IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 8, 2011

Norman Stephens, CEO
Portneuf Medical Center
777 Hospital Way
Pocatello, Idaho 83201

RE: Portneuf Medical Center, provider #130028

Dear Mr. Stephens:

Based on the revisit/recertification survey at Portneuf Medical Center on May 24, 2011, by our staff, we have determined that Portneuf Medical Center continues to be out of compliance with the Medicare Condition of Participation on Patient Rights (42 CFR 482.13).

The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Also enclosed is your copy of a Post-Certification Revisit Report (CMS-2567B), listing deficiencies that have been corrected. State licensing deficiencies will be sent to you under separate cover.

Due to the hospital's failure to correct the deficiencies and achieve compliance we are recommending that the Centers for Medicare and Medicaid Services (CMS) Region X Office, Seattle, Washington, terminate your approval to participate in the Medicare program.

CMS will be in contact with you regarding the procedures, timelines, and appeal rights associated with this recommendation that must be followed.

Sincerely,

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

ec: Catherine Mitchell, CMS Region X Office
Debra Ransom, R.N., R.H.I.T., Bureau Chief
Steve Millward, Administrative Assistant to Randy May

FILE COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.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

June 8, 2011

Norman Stephens, Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

RE: Portneuf Medical Center, Provider #130028

Dear Mr. Stephens:

This is to advise you of the findings of the Medicare/Licensure survey at Portneuf Medical Center, which was concluded on May 24, 2011.

The Statement of Deficiencies/Plan of Correction, form CMS-2567, was sent to you previously. Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

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 HOSPITAL 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.

After you have completed your Plan of Correction, return the original to this office by **June 21, 2011**, and keep a copy for your records.

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,

Susan Costa/sc

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
Enclosures

Portneuf MEDICAL CENTER
Be well.

777 Hospital Way, Pocatello, Idaho 83201
Switchboard: (208) 239-1000
Physician Referrals: (877) 721-6673

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JUN 10 2011
FACILITY STANDARDS

June 8, 2011

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

Dear Ms. Creswell,

Thank you again for the opportunity to address the concerns that have been raised from our State Survey on May 24th, 2011. As with our previous survey, we are taking these concerns very seriously and have worked very hard to put together a comprehensive Plan of Correction. Portneuf Medical Center is committed to making the necessary corrections to reflect our commitment to our patients and to provide quality care to patients and to insure that patients are having their Patient Rights met. Portneuf is committed to providing the highest standard of care for our patients and to improving the charting and documentation to reflect the quality of care that is being provided.

Attached you will find a comprehensive Plan of Correction that includes a full restructure of our Restraint Program and appropriate corrections to our Grievance Program. We have a comprehensive education and documentation process for the Plan of Correction as well, and are performing regular audits to insure compliance.

In addition we have provided a comprehensive plan of correction for all Nursing Standards of Practice, Nursing Care Plans, Medical Records, Physical Plant, and Infection Control deficiencies.
As you will see from that attached plan, we began to make changes immediately upon notice of deficiencies. We have taken this survey very seriously and have worked hard to make sure that the correction is appropriate, comprehensive, and sustainable.

Please let us know if you have any questions or concerns about the attached Plan of Correction and the associated documents.

Sincerely,

Norman Stephens
President and CEO

John Traul, MD
Medical Staff President

Cc: Catherine Mitchell, CMS Regional Office
Rosemarie Savino, RN, BSN, The Joint Commission

Portneuf MEDICAL CENTER
Be well.

777 Hospital Way, Pocatello, Idaho 83201
Switchboard: (208) 239-1000
Physician Referrals: (877) 721-6673

June 10, 2011

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JUN 13 2011
FACILITY STANDARDS

Teresa Hamblin, RN, MS
Bureau of Facility Standards
P.O. Box 83720
Boise, ID 83720-0036

Fax: 208-364-1888

Dear Teresa,

Thank you for the opportunity to clarify our Plan of Correction. Please amend our Form 2567 with the following:

1. Attached is a signed copy of our form 2567 signed by Norman Stephens, President and CEO
2. Attached is a revised copy of our Restraint Policy with clarification on the following:
   a. Defining LIP for the purpose of restraints
   b. Adding monitoring requirements for patients under the custody of law enforcement per COP A-0154 showing that the requirement to monitor restraints resides with law enforcement. Staff will monitor physiological status and care of patient.
3. Below are clarification of the audits being performed for specific tags

ID Prefix Tag	
A166-178	Routine audits of 100% of charts through the end of the current quarter and reassessment based on compliance to set next quarter monitoring rates. (see attached Restraint Audit Form)
A396	Care Plans being audited in routine chart checks and reported to administration on a daily basis. (see attached Nursing Chart Checklist form)
A450	Admissions auditing 100% of orders and notifying ordering LIP to get complete order. VP of Clinical and Support Service performing audits and reporting to Admissions Task Force.

Please let us know if there is anything further that we can help with.

Sincerely,

D. Richelle Heldwein, MPH
Chief Quality Officer

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

PRINTED: 06/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/24/2011
NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITAL WAY POCATELLO, ID 83201	

(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)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your hospital. Surveyors conducting the recertification were: Susan Costa, RN, HFS, Team Leader Gary Gulles, RN, HFS Aimee Hastriter, RN, HFS Karen Robertson, RN, BS, HFS Teresa Hamblin, RN, MS, HFS Mark Grimes, Supervisor of Facility Fire Safety and Construction Program Acronyms used in this report include: BHS - Behavioral Health Services B/P - Blood Pressure CFR - Code of Federal Regulations CT - Computerized Tomography c/o - complaint of cont. - continued ED - Emergency Department EMS - Emergency Medical Services HIM - Health Information Management H&P - History and Physical IM - Intramuscular IPOC - Interdisciplinary Plan of Care IV - Intravenous LIP - Licensed Independent Practitioner LPN - Licensed Practical Nurse MD - Medical Doctor MRI - Magnetic Resonance Imaging NG - Nasogastric NP - Nurse Practitioner OR - Operating Room PA - Physician Assistant POC - Plan of Care PRN - As Needed	A 000	**PORTNEUF MEDICAL CENTER** **PLAN OF CORRECTION** **06-08-11 (see next page)**	

RECEIVED
JUN 13 2011
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

NORMAN STEPHENS — PRESIDENT/CEO — 06/10/2011

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.

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

PRINTED: 06/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) 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.

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	130028		05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 000	Continued From page 1 Pt - Patient RN - Registered Nurse	A 000	**PORTNEUF MEDICAL CENTER**	
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interviews and review of medical records, hospital policies, grievance documentation, and personnel files, it was determined the hospital failed to protect and promote patients' rights. This prevented the hospital from processing all grievances, compromised the hospital's ability to keep patients safe, and prevented staff from utilizing restraints in a consistent manner. Findings include: 1. Refer to A118 as it relates to the facility's failure to ensure a process for prompt resolution of all patient grievances had been implemented. 2. Refer to A166 as it relates to the facility's failure to ensure the use of restraints was in accordance with a written modification to patients' plans of care. 3. Refer to A168 as it relates to the facility's failure to ensure restraints were used only in accordance with the order of a physician or LIP and LIPs ordering restraints were authorized to do so by hospital policy in accordance with State law. 4. Refer to A169 as it relates to the facility's failure to ensure restraint orders were not written as a standing order or on an as needed basis.	A 115	**PLAN OF CORRECTION 06-08-11** **A115 –PATIENT RIGHTS – CHIEF EXECUTIVE OFFICER** Portneuf Medical Center immediately implemented an education program for Directors on Patient Rights to include a requirement of a pre and post test of the education, to be completed by all Directors by 06-01-11(see attached Directors Education Packet) All Directors in the facility were required to take a pre-test on Patient Rights. They were then required to read the Conditions of Participation related to Patient Rights and then attend a mandatory education session on Patient Rights, Restraints, Grievances, and Incident Reporting. Each Director was then required to take a post test related to the above subjects. All Directors educated staff on the Patient Rights and Restraints (see attached Staff Education Packet)	06-01-11 06-06-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 115	Continued From page 2 5. Refer to A171 as it relates to the facility's failure to ensure restraints, used for the management of violent or self-destructive behavior, were limited to 4 hours for adults. 6. Refer to A174 as it relates to the facility's failure to ensure restraints were discontinued at the earliest possible time. 7. Refer to A176 as it relates to the facility's failure to ensure physicians who ordered restraints received training regarding restraints. 8. Refer to A178 as it relates to the facility's failure to ensure patients, who had behavioral restraints applied, were seen face-to-face within 1-hour after the initiation of the intervention by a person authorized to conduct restraint evaluations. The cumulative effect of these negative systemic practices seriously impeded the ability of the hospital to provide care of adequate quality.	A 115		
A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD Is not met as evidenced by: Based on review of grievances and staff interview, it was determined the hospital failed to ensure a process for the prompt resolution of all patient grievances had been implemented. This affected the resolution of 1 of 1 grievance filed while the patient (Patient #25) was still an inpatient in the hospital and had the potential to	A 118	**A118 –GRIEVANCE PROCESS** **CHIEF QUALITY OFFICER** Portneuf Medical Center immediately implemented a Director education program on the requirement and process for handling patient grievances and included these elementsin the pre and post test on patient rights. (see attached Director's Education Packet) Staff educated on Patient Rights and the requirement for handling patient grievances (See Staff Education Packet) Audits, tracking and trending of staff compliance with the grievance reporting process being completed by the Grievance Committee. Portneuf has seen a marked increase in the number of Grievances received since staff training (See attached Grievance Graphs)	06-01-11 06-06-11

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A 118	Continued From page 3 impact all patients who wished to file grievances while still in the hospital. This resulted in a lack of follow through for current inpatients who wished to file a grievance. Findings include: 1. Patient #25's medical record documented a 74 year old female who presented to the ED on 4/28/11 for seizures. She was triaged at 9:23 AM. An "EMERGENCY FLOW SHEET RECORD," dated 4/28/11, indicated Patient #25 was placed on an automatic blood pressure machine at 9:30 AM and it continued to monitor her blood pressure at intervals through 4:02 PM that same day. The ED record documented Patient #25 was admitted to the cardiovascular unit at approximately 4:00 PM that same day. Patient #25 remained an inpatient until she was discharged on 4/30/11. An incident report, dated 4/29/11 at 10:20 AM, read Patient #25's "Niece stated pt's arm was hurting in the ED with B/P cuff on. She notified ED nurse. By the time pt was admitted to the unit, 2 skin tears were noted on arm 1 inner arm at elbow and 1 outer arm at elbow area...Niece feels like her concerns were not validated and is frustrated with new skin tears, edema, and decreased mobility of hand this am." While an incident report had been generated based on the event, a grievance was not initiated. The Chief Quality Officer was interviewed on 5/26/11 at 8:25 AM. She confirmed the incident had not been filed as a grievance. She stated she had spoken to the niece about the incident. She said the niece complained that the skin tears had been caused by the automatic blood pressure cuff in the ED. She stated the complaint	A 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/24/2011
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A 118	Continued From page 4 had not been logged as a grievance and was not part of the hospital's grievance process. She stated a written response had not been sent to the complainant. 2. The Quality Improvement Adviser, who was responsible for processing grievances at the hospital, was interviewed on 5/18/11 beginning at 3:30 PM. She stated if current inpatients or their representative made a complaint, it was handled by staff on the floor. She said Unit Directors investigated and attempted to resolve complaints but she said they were not filed as a grievances. She stated she could not think of an instance in the past 2 years where a grievance had been generated while a patient was still being treated in the hospital. 3. The Director of Medical & Surgical Services was interviewed beginning at 10:10 AM on 5/14/11. She stated if a current patient made a complaint about their care, she would investigate the allegation. She stated she would not enter the allegation as a grievance. She said if a patient made a complaint after they were discharged from the hospital, then it was automatically entered as a grievance. The hospital did not implement a consistent grievance process which provided inpatients and/or their representatives the opportunity to file a grievance. This prevented prompt resolution of the grievances.	A 118		
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the	A 166	**A166 (See Next Page)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13D028	A. BUILDING B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 166	Continued From page 5 patient's plan of care. This STANDARD is not met as evidenced by: Based on record review, staff interview, and policy review, it was determined the hospital failed to ensure the use of restraints were in accordance with a written modification to patients' plans of care for 6 of 10 restrained patients (#1, #13, #21,#30, #37, and #38) whose records were reviewed. This had the potential to interfere with coordination and consistency of patient care. Findings include: 1. Patient #1 was a 26 year old female who was admitted to BHS on 5/12/11. Mechanical restraints and chemical restraints were initiated on 5/15/11 at 10:25 PM, according to documentation on "Behavioral Health Services Restraint and Seclusion Physician Order/Evaluation Form." Mechanical restraints were released on 5/16/11 at 1:20 AM, according to documentation on a "BHS BEHAVIORAL SECLUSION AND RESTRAINT LOG." The "BHS Treatment Plan" (plan of care), dated 5/15/11, was reviewed on 5/19/11. The plan of care did not include the use of restraints. A BHS policy, "Treatment Planning," updated November 2007, stated revisions to goals and interventions would be included in the treatment plan review section. Each time the treatment plan was revised, staff was to enter a date. If the treatment plan had been revised, staff was to indicate this and note any revisions in the appropriate area (goals, objectives, treatment, etc.). During an interview on 5/20/11 at 9:25 AM, the	A 166	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A166** The Restraint Policy was revised to include requirements to include restraints in the patient care plan. (see attached Restraint Policy) All restraint documentation removed from computer documentation system and replaced with paper system to maintain integrity of all elements (See attached Restraint Documentation Packet) Staff educated on the policy and procedure revisions and documentation requirements (see attached Staff Education Packet and Restraint Documentation Packet)	06-06-11 06-07-11 06-08-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130028	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 05/24/2011
NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITAL WAY POCATELLO, ID 83201	

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A 166	Continued From page 6 Accreditation Officer reviewed Patient #1's plan and confirmed there was no documentation in the plan referencing the use of restraints. She stated she would talk to the Director of BHS and get back to surveyors with any additional information. At 10:00 AM on the same date, she stated she had spoken to the Director of BHS and he explained restraints were referenced on a restraint debriefing form. Copies of the forms were provided to surveyors via fax on 5/23/11. The form "BEHAVIORAL HEALTH SERVICES POST SECLUSION AND RESTRAINT PATIENT DEBRIEFING" included the following questions: 1) from the patient's point of view what happened? 2) Have the patient identify events that contributed to the incident. 3) Do these triggers occur often for this patient? 4) Have these triggers caused the same type of reaction for the patient in the past? 5) What other alternatives were discussed to the triggers identified above? The form did not include a treatment plan. Patient #1's plan of care was not modified to reflect the use of restraints. 2. Patient #37 was a 76 year old male who was admitted to the hospital on 3/16/11 and transferred to the Rehabilitation Unit on 3/18/11 for care related to a stroke. Patient #37's record contained physician orders for a Vail bed restraint (not to exceed 24 hour periods) on the following dates: 3/23/11 at 7:15 PM 3/25/11 at 1:30 PM 3/26/11 at 1:00 PM 3/27/11 at 1:00 PM	A 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130028	A. BUILDING B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 166	Continued From page 7 3/28/11 at 1:00 PM 3/29/11 at 1:00 PM 3/30/11 at 1:00 PM 3/31/11 at 1:00 PM 4/01/11 (not timed) 4/03/11 (not timed) Patient #37's "INPATIENT REHAB INTERDISCIPLINARY TREATMENT PLAN," initiated 3/21/11, was not updated to include the orders for a Vail bed restraint. A hospital policy, "INTERDISCIPLINARY PLAN OF CARE," revised July 2007, stated the plan of care included nursing interventions and treatments and medical treatments. During an interview on 5/19/11 at 4:20 PM, the Accreditation Officer reviewed Patient #37's record and confirmed the plan of care did not include a Vail bed restraint. Patient #37's written plan of care was not updated to include use of a Vail bed restraint. 3. Patient #38 was an 89 year old male admitted to the medical unit of the hospital on 5/04/11 for care primarily related to altered mental status. An order was written by a physician on 5/04/11 at 4:10 PM for "restraints PRN." On 5/05/11 at 2:40 AM, an LPN documented on the "Daily Focus Assessment Report" under "Restraints" the patient was placed in soft, bilateral wrist restraints. The mechanical restraints were discontinued on 5/05/11 at 5:00 AM. Patient #38's plan of care was not updated to show the use of mechanical restraints.	A 166		

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(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)	(X5) COMPLETION DATE
A 166	Continued From page 8 In an Interview on 5/20/11 at 9:25 AM, the Accreditation Officer stated any change in a patient's condition needs to be updated on the plan of care. In an interview on 5/20/11 at 9:40 AM, the Director of Medical & Surgical Services reviewed Patient #38's chart and stated the plan of care was not updated to include the use of mechanical restraints. She further stated she expected the plan of care to be updated when any restraint was used. Patient #38's plan of care was not updated to show the use of mechanical restraints. 4. Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 was initially examined in the ED and was then admitted to the medical unit for further treatment. Nursing notes documented Patient #30 was restless and anxious on the night of 2/07/11 and through the early morning of 2/08/11. At 10:15 AM on 2/08/11, the nursing note stated Patient #30 "...became combative and also aggressive. Called code orange [a call to staff to assist in the restraint of a patient] and patient was put on four point restraints around this time." Subsequent nursing notes stated Patient #30 continued in restraints until 4:50 PM on 2/08/11. Restraints were not incorporated into Patient #30's POC while she was restrained. Instead, the POC for restraints stated they were initiated on 2/08/11 at 8:38 PM, 3 hours and 45 minutes after Patient #30 was removed from restraints. This	A 166		

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	130028		05/24/2011

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A 166	Continued From page 9 was corroborated on 5/18/11 at 9:25 AM, by the RN who cared for Patient #30 while she was restrained. The hospital did not update Patient #30's POC to reflect that she was in restraints. 5. Patient #13 was a 55 year old male admitted to the critical care unit on 5/10/11 for care after a heart attack and subsequent cardiac catheterization. His medical record contained daily restraint orders (from 5/10/11 at 7:30 AM through 5/21/11 at 7:30 AM) for bilateral soft wrist restraints. Patient #13's care plan did not include goals and interventions related to the use of soft wrist restraints. A Clinical Lead from the critical care unit reviewed Patient #13's medical record. She confirmed Patient #13's care plan did not include the use of restraints. The use of restraints was not incorporated into Patient #13's POC. 6. Patient #21 was a 78 year old male admitted to the hospital on 2/25/11 after suffering a femur fracture. The discharge summary, completed by the physician on 2/28/11, indicated Patient #21 suffered respiratory complications during surgery and required sustained intubation and mechanical ventilation. The medical record contained an initial restraint order for bilateral soft wrist restraints on 2/26/11 at 4:00 PM. Patient #21's care plan did not include goals and	A 166		

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A 166	Continued From page 10 interventions related to the use of the soft wrist restraints. The Quality Improvement Advisor reviewed Patient #21's medical record. She confirmed the use of restraints was not incorporated into the care plan. Patient #21's POC did not address restraint usage.	A 166		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on record review, staff interview, and review of hospital policies and personnel records, it was determined the hospital failed to ensure restraints were used only in accordance with the order of a physician or LIP and LIPs ordering restraints were authorized to do so by hospital policy in accordance with State law. This impacted 5 of 10 restrained patients (#1, #8, #17, #28, and #38) whose records were reviewed and resulted in staff, instead of physicians or LIPs, determining the type and duration of restraints to be used. It also resulted PAs ordering restraints without demonstrated administrative approval. Findings include: 1. Incomplete Physician Orders:	A 168	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A168** The Restraint Policy was revised to exclude PA's from ordering restraints and requiring a physician order for all restraints (see attached Restraint Policy) Letter sent to all Mid-level providers notifying them of the change to the restraint policy (See attached Mid-level Education Packet) Education to staff indicating that only physicians are allowed to order restraints (see Staff Education Packet)	06-06-11 06-03-11 06-08-11

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A 168	Continued From page 11 a. Patient #38 was an 89 year old male admitted to the medical unit of the hospital on 5/04/11 for care primarily related to altered mental status. An order was written by a physician on 5/04/11 at 4:10 PM for "Restraints PRN." The order did not include the type of restraint to be used, the length of time for the restraint, or the number of limbs to be restrained. On 5/05/11 at 2:40 AM, an LPN documented on the "Daily Focus Assessment Report" under "Restraints" that the patient was placed in soft, bilateral wrist restraints. The mechanical restraints were discontinued on 5/05/11 at 5:00 AM. A medical unit RN was interviewed on 5/19/11 at 3:35 PM. She confirmed the restraint order was limited to "Restraints PRN." The mechanical restraints used on Patient #38 were not in accordance with a complete physician order. b. Patient #8 was an 18 year old male admitted to BHS on 4/22/11 for care primarily related to psychosis. On 4/22/11 at 6:40 PM, an order was written by the attending physician for mechanical restraints to be applied. The order did not include the type of mechanical restraint to be used, the length of time for the restraint, or the number of limbs to be restrained. On the "PATIENT CHECKS-CODE AND INITIAL" form, the behavioral health technician documented Patient #8 was out of leg restraints at 6:53 PM and out of arm restraints at 7:00 PM.	A 168		

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A 168	Continued From page 12 During an interview on 5/16/11 at 3:55 PM, the Director of BHS stated they did not get specific orders for mechanical restraints, such as 4 limbs or 2 limbs. The restraints used on Patient #8 were not in accordance with a complete physician order. c. Patient #1 was a 26 year old female who was admitted to BHS on 5/12/11. Her medical record indicated that physician orders for mechanical and chemical restraints were obtained via telephone on 5/15/11 at 11:05 PM. The order for mechanical restraints did not indicate the type of mechanical restraint and the limbs to be restrained. The order for chemical restraints did not indicate the specific medication orders to be used as chemical restraints. Telephone order documentation did not include the name of the RN who received the order. A separate physician's order, dated 5/15/11 at 10:35 PM, included medication orders for Ativan 2 mg IM every 4 hours PRN and Geodon 10 mg every 4 hours PRN. According to documentation on a "Behavioral Health Services Restraint and Seclusion Physician Order/Evaluation Form," in Patient #1's record, mechanical restraints and chemical restraints were initiated on 5/15/11 at 10:25 PM. A "Behavioral Health Services Seclusion and Restraint Flowsheet" documented Patient #1 was placed in 4 point restraints at that time. A BHS staff RN and the Director of BHS were interviewed on 5/16/11 at 3:55 PM. The staff RN was asked to look at Patient #1's restraint orders	A 168		

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A 168	Continued From page 13 and explain them. She stated BHS staff used Velcro restraints and generally restrained 4 limbs when they received an order for mechanical restraints. She stated they generally released limbs one at a time depending on the patient's control. The Director of BHS stated they did not get specific orders for mechanical restraints, such as 4 limbs or 2 limbs. The Psychiatrist who authorized restraints for Patient #1 on 5/15/11 was interviewed on 5/19/11 at 9:20 AM. When asked what chemical restraints he had ordered for Patient #1 on 5/15/11 at 11:05 PM, he replied Ativan and Geodon. Restraint orders did not include the type of mechanical and chemical restraints ordered or the limbs to be restrained. d. Patient #17 was a 21 year old female who came into the ED on 4/11/11 and transferred to BHS on 4/12/11. The following orders for restraints were incomplete: > An MD order for seclusion, dated 4/13/11 9:10 AM, did not state for how long the seclusion was being ordered. > An MD order for (unspecified) restraints, dated 4/13/11 1:40 PM, did not state the type of restraint that was being ordered. > An MD order for seclusion and mechanical restraints, dated 4/13/11 at 4:30 PM, did not state the type of mechanical restraints ordered or the limbs to be restrained. The order for seclusion did not state a time frame for the seclusion. > A PA order for mechanical restraints, dated 4/13/11 at 10:20 PM, did not state the type of	A 168		

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A 168	Continued From page 14 mechanical restraints ordered or the limbs to be restrained. > A PA order for mechanical restraints, dated 4/14/11 at 2:30 AM, did not state the type of mechanical restraints or the limbs to be restrained. > An MD order for mechanical restraints, dated 4/14/11 8:15 AM, did not state the type of mechanical restraints ordered or the limbs to be restrained. > An MD order for mechanical restraints, dated 4/14/11 12:00 PM, did not state the type of mechanical restraints ordered or the limbs to be restrained. The Director of BHS was interviewed on 5/16/11 at 3:55 PM. He stated they did not get specific orders for mechanical restraints, such as 4 limbs or 2 limbs. The restraint orders were insufficient to direct staff in the type of restraints to use and in the duration of seclusion. 2. Restraints Applied Without a Physician/LIP Order: The hospital policy, "RESTRAINTS AND SECLUSION," revised 11/06/08, stated orders for medical restraints were to be obtained from the LIP within 12 hours of restraint initiation. The policy included a definition of a Medical/Surgical/Restraint as a restraint for "Non-behavioral use, for example, to protect lines from being pulled out by disoriented patients." The policy did not require an order from an LIP be obtained prior to, during, or immediately after, the initiation of a restraint, to ensure restraints were	A 168		

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A 168	Continued From page 15 initiated only in accordance with the order of an LIP. The hospital's policy allowed for the use of restraint for up to 12 hours without an order from an LIP. 3. Physician Assistants Ordering Restraints: a. Patient #17 was a 21 year old female who came into the ED on 4/11/11 and transferred to BHS on 4/12/11. Mechanical restraints were ordered by a PA on 4/13/11 at 10:20 PM and 4/14/11 at 2:30 AM. During an interview on 5/17/11 at 10:30 AM, the Chief Quality Officer reviewed Patient #17's record and confirmed the findings. Physician assistants are not LIPs in Idaho. The Idaho Rules for the Licensure of Physician Assistants, at IDAPA 22.01.03.010.07, indicate a physician assistant must render patient services under the direction of a supervising and alternate surpervising physician. The hospital policy, "RESTRAINTS AND SECLUSION," revised 11/06/08, stated an order for medical restraints and behavioral restraints must be obtained from a physician or LIP. This policy did not reference exceptions for PAs who are not LIPs. The "Allied Health Practitioner Professional Policy Bylaws Attachment B," dated 5/11/11, identified PA's as allied health practitioners and stated that all allied health practitioners "will provide services only under supervision of a member of the medical staff." During an interview on 5/19/11 at	A 168		

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A 168	Continued From page 16 9:20 AM, a staff Psychiatrist described PAs and NPs as "allied health care practitioners" rather than LIPs. During an interview on 5/17/11 10:30 AM, the Chief Quality Officer confirmed PAs ordered restraints at the hospital. She explained the orders were co-signed by physicians. The Chief Quality Officer and the Accreditation Officer were interviewed by telephone on 5/23/11 at 1:30 PM. They stated the bylaws were general and did not address PAs ordering restraints, which should be addressed in individual credentialing files for PAs. They confirmed the hospital's restraint policy did not specifically address PA's authorization to order restraints. The hospital provided additional documents after the above referenced telephone call. These included "Clinical Privileges" and a "Delegation of Services Agreement" for one PA who had ordered restraints on Patient #17. Neither document specifically referenced authorization to order restraints. The "Clinical Privileges" document referenced the ability of the PA to order therapeutic modalities such as medications and treatments, but did not specify restraints. Restraint orders were not in accordance with a physician or LIP. The hospital's bylaws, credentialing files, and restraint policy did not reflect an exception to allow PAs to order restraints. b. Patient #28's medical record documented a 24 year old male who was admitted to the hospital's	A 168		

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A 168	Continued From page 17 BHS on 1/18/11 and was discharged on 2/01/11. His diagnosis was schizophrenia. A nursing note written at 7:00 PM on 1/18/11, stated "Pt became verbally paranoid about other pts talking about him and then began talking about wanting to die. Provided direct staff support and attempted to redirect the pt. Pt was near the Nurses Station. Pt began trying to hit his head against the wall and was physically restrained from 1805 [6:05 PM] until 1815 [6:15 PM]." The "Behavioral Health Services Restraint & Seclusion Physician Order/Evaluation Form," stated "Physical Restraints" were initiated on 1/18/11 at 6:05 PM. The telephone order for the restraints was written at 6:05 PM on 1/18/11 and stated a PA gave the order. The PA signed the order at 6:30 PM. Also, nursing notes stated Patient #28 began kicking a door which again led to him being physically restrained for 10 minutes, beginning at 4:45 PM on 1/19/11. The order for the restraint was written at 5:35 PM on 1/19/11 by a PA. Patient #28's medical record was reviewed with the Director of BHS beginning at 9:00 AM on 5/19/11. He confirmed the orders for restraint were written by a PA. Restraints were not utilized in accordance with an order by a physician or LIP. 4. Physician Orders Not Followed: Patient #28's medical record also contained a form labeled "Physician Orders," dated 1/20/11 at 10:10 AM, which ordered soft wrist and soft ankle restraints placed on Patient #28. It was signed by a physician at the time. A corresponding nursing	A 168		

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A 168	Continued From page 18 note was not present in the medical record so it could not be determined when Patient #28 was placed in restraints and when they were released. The policy "RESTRAINTS AND SECLUSION," dated 11/06/08, defined a "Rigid Restraint" as "Leather/all-Velcro/Velcro nylon." The policy did not define "soft restraints." The Charge Nurse on the BHS was interviewed on 5/26/11 at 11:50 AM. He stated "soft restraints" were used on medical units but were not used on the Behavioral Health Unit. He said these were lighter and flimsier. He stated the Behavioral Health Unit only used sturdier more rigid Velcro/nylon restraints for behavioral interventions. He stated even though they were ordered, Patient #28 could not have been restrained using soft restraints because these were not available for use on the BHS. The physician ordered the wrong type of restraints for Patient #28. He did not order the type of restraints used on the BHS. Nursing staff did not use restraints in accordance with the physician order because they used a different type of restraints that were available to them.	A 168		
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on record review, staff interview, and policy review, it was determined the hospital failed to ensure restraint orders were not written	A 169	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A169** Education provided to nursing staff, and individual physicians regarding the revised restraint policy and specifically that PRN restraint orders are not allowed under any circumstance. (see attached Physician Education Packet and Staff Education Packet)	06-08-11

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A 169	Continued From page 19 as a standing order or on an as needed basis for 4 of 10 restrained patients (#1, #17, #37, and #38) whose records were reviewed. This resulted in the use of restraints on a PRN basis. Findings include: 1. Patient Examples of Restraint Orders Written as PRN/As-Needed Orders a. Patient #38 was an 89 year old male admitted to the medical unit of the hospital on 5/04/11 for care primarily related to altered mental status. On 5/05/11 at 2:40 AM, an LPN documented Patient #38 was placed in soft, bilateral wrist restraints on a form titled "Daily Focus Assessment Report." An order was written by a physician on 5/04/11 at 4:10 PM for "Restraints PRN." A medical unit RN was interviewed on 5/19/11 at 3:35 PM. She reviewed Patient #38's record and confirmed the PRN order for restraints. The restraints used on Patient #38 were written as a PRN order. b. Patient #1 was a 26 year old female who was admitted to BHS on 5/12/11. The medical record documented receipt of a physician's telephone order for mechanical and chemical restraints on 5/15/11 at 11:05 PM. A separate physician's order, dated 5/15/11 at 10:35 PM, included medication orders for Ativan 2 mg IM every 4 hours PRN and Geodon 10 mg every 4 hours PRN. According to documentation on "Behavioral Health Services Restraint and Seclusion Physician Order/Evaluation Form," mechanical	A 169		

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A 169	Continued From page 20 restraints and chemical restraints were initiated on 5/15/11 at 10:25 PM. The Psychiatrist who authorized restraints for Patient #1 on 5/15/11 was interviewed on 5/19/11 at 9:20 AM. When asked what chemical restraints he had ordered for Patient #1 on 5/15/11 at 11:05 PM, he replied Ativan and Geodon. He explained he considered Ativan and Geodon restraints when used to manage a patient's behavior who was at imminent risk of hurting self or staff. At other times, he explained, the same medications could be considered standard symptomatic treatment. In the case of Patient #1, he acknowledged writing the order as PRN and explained his intentions were that the medication would be given one time as a chemical restraint and then be used PRN for symptomatic treatment. The order for chemical restraints was written as a PRN order. c. Patient #17 was a 21 year old female who came into the ED on 4/11/11 and transferred to BHS on 4/12/11. On 4/11/11 at 8:45 PM, an ED physician's order included "Restraints as needed." The type of restraints was not indicated. During an interview on 5/17/11 at 10:00 AM, an RN reviewed Patient #17's record and confirmed the restraints were ordered on an as-needed basis. An order for an unknown type of restraint was written as an as-needed order.	A 169		

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A 169	Continued From page 21 2. Restraint Orders Treated as PRN Orders: a. The hospital policy, "RESTRAINTS AND SECLUSION," revised 11/06/08, stated when a trial removal of restraints was attempted and failed, the restraint could be re-applied within the 24 hour period. When staff discontinued a restraint or seclusion and restarted the restraints under the same order, it constituted PRN use of the order. The policy allowed for PRN use of restraints. b. The Director of Critical Care was interviewed on 5/17/11 at 3:30 PM. She stated for patient's restrained for medical reasons, the order for restraints were appropriate for a 24 hour period of time. She stated if restraints were discontinued because they were no longer needed and then reapplied at a later time, as long as it was within the 24 hour time frame of the order, a new order for restraints was not required. She stated this was facility policy and the practice in her department. c. Patient #37 was a 76 year old male who was admitted to the hospital on 3/16/11 and transferred to the Rehabilitation Unit on 3/18/11 for care related to a stroke. Patient #37's record contained physician orders for a Vail bed restraint (not to exceed 24 hour periods) on the following dates: 3/23/11 at 7:15 PM for safety, impulsive, fall risk, confusion 3/25/11 at 1:30 PM for fall risk, safety 3/26/11 at 1:00 PM for high fall risk, safety	A 169		

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A 169	Continued From page 22 3/27/11 at 1:00 PM for high fall risk, safety 3/28/11 at 1:00 PM for high fall risk, patient very impulsive 3/29/11 at 1:00 PM for high fall risk, impulsivity 3/30/11 at 1:00 PM for impulsivity, high fall risk 3/31/11 at 1:00 PM for impulsivity, high fall risk with history of falls 4/01/11 (not timed) for impulsivity, high fall risk with history of falls 4/03/11 (not timed) for impulsivity, high fall risk Nursing documentation was not clear or consistent as to when Patient #37 was restrained in a zipped up Vail bed and when he was not. The hospital policy titled RESTRAINTS AND SECLUSION, revised 11/08, did not address the use of Vail bed restraints. On 5/19/11 at 4:40 PM, an RN was interviewed, who worked on the Rehabilitation Unit where Patient #37 received care. The RN was asked how he would implement an order for "Vail bed restraints not to exceed 24 hours." He stated he would use the Vail bed on an as-needed basis, leave it open when he felt it appropriate and close it when he felt appropriate. He stated he would not have to get a new order within the 24 hour period because an order for 24 hours would cover the need to use the Vail bed. He stated it would "not be realistic" to get a new order every time a patient was put back in a Vail bed. He reviewed Patient #37's record and stated he agreed the nursing documentation was not clear as to when the restraints were on or off. He explained the hospital used to have a system where nursing staff would document hourly whether the restraints were on or off a patient. However, he stated, the new computer system did not allow	A 169		

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A 169	Continued From page 23 ease of documentation of when restraints were on or off. PRN restraints were initiated and ordered throughout the hospital.	A 169		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospital failed to ensure orders for restraint, used for the management of violent or self-destructive behavior, were limited to 4 hours for adults, for 1 of 6 adult patients reviewed (#30), who had behavioral restraints applied. This resulted in a lack of direction to staff regarding how long to continue the restraint. Findings include: Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 was initially examined in	A 171	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A171** Education provided to nursing staff and individual physicians regarding the revised policy clarifying the difference between medical restraint and behavior restraints and the different requirements for each (see attached Staff Education Packets and Physician Education Packet) All restraint documentation removed from computer documentation system and replaced with paper system to maintain integrity of all elements (See attached Restraint Documentation Packets)	06-08-11 06-08-11

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A 171	Continued From page 24 the ED and was then admitted to the medical floor for further treatment. Nursing notes documented Patient #30 was restless and anxious on the night of 2/07/11 and through the early morning of 2/08/11. At 10:15 AM on 2/08/11, the nursing note stated Patient #30 "...became combative and also aggressive. Called code orange and patient was put on four point restraints around this time." Nursing notes stated Patient #30 continued in restraints 5 hours and 35 minutes, until 4:50 PM on 2/08/11. Patient #30's medical record had documented telephone orders for wrist and ankle restraints written at 10:15 AM on 2/08/11. The order stated it was a "Medical/Surgical" restraint order with a time limit of 24 hours. However, the order clearly constituted a behavioral restraint as the order stated Patient #30 was "biting, hitting, kicking, harm to self." The order was a form which contained boxes for "Medical/Surgical...24 hours, Adult Behavioral Health...4 hours, Age 9-17 Behavioral Health...2 hours, Age 9 & younger Behavioral Health...1 hour." The incorrect box was checked. The RN who obtained the order for restraints was interviewed beginning at 9:25 AM on 5/18/11. He stated Patient #30 was violent, assaultive to staff, and a danger to herself. He confirmed the restraint order was written for 24 hours. The restraint order for Patient #30 exceeded the 4 hour allowable time. This resulted in her being restrained for more than 4 hours without the physician reassessing the need for continued restraint.	A 171		
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT	A 174	**A174 (See Next Page)**	

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A 174	Continued From page 25 OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by: Based on review of medical records and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 1 of 6 adult patients (#30) who had behavioral restraints applied and whose record was reviewed. This resulted in a patient being restrained longer than necessary. Findings include: Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 was initially examined in the ED and was then admitted to the medical floor for further treatment. Nursing notes documented Patient #30 was restless and anxious on the night of 2/07/11 and through the early morning of 2/08/11. At 10:15 AM on 2/08/11, the nursing note stated Patient #30 "...became combative and also aggressive. Called code orange and patient was put on four point restraints around this time." Nursing notes stated Patient #30 continued in restraints 5 hours and 35 minutes, until 4:50 PM on 2/08/11. The nursing note at 11:00 AM on 2/08/11 noted Patient #30 was in 4 point restraints. Her behavior and mental/emotional status were not documented. Reasons for restraint listed "Could	A 174	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A174** Education provided to staff on requirement to discontinue restraints at the earliest time possible (see attached Staff Education Packet)	06-08-11

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A 174	Continued From page 26 Roll or Fall out of Bed, Unsteady Gait or Balance, Pulling Out Invasive Lines, Harmful to Self, Harmful to Others." No details were documented. The nursing note at 12:00 noon on 2/08/11, stated the same exact information. Again, the note stated Patient #30 was in 4 point restraints. Her behavior and mental/emotional status were not documented. The nursing note at 1:00 PM was essentially the same except "Could Roll or Fall out of Bed" was not listed as a reason for restraint. The nursing note at 2:00 PM was essentially the same except 6 reasons for restraint were listed. Reasons listed also included "Attempts to Self-Transfer" and "Unable to Sit Upright." A separate nursing note at 2:00 PM, labeled "Patient Rounding," stated "Patient remains on need for four point restraints. Released patient's restraints and patient cont. to be aggressive and try to bite herself." No other details were documented. The nursing note at 3:00 PM was essentially the same as the note at 1:00 PM. No mention of current behavior was documented. The nursing note at 4:00 PM did not document any behaviors. The nursing note at 4:50 PM stated the restraints were discontinued. No assessment of Patient #30's emotional/behavioral state was documented. The next nursing note, at 6:00 PM, stated "Patient in room awake, Doing well without restraints." The RN who cared for Patient #30 and who wrote the above notes, was interviewed beginning at 9:25 AM on 5/18/11. He stated Patient #30 was alternately restless and sleeping while she was restrained. He confirmed the documentation. The hospital did not document the continued need to restrain Patient #30.	A 174		

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A 176	482.13(e)(11) PATIENT RIGHTS: RESTRAINT OR SECLUSION Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure 1 of 2 physicians who ordered restraints and who were interviewed, had received training regarding restraints. This resulted in a lack of direction to the medical staff regarding the correct use of restraints. Findings include: 1. Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 had telephone orders from her attending physician for wrist and ankle restraints, written at 10:15 AM on 2/08/11. The order was signed by the physician on 2/10/11 at 7:30 AM. The order stated it was a "Medical/Surgical" restraint order. However, the restraint order was clearly for behavioral restraints as it stated Patient #30 was "biting, hitting, kicking, harm to self." The order should have been limited to 4 hours per regulation 42 CFR Part 482.13(e)(11). However, it was written	A 176	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A176** Medical Executive and Clinical Service Line Chiefs met and developed a comprehensive physician education program which required all medical staff to review the Restraint Policy, COPs, and Restraint Education and sign an attestation that they have reviewed and understand the materials (see attached Physician Education Packet)	06-08-11

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A 176	Continued From page 28 for 24 hours. Nursing notes stated Patient #30 continued in restraints for 5 hours and 35 minutes, until 4:50 PM on 2/08/11. Physician progress notes did not show evidence of assessment of the need for restraints. Physician notes did not document an examination of Patient #30 while she was restrained and they did not document an assessment of her need for restraint. A visit to Patient #30 was not conducted by the ordering physician until 2/09/11 at 7:00 AM. The visit note did not mention the restraint. The physician who ordered the restraints for Patient #30 was interviewed on 2/18/11 at 8:55 AM. He confirmed the order and the lack of an assessment of the need for restraints. He stated he was not sure if Patient #30 needed 4 point restraints or not. He stated he had not received any training from the hospital regarding restraints. He also stated he was not familiar with the hospital's restraint policy. 2. The policy "RESTRAINTS AND SECLUSION," dated 11/06/08, was the comprehensive policy for all restraints utilized at the hospital. The policy did not address training requirements for physicians who ordered restraints or for staff who applied and monitored restraints. This was confirmed by the Chief Quality Officer who was interviewed on 5/26/11 beginning at 8:25 AM. The hospital failed to train physicians in the use of restraints.	A 176		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the	A 178	**A178 (See Next Page)**	

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A 178	Continued From page 29 management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure 1 of 6 adult patients (#30), who had behavioral restraints applied and whose records were reviewed, was seen face-to-face within 1-hour after the initiation of the intervention by a person authorized to conduct restraint evaluations. This resulted in the absence of a comprehensive evaluation of the patient to determine alternate causes for the behavior and whether non-coercive measures could be used to control behaviors. Findings include: Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 had a telephone order from her attending physician for wrist and ankle restraints, written at 10:15 AM on 2/08/11. The order stated Patient #30 was "biting, hitting, kicking, harm to self."	A 178	**A115 - RESTRAINTS** **CHIEF NURSING OFFICER** **A178** Education provided to nursing staff and individual physicians regarding the revised policy and clarifying the difference between medical restraint and behavior restraints, the different requirements for each, and the need for a face-to-face assessment within 1 hour by a physician. (see attached Staff Education Packets and Physician Education Packet) All restraint documentation removed from computer documentation system and replaced with paper system to maintain integrity of all elements (See attached Restraint Documentation Packets)	06-08-11 06-08-11

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A 178	Continued From page 30 After Patient #30 was placed in restraints, she was not seen face to face by a physician or LIP in order to assess the need for restraint and possible alternative interventions. The only documented physician visit on 2/08/11, after the restraint was applied, was written by the nephrologist at 7:00 PM that evening. The note did not mention the use of restraints. Physician progress notes by a psychiatrist and by the attending physician were documented on 2/09/11 at 10:56 AM and 7:00 AM, respectively. Neither physician progress note mentioned the restraint. The physician who ordered the restraints for Patient #30 was interviewed on 2/18/11 at 8:55 AM. He stated he did not visit Patient #30 after he ordered the restraints. The Core Measures Resource Nurse reviewed the record and was interviewed beginning at 9:25 AM on 5/18/11. He confirmed a face to face visit to Patient #30, within 1 hour of the restraints being applied, was not documented. The hospital did not provide a face to face visit by a physician or LIP after Patient #30 was placed in restraints to control her behavior.	A 178		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE 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, and staff interview it was determined the hospital failed to ensure an RN evaluated and appropriately addressed abnormal findings during the	A 395	**A395 NURSING STANDARDS OF PRACTICE** **CHIEF NURSING OFFICER** ED staff counseled and re-educated on the elements of comprehensive vital signs and patient monitoring. Policy reviewed, audit tool developed and implemented to monitor compliance. (see ED Staff Education)	06-08-11

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A 395	Continued From page 31 admission assessment process of 2 of 14 ED patients (#22 and #25) whose records were reviewed. This resulted in Patient #25 sustaining skin tears and the potential for other negative patient outcomes. Findings include: 1. Patient #22 was a 60 year old male who was brought in to the ED by paramedics on 1/29/11. The paramedic report at 2:05 PM indicated Patient #22 had left sided weakness, left knee pain, slurred speech and a blood pressure of 150/110. The report indicated Patient #22 fell at his place of business and was found by a friend who contacted EMS. The triage nurse performed an admission assessment at 2:10 PM, and the blood pressure at that time was 211/76. The narrative note by the triage nurse stated, "Pt here via EMS with c/o pain, inability to bear weight on left knee. Report also hinted at a possible problem with slurred speech, but wife states speech is normal and he just needs a drink of water." A physician entry note at 3:11 PM included the diagnosis of acute left knee injury, as well as the patient disposition of home, condition stable. The final nursing entry was at 3:25 PM, described as a "discharge note." The entry read "Patient discharged home, patient is in a wheelchair. Accompanied by spouse." The vital signs were taken and the blood pressure was 176/87. An entry by the physician who assessed Patient #22 was dated 1/30/11 at 7:06 AM, and included as the chief complaint a fall with resulting left knee pain. The physician described Patient #22	A 395		

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A 395	Continued From page 32 as not able to bear weight or walk on his left leg. A review of systems was noted by the physician, with the statement: "Pt reports being at his otherwise baseline state of health, no other assoc. system complaints." A neurological assessment by the physician, dated 1/30/11 at 7:15 AM, stated "speech normal, symmetric strength." The record included the result of x-rays of the left knee done on 1/29/11 at 2:28 PM. Patient #22's vital signs were taken two times during the hour and 15 minutes he spent in the ED. The nurse did not assess the left sided weakness or further evaluate the slurred speech reported by the paramedics upon admission. The medical record did not contain documentation that the nurse notified the physician of the elevated blood pressure. In an interview on 5/20/11 at 9:00 AM, the ED Director reviewed Patient #22's record and stated the admission blood pressure of 211/76 was outside of parameters. He stated the electronic medical records computer program would alert the nurse with a "V" on the computer when abnormal vital signs were entered into the system. The Director stated the "V" indicated further management would be required by the nurse, which included placing the patient on a monitor, taking and recording vital signs every 15 minutes, and alerting the physician of the abnormal result. The Director stated the abnormal blood pressure parameters were systolic greater than 180 or less than 75 and a diastolic of greater than 130 or less than 45. The Director stated the RN caring for Patient #22	A 395		

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A 395	Continued From page 33 should have placed him on a monitor and notified the physician of the elevated blood pressure. He confirmed the medical record did not contain *additional vital signs or documentation that the* physician was notified. The record indicated Patient #22 was brought back to the ED at 6:17 PM that evening by his wife with complaints of left sided weakness, slurred speech, and confusion. The admitting RN noted Patient #22's blood pressure at that time was 197/96. Patient #22 was transported to a referral facility shortly after with a diagnosis of intracerebral hemorrhage (bleeding in the brain, also known as a stroke). During an interview on 5/20/11 at 10:00 AM, the physician that assessed Patient #22 during his first visit to the ED reviewed the record and stated he had questioned the wife of Patient #22 regarding his slurred speech. The physician stated Patient #22 and his wife assured him his speech was okay, and his main complaint was left knee pain. The physician stated he had not documented his conversation with Patient #22 or his wife regarding the slurred speech. The physician stated pain could cause an increase in blood pressure. The physician explained Patient #22 had been his last patient for his shift, and he left the facility shortly after discharging Patient #22. The physician stated he returned on 1/30/11 and dictated notes for Patient #22, not knowing that Patient #22 had been readmitted that evening and then transported to another facility. Nursing staff did not appropriately evaluate Patient #22's abnormal vital signs.	A 395		

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(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)	(X5) COMPLETION DATE
A 395	Continued From page 34 2. Patient #25's medical record documented a 74 year old female who presented to the ED on 4/28/11 for seizures. She was triaged at 9:23 AM. An "EMERGENCY FLOW SHEET RECORD," dated 4/28/11, indicated Patient #25 was placed on an automatic blood pressure machine at 9:30 AM and it continued to monitor her blood pressure at intervals through 4:02 PM that same day. The ED record documented Patient #25 was admitted to the cardiovascular unit at approximately 4:00 PM that same day. Patient #25 remained an inpatient until she was discharged on 4/30/11. The ED record did not mention skin tears. An incident report, dated 4/29/11 at 10:20 AM, read Patient #25's "Niece stated pt's arm was hurting in the ED with B/P cuff on. She notified ED nurse. By the time pt was admitted to the unit, 2 skin tears were noted on arm 1 inner arm at elbow and 1 outer arm at elbow area...Niece feels like her concerns were not validated and is frustrated with new skin tears, edema, and decreased mobility of hand this am." Two pictures of Patient #25's arm were present which noted 2 large skin tears. The Chief Quality Officer was interviewed on 5/26/11 at 8:25 AM. She stated she had spoken to the niece about the incident. She said the niece complained that the skin tears had been caused by the automatic blood pressure cuff in the ED. She stated the skin tears were caused by the automatic blood pressure cuff. The nurse who cared for Patient #25 failed to monitor her skin to prevent breakdown from the blood pressure cuff.	A 395		

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	130028		05/24/2011

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A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by: Based on medical record review, review of facility policies, and staff interview it was determined the facility failed to ensure thorough nursing care plans were developed for 3 of 30 patients (#7, #13, #30) whose inpatient records were reviewed. Lack of a complete care plan had the potential to result in unaddressed patient care needs and interfere with coordination of patient care among staff members. Findings include: 1. The facility's "INTERDISCIPLINARY PLAN OF CARE" policy, last revised July 2007, was reviewed. According to the policy, the plan of care was developed using the nursing processes of assessment, diagnosis, planning, and implementation, and evaluation. Documentation in the policy stated that actual or potential diagnoses to be addressed in the care plan were determined as a result of the patient assessment. Complete care plans were not developed as follows: a. Patient #13 was a 55 year old male admitted to the facility on 5/10/11 for care after a heart attack and subsequent cardiac catheterization. A physician consultation, dated 5/10/11, indicated Patient #13 was being treated for acute respiratory failure, acute renal failure, poorly controlled diabetes mellitus, and an acute myocardial infarction.	A 396	**A396 NURSING CARE PLANS** **CHIEF NURSING OFFICER** Plan of Care computer documentation system revised to be more comprehensive. Staff counseled and educated on the need for comprehensive documentation of the plan of care for all patients (See Care Plan Education)	06-08-11

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A 396	Continued From page 36 Patient #13's nursing care plan included interventions and goals related to mechanical ventilation, altered cardiac function, core measures (such as vaccinations, venous thromboembolism prophylaxis, etc.), a basic, age-appropriate care plan (which included shift assessments, vital signs, pain assessment, education, etc.), and anxiety. The care plan did not include the diagnoses related to diabetic managment or renal failure, and did not include interventions or goals related to these healthcare issues. The Director of Critical Care was interviewed on 5/17/11 at 9:30 AM. She reviewed Patient #13's care plan and verified information related to diabetic management and renal failure were not included in the plan. She stated she would have expected these issues to be addressed in the nursing care plan. Goals and interventions related to Patient #13's acute renal failure and poorly controlled diabetes mellitus were not incorporated into her POC. b. Patient #30's medical record documented a 20 year old female who was admitted to the hospital on 2/07/11 and was discharged on 2/10/11. Her diagnoses included acute renal failure and lithium toxicity. She also had a history of bipolar disorder. Patient #30 was initially examined in the ED and was then admitted to the medical unit for further treatment. An ED nursing note at 1:08 PM on 2/07/11, stated the nurse tried 3 times unsuccessfully to draw blood for testing. The note stated the attempt was successful by using Patient #30's foot to draw the blood. A nursing note at 8:45 AM on 2/08/11, stated the Life Flight	A 396		

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A 396	Continued From page 37 nurse had been summoned to attempt to draw more blood for testing. The attempt was not successful. A physician order, dated 2/10/11 at 7:40 AM, stated "May use lower extremities for blood draw." As noted above, Patient #30 was very anxious. She became agitated and this led to her being restrained on 2/08/11 at 10:15 AM. Patient #30's "Patient Care Plan Report," initiated at 3:00 PM on 2/07/11, and updated through out her stay, did not address problems obtaining blood samples for testing. The RN, who cared for Patient #30 on 2/07/11 and 2/10/11, was interviewed on 5/18/11 beginning at 9:25 AM. He confirmed blood draws were not included in Patient #30's POC. He stated she underwent multiple unsuccessful attempts to draw blood by multiple staff and eventually blood was drawn from her foot. Patient #30's POC was not complete. c. Patient #7 was a 7 week old male infant admitted to the facility on 5/15/11 for bronchiolitis. (According to the National Institutes of Health, bronchiolitis is swelling and mucus buildup in the smallest air passages in the lungs, usually due to a viral infection. It usually affects children under the age of 2 years.) The H&P, dictated by the admitting pediatrician on 5/15/11, indicated Patient #7 was on oxygen and had difficulty with breastfeeding and breathing due to nasal stuffiness. Record review indicated Patient #7 had an NG tube placed on 5/16/11 at 5:30 PM, due to difficulty breastfeeding, in an attempt to increase	A 396		

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A 396	Continued From page 38 fluids and avoid the need for IV fluids. Patient #7's nursing care plan included interventions and goals related to pain, knowledge deficit, anxiety, and impaired gas exchange. The care plan did not include the diagnosis, goals, or interventions for impaired nutrition related to difficulty breathing while eating. The Director of Women's and Children's Services was interviewed on 5/17/11 at 9:15 AM. She reviewed Patient #7's care plan and verified information related to nutrition and inadequate oral intake, as well as, the recent placement of an NG tube, were not included in the plan. She stated she would have expected that nutrition would have been included in the care plan. Patient #7's POC was not revised to reflect his unique needs.	A 396		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on record review, and staff interview, it was determined the hospital failed to ensure that complete, legal medical records were accurate, completed, accessible, and provided upon	A 438	**A438 MEDICAL RECORDS** **CHIEF FINANCIAL OFFICER** A Medical Records Task Force was convened with the following members: HIM Director, IT Director, Admissions Director and Chief Financial Officer. This task force met and immediate action was taken to clarify the process for getting the complete medical record gathered and compiled. IT determined that the current EMR system was not allowing nursing records to cross over to the complete medical record if there was an open encounter on the record. An open encounter is an assessment or checklist in the electronic charting system that has not been finalized electronically by the caregiver. (Continued on the next page)	06-01-11

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A 438	Continued From page 39 request for 5 of 14 ED patients (#22, #42, #47, #51, #52) whose complete, legal medical records were requested. Failure to obtain and provide the complete and accurate record had the potential to negatively impact coordination, quality, and safety of patient care. Findings include: 1. The complete, legal ED medical record for Patient #22's 1/29/11 ED admission was requested. The medical record received documented evaluation and treatment related to knee pain as a result of a fall. It further documented Patient #22 was discharged home at 3:25 PM on 1/29/11. The record contained a report of a head CT scan performed on 1/29/11 at 7:57 PM and sent to the ED. This was four hours and 32 minutes after the documented time of discharge. Patient #22's ED record did not include a physician order for the head CT scan. On 5/18/11 at 12:05 PM, the HIM Manager was interviewed regarding the contents of Patient #22's record. The HIM Manager confirmed she had provided the entire legal medical record as requested, and demonstrated on her computer how she reviewed patient medical record information. The HIM Manager stated her computer program indicated Patient #22 had only one admission to the ED on 1/29/11. She was unable to explain the CT scan report found in the ED medical record. The Director of HIM was interviewed on 5/18/11 at 12:30 PM. She determined Patient #22 had made two visits to the ED on 1/29/11. She stated Patient #22 had been discharged around 3:25 PM, but had returned to the ED shortly after 6:00 PM. She stated the ED staff appeared to	A 438	**A438 MEDICAL RECORDS (Cont)** **CHIEF FINANCIAL OFFICER** A backlog of open encounters was identified and all staff educated and counseled to close any open encounters in the EMR system cleaning out the backlog and allowing data to flow over to the closed record. A log of open encounters was created and is sent to Directors on a daily basis to assist them in closing the open encounters in a timely manner so that the complete record can flow to HIM. (see Open Encounters E-mail) Designated HIM staff were given access to all electronic charting systems and trained on how to print documents for the legal record from all systems. HIM is auditing charts and reporting any missing documentation to the Director and the VP of that area. ED Staff re-educated on the importance of accurate documentation. ED EMR revised to minimize the number of choices in drop down menus to prevent additional errors (See attached ED Staff Education)	06-01-11 06-05-11 06-08-11 06-07-11

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A 438	Continued From page 40 continue documentation in the first admission record (from the admission at 2:10 PM on 1/29/11) as if Patient #22 had not been discharged. She stated both visits were under the same episode. She stated each time a patient was seen in the ED it was to be considered a new episode. The Director of HIM explained the facility used one software program in the ED which was merged with the software program used by the HIM Department for storing medical records. She stated the records generated from the program used by the ED were not considered legal medical records. She stated every night around midnight the information from ED records was merged into the HIM software program and was then considered the legal medical record. The Director of HIM stated the ED Director had access to the ED software program, and potentially to additional patient information. In an interview on 5/18/11 at 3:45 PM, the ED Director was able to obtain more information about Patient #22's admissions to the ED on 1/29/11. The ED Director stated Patient #22 had returned to the ED at 6:17 PM, and the staff pulled his previous visit from the archives. The ED Director then provided documentation from the second ED admission. The ED Director stated Patient #22 had two records in the ED software system, but not in the HIM system. The Director was able to print two separate ED visits for Patient #22 for 1/29/11 on the software program specific to the ED. The ED Director stated the two software programs did not always communicate with one another. Patient #22's legal medical record provided by	A 438		

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A 438	Continued From page 41 HIM was not complete. 2. Patient #52's medical record documented a 24 year old female who presented to the ED on 3/21/11 at 1:43 PM. She complained of drainage from her suture line following caesarean section surgery. No vital signs, including temperature, pulse, respiration, blood pressure, and oxygen saturation levels, were documented in her medical record. The Director of HIM was interviewed on 5/19/11 at 11:25 AM. She reviewed the medical record and confirmed vital signs were not documented. She stated she did not know why the record was not complete but she said the vital signs were not part of the medical record. She stated the ED sometimes used another system to document vital signs that did not interface with the hospital's medical record and speculated this could be the reason for the missing information. Patient #52's medical record was not complete. 3. Patient #51's medical record documented a 69 year old male who presented to the ED on 3/17/11 at 2:36 PM. He complained of swollen genitals. Fore skin reduction was performed in the ED utilizing Propofol, an anesthetic. A nursing note at 3:50 PM on 3/17/11, stated the Propofol was administered by an RN. Another nursing note at 4:12 PM on 3/17/11, stated the Propofol was administered by a physician. The Core Measures Resource Nurse reviewed the medical record on 5/19/11 at 11:00 AM. He stated the physician actually administered the	A 438		

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A 438	Continued From page 42 Propofol. Patient #51's medical record was not accurate. 4. Patient #42's medical record documented a 5 year old male who presented to the ED on 5/13/11 at 6:22 PM with a depressed skull fracture. He was transferred to another acute care hospital for specialized neurosurgical care at approximately 10:21 PM on 5/13/11. Transfer forms, including physician certification that the benefits of the transfer outweighed the risks and parental consent for the transfer were not included in the medical record. The Core Measures Resource Nurse reviewed the medical record on 5/19/11 at 11:00 AM. He contacted HIM personnel and stated the transfer forms could not be found. He stated he believed the transfer forms had been completed but had not been saved in the medical record. Patient #42's medical record was not complete. 5. Patient #47's medical record documented a 59 year old male who presented to the ED on 5/08/11 at 9:43 AM complaining of chest pain. He was diagnosed with a myocardial infarction. He was transferred to another acute care hospital for specialized care at approximately 10:16 AM on 5/08/11. A nursing note at 10:16 AM on 2/08/11, stated "Transfer-[receiving hospital], Disposition Transport: Taxi/Public Transport." A physician note at 10:17 PM on 5/08/11, stated Patient #47 was actually transported by ambulance to the receiving hospital. The Core Measures Resource Nurse reviewed	A 438		

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A 438	Continued From page 43 the medical record on 5/19/11 at 11:00 AM. He confirmed the contradictions in the medical record. Patient #47's medical record was not accurate.	A 438		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and review of patient records, it was determined the hospital failed to ensure medical record documentation was complete with properly authenticated physician orders for 1 of 6 outpatients (#31) whose records were reviewed from the outpatient imaging center. This had the potential to interfere with coordination of patient care, result in misinterpretation of information, or cause a medical error. Findings include: Patient #31 was a 43 year old male who had an outpatient MRI scan performed on 5/18/11 at 9:00 AM. His record contained a pre-printed form from the referring physician practice group. The form listed the name of the practice and three office addresses. The form had not been dated or timed, however Patient #31's name and date of birth were hand-written in. The individual who filled out the form indicated which test was to be done (an MRI of the cervical spine) and documented Patient #31 had a history of neck pain.	A 450	**A450 MEDICAL RECORDS** **VP, CLINICAL AND SUPPORT SERVICES** An Admissions Task Force was convened with the following members: VP of Clinical and Support Services, Chief Financial Officer, Directors of Admissions, Radiology, Lab, Respiratory, and Physical Medicine. Task Force redefined the process for the verification and collecting of physician orders for testing. Orders will be reviewed by admissions for all necessary elements prior to proceeding to the testing area. Letter sent to all medical staff and physician office staff reminding them of the required elements for all orders. (see Physician Orders Memo)	06-06-11

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A 450	Continued From page 44 The lower portion of the form provided three options for imaging centers, one of which was the imaging center surveyed. Additional information on the form addressed pre-authorization of the imaging study and served as a notice to the patient that a pre-authorization was done as a courtesy with instructions for patients to verify individual coverage with their insurance. At the very bottom of the form were the signatures of five physicians and two PAs. One physician's signature had been circled. It was unclear if the form was an order form for the imaging center or an informational document for the patient. In an interview on 5/18/11 at 9:10 AM, the technician performing the MRI reviewed the form for Patient #31 and stated the ordering physician was the signature with the circle around it. In an interview on 5/18/11 at 9:15 AM, the Manager of Outpatient Imaging reviewed the form described above. He could not verify who had circled the physician name or completed the form. He stated this form was considered a physician order. The facility accepted physician orders that were not properly authenticated.	A 450		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.	A 701	**A701 (See Next Page)**	

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A 701	Continued From page 45 This STANDARD is not met as evidenced by: Based on observation, review of kitchen logs and hospital policies, and staff interviews, it was determined the hospital failed to ensure 1 of 1 kitchen evaluated for environmental issues was maintained in such a manner as to ensure the safety and well-being of patients. Failure to maintain a clean food storage and preparation environment directly impacted the well-being of all patients receiving care in the hospital. Failure to stay current on repairs had the potential to impact patient health and safety. Findings include: 1. During a tour of the hospital's kitchen, on 5/19/11 from 3:30 PM to 4:45 PM, accompanied by the Dietary Manager and the Chef, the following concerns were noted: a. The following food was observed to be undated and/or expired: i. In a refrigerated cart storing sandwich items, the container of cheese slices was undated. ii. The deli refrigerator had a container of cherry topping dated 5/11/11. At the time of the observation the Dietary Manager stated food which was prepared and then stored in the refrigerator was good for seven days. She discarded the cherry topping as it had expired. iii. A refrigerator in the "Grill" section of the cafeteria had four undated containers of brownies. The Dietary Manager discarded the brownies as they were identified.	A 701	**A701 MAINTENANCE OF PHYSICAL PLANT** **VP, CLINICAL AND SUPPORT SERVICES** Laboratory sinks were cleaned, re-designated as clean or dirty and labeled accordingly. Dietary management and staff educated in the standards of cleanliness and expectations outlined. Cleaning and audit schedules established (See Dietary Cleaning) Lab and Dietary management and staff were educated by the Infection Control Preventionist on the hospital-wide process for hand hygiene audits and provided the tools for auditing. The VP of Clinical and Support Services is auditing compliance on a regular basis. (see Hand Hygiene Audit Tools). The Freezer has been repaired and no longer has a leak.	06-06-11 06-10-11 06-02-11 06-08-11

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A 701	Continued From page 46 b. The walk-in freezer unit had condensation leaking onto food storage racks. Four boxes of frozen meat were directly under the leak. One box of meat had areas of ice where condensation from the freezer had dripped and refrozen. Water dripping from the leaking freezing unit had the potential to compromise the integrity of the frozen foods below. There were also metal food storage racks with hanging ice from the dripping freezer unit. The floor under the freezer unit and food storage racks had multiple areas of pooled condensation which had refrozen. This posed a safety hazard for kitchen staff. During the tour the Chef stated the leak in the walk-in freezer had been noted on Monday, 5/16/11. He said the refrigeration company workers had been in on 5/19/11, but were not able to replace a part for the freezer unit. He stated a plastic bucket would be collecting the condensation until the freezer unit was fixed. c. The dishwashing area floor was wet due pooled water under the sink which extended beyond the rubber mats used for staff while working at the sink. The Dietary Manager and the Chef confirmed the presence of pooled water in this location during the tour on 5/19/11. d. The deep fryer had thick amounts of floating fried food particles in the corners. There was no log to indicate when the oil had last been replaced.	A 701		

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NAME OF PROVIDER OR SUPPLIER PORTNEUF MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 777 HOSPITAL WAY POCATELLO, ID 83201	

(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)	(X5) COMPLETION DATE
A 701	Continued From page 47 During the tour on 5/19/11 the Chef stated the deep fryer had an auto filtration system that filtered the oil daily. He stated he personally changed the oil weekly but did not maintain a log to record the dates this was done. e. The dishwasher had a sign on it which indicated the water was to be replaced every two hours. There was no log to indicate when the water had last been changed. During the tour on 5/19/11 neither the Dietary Manager nor the Chef were able to state when the water had last been changed, and when it was due to be changed again. The Chef also confirmed there was no log to record the dishwasher water replacement activities. f. The ventilation hood above the grill and stove had panels with a thick amount of grease and dust. The Dietary Manager was present during the tour of the department of 5/19/11, and stated the panels above the grill were cleaned on a rotation basis. She described how one panel would be removed daily and cleaned in the dishwasher. The Dietary Manager stated she would make sure all the panels would be cleaned that night. A second tour of the kitchen was done on 5/20/11 at 8:40 AM. The thick layer of dust and grease was still present on the panels. The Dietary Manager confirmed the panels had not been cleaned. g. Sections of the kitchen floor were stained from	A 701		

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	130028		05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 701	Continued From page 48 previous spills of food and liquids. Small pieces of food littered the floor behind the grill and oven unit. During the tour on 5/19/11, the Dietary Manager stated housekeeping was responsible for cleaning the department after the kitchen was closed. The nightly cleaning included scrubbing and hosing down the floors and behind the equipment. A second tour to of the kitchen was done on 5/20/11 at 8:40 AM. The floors behind the grills and oven unit contained dust and food items that had been noted on the previous day. During the tour the presence of the food and debris were verified by the Dietary Manager. She stated she spoke with the Housekeeping Supervisor on the evening of 5/19/11 about cleaning. A policy titled "INFECTION CONTROL/FOOD SERVICE," dated October 1979, and reviewed January 2001, addressed food storage and staff responsibilities. The policy stated the nutritional services department would develop and maintain clean and sanitary work areas, equipment, and storage areas. The physical environment of the dietary department was not adequately maintained to ensure the safety and well-being of patients.	A 701		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and	A 749	**A749 (See Next Page)**	

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	130028		05/24/2011

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A 749	Continued From page 49 communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on staff interview, observation, and review of facility policy and procedures, it was determined the Infection Control Coordinator failed to develop a surveillance program for 2 of 2 non-patient care areas (Laboratory and Nutritional Services) surveyed to identify and evaluate infection control practices. The failure to develop a program to monitor the non-patient care areas had the potential to expose hospital patients and staff to infection. Findings include: 1. During a tour of the Laboratory with the Lab Director and the Director of Support Services on 5/19/11 from 9:00 AM to 9:30 AM, the following infection control concerns were noted: a. The Blood Bank area had one sink, which had tubing from equipment draining into it. On the left corner of the sink were two containers of commercial hand lotion. On the right corner of the sink was an antibacterial skin moisturizer, which was provided by the hospital. At the time of the tour, the Lab Director stated the sink was a designated "dirty" sink, and the commercial hand lotions were against hospital policy and would be removed. He stated the sink was not to be used as a hand washing area. The Lab Director stated there was no clean sink in the blood bank area of the lab. b. The main lab area had four sinks, three of which were designated as "dirty" sinks with tubing from equipment draining into them, or urine	A 749	**A749 INFECTION CONTROL VP, CLINICAL AND SUPPORT SERVICES** Laboratory sinks were cleaned, re-designated as clean or dirty and labeled accordingly. Laboratory staff and Dietary staff re-educated by the Infection Control Preventionist on the importance of Hand Hygiene and routine audits being performed in both areas and reviewed by Infection Control in compliance with the hospital-wide Hand Hygiene policy The Freezer has been repaired and no longer has a leak.	05-20-11 06-01-11 06-08-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130028	A. BUILDING B. WING	05/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 749	Continued From page 50 specimens to be discarded piled in the sink. The fourth sink was full of crushed ice to the point it could not be used to wash hands. During the tour, the Lab Director stated the three "dirty" sinks were not to be used by staff for hand washing, and stated the only designated "clean" sink to be used by staff for hand washing was the sink that had the ice in it. The Lab Director stated there was a sink in the staff break room, as well as, in the restroom which was adjacent to the break room. The access to the break room was behind a door. The restroom was through the breakroom behind another door. A policy, "Hand Hygiene," dated May 2008, detailed when hand washing was to be done rather than the use of alcohol hand sanitizing rub. The policy stated hand washing was to be done at the start of the work shift, before eating or drinking, after using the restroom, and after coughing or sneezing. During the tour on 5/19/11 at 9:00 AM, a lab employee stated it was difficult to wash hands as a result of the lack of available "clean sinks." She stated she utilized hand sanitizers. The lab lacked sufficient access to designated "clean" sinks for staff to perform appropriate hand hygiene. 2. During a tour of the hospital's kitchen with the Dietary Manager and Chef, on 5/19/11 from 3:30 PM to 4:45 PM, the following infection control concerns were noted in the kitchen: a. The walk-in freezer unit had condensation	A 749		

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A 749	Continued From page 51 leaking onto food storage racks. Four boxes of frozen meat were directly under the leak. One box of meat had areas of ice where condensation from the freezer had dripped and refrozen. Water dripping from the leaking freezing unit had the potential to compromise the integrity of the frozen foods below. During the tour on 5/19/11 beginning at 3:30 PM, the Chef stated the leak in the walk-in freezer had been noted on Monday, 5/16/11. He said the refrigeration company workers had been in on 5/19/11, but were not able to replace a part for the freezer unit. He stated a plastic bucket would be collecting the condensation until the freezer unit was fixed. b. The dishwasher had a sign which indicated the water was to be replaced every two hours. There was no log to indicate when the water was changed. On 5/19/11 at 3:30 PM, neither the Dietary Manager nor the Chef were able to state when the water had last been changed, and when it was due to be changed again. The Chef also confirmed there was no log to record the dishwasher water replacement activities. c. At 4:30 PM on 5/19/11, a kitchen staff member was observed assembling food on the tray line and was noted to be wearing one glove. He was observed to scratch his forehead and hair with his ungloved hand. He continued to assemble the patient food tray without pausing to wash his hands or to use hand sanitizer. The staff member was questioned immediately	A 749		

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A 749	Continued From page 52 after the observation regarding the use of one glove. He stated he "did not want to cross contaminate." He was asked about the touching of his face and hair and failure to perform hand hygiene. He stated, "You caught me." The staff member indicated he was aware that hand sanitizer was within reach of his work area. d. During a second tour of the kitchen area with the Dietary Manager, on 5/20/11 at 8:40 AM, a clipboard with a form titled "Assembler Cold Food Temperature Log" was noted in the food tray line assembly area. It was dated 5/19/11 and listed scheduled times foods were checked for temperatures. The pre-printed times on the form were 10:00 AM, 1:30 PM, 4:00 PM, and 6:30 PM. The 4:00 PM and 6:30 PM times slots were blank. On 5/20/11 at 8:40 AM, the Assistant Director of Dietary reviewed the log and confirmed no temperatures had been taken for foods at 4:00 PM and 6:30 PM on 5/19/11. In a phone interview on 5/23/11 at 1:30 PM, the Infection Control Coordinator stated she had no formal surveillance program for non-patient care areas such as laboratory and dietary. She stated she tried to perform an informal rounding of ancillary departments once a month. The Infection Control Coordinator did not have an active surveillance program with the Laboratory and Nutritional Services Departments.	A 749		

IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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July 13, 2011

Norman Stephens, Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **May 24, 2011**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005080

Allegation #1: Facility did not fully evaluate and report patient symptoms during first ED visit. Patient returned after 2 hours with symptoms of a stroke.

Findings #1: An unannounced survey was conducted at the facility from 5/16/11 to 5/24/11. Clinical records and facility policies were reviewed, and staff interviews were conducted. Fourteen records of patients who were treated in the ED over a 6 month period were reviewed.

One record indicated a patient had been admitted to the ED at 2:10 PM and discharged at 3:25 PM. The record indicated the patient fell and had been brought to the ED by EMS. It was stated in the record that the patient had slurred speech, knee pain, left sided weakness, and elevated blood pressure. The patient was noted to have an elevated blood pressure upon admission. No further monitoring of the patient's blood pressure, slurred speech, or left sided weakness was done by the nurse.

The patient's vital signs were taken two times during the hour and 15 minutes he spent in the ED. The nurse did not assess the left sided weakness or further evaluate the slurred speech reported by the paramedics upon admission. The medical record did not contain documentation that the

nurse notified the physician of the elevated blood pressure.

The patient was discharged to home with a knee splint, a referral to an orthopedist, and a prescription for pain medication. A second set of vital signs were recorded at the time of discharge.

The record noted the patient returned to the ED two hours later with a complaint of left sided weakness and confusion. The record of the second ED visit documented a CT scan was done and the patient was subsequently transferred to another facility for treatment of a stroke.

Therefore, the allegation was substantiated and federal deficiencies were cited at CFR 482.23(b)(3) for the failure of the nurse to appropriately evaluate and report abnormal vital signs and assessment.

Conclusion: Substantiated. Federal deficiency related to the allegation was cited.

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin for Susan Costa

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Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
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July 19, 2011

Norman Stephens, Administrator
Portneuf Medical Center
777 Hospital Way
Pocatello, ID 83201

Provider #130028

Dear Mr. Stephens:

On **May 24, 2011**, a complaint survey was conducted at Portneuf Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005047

Allegation: Patients suffered skin breakdown due to poor practices in the emergency department.

Findings: An unannounced visit was made to the hospital from 5/16/11-5/24/11. The investigation was conducted in conjunction with a recertification survey and a review of all hospital conditions of participation. Patient care was observed. Staff and patients/families were interviewed. Policies and the medical records of 52 patients were reviewed.

One case was identified in which a patient received skin tears during treatment. A medical record documented a 74 year old female, who presented to the ED on 4/28/11 for seizures. She was triaged at 9:23 AM. An "EMERGENCY FLOW SHEET RECORD," dated 4/28/11, indicated the patient was placed on an automatic blood pressure machine at 9:30 AM and it continued to monitor her blood pressure at intervals through 4:02 PM that same day. The ED record documented the patient was then admitted to the cardiovascular unit. The patient remained an inpatient until she was discharged on 4/30/11. The ED record did not mention skin tears.

An incident report, dated 4/29/11 at 10:20 AM, read the patient's "Niece stated pt's arm was

hurting in the ED with B/P cuff on. She notified ED nurse. By the time pt was admitted to the unit, 2 skin tears were noted on arm 1 inner arm at elbow and 1 outer arm at elbow area." Two pictures of the patient arm were present which noted 2 large skin tears.

The Chief Quality Officer was interviewed on 5/26/11 at 8:25 AM. She stated the skin tears were caused by the automatic blood pressure cuff. She stated action had not been taken by the hospital to prevent skin tears from occurring to other patients who would be connected to an automatic blood pressure cuff for extended periods of time.

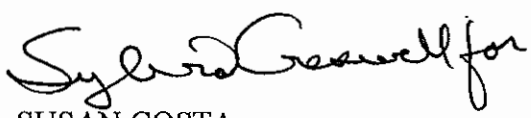
A deficiency was cited at 42 CFR Part 482.23(b.3) for the hospital's failure to take action to prevent skin tears.

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

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

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



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