



IDAHO DEPARTMENT OF
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February 7, 2013

James Angle, CEO
St Lukes Magic Valley RMC
P.O. Box 409
Twin Falls, ID 83301

Provider #130002

Dear Mr. Angle:

On **January 8, 2013**, a complaint survey was conducted at St Lukes Magic Valley RMC. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005698

ALLEGATION #1: A towel was placed over a patient's face while she was in restraints, which resulted in difficulty breathing.

FINDINGS #1: An unannounced survey was conducted at the hospital from 1/07/13 through 1/08/13. Surveyors reviewed medical records related to patient rights and quality of care, including 6 current patient records and 4 closed records. Restraint logs, grievance logs, quality assurance/performance improvement information, hospital policies and administrative documents were reviewed. Surveyors also interviewed staff and current patients and observed interactions between patients and staff.

The hospital's policy, titled "Restraints/Seclusion," documented "...Monitoring of a patient in restraints is done through 1:1 staffing." The policy also stated "...Documented reassessments should occur no less frequent than every 15 minutes..." and indicated the staff should have assessed for signs of injury, skin integrity, nutrition/hydration needs, circulation/range of motion, vital signs, hygiene/elimination needs, physical/psychological status, comfort, and readiness for discontinuation of restraints.

One medical record that was reviewed documented a 35 year old female patient who was admitted to the facility in mid August of 2012 and discharged to a state psychiatric facility at the end of August, 2012. Diagnoses included major depressive disorder, PTSD and poly substance dependence.

On 8/22/12 at 6:45 PM, an order for soft, bilateral wrist and ankle restraints was documented. The "The 24 - HOUR RESTRAINT DOCUMENTATION RECORD" indicated the patient became agitated, and staff informed her she was being moved to an observation room. According to documentation, the patient then became violent and aggressive, throwing objects and trying to hit, bite and spit at staff. When the patient was unable to control her behavior, 4 point, soft restraints were applied and 1:1 staff was assigned. Documentation included vital signs were monitored during the time the patient was in restraints, at 6:50 PM, 7:40 PM and 8:37 PM. The form also indicated staff assessed the patient at least every 15 minutes for skin break-down/injuries, nutrition/hydration needs, circulation/range of motion, vital signs, hygiene/elimination needs, physical/psychological status, comfort, and readiness for discontinuation of restraints. The document stated the patient was released from restraints on 8/22/12 at 8:37 PM.

There was no documentation that a towel was placed over the patient's face.

A nurse who was working at the time the patient was restrained was interviewed on 1/08/13, beginning at approximately 1:00 PM. She reviewed the patient's record, including documentation related to the 8/22/12 restraint. The nurse was able to accurately describe the facility's policy related to restraints. She said it was not the practice of the facility to place a towel over a patient's face while in restraints. The nurse said if a patient was spitting at staff, staff was expected to cover themselves with mask, gloves and/or gowns if necessary, but never to cover a patient's face.

Due to lack of sufficient evidence, the allegation that a towel was placed over a patient's face while the patient was in restraints could not be substantiated.

CONCLUSION #1: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #2: Staff denied a patient's request to meet with her attending physician and would not transport a patient to previously scheduled appointments for pain management.

FINDINGS #2: An unannounced survey was conducted at the hospital from 1/07/13 through 1/08/13. Surveyors reviewed medical records related to patient rights and quality of care, including 6 current patient records and 4 closed records. Restraint logs, grievance logs, quality assurance/performance improvement information, hospital policies and administrative documents

were reviewed. Surveyors also interviewed staff and current patients and observed interactions between patients and staff.

One medical record that was reviewed documented a 35 year old female patient who was admitted to the facility in mid August of 2012 and discharged to a state psychiatric facility at the end of August, 2012. Diagnoses included major depressive disorder, PTSD and poly substance dependence.

The "Psychiatric Evaluation," dated 8/13/12 at 10:36 AM, included "The patient reports her physical pain vacillating between a 5 out of 10 and 7 out of 10 with 10 being the worst pain in her life. The patient repeatedly states that she does not believe her narcotic pain medication is sufficiently dosed to adequately treat her pain."

A "Psychiatric Inpatient Progress Note," dated 8/22/12 at 3:44 PM, said the patient requested to stop all her medications and "...start from scratch." The note indicated the patient was attempting to contact another healthcare provider to discuss the medications she was taking for pain. The progress note went on to state "I do not blame her for wanting to get rid of whatever is not working. I hesitate with the Neurontin because (Name of Pain Management Provider) is handling her pain issues.

A nurse was interviewed on 1/08/13, beginning at 1:00 PM. She reviewed the medical record and stated the healthcare provider who was treating the patient related to pain management was also employed by the facility. She said the provider continued to see and treat the patient during this admission.

Though the patient had concerns related to management of her pain, the medical record documented the patient's pain management provider was treating her while she was in-patient in the facility. Therefore, the documentation did not support the need for the patient to be transported to the pain providers office for appointments.

Due to a lack of evidence, the allegation could not be substantiated.

CONCLUSION #2: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #3: The hospital did not facilitate transportation in a timely manner for a patient who was scheduled for transfer to a state facility.

FINDINGS #3: An unannounced survey was conducted at the hospital from 1/07/13 through 1/08/13. Surveyors reviewed medical records related to patient rights and quality of care, including 6 current patient records and 4 closed records. Restraint logs, grievance logs, quality

assurance/performance improvement information, hospital policies and administrative documents were reviewed. Surveyors also interviewed staff and current patients and observed interactions between patients and staff.

One medical record that was reviewed documented a 35 year old female patient who was admitted to the facility in mid August of 2012 and discharged to a state psychiatric facility at the end of August, 2012. Diagnoses included major depressive disorder, PTSD and poly substance dependence.

A "Psychiatric Inpatient Progress Note," dated 8/21/12 at 11:32 AM, documented the patient was feeling somewhat abandoned due to the fact that she was still at Canyon View and not the state facility. The progress note went on to document that state agencies were in the process of coordinating and arranging transfer of the patient to the state facility before the following Monday.

The "Psychiatric Discharge Summary," dated 8/29/12 at 3:52 PM, documented the patient was discharged to a state facility.

The Nursing Manager was interviewed on 1/07/13, beginning at approximately 10:45 AM. He stated the hospital does not transport patients to state facilities. The Nursing Manager went on to say that transportation was arranged between the county and the state facility, and once transportation was coordinated, the hospital was usually notified the day before transport was scheduled to occur.

The allegation that the hospital failed to arrange transportation to a state facility could not be substantiated due to a lack of sufficient evidence.

CONCLUSION #3: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #4: A patient was not informed of her rights.

FINDINGS #4: An unannounced survey was conducted at the hospital from 1/07/13 through 1/08/13. Surveyors reviewed medical records related to patient rights and quality of care, including 6 current patient records and 4 closed records. Restraint logs, grievance logs, quality assurance/performance improvement information, hospital policies and administrative documents were reviewed. Surveyors also interviewed staff and current patients and observed interactions between patients and staff.

Documentation of notification of patient rights and responsibilities was found in all 10 patient records that were reviewed during the survey. All were signed by the patient or patient's

designee.

A copy of Patient Rights was also posted in each patient hallway, English and Spanish versions, for the convenience of patients.

Due to a lack of evidence, the allegation that the patient was not informed of her rights could not be substantiated.

CONCLUSION #4: Unsubstantiated. Lack of sufficient evidence.

ALLEGATION #5: A patient with a history of stroke and seizures was not assessed after she presented with slurred speech.

FINDINGS #5: An unannounced survey was conducted at the hospital from 1/07/13 through 1/08/13. Surveyors reviewed medical records related to patient rights and quality of care, including 6 current patient records and 4 closed records. Restraint logs, grievance logs, quality assurance/performance improvement information, hospital policies and administrative documents were reviewed. Surveyors also interviewed staff and current patients and observed interactions between patients and staff.

One medical record that was reviewed documented a 35 year old female patient who was admitted to the facility in mid August of 2012 and discharged to a state psychiatric facility at the end of August, 2012. Diagnoses included major depressive disorder, PTSD and poly substance dependence.

On 8/24/12, the "MEDICATION ADMINISTRATION RECORD" documented the patient received medication for pain and medication to treat anxiety, as well as other routine medications, throughout the day. All medications were administered in accordance with physician's orders.

A nursing note, dated 8/24/12 at 8:00 PM, documented a "Shift Assessment." The assessment stated the patient was disoriented, spoke slowly and appeared groggy. The assessment also included the use of 1:1 staff in order to maintain constant observation of the patient. Vitals signs were documented at 8:45 PM and were within normal limits. The nurses note also stated the patient requested additional pain medication, which was not given based on the patient's condition and symptoms at the time.

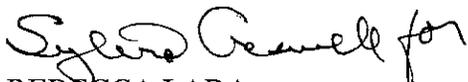
The allegation that nursing staff failed to assess the patient when she presented with a change in condition could not be substantiated based on a lack of sufficient evidence.

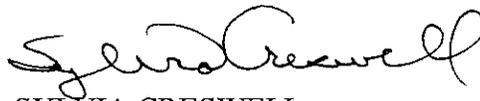
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CONCLUSION #5: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,


REBECCA LARA
Health Facility Surveyor
Non-Long Term Care


SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

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