



IDAHO DEPARTMENT OF
HEALTH & WELFARE

G.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 19, 2013

Sally Jeffcoat, CEO
St Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Ms. Jeffcoat:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on February 8, 2013.

Enclosed is a Statement of Deficiencies/Plan of Correction form, CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

An acceptable plan of correction (PoC) contains the following elements:

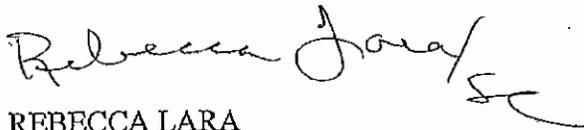
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the PoC is effective in bringing the SC into compliance, and that the hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

Sally Jeffcoat, Administrator
February 19, 2013
Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **March 4, 2013**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please write or call this office at (208) 334-6626.

Sincerely,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/
Enclosures



RECEIVED
MAR 04 2013

February 27, 2013

Sylvia Creswell
Idaho Department of Health and Welfare
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036

FACILITY STANDARDS

Dear Ms. Creswell:

Enclosed please find Saint Alphonsus Regional Medical Center's plan of correction (POC), which is intended to address a deficiency cited during a complaint investigation concluded on February 8, 2013.

The hospital does not admit or concede to a deficiency, but to the extent that an actual deficiency does exist, Saint Alphonsus Regional Medical Center is taking appropriate action to correct the deficiency, including the steps outlined in the attached POC. This plan of correction addresses Medicare tag A811.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. Please contact me at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Aline Lee, RN
Director of Patient Safety, Regulatory Compliance, and Infection Prevention
Saint Alphonsus Health System

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

PRINTED: 02/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1066 NORTH CURTIS ROAD BOISE, ID 83706	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Rebecca Lara, RN, BA, HFS, Team Leader Gary Gulles, RN, BS, HFS Acronyms used in this report include: EMR = Electronic Medical Record H&P = History and Physical	A 000		
A 812	482.43(b)(6) DISCHARGE PLANNING [The hospital must] include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the facility failed to ensure an identifiable discharge planning evaluation was documented in the medical record for 10 of 10 patients (Patients #1 - #10) whose records were reviewed. This had the potential to result in unidentified patient post-discharge needs. Findings include: 1. The policy Discharge "Planning for Inpatient Psychiatric Patients," dated 1/31/12, stated "The Nursing Admission Assessment and all subsequent multidisciplinary evaluations and assessments will contain trigger questions to identify the patient's need for referrals to other members of the healthcare team." The policy did not identify these "trigger questions" and did not	A 812		

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MAR 04 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Rolney J. Reider
TITLE
CEO
(X6) DATE
2.28.13

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.

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A 812	<p>Continued From page 1</p> <p>direct staff as to how discharge planning evaluations would be documented so they would be identifiable to staff.</p> <p>The Discharge Planning Team Leader was interviewed on 2/07/13 beginning at 12:50 PM. She stated the information for discharge planning evaluations was taken from various sources. She confirmed the policy did not identify these sources or how discharge planning evaluations were documented.</p> <p>2. An identifiable discharge planning evaluation could not be found in 10 of 10 medical records as follows:</p> <p>a. Patient #1's medical record documented an 18 year old male who was admitted to the psychiatric unit on 2/01/13 and was currently a patient as of 2/06/13. His diagnoses included psychosis and possible bipolar disorder. His medical record did not contain an identifiable discharge planning evaluation.</p> <p>Patient #1's medical record was reviewed with the Discharge Planner of the Behavioral Health Unit on 2/06/13 beginning at 1:00 PM. She identified plans for Patient #1's discharge but she was not able to identify the discharge planning evaluation in the medical record.</p> <p>b. Patient #2's medical record documented a 34 year old female who was admitted to the Behavioral Health Unit of the facility on 2/01/13. Her diagnoses included major depression, rule out somatization disorder (psychiatric condition marked by multiple medically unexplained physical, or somatic, symptoms) and chronic</p>	A 812		

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A 812	<p>Continued From page 2 neck pain secondary to surgery.</p> <p>Patient #2's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit on 2/07/13, beginning at 8:15 AM. She identified plans for Patient #2's discharge, but was not able to identify a discharge planning evaluation in the record.</p> <p>c. Patient #3's medical record documented a 68 year old female who was admitted to the psychiatric unit on 2/03/13 and was currently a patient as of 2/06/13. Her diagnoses was possible adjustment disorder versus major depression. Her medical record did not contain an identifiable discharge planning evaluation.</p> <p>Patient #3's medical record was reviewed with the Discharge Planner of the Behavioral Health Unit on 2/08/13 beginning at 1:00 PM. She identified plans for Patient #2's discharge but she was not able to identify the discharge planning evaluation in the medical record.</p> <p>d. Patient #4's medical record documented a 53 year old female who was admitted to the Behavioral Health Unit of the facility on 2/04/13. Her diagnoses included psychotic disorder, rule out somatic disorder (psychiatric condition marked by multiple medically unexplained physical, or somatic, symptoms), bipolar disorder, hypertension and diabetes.</p> <p>Patient #4's medical record was reviewed with the Discharge Planner of the Behavioral Health Unit on 2/06/13 beginning at 1:00 PM. She identified plans for Patient #1's discharge but she was not able to identify the discharge planning evaluation</p>	A 812		

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A 812	<p>Continued From page 3 in the medical record.</p> <p>e. Patient #5's medical record documented a 29 year old male who was admitted to the facility through the ED on 12/16/12. He was diagnosed with severe traumatic brain injury related to jumping from a moving vehicle. The injury resulted in surgical intervention, bilateral craniotomies with removal of hematoma, (surgical removal of part of the bone from the skull to expose the brain and remove a blood clot). Other diagnoses included a history of schizophrenia and a suicide attempt. According to the H&P, dated 1/05/13, Patient #5 was moved from the Neurological Floor to the Rehabilitation Unit on 12/29/12. On 1/04/13, he was discharged from the Rehabilitation Unit and admitted to the Behavioral Health Unit. Patient #5 was discharged from the facility on 1/09/13.</p> <p>Patient #5's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit. An identifiable discharge planning evaluation was not found in the record.</p> <p>f. Patient #6's medical record documented a 63 year old female who was admitted to the psychiatric unit on 1/23/13 and was currently a patient as of 2/06/13. Her diagnosis was bipolar disorder. Her medical record did not contain an identifiable discharge planning evaluation.</p> <p>Patient #6's medical record was reviewed with the Discharge Planner of the Behavioral Health Unit on 2/06/13 beginning at 1:00 PM. She identified plans for Patient #6's discharge but she was not able to identify the discharge planning evaluation in the medical record.</p>	A 812		

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A 812	Continued From page 4 g. Patient #7's medical record documented a 52 year old male who was transferred to the Behavioral Health Unit of the facility from the ED on 12/21/12. His diagnoses included bipolar disorder, last phase manic with psychotic features, hypertension, diabetes and obesity. Patient #7 was discharged from the facility on 1/11/13. Patient #7's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit on 2/07/13, beginning at 8:16 AM. She identified plans for Patient #7's discharge, but was not able to identify a discharge planning evaluation in the record. h. Patient #8's medical record documented a 56 year old male who was admitted to Behavioral Health Unit on 1/11/13. His diagnoses included schizophrenia by history and psychosis. Patient #8 was discharged from the facility on 1/29/13. Patient #8's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit on 2/07/13, beginning at 8:16 AM. She identified plans for Patient #8's discharge, but was not able to identify a discharge planning evaluation in the record. i. Patient #9's medical record documented a 34 year old male who was admitted to the Behavioral Health Unit of the facility on 12/08/12. His diagnoses included schizo-affective disorder, bipolar type and history of polysubstance abuse. Patient #9 was discharged from the facility on 12/12/12.	A 812		

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A 812	<p>Continued From page 5</p> <p>Patient #9's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit on 2/07/13, beginning at 8:15 AM. She identified plans for Patient #9's discharge, but was not able to identify a discharge planning evaluation in the record.</p> <p>J. Patient #10's medical record documented a 24 year old male who was admitted to the Behavioral Health Unit on 11/06/12. His diagnoses included major depression, recurrent, marijuana abuse and diabetes. Patient #10 was discharged from the facility on 11/08/12.</p> <p>Patient #10's EMR was reviewed with the Nurse Manager of the Behavioral Health Unit on 2/07/13, beginning at 8:15 AM. She identified plans for Patient #10's discharge, but was not able to identify a discharge planning evaluation in the record.</p> <p>Identifiable discharge planning evaluations were not included in patients' medical records.</p>	A 812			

Federal Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
 Complaint Survey Concluded February 8, 2013

Tag	Plan of Correction	Completion Date
<p><i>ase</i> A811 The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan.</p>	<p>The Inpatient Counselor Team Lead and corresponding team of Inpatient Counselors (IC) and Clinical Resource Associate (CRA) developed and implemented the plan of correction related to the tag A811 (A812 in the report). The Team Lead led the group in developing a written document that delineates requirements for the documentation of the discharge planning evaluation for use in establishing an appropriate discharge plan. The documentation requirements were completed on 2/25/13. Requirements were defined for the Initial Assessment and Plan, Reassessment/re-evaluation, Implementation/Coordination of Care and the Final Discharge Plan.</p> <p>Initial Assessment and Plan: Will be completed by an IC and documented in the Care Management Initial Form within the patient electronic medical record. Patient and/or caregiver, as appropriate, will be included in the Discharge Evaluation discussion. The initial assessment will include, at a minimum:</p> <ol style="list-style-type: none"> 1) Current living situation. 2) Initial and, if appropriate, backup plan for discharge living situation. 3) Evaluation of current providers and services. 4) Access to medications. 5) Assessment of any concurrent medical conditions requiring additional resources. 6) Patient and/or caregiver's ability and willingness to participate in the plan. 7) Documentation regarding discussion of the initial plan with patient and/or caregiver. <p>Reassessment and re-evaluation: The initial assessment and plan will be reviewed by the Multi-disciplinary Treatment Plan Team (TPT) and by the CRA. The TPT will reassess/re-evaluate current patient needs for discharge and will document any changes to the initial assessment and plan in the Care Management Ongoing Form. The CRA will review the plan and re-assessment with the patient as appropriate.</p> <p>Implementation/Coordination of Care: Documentation of the following will be included in the Care Management Ongoing Form:</p> <ol style="list-style-type: none"> 1) Services and referrals that have been set up (contacts, phone numbers, time frames, and why service is needed). 2) Involvement of family and/or community services. 3) Insurance coverage/benefits, if applicable. 4) Documentation of patient choice of providers and services, when applicable. 	<p>03/31/13</p>

Federal Survey Plan of Correction
 Saint Alphonsus Regional Medical Center
 Complaint Survey Concluded February 8, 2013

Tag	Plan of Correction	Completion Date
	<p>Final Discharge Plan: The final plan will be documented in the Care Management Ongoing Form, and will include discharge location and any updates to the discharge plan. Follow-up appointments, resources, medications, and education will be documented in the Depart section of the electronic medical record and a copy given to the patient or caregiver.</p> <p>The Inpatient Counselor Team Lead will meet with IC and CRA staff members in March, 2013 to provide education on the documentation requirements. An audit tool will be developed to be used to monitor compliance with the documentation requirements. At the meeting, the team will decide on the number of audits per week each team member will complete. The data from the audits will be summarized, analyzed and feedback will be provided to staff members. The audit results will be sent to the Director of Health Information Management to be included in the process for overall evaluation of the medical record.</p> <p>The Inpatient Counselor Team Lead is in the process of revising the Behavioral Health Discharge Planning for Inpatient Psychiatric Patients policy. Full revision will be completed by March 31st, 2013. The policy will describe the required components of a discharge plan and the ongoing discharge planning quality monitoring process. Audit results will be reviewed on a quarterly basis.</p> <p>The Inpatient Counselor Team Lead is responsible for the implementation of this plan of correction.</p>	



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March 15, 2013

Sally Jeffcoat, CEO
St. Alphonsus Regional Medical Center
1055 North Curtis Road
Boise, ID 83706

Provider #130007

Dear Ms. Jeffcoat:

On **February 8, 2013**, a complaint survey was conducted at St. Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005870

ALLEGATION #1: The family members of patients were not informed of patients' status and allow to participate in care planning.

FINDINGS #1: An unannounced survey was conducted at the hospital from 2/06/13 through 2/08/13. Surveyors reviewed medical records, administrative documents, and hospital policies related to patient rights and discharge planning. Patients on the Behavioral Health Unit were interviewed about discharge planning and their rights as patients, including the right of patients and families to participate in planning for their care. Staff from the Rehabilitation Unit and Behavioral Health Unit were interviewed during the survey, as well.

The records of five current patient records and five closed patient records from the Behavioral Health Unit were reviewed. Some medical records documented patients who were admitted directly to the Behavioral Health Unit, while others documented patients who were transferred to the Behavioral Health Unit from various units in the hospital.

One medical record reviewed documented a 29 year old male who was admitted to the facility through the Emergency Department on 12/16/12. He was diagnosed with severe traumatic brain

Sally Jeffcoat, CEO

March 15, 2013

Page 2 of 8

injury related to jumping from a moving vehicle. The injury resulted in surgical intervention, ~~bilateral craniotomies with removal of hematoma.~~ Other diagnoses included a history of schizophrenia and suicide attempt. According to the patient's History & Physical examination, dated 1/05/13, ~~the patient was moved from the facility's Neurological Floor to the Rehabilitation Unit on 12/29/12. On 1/04/13, he was discharged from the Rehabilitation Unit and admitted to the Behavioral Health Unit. The patient was discharged from the facility on 1/09/13.~~

The medical record contained documentation entered by an Occupational Therapist during the time the patient was on the Rehabilitation Unit. On 12/31/12, the Occupational Therapist documented a conversation with the patient's mother. The note stated the patient's mother expected the patient to go to the Behavioral Unit soon. The note stated the patient's mother had been trying to coordinate admission to the Behavioral Health Unit, just prior to his injury.

An occupational therapy note, dated 1/01/13, documented the therapist attempted to see the patient on 2 occasions. The note stated the patient's mother was present and the patient was found to be sleeping. Documentation included the patient's mother was uncomfortable taking the patient home and wanted to discuss concerns with the Social Worker. The Occupational Therapist documented he informed nursing staff of the mother's request. The note indicated the patient roused and completed self care, but refused to participate in other tasks. The note stated the patient was observed ambulating and was oriented and recalled the therapist's name.

Another occupational therapy note, dated 1/02/13, stated the patient's mother indicated she was not comfortable bringing her son home and requested his mental health issues be further addressed in a behavioral health setting.

The medical record from the time the patient was on the Rehabilitation Unit included documentation entered by a Social Worker. A note, dated 1/02/13, documented the Social Worker met with the patient's mother to discuss "transition to more mental health focused placement." The note documented the patient was placed on "MD hold" the previous evening. The Social Worker documented she had contacted another local psychiatric facility where a program existed that would have best met the needs of the patient. The Social Worker documented the program would have addressed mental health needs, as well as substance abuse issues. Documentation went on to state the program could not accept the patient while he had a PEG (surgically placed feeding tube to the stomach) tube in place. The Social Worker documented she was exploring other options for placement.

On 1/03/13, the Social Worker on the Rehabilitation Unit documented the patient's mother was informed of the patient's attempt to elope from the facility. She was informed the physician entered a mental/legal hold order to prevent the patient from leaving the unit again. Sitters who were assigned to constantly observe the patient were ordered and hospital security was informed

Sally Jeffcoat, CEO
March 15, 2013
Page 3 of 8

of the risk of elopement as well.

A social services note, dated 1/04/13, indicated the patient's mother was aware the patient was being transferred to the Behavioral Health Unit of the facility. The note stated the patient handled the news of transfer to the behavioral unit well.

A progress note, dated 1/02/13, entered by a physician who cared for the patient during his time on the Rehabilitation Unit, documented "The patient seems to be doing extremely well from a traumatic brain injury standpoint. It appears that the majority of his issues are psychiatric."

On 1/03/13, a physician who cared for the patient during his time on the Rehabilitation Unit documented "The patient did not meet the 3 hours, as he has been refusing therapy. As mentioned above, we are working on getting him into the Psychiatric Unit as it appears his psychiatric diagnosis has more pressing issues as it is keeping him from therapy participation."

Another rehabilitation note by a physician, dated 1/04/13, documented "He has not really been participating well here in Rehabilitation and does not really have much in terms of rehabilitation needs."

The medical record also contained communication notes from the Behavioral Health Unit that were documented by the Social Worker/Discharge Planning Team Lead. A note dated 1/08/13 documented a conversation with the patient's mother. The note discussed the patient's mother's frustration because the patient was transferred to the Behavioral Health Unit. The note stated the Social Worker explained there was no choice once the patient was placed on a mental/legal hold.

The Social Worker, who was assigned to the Rehabilitation Unit and communicated with the patient's mother, was interviewed on 2/17/13, beginning at 1:35 PM. She reviewed the patient's medical record and stated she remembered the patient and the patient's mother. She remembered speaking with the patient's mother by phone and in person about the patient's condition. She stated the patient was disinterested in the activities/therapies on the Rehabilitation Unit and was not participating. The Social Worker recalled the patient's mother initially being upset about the patient leaving the Rehabilitation Unit, but said the patient's mother was aware of the patient's lack of participation in therapies and his attempt to elope. The Social Worker stated the patient's mother was aware that other local psychiatric programs would not accept the patient until his PEG/feeding tube was removed.

The Social Worker/Discharge Planning Team Leader, who was assigned to the Behavioral Health Unit, was interviewed on 1/07/13, at approximately 10:45 AM. According to the Social Worker, family members are routinely involved in the care and discharge planning for patients. She reviewed the patient's medical record and stated she remembered the patient and his mother. The

Social Worker said the patient's mother was involved with the care of the patient, including discharge planning. She recalled speaking with the patient's mother about his status and discharge planning needs. She stated it was her impression that the patient's mother was involved in his care.

Current patients were interviewed during the survey about the opportunity of patients and their families to participate in care planning. According to the patients, they felt the staff involved them in their plans of care. Two of the patients interviewed spoke specifically of family members being involved in their care from the time they were admitted. All patients who were interviewed stated the nurses, therapists and physicians maintained frequent contact with them and encouraged participation in planning for their care.

It could not be verified that family members and guardians were not involved in planning for the patients' care and provided updated information regarding patients' status.

CONCLUSION #1: Unable to substantiate. Lack of sufficient evidence.

ALLEGATION #2: The facility did not honor guardians' requests.

FINDINGS #2: An unannounced survey was conducted at the hospital from 2/06/13 through 2/08/13. Surveyors reviewed medical records, administrative documents, and hospital policies related to patient rights and discharge planning. Patients on the Behavioral Health Unit were interviewed about discharge planning and their rights as patients, including the right of patients and families to participate in planning for their care. Staff from the Rehabilitation Unit and Behavioral Health Unit were interviewed during the survey, as well.

Five current patient records and five closed patient records from the Behavioral Health Unit were reviewed. Some medical records documented patients who were directly admitted to the Behavioral Health Unit, while others documented patients who were transferred to the Behavioral Health Unit from various units in the hospital.

One medical record that was reviewed documented a 29 year old male who was admitted to the facility through the Emergency Department on 12/16/12. He was diagnosed with severe traumatic brain injury related to jumping from a moving vehicle. The injury resulted in surgical intervention, bilateral craniotomies with removal of hematoma, (surgical removal of part of the bone from the skull to expose the brain and remove a blood clot). Other diagnoses included a history of schizophrenia and suicide attempt. According to the History & Physical, dated 1/05/13, the patient was moved from the facility's Neurological Floor, to the Rehabilitation Unit on 12/29/12. On 1/04/13, he was discharged from the Rehabilitation Unit and admitted to the Behavioral Health Unit. The patient was discharged from the facility on 1/09/13.

Sally Jeffcoat, CEO
March 15, 2013
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The medical record contained a document, "LETTER OF TEMPORARY GUARDIANSHIP." The document indicated the patient was appointed a temporary guardian on 1/04/13. The document included "~~The temporary guardianship confers the power and duty of (temporary guardian's name) to access, use, and disclose individually identifiable health information or other medical records of (patient's name).~~" A date stamp at the bottom of the document showed the facility received a copy of the document on 1/04/13.

The medical record contained another document, "ORDER APPOINTING TEMPORARY GUARDIAN FOR ALLEGED INCAPACITATED PERSON." Documentation stated the request was filed with the District Court on 1/03/13 and went on to state "Petitioner, (temporary guardian's name), is hereby appointed as temporary guardian of (patients name), to serve in such capacity for a period up to ninety (90) days." A date stamp at the bottom of the document showed the facility received a copy of the document on 1/08/13.

A communication note in the patient's record, dated 1/08/13 and entered by the Social Worker/Discharge Planning Team Lead Team assigned to the Behavioral Health Unit, documented a discussion with the patient's mother/temporary guardian. The note included confirmation that the patient's "mother holds legal guardianship..." Additionally, the note documented a conversation about possible discharge planning options, indicating the mother's involvement in care/discharge related decisions.

The Nurse Manager for the Behavioral Health Unit was interviewed on 2/07/13, beginning at 8:15 AM. She reviewed the medical record and was able to recall the patient. She stated the patient's mother was awarded temporary guardianship during the patient's hospitalization on the Behavioral Health Unit. When reviewing and discussing the temporary guardianship paperwork found in the patient's record, the Nurse Manager said the initial temporary guardianship paperwork, received by the facility on 1/04/13, only allowed the temporary guardian to access, use and disclose the patient's identifiable medical records and health information. She said the patient's mother became upset when the patient was allowed to make decisions about his own care, such as signing a medical release to allow the discharge planner to forward the patients medical records to another psychiatric facility for potential placement. The Nurse Manager stated the facility forwarded a copy of the document to their legal department for clarification of the language and intent. She went on to say the legal department confirmed the document only allowed the temporary guardian access to medical records/health information.

The Nurse Manager stated the unit later, on 1/08/13, received a copy of the second document related to temporary guardianship. She said the facility understood the second document, "ORDER APPOINTING TEMPORARY GUARDIAN FOR ALLEGED INCAPACITATED PERSON;" awarded full, temporary guardianship to the patient's mother. She said though the

facility honored the mother's temporary guardianship, the facility was also required to ensure the rights of the patient. She stated the patient had a right to participate in his treatment/care. The Nurse Manager recalled disagreement between the patient and his mother related to the patient's discharge plans. She stated the patient's mother preferred the patient was transferred to an in-patient chemical dependence setting, but the patient did not wish to be involved in an in-patient setting. Nor did he wish to be involved in chemical dependency treatment according to the Nurse Manager.

Evidence reviewed during the survey indicated the facility honored patients' rights, verified the language and intent of temporary guardianship documents, and involved patients and temporary guardians in patients' plans of care. Therefore, the allegation that the facility did not honor guardian's requests could not be substantiated.

CONCLUSION #2: Unable to substantiate. Lack of sufficient evidence.

ALLEGATION #3: The facility did not provide adequate discharge planning.

FINDINGS #3: An unannounced survey was conducted at the hospital from 2/06/13 through 2/08/13. Surveyors reviewed medical records, hospital policies related to patient rights and discharge planning and administrative documents. Patients on the Behavioral Health Unit were interviewed about discharge planning and their rights as patients, including patients and families opportunity to participate in patients plans of care. Staff from the Rehabilitation Unit and Behavioral Health Unit were interviewed during the survey as well.

Five current patient records and five closed patient records from the Behavioral Health Unit were reviewed. Some medical records documented patients who were directly admitted to the Behavioral Health Unit, while others documented patients who were transferred to the Behavioral Health Unit from various units in the hospital.

One medical record that was reviewed documented a 29 year old male who was admitted to the facility through the ED on 12/16/12. He was diagnosed with severe traumatic brain injury related to jumping from a moving vehicle. The injury resulted in surgical intervention, bilateral craniotomies with removal of hematoma, (surgical removal of part of the bone from the skull to expose the brain and remove a blood clot). Other diagnoses included a history of schizophrenia and suicide attempt. According to the H&P, dated 1/05/13, the patient was moved from the facility's Neurological Floor, to the Rehabilitation Unit on 12/29/12. On 1/04/13, he was discharged from the Rehabilitation Unit and admitted to the Behavioral Health Unit. The patient was discharged from the facility on 1/09/13.

The medical record contained communication notes from the Behavioral Health Unit that were

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documented by the Social Worker/Discharge Planning Team Lead. A note dated 1/08/13 documented a conversation with the patient's mother. The note discussed the patient's mother was frustrated because the patient was transferred to the Behavioral Health Unit. The note stated ~~the Social Worker explained there was no choice once the patient was placed on a mental/legal hold.~~ The note indicated the Social Worker agreed to follow up on the mother's request for the patient to return to the Rehabilitation Unit once the mental/legal hold was discontinued.

A communication note in the patient's record, dated later in the day on 1/08/13 and entered by the Social Worker/Discharge Planning Team Lead Team, documented a discussion with the patient's mother/temporary guardian. The note included confirmation that the patient's "mother holds legal guardianship..." Additionally, the note documented a conversation about possible discharge planning options, indicating the mother's involvement in care/discharge related decisions.

On 1/09/13, the Social Worker/Discharge Planning Team Lead documented a conversation with the patient's mother/guardian related to discharge plans. The documentation indicated various discharge treatment options were discussed. The note documented referral information was sent to several local facilities, in-patient and out-patient. The note went on to state that the Social Worker attempted to contact the patient's mother again to update her related to potential referrals and time for discharge, but was unable to reach her. The note stated a detailed voice mail message was left for the patient's mother.

A later note on the same day, 1/09/13 and entered by a RN, discussed the patient's discharge. The patient was discharged to the care of his mother, the temporary legal guardian. The note documented discharge instructions were discussed with the patient and mother at the time of discharge. Discharge instructions included referral to a local facility for medication management and out-patient services, including counseling. Medications were discussed, and written prescriptions were given to the patient and patient's mother.

Current patients were interviewed during the survey about discharge planning. According to the patients who were interviewed, they felt their discharge needs were being addressed. Patients also confirmed discharge planning began soon after they were admitted to the unit.

Although it could not be proven that the facility did not provide adequate discharge planning, a related deficiency was cited at 42 CFR 482.43(B)(6) related to the facility's failure to consistently document discharge planning evaluations in all medical records that were reviewed during the survey. It was found that 10 of 10 medical records reviewed, including the record of the patient referenced above, lacked an identifiable discharge planning evaluation.

CONCLUSION #3: Unable to substantiate. Lack of sufficient evidence.

Sally Jeffcoat, CEO

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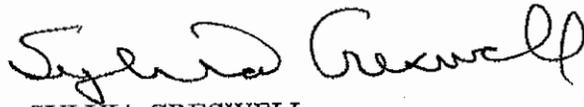
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No further action is required by the facility, as the hospital has already provided a plan of correction to the deficiency cited. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,



GARY GILES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/