM, stated Patient #1 had repeatedly gotten out of bed without waiting for assistance. The entry stated video monitoring was ordered for the night shift. Entries dated 4/13/19 at 4:23 AM and 6:48 PM, 4/14/19 at 3:13 AM and 7:35 PM, and 4/15/19 at 2:46 PM, signed by RNs, stated video monitoring was being used in his room for safety. Patient #1's record did not include documentation stating he or his family were notified that video monitoring was implemented.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care stated no patient/family consent or notification of video monitoring was required because the video was not recorded.

The hospital failed to ensure Patient #1 and his family were informed that video monitoring was used in his room.
A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

This STANDARD is not met as evidenced by:

Based on staff interview and review of medical records, the contents of a "Welcome" packet, a brochure addressing rights and responsibilities, admission consent forms, and hospital policy, it was determined the facility failed to ensure 6 of 6 patient records ( #'s 1-6) included documentation that patients or their representatives were informed of visitation rights. This had the potential to interfere with the exercise of patient visitation rights. Findings include:

A brochure, titled "Your Rights and
Responsibilities as a Patient," was reviewed. It
did not include rights information related to
visitation.

An admission consent form, "CONSENT TO
MEDICAL CARE AND PATIENT SERVICES
AGREEMENT," revised 3/2013, was reviewed. It
did not address visitation rights or include
acknowledgment that visitation rights were
provided.

A policy, "Visitation," approved 1/09/2017, was
reviewed. It included general visiting hours,
restrictions based on number of people ("no more
than four people at one time"), restrictions related
to children under age 18 ("children 14 and under
must be accompanied by an adult" and "children
between 15-17 years of age must come with an
adult who remains in the building"). The policy
did not address how visitation rights would be
communicated to patients and their
representatives.

A "Welcome" packet of information was reviewed.
According to the CNO, during an interview on
5/13/19 at 4:15 PM, the packet was included in
patient rooms. The packet included the following
information related to visitation rights:

- "You, or your support person, have the right to
decide who can visit."
- "For your benefit or the benefit of other patients,
visiting may be limited by time of day, frequency,
length, or number of visitors as determined by
you, your support person or nursing staff."
- "Reasons for limiting visitation may include:
  - Your condition
  - Your sleeping patterns
  - Your reaction to previous visitation such as

- A216 Continued From page 8

- A216
### A216

**Summary Statement of Deficiencies**

- Increased anxiety, fatigue, or change in vital signs
- Nursing care and treatment at the time of visitation
- The health of the visitor. Visitors must not have been exposed to any communicable disease, have fever or symptoms of infection

The visitation information included in the patient welcome packet did not include:

- The specific restrictions listed in hospital policy related to children and length of stay
- The right to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

Patient records #1-6 were reviewed. There was no documentation patients #1-6 were informed of their visitation rights or were given the welcome packet that included visitation rights.

The CNO was interviewed on 5/13/19 at 4:15 PM. She acknowledged the hospital did not document that patients were informed of visitation rights or given welcome packets. When the surveyor pointed out that hospital policy included some restrictions that were not included in the welcome packet, she responded "We have open visitation."

Patient records #1-6 did not include documentation patients or their support persons had been informed of visitation rights.

### A385

**Nursing Services**

- CFR(s): 482.23

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**Provider's Plan of Correction**

Each corrective action should be cross-referenced to the appropriate deficiency.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

130007

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ______________________
B. WING ______________________

C. STREET ADDRESS, CITY, STATE, ZIP CODE
1055北TH CURTIS ROAD
BOISE, ID 83706

(X3) DATE SURVEY COMPLETED
05/16/2019

NAME OF PROVIDER OR SUPPLIER
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

(X4) PREFIX

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

A 385 Continued From page 10

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

This CONDITION is not met as evidenced by:
Based on record review, policy review, “job aide” review, grievance documentation review, staff interview, caregiver interview, and observation, it was determined the hospital failed to ensure nursing services were organized and supervised to effectively address patients’ potential or actual skin care issues. This resulted in incomplete care planning and lack of skin assessment and early interventions to reduce the risk of skin breakdown. Finding include:

1. Refer to A-395 as it relates to the failure of the hospital to ensure nursing staff assessed skin in accordance with hospital policy and intervened to address identified skin care needs.

2. Refer to A-396 as it relates to the failure of the hospital to ensure the development of comprehensive care plans to address potential or known skin integrity issues.

3. Refer to A-1133, under the Condition of Rehabilitation Services, as it relates to nursing staff’s failure to obtain orders and clarify incomplete orders.

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

A 395 RN SUPERVISION OF NURSING CARE

CFR(s): 482.23(b)(3)

A 395

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

(X5) COMPLETION DATE

A 385

05/16/2019

Facility ID: IDDK97 If continuation sheet Page 11 of 33
A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:

Based on record review, policy review, nursing "job aide" review, grievance documentation review, observation, staff and caregiver interview, it was determined the hospital failed to ensure nursing staff assessed skin in accordance with hospital policy and intervened to address skin needs for 5 of 6 patients (#1, #2, #3, #5, and #6) whose records were reviewed. This resulted in skin deterioration in 4 patients and had the potential to result in skin deterioration and unmet patient needs in all patients with identified skin care needs. Findings include:

The hospital policy, "Braden Scale for Predicting Pressure Injury Risk and Skin Assessment," approved 6/22/2017, stated:

- "Reassessment of head to toe skin integrity will be performed and documented at a minimum every shift and as needed."

- "Skin will be assessed underneath medical devices, at minimum, every shift."

A nursing "job aide," (a summary of nursing assessment requirements in table format), included guidance to nursing staff to assess incisions/wounds and do a pressure ulcer assessment on admit and every shift.

A hospital policy, "Charting Guidelines -- Rehabilitation," approved 1/04/2018, stated:

- A "complete review of systems will be
**SAINT ALPHONSUS REGIONAL MEDICAL CENTER**

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<th>(X4) ID PREVIOUS TAG</th>
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<th>COMPLETION DATE</th>
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<tr>
<td>A 395</td>
<td>Continued From page 12 performed upon admission and daily.</td>
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<td>- &quot;Baseline physical assessment will include a minimum of...Skin Mucosa: head to toe inspection...indisision and/or wound assessment&quot;</td>
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<td>Hospital policies and &quot;job aides&quot; guidelines for nursing staff assessment requirements were not followed. Examples include:</td>
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<td>1. Patient #2 was a 72 year old male initially admitted to the hospital on 2/05/19 for left ankle surgery after a traumatic injury. He was admitted to the rehabilitation unit on 2/18/19 and discharged from the hospital on 3/01/19.</td>
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<td>The operative report, dated 2/06/19, indicated Patient #2 &quot;had some fracture blisters on the posterior aspect of his calf that had popped. These were dressed with Xeroform...&quot;</td>
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<td>A progress note, dated 2/08/19, signed by a PA, stated &quot;Fresh dressings were reapplied with a Mepilex, Ace [sic] wraps were also placed and he was put into a long-leg walker boot.&quot; It could not be determined if the fresh dressings were specific to the surgical site at the left ankle or whether they included the calf wound identified after Patient #2's surgery on 2/06/19.</td>
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<td>A progress note, dated 2/16/19, signed by a PA, stated the CAM boot and dressings were removed and the skin examined. &quot;There was a possible prior skin tear noted proximally, just distal to the patient's gastrocnemius. This did not have any surrounding erythema or evidence of infection as well. There did appear to be evidence of granulation tissue formation.&quot; &quot;Wound dressings were then replaced with</td>
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<tr>
<td>A 395</td>
<td>Continued From page 13 Xeroform and Medipore dressings, Kerlix and an Ace [sic] wrap. The Cam [sic] walking boot was then replaced as well. The neurovascular status was then again checked out and Cam [sic] boot was replaced.&quot;</td>
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A progress note, dated 2/18/19, signed by a PA, documented "sutures were removed and dressings were replaced." There was no specific reference to the condition of Patient #2's skin at the site of the prior referenced calf wound.

Patient #2 was subsequently admitted to the rehabilitation unit on 2/18/19. There were no specific orders that addressed wound care or the CAM boot, whether the CAM boot should be worn continuously or while out of bed. There was no nursing clarification related to the missing orders.

There was no nursing documentation on the rehabilitation unit indicating Patient #2's skin had been assessed under the CAM boot and dressings, either upon admission to the rehabilitation unit, or per shift, until 10 days later, on 2/28/19.

An RN progress note, dated 2/28/19, related to Patient #2, stated: "MD and this nurse undressed ace [sic] wrap on left ankle, surgical incisions are well approximated slight erythema. However, there appears to be an unstageable pressure injury on left lateral calf that is 100% eschar covered with drainage. The pt [patient] reports that since he has been in the hospital, his dressing has been changed 1 time that he can remember. This nurse received a verbal wound care consult order..."

Grievance documentation indicated Patient #2's
A395 Continued From page 14

significant other had filed a complaint on his behalf on 3/04/19, alleging that Patient #2 had "complained on several occasions that he felt pain in his calf on his left leg" and according to Patient #2 and her own observation, "nursing staff did not remove his ace [sic] bandage to check the area of his complaint."

A phone call was made to Patient #2 on 5/16/19 at 11:25 AM. Patient #2 was not available to talk. His significant other, the complainant, was interviewed. Consistent with the written grievance filed with the hospital, Patient #2's significant other stated Patient #2 had reported his calf pain on multiple occasions to staff, and no-one unwrapped his ACE wrap to look at the area where he was pointing until he was ready for discharge.

Patient #2's record included nursing documentation on the "Direct Charting Flowsheet" that Patient #2 reported "leg pain" 1 or more times after admission to the rehabilitation unit on 2/18/19, including on the following dates: 2/19/19, 2/20/19, 2/21/19, 2/22/19, 2/23/19, 2/24/19, and 2/27/19. There was no documentation nursing staff subsequently examined Patient #2's skin on his left leg in response to his report of pain.

A wound consult RN note, dated 2/28/19, stated "S [subjective]: Wound care evaluation requested for wound to L [left] posterior calf. O [objective]: Soft gray/brown eschar with separating edges measuring 5.5 cm x 6 cm, yellow slough at edges. Surrounding skin is intact, pink. Minimal amount of serous drainage on telfa dressing placed earlier today. A [assessment]: Cleansed with NS and gauze, applied sting free barrier film"
| (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: | 130007 |
| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING | |
| B. WING | |
| (X3) DATE SURVEY COMPLETED | C | 05/16/2019 |

**NAME OF PROVIDER OR SUPPLIER**
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1055 NORTH CURTIS ROAD
BOISE, ID 83706

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| A 395             | Continued From page 15 to surrounding skin. Duoderm thin over wound, covered with tegaderm followed by ABD pad in case dressing becomes overwhelmed with drainage. P [plan]: Will follow up in AM with wound care PA, [name] to provided [sic] sharp debridement if necessary. "A discharge summary, written by a PA, dated 3/01/19, stated "At the end of his [Patient #2's] rehabilitation efforts, he was found to have a wound to the left gastrocnemius area that was related to pressure from the Cam [sic] boot."

The Risk Manager and the Performance Improvement Coordinator were interviewed together on 5/15/19 at 9:55 AM. They confirmed there was no documentation nursing staff had removed the CAM boot and dressing and assessed Patient #2's skin under the boot from the time of admission to the rehabilitation unit on 2/18/19 until 2/28/19, at which time the enlarged wound on the calf was found.

Nursing staff did not assess and evaluate Patient #2's skin care needs under his CAM boot and ACE wrap in accordance with hospital policy.

2. Patient #6 was a 78 year old female admitted to the hospital on 5/02/19 after a motor vehicle collision. A tibial fracture was surgically repaired on 5/04/19. She was moved to the rehabilitation unit on 5/09/19.

A practitioner order, dated 5/09/19, signed by a PA, specified Patient #6 was to wear a "Hinged knee brace to left leg." The order did not say whether the brace was to be worn at all times, whether it could be removed while Patient #6 was

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**FORM CMS-2567(02-99) Previous Versions Obsolete**
Event ID: 8TNO11 Facility ID: IDDK97 If continuation sheet Page 16 of 33
A395 Continued From page 16

In bed, or for BID skin checks.

Nursing notes were reviewed. There was no documentation to indicate nursing staff had assessed Patient #6's skin beneath her knee brace, in accordance with hospital policy, or made attempts to clarify the incomplete practitioner order.

Patient #6 was observed in her room on 5/15/19 at 10:50 AM wearing her knee brace.

The Director of Acute Care was interviewed on 5/15/19 at 2:45 PM. She reviewed Patient #6's medical record and confirmed there was no documentation that nursing had removed Patient #6's hinged knee brace and assessed her skin beneath the brace.

Nursing staff did not assess and evaluate Patient #6's skin condition beneath a knee brace, in accordance with hospital policy.

3. Patient #1 was an 85 year old male, admitted to the hospital's rehabilitation unit on 4/11/19, for care following a TKA. He was discharged on 4/24/19.

   a. The hospital's policy, "Charting Guidelines - Rehabilitation," approved 1/04/18, stated "Incision and/or wound assessment will be done on post-operative patients upon arrival to the floor and once a shift."

Patient #1's record included a "History & Physical," dated 4/12/19, signed by a PA. It stated, "His surgical site has ABD and stockinette, small amount of drainage. We will
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<td>A 395</td>
<td>Continued From page 17 monitor and manage.</td>
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Patient #1's record included a "Direct Charting Flowsheet" that documented assessment of his surgical incision and dressing. It documented an assessment by an RN on 4/11/19 at 4:30 PM. The next assessment was documented on 4/16/19 at 9:00 AM, 5 days later. The flowsheet stated the dressing was reinforced at that time. The next assessment was documented on 4/22/19, at 9:00 AM, 6 days later. No assessment of Patient #1's incision was documented between 4/11/19 and 4/16/19, or between 4/16/19 and 4/22/19.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed his surgical incision was not assessed daily.

Patient #1's surgical incision was not assessed daily as required by hospital policy.

b. Patient #1's record included a "History & Physical," dated 4/12/19, signed by a PA. It included, "Skin: The patient has a sore on his buttock, which is being covered with Mepilex. Nursing to follow and manage."

Patient #1's record included a "Handoff Form." An entry, dated 4/11/19 at 8:27 PM, signed by the RN, stated, "Pt has sore on buttock - mepilex applied." The note did not identify which buttock.

Patient #1's record included an "Admission Profile," form, dated 4/11/19 at 4:36 PM, signed by the RN. The profile documented Patient #1's initial assessment upon admission to the rehabilitation unit. It did not include...
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CUA Identification Number:**

130007

**Name of Provider or Supplier:**

Saint Alphonsus Regional Medical Center

**Address:**

1055 North Curtis Road
Boise, ID 83706

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#### Summary Statement of Deficiencies

**A 395** Continued From page 18

documentation of the sore on his buttock. There was no assessment, description or measurements of the sore.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and stated the sore was on his left buttock. She confirmed his record did not include an initial assessment or measurements of the sore on his left buttock. The Director of Acute Care stated wound measurements were not completed by RNs on the floor as they lacked consistency. She stated measurements were completed by the hospital's wound care team, however there was no order for the hospital's wound care team to address Patient #1's sore. The Director of Acute Care stated if the wound care team was not involved in a patient's care, wound measurements were not completed.

Patient #1's left buttock wound was not assessed on admission.

c. Patient #1's record included a "Direct Charting Flowsheet" that documented assessment of his left buttock sore. It documented an assessment by an RN on 4/11/19 at 4:30 PM. The next assessment was documented on 4/18/19 at 11:14 AM, 7 days later.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed the sore on his left buttock was not assessed daily.

Patient #1's left buttock wound was not assessed daily.

d. Patient #1's record included an
"Ostomy/Wound Progress Note," dated 4/17/19 at 4:21 PM, signed by the wound care nurse. The note stated, "Pt with area of partial thickness skin breakdown on R [right] buttock. 1 cm X 1.5 cm, 0.1 cm deep...This appears to be chronic, pt states it has been there approximately 1 year. Stage II pressure injury. No documentation until today so is therefore considered hospital acquired." It could not be determined why Patient #1's pressure ulcer was not identified at the time of his admission to the rehabilitation unit, 6 days earlier.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed the pressure ulcer on his right buttock was first identified 6 days after his admission to the rehabilitation unit.

Patient #1 did not receive a comprehensive skin assessment at the time of his admission to the rehabilitation unit.

e. Patient #1's record included a "Direct Charting Flowsheet" that documented pressure ulcer prevention, including redistribution of weight, avoidance of friction/shear, moisture management, and mobility management. One or more of the pressure ulcer prevention measures were documented by an RN on 4/11/19, 4/12/19, 4/13/19, 4/14/19, 4/15/19, 4/18/19, 4/19/19, 4/22/19, 4/23/19, 4/24/19, and 4/26/19. No pressure ulcer prevention measures were documented on 4/16/19, 4/17/19, 4/20/19, 4/21/19, or 4/25/19.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed pressure ulcer preventions
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<th>A 395</th>
<th>Continued From page 20 measures were not consistently implemented.</th>
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<td>The hospital failed to ensure on-going and consistent pressure ulcer prevention measures for Patient #1.</td>
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<td>f. The National Pressure Ulcer Advisory Panel's pressure injury prevention guidelines include a recommendation to reposition patients at least every 2 hours.</td>
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<td>Patient #1's pressure ulcer prevention measures included redistribution of weight and mobility management. Both measures included frequent turning to avoid pressure ulcers. His record included documentation of his position, with 50 entries between 4/11/19 and 4/24/19. Two of the 50 entries documented Patient #1 was positioned on his right side. The other 48 entries documented that he was sitting, supine, or supine with head of bed elevated, positions that would not relieve the pressure on his buttocks to avoid worsening of his pressure ulcer.</td>
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<td>During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed it did not document repositioning every 2 hours to avoid pressure to his buttocks.</td>
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<td>Patient #1 was not repositioned every 2 hours to avoid pressure ulcers.</td>
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<td>4. Patient #5 was a 57 year old male, admitted to the hospital on 4/05/19, with a primary diagnosis of acute encephalopathy. He was discharged on 4/16/19.</td>
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<td>The agency's policy, &quot;Intravenous Therapy, &quot;</td>
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**A 395 Continued From page 21**

Peripheral, Adult," approved 9/28/17, stated
"Sterile dressings shall be applied and maintained
on all PIVs. Change when it is damp, loose, or
soiled and at least every 5-7 days."

Patient #5's record included a "Direct Charting
Flowsheet" that documented assessments of his
peripheral IV site, from 4/05/19 to 4/16/19. The
assessments stated his IV site was intact, with no
evidence of infiltration or phlebitis, and was
covered with a transparent dressing. Patient #5's
record did not include documentation that his IV
dressing was changed during his 12 day
hospitalization.

Patient #5's record included a "Nursing Progress
Note," dated 4/16/19 at 4:58 PM. The note
stated, "Upon dc [discontinuation] IV, RN
discovered a possible stage 2 pressure ulcer on
Right Forearm where IV catheter was inserted,
just distal to insertion site, covered by tegaderm
and coban."

Coban is an elastic, self-adherent gauze wrap. It
is not transparent. Patient #5's record did not
document the application or presence of Coban
on his IV site. It could not be determined when
the Coban was applied, or if the skin under the
Coban was assessed prior to 4/16/19.

During an interview on 5/15/19 at 2:00 PM, the
Director of Acute Care reviewed Patient #5's
record. She stated his IV was inserted in the ED,
and his record did not state what type of dressing
was applied to his IV site. The Director of Acute
Care confirmed Patient #5's flowsheet
documented a transparent dressing and it could
not be determined if the Coban was applied in the
ED or later. Additionally, she confirmed there
A 395 Continued From page 22

was no documentation stating his IV dressing was changed during his 12 day hospitalization or that his skin under the Coban was assessed.

Patient #5's IV dressing was not changed as required by hospital policy, and his skin was not assessed to prevent breakdown.

5. Patient #3 was a 12 year old male admitted to the hospital on 3/03/19, with a primary diagnosis of attempted suicide. He was discharged on 3/06/19.

The hospital's policy, "Intravenous Therapy, Peripheral - Pediatric," approved 12/29/17, stated "The IV site is observed every two hours and condition of the site including phlebitis score documented. The IV is discontinued immediately if infiltration or signs and symptoms of inflammation develop at the site."

Patient #3's record included a "Direct Charting Flowsheet" that documented assessments of his peripheral IV site. Assessments were documented on 3/05/19 at 8:00 AM, 12:00 PM, and 7:30 PM. The next assessment was documented on 3/06/19 at 8:00 AM, 12.5 hours after the previous assessment.

Patient #3's record included a "Nursing Progress Note," dated 3/06/19 at 11:45 AM. The note stated, "After removing the coban and tape with tegaderm, the patient's arm had skin that was severely [sic] compromised from the coban that had been left on the patient from the start of the IV. Paper tape underneath the coban had to be removed with a lot of moisture and alcohol. The skin has breakdown and a blister from the IV."
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<td>Patient #3's record included a &quot;Handoff Form&quot; with an entry dated 3/06/19 at 4:44 PM, signed by an RN. The entry stated, &quot;IV discontinued and actions taken to aid in damage.&quot; His record did not include a physician's order for care to his IV site and did not state what actions were taken. During an interview on 5/15/19 at 1:50 PM, the Director of Acute Care reviewed Patient #3's record. She confirmed his IV site was not assessed every 2 hours as required by hospital policy. Additionally, she confirmed there was no physician's order for care of the comprised skin at his IV site. Patient #3's IV site was not assessed as required by hospital policy. Care was provided to his IV site without a physician's order.</td>
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<td>NURSING CARE PLAN CFR(s): 482.23(b)(4)</td>
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<td>The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan. This STANDARD is not met as evidenced by: Based on medical record review, hospital policy review, and staff interview, it was determined the hospital failed to ensure comprehensive POCs were developed related to skin integrity for 3 of 3 patients (#1, #2, and #6) admitted to the rehabilitation unit and whose care plans were reviewed. This resulted in a lack of direction to staff caring for these patients and had the potential to contribute to skin breakdown. Findings include:</td>
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The hospital's policy "Interprofessional Plan of Care - SAHS," approved 7/13/18, stated "Patients receive care and treatment based on an assessment of the patient's individualized needs. The data obtained from the assessment is used to determine and prioritize the patient's plan for care."

This policy was not followed. Examples include:

1. Patient #1 was an 85 year old male, admitted to the hospital's rehabilitation unit on 4/11/19, for care following a TKA. He was discharged on 4/24/19.

Patient #1's record included a "History & Physical," dated 4/12/19, signed by a PA. It included, "Skin: The patient has a sore on his buttock, which is being covered with Mepilex. Nursing to follow and manage.

Patient #1's record included an "Ostomy/Wound Progress Note," dated 4/17/19 at 4:21 PM, signed by the wound care nurse. The note stated, "Pt with area of partial thickness skin breakdown on R [right] buttock. 1 cm X 1.5 cm, 0.1 cm deep...This appears to be chronic, pt states it has been there approximately 1 year. Stage II pressure injury. No documentation until today so is therefore considered hospital acquired."

Patient #1's record included a "Care Plan," implemented 4/11/19, that addressed acute pain, activity intolerance, and fall risk. His care plan did not address skin integrity or pressure ulcer prevention.

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's care
SAINT ALPHONSUS REGIONAL MEDICAL CENTER

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<td>plan and confirmed it did not address skin integrity or pressure ulcer prevention. The hospital failed to ensure a care plan was developed to address care of Patient #1's skin problems and prevent additional skin breakdown.</td>
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<td>2. Patient #2 was a 72 year old male initially admitted to the hospital on 2/05/19 after a traumatic injury. On 2/06/19, Patient #2 underwent &quot;status post open reduction internal fixation&quot; related to a &quot;left trimalleolar ankle fracture.&quot; He was admitted to the rehabilitation unit on 2/18/19 and discharged on 3/01/19. The operative report, dated 2/06/19, indicated Patient #2 &quot;had some fracture blisters on the posterior aspect of his calf that had popped. These were dressed with Xeroform.&quot;</td>
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<td>A progress note, dated 2/08/19, signed by a PA, stated &quot;Fresh dressings were reapplied with a Mepilex, Ace [sic] wraps were also placed and he was put into a long-leg walker boot.&quot; It could not be determined if the fresh dressings were specific to the surgical site at the left ankle or whether it included the calf wound identified after the surgery on 2/06/19.</td>
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<td>A progress note, dated 2/16/19, signed by a PA, stated the CAM boot and dressings were removed and the skin examined. &quot;There was a possible prior skin tear noted proximally, just distal to the patient's gastrocnemius. This did not have any surrounding erythema or evidence of infection as well. There did appear to be evidence of granulation tissue formation.&quot; &quot;Wound dressings were then replaced with Xeroform and Medipore dressings, Kerlix and an</td>
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Ace [sic] wrap. The Cam [sic] walking boot was then replaced as well. The neurovascular status was then again checked out and Cam [sic] boot was replaced."

A progress note, dated 2/18/19, signed by the PA documented "sutures were removed and dressings were replaced." There was no specific reference to the condition of the skin at the site of Patient #2's calf wound.

There was no nursing documentation on the rehabilitation unit that Patient #2's skin had been assessed, under the CAM boot and dressings, either upon admission to the rehabilitation unit on 2/18/19, or per shift, until 10 days later, on 2/28/19.

An RN progress note, dated 2/28/19, related to Patient #2, stated: "MD and this nurse undressed ace [sic] wrap on left ankle... there appears to be an unstageable pressure injury on left lateral calf that is 100% eschar covered with drainage. The pt [patient] reports that since he has been in the hospital, his dressing has been changed 1 time that he can remember. This nurse received a verbal wound care consult order..."

A wound consult RN note, dated 2/28/19, stated "S [subjective]: Wound care evaluation requested for wound to L [left] posterior calf. O [objective]: Soft gray/brown eschar with separating edges measuring 5.5cm x 6cm, yellow slough at edges. Surrounding skin is intact, pink. Minimal amount of serous drainage on telfa dressing placed earlier today. A [assessment]: Cleansed with NS and gauze, applied sting free barrier film to surrounding skin. Duoderm thin over wound, covered with Tegaderm followed by ABD pad in
case dressing becomes overwhelmed with drainage. P [plan]: Will follow up in AM with wound care PA, [name] to provide [sic] sharp debridement if necessary."

A discharge summary, written by a PA, dated 3/01/19, stated "At the end of his [Patient #2]'s rehabilitation efforts, he was found to have a wound to the left gastroc [gastrocnemius] area that was related to pressure from the Cam [sic] boot."

Patient #2's record included a "Care Plan," initiated at that time of admission to the rehabilitation unit on 2/18/19, that addressed activities of daily living, physical mobility and fall risk. His care plan did not address skin integrity or pressure ulcer prevention, upon initiation of the care plan or throughout his stay in the rehabilitation unit.

The Risk Manager and the Performance Improvement Coordinator were interviewed together on 5/15/19 at 9:55 AM. They confirmed Patient #2's care plan did not address skin integrity or pressure ulcer prevention.

Patient #2's care plan did not address identified skin issues. His care plan was incomplete.

3. Patient #6 was a 78 year old female admitted to the hospital on 5/02/19 after a motor vehicle collision. A tibial fracture was surgically repaired on 5/04/19. She was moved to the rehabilitation unit on 5/09/19.

A practitioner order, dated 5/09/19, signed by a PA, specified Patient #6 was to wear a "Hinged knee brace to left leg." A brace could put
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<td>pressure on the skin and lead to skin breakdown.</td>
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<td>A practitioner wound care order for Patient #6, dated 5/09/19, signed by an MD, specified wound care &quot;daily with normal saline pain [sic] with Betadine cover with Xeroform and dry sterile dressing. Notify MD for drainage or breakdown in skin or any skin changes&quot;</td>
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<td>Patient #6's &quot;Care Plan,&quot; initiated 5/09/19, addressed activities of daily living, bowel incontinence, and fall risk. Her care plan did not address skin integrity issues or pressure ulcer prevention.</td>
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<td>The Director of Acute Care was interviewed on 5/15/19 at 2:45 PM. She reviewed Patient #6's medical record and confirmed her care plan did not address impaired skin integrity or pressure ulcer prevention.</td>
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<td>Patient #6's nursing care plan did not address her identified skin issues. Her care plan was incomplete.</td>
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<td>All rehabilitation services orders must be documented in the patient's medical record in accordance with the requirements at §482.24.</td>
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<td>This STANDARD is not met as evidenced by: Based on medical record review, policy review, observation, and staff interview, it was determined the hospital failed to ensure rehabilitation patients' records included orders or</td>
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1055 NORTH CURTIS ROAD
BOISE, ID 83706
A1133 Continued From page 29

Complete orders for all necessary care for 3 of 3 patients (#1, #2, and #6) admitted to the rehabilitation unit and whose records were reviewed. This resulted in lack of assessment and care provided to patients’ skin. Findings include:

A hospital policy “ORDERS LICENSED INDEPENDENT PRACTITIONERS (LIP),” revised 7/2008, stated:

- "Orders must be clear, legible and completed. Orders that are illegible or incomplete will not be carried out until rewritten or clarified."

- "At each handoff, orders should be reviewed by both the Sending Nurse and the Receiving Nurse at the same time."

Practitioner orders were missing or incomplete. Examples include:

1. Patient #2 was a 72 year old male initially admitted to the hospital on 2/05/19 for left ankle surgery on 2/06/19 after sustaining a traumatic injury. He was admitted to the rehabilitation unit on 2/18/19 and discharged home on 3/01/19.

A "History & Physical" examination, dated 2/19/19, completed by a PA, stated "He [Patient #2] has a CAM boot on the left foot."

Practitioner progress notes, dated 2/21/19, 2/22/19, 2/23/19, 2/25/19, 2/27/19, 2/28/19, documented Patient #2 was wearing a boot on the left lower extremity over an ace wrap.

Practitioner orders were reviewed for the rehabilitation unit stay from 2/18/19 through
A1133 Continued From page 30

3/01/19. There were no orders that addressed Patient #2's lower extremity CAM boot or ACE wrap. It could not be determined whether his boot was supposed to be worn at all times or could be removed for BID skin checks and while in bed.

A discharge summary, dated 3/01/19, written by a PA, stated "At the end of his [Patient #2's] rehabilitation efforts, he was found to have a wound to the left gastrocnemius area that was related to pressure from the Cam [sic] boot."

During an interview on 5/15/19 at 9:00 AM, the Risk Manager confirmed there was no order for the CAM boot or ACE wrap during Patient #2's stay on the rehabilitation unit. She stated "sometimes orthopedic doctors do not want boots or dressings removed. Staff may have assumed they were supposed to stay on."

Practitioner orders for the CAM boot and dressings were missing in Patient #2's medical record.

2. Patient #6 was a 78 year old female admitted to the hospital on 5/02/19 after a motor vehicle collision. A tibial fracture was surgically repaired on 5/04/19. She was moved to the rehabilitation unit on 5/09/19 and was a current patient at the time of the survey.

A practitioner order, dated 5/09/19, signed by a PA, specified Patient #6 was to wear a "Hinged knee brace to left leg." The order did not say whether her brace was to be worn at all times, whether it could be removed at times, such as while she was in bed or for BID skin checks.
Patient #6 was observed in her room on 5/15/19 at 10:50 AM wearing her knee brace.

The Director of Acute Care was interviewed on 5/15/19 at 2:45 PM. She reviewed Patient #6’s medical record and confirmed the practitioner’s order did not clarify whether Patient #6’s brace was to be worn continuously or only while walking.

Practitioner orders for Patient #6’s hinged knee brace were incomplete and lacked clarity.

3. Patient #1 was an 85 year old male, admitted to the hospital’s rehabilitation unit on 4/11/19, for care following a TKA. He was discharged on 4/24/19.

Patient #1’s record included a “History & Physical” dated 4/12/19, signed by a PA. It included, “Skin: The patient has a sore on his buttock, which is being covered with Mepilex. Nursing to follow and manage. His surgical site has ABD and stockinette, small amount of drainage. We will monitor and manage.”

Patient #1’s record included a “Handoff Form.” An entry dated 4/11/19 at 8:27 PM, signed by the RN, stated, “Pt has sore on buttock - mepilex applied.”

Patient #1’s record did not include a physician’s order for care of the sore on his buttock, including type of dressing to be applied or frequency of dressing changes. His record did not include a physician’s order for care of his surgical incision, including if/when the dressing should be removed.
A1133 Continued From page 32

During an interview on 5/15/19 at 1:10 PM, the Director of Acute Care reviewed Patient #1's record and confirmed a sore on his buttock was documented at the time of his admission. She confirmed there was no physician's order for care of his sore or his surgical incision.

The hospital failed to ensure Patient #1's record included all physician orders required for his care.
May 28, 2019

Andrew Cosentino, Administrator
Saint Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Mr. Cosentino:

An unannounced on-site complaint investigation was conducted from May 13, 2019 to May 16, 2019 at Saint Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00008078

Allegation #1: The hospital failed to assess skin adequately, resulting in a pressure sore.

Findings #1: Two surveyors conducted an unannounced survey from 5/13/19 until 5/16/19 to investigate a complaint. During the survey, surveyors conducted focused reviews of 6 patient records and 6 grievances. Additionally, surveyors reviewed selected policies and procedures, and interviewed staff, patients, and one patient representative.

It was determined the hospital failed to ensure nursing staff assessed skin in accordance with hospital policy and failed to intervene to address skin needs for 5 of 6 patients whose records were reviewed. This resulted in skin deterioration in 4 patients and had the potential to result in skin deterioration and unmet patient needs in all patients with identified skin care needs.

Findings include:

The hospital policy, "Braden Scale for Predicting Pressure Injury Risk and Skin Assessment," approved 6/22/2017, stated:
- "Reassessment of head to toe skin integrity will be performed and documented at a minimum every shift and as needed."

- "Skin will be assessed underneath medical devices, at minimum, every shift."

A hospital policy, "Charting Guidelines -- Rehabilitation," approved 1/04/2018, stated:

- A "complete review of systems will be performed upon admission and daily."

- "Baseline physical assessment will include a minimum of...Skin Mucosa: head to toe inspection...incision and/or wound assessment"

Hospital policies for nursing staff assessment requirements were not followed. Two examples follow:

1. One patient was a 72 year old male initially admitted to the hospital on 2/05/19 for left ankle surgery after a traumatic injury. He was admitted to the rehabilitation unit on 2/18/19 and discharged from the hospital on 3/01/19.

   The operative report, dated 2/06/19, indicated Patient #2 "had some fracture blisters on the posterior aspect of his calf that had popped. These were dressed with Xeroform..."

   A progress note, dated 2/08/19, signed by a physician assistant, stated "Fresh dressings were reapplied with a Mepilex, Ace wraps were also placed and he was put into a long-leg walker boot." It could not be determined, by the documentation, if the fresh dressings were specific to the surgical site at the left ankle or whether they included the calf wound identified after the surgery on 2/06/19.

   A progress note, dated 2/16/19, signed by a physician assistant, stated the CAM boot and dressings were removed and the skin examined. "There was a possible prior skin tear noted proximally, just distal to the patient's gastrocnemius (calf). This did not have any surrounding erythema or evidence of infection as well. There did appear to be evidence of granulation tissue formation." "Wound dressings were then replaced with Xeroform and Medipore dressings, Kerlix and an Ace wrap. The Cam walking boot was then replaced as well. The neurovascular status was then again checked out and Cam boot was replaced."

   A progress note, dated 2/18/19, signed by a physician assistant, documented "sutures were removed and dressings were replaced." There was no specific reference to the condition of the skin at the calf wound.
During the admission to the rehabilitation unit on 2/18/19, there were no specific orders that addressed wound care or the CAM boot, whether the CAM boot should be worn continuously or while out of bed. There was no nursing clarification related to the missing orders. There was also no care plan that addressed skin integrity or pressure ulcer prevention.

There was no nursing documentation on the rehabilitation unit that the patient's skin had been assessed, under the CAM boot and dressings, either upon admission to the rehabilitation unit, or per shift, until 10 days later, on 2/28/19.

An RN progress note, dated 2/28/19, stated: "MD and this nurse undressed ace wrap on left ankle, surgical incisions are well approximated slight erythema. However, there appears to be an unstageable pressure injury on left lateral calf that is 100% eschar covered with drainage. The pt reports that since he has been in the hospital, his dressing has been changed 1 time that he can remember. This nurse received a verbal wound care consult order..."

Grievance documentation indicated this patient's significant other had filed a complaint on his behalf on 3/04/19, alleging that the patient had "complained on several occasions that he felt pain in his calf on his left leg" and according to the patient and her own observation that "nursing staff did not remove his ACE bandage to check the area of his complaint."

A phone call was made to this patient on 5/16/19 at 11:25 AM. He was not available to talk. His significant other, the complainant, was interviewed. Consistent with the written grievance filed with the hospital, the patient's significant other stated the patient had reported his calf pain on multiple occasions to staff, and no-one unwrapped his ACE wrap to look at the area where he was pointing until he was ready for discharge.

The patient's record included nursing documentation on the "Direct Charting Flowsheet" that he reported "leg pain" one or more times after admission to the rehabilitation unit on 2/18/19, including on the following dates: 2/19/19, 2/20/19, 2/21/19, 2/22/19, 2/23/19, 2/24/19, and 2/27/19. There was no documentation nursing staff subsequently examined the skin on his left leg in response to his report of pain.

A wound consult RN note, dated 2/28/19, stated "S: Wound care evaluation requested for wound to L posterior calf. O: Soft gray/brown eschar with separating edges measuring 5.5 cm x 6 cm, yellow slough at edges. Surrounding skin is intact, pink. Minimal amount of serous drainage on telfa dressing placed earlier today. A: Cleansed with NS and gauze, applied sting free barrier film to surrounding skin. Duoderm thin over wound, covered with tegaderm followed by ABD pad in case dressing becomes overwhelmed with drainage. P: Will follow up in AM with wound care PA to provided sharp debridement if necessary."
A discharge summary, written by a physician assistant, dated 3/01/19, stated "At the end of his rehabilitation efforts, he was found to have a wound to the left gastroc area that was related to pressure from the Cam boot."

The Risk Manager and the Performance Improvement Coordinator were interviewed together on 5/15/19 at 9:55 AM. They confirmed there was no documentation nursing staff had removed the CAM boot and dressing and assessed the patient's skin under the boot from the time of admission to the rehabilitation unit on 2/18/19 until 2/28/19, at which time the enlarged wound on the calf was found.

In summary, nursing staff did not assess and evaluate this patient's skin care needs under his CAM boot and ACE wrap in accordance with hospital policy.

2. A second patient example, was a 78 year old female admitted to the hospital on 5/02/19 after a motor vehicle collision. A tibial fracture was surgically repaired on 5/04/19. She was moved to the rehabilitation unit on 5/09/19 and was a current patient at the time of the survey.

A practitioner order, dated 5/09/19, signed by a physician assistant, specified she was to wear a "Hinged knee brace to left leg." The order did not say whether the brace was to be worn at all times or whether it could be removed while Patient #6 was in bed or for skin checks. The nursing care plan did not address skin integrity or pressure ulcer prevention.

Nursing notes were reviewed. There was no documentation to indicate nursing staff had assessed this patient's skin beneath her knee brace, in accordance with hospital policy, or made attempts to clarify the incomplete practitioner order.

The patient was observed in her room on 5/15/19 at 10:50 AM wearing her knee brace. The Director of Acute Care was interviewed on 5/15/19 at 2:45 PM. She reviewed the patient's medical record and confirmed there was no documentation that nursing had removed the patient's hinged knee brace and assessed her skin beneath the brace.

In summary, nursing staff did not assess and evaluate this patient's skin condition beneath a knee brace, in accordance with hospital policy.

**Conclusion #1:** The allegation of inadequate skin care was substantiated. The hospital was cited for nursing related deficiencies at: Code of Federal Regulations (CFR) 482.23(b)(3) for failure to assess skin and provide skin related interventions in accordance with hospital policy; and CFR 482.23(b)(4) for failure to develop care plans that addressed identified skin care needs.

The hospital was also cited for rehabilitation related deficiencies at CFR 482.56(b)(1) for failure
to ensure practitioner orders were present or complete as it related to skin care orders and orthopedic devices.

Allegation #2: The hospital failed to respond adequately to a patient/caregiver grievance.

Findings #2: Two of six grievances reviewed did not meet regulatory requirements. Findings include:

Facility policy, "Concern and Grievance Management Program -- SAHS," approved 5/30/2018, was reviewed. The policy stated:

- "The resolution of a formal grievance should be completed within seven (7) days of receiving the grievance. If the grievance cannot be completed within 7 days, the patient will be contacted in writing within the initial 7 days and informed they will be contacted with additional information concerning the status of the review within thirty (30) days. If the investigation requires longer than 30 days, the patient will be provided a letter of extension indicating the circumstances and the date for final review, within 30 days."

- "Once the grievance investigation is completed, the patient will be contacted in writing, unless the complainant specifically states they do not want a written response (such requests should be documented)."

- "Written notice will include the name of the facility contact person appropriate to the grievance; the steps taken on behalf of the patient to investigate the grievance; the results of the grievance process, date of completion, as well as the contact information for the Bureau of Facility Standards and the Joint commission."

This policy was not followed. Examples include:

1. One patient's letter of response to a grievance received 2/08/19 did not meet regulations for grievance resolution as follows: The letter was sent late. It did not state who the complainant could contact with additional information or questions. It did not include the steps taken to investigate the grievance and it did not state the date of completion of the investigation. This information was confirmed by the Patient Relations Supervisor and Risk Manager during an interview on 5/15/19 at 8:45 AM.

2. A second letter of response was not complete or accurate, as follows: A complaint was received by the hospital on 3/04/19. It stated the complainant alleged her significant other complained of leg pain repeatedly while hospitalized, and staff dismissed his pain as normal and did not look at the site of his complaint, and that a large pressure ulcer was not found until he
was being evaluated for discharge.

A letter of response, dated 4/03/19, documented sending the complainant's concerns to managers for the telemetry unit and the rehabilitation unit. The letter of response from the hospital was addressed to the patient. It stated "Your wife voiced frustration that our staff seemed to dismiss your leg pain concerns and did not identify your pressure ulcer sooner."

The letter of response stated "In review of your Electronic Medical Record, it is documented that there were daily skin and wound assessments charted while on the telemetry floor. While on Rehab, the pain you experienced was noted to be incisional pain not pain where the pressure ulcer was located."

The letter of response did not address skin assessments completed while on the rehabilitation unit. There were no documented skin assessments of the patient's left leg under his CAM boot, ACE wrap, and dressing, included in his medical record from the time of admission to the rehabilitation unit on 2/18/19 until 10 days later, on 2/28/19.

The information in the hospital's letter of response to the patient, described his pain as "incisional pain." This information did not match the information surveyors viewed in his record. The patient's record for the inpatient stay to the rehabilitation unit, beginning 2/18/19, included nursing documentation on the "Direct Charting Flowsheet" that the patient reported "leg pain" 1 or more times on 2/19/19, 2/20/19, 2/21/19, 2/22/19, 2/23/19, 2/24/19, and 2/27/19. There was no documentation nursing staff (or medical staff) examined his left leg for 10 days, after admission to the rehabilitation unit on 2/18/19 until 2/28/19, just prior to the patient's discharge on 3/01/19.

The Patient Relations Coordinator was interviewed on 5/15/19 at approximately 9:55 AM. She stated the letter of response to the grievance was written based on information provided by unit managers and that it was her understanding the patient had reported incisional pain (ankle area) instead of leg pain. She acknowledged the letter of response from the hospital to the patient did not address whether the patient's skin had been assessed on the rehabilitation unit. The letter of response did not include complete or accurate information as to the steps taken on behalf of the patient to investigate the grievance and the results of the investigation.

**Conclusion #2:** Therefore, the complaint was substantiated and the hospital was cited at CFR 482.13(a)(2)(iii) for failure to meet written notice requirements in response to patient grievances.

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/slj