



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 11, 2012

Ms. Tracey Sessions, Administrator
State Hospital South
700 East Alice Street
Blackfoot, ID 83221

RE: State Hospital South, Provider #134010

Dear Ms. Sessions:

This is to advise you of the findings of the Medicare/Licensure survey at State Hospital South, which was concluded on May 25, 2012.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar 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:

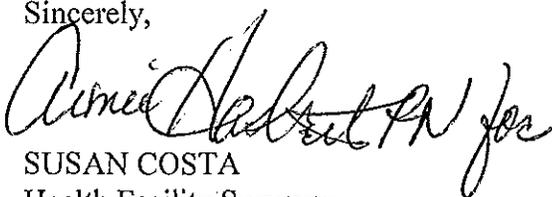
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date 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 and State Form 2567.

Ms. Tracey Sessions, Administrator
June 11, 2012
Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **June 24, 2012**, 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
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
Enclosures



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

TRACEY G. SESSIONS – Administrative Director
STATE HOSPITAL SOUTH
700 East Alice Street
P.O. Box 400
Blackfoot, Idaho 83221-0400
PHONE 208-785-1200
FAX 208-785-8448
EMAIL sessionT@dhw.idaho.gov

June 20, 2012

Susan Costa, Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell, Co-Supervisor
Non-Long Term Care

Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720-0009

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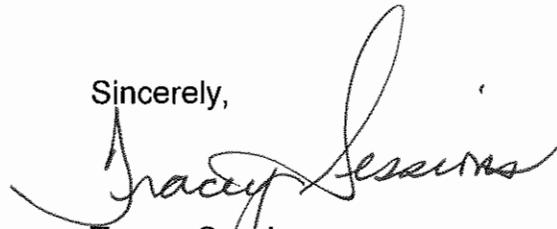
RE: State Hospital South, Provider #134010

Dear Ms. Costa and Ms. Creswell:

Enclosed please find the Plan of Correction in response to the Medicare deficiencies and State licensure deficiencies as a result of the findings from the Medicare/Licensure survey at State Hospital South which concluded on May 25, 2012.

Thank you.

Sincerely,



Tracey Sessions
Hospital Administrator

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134010	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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NAME OF PROVIDER OR SUPPLIER STATE HOSPITAL SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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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
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A 000

INITIAL COMMENTS

A 000

The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were:

Suzi Costa RN, HFS, Team Lead
Aimee Hastriter RN, BS, HFS
Karen Dewey RN, BSN, HFS

The following acronyms were used in this report:

biPAP - bilevel Positive Airway Pressure
COPD - Chronic Obstructive Pulmonary Disease
CPAP - Continuous Positive Airway Pressure
DON - Director of Nursing
H&P - History and Physical
lpm - liters per minute
RN - Registered Nurse

A 396

482.23(b)(4) NURSING CARE PLAN

A 396

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 staff interview and review of medical records and policies, it was determined the hospital failed to ensure a nursing care plan was developed on admission and addressed the nursing needs of 5 of 5 patients (#1, #2, #4, #5 and #6) whose treatment plans were reviewed. This resulted in a lack of direction for nursing staff. Findings include:

1. Patient #4 was a 59 year old female admitted on 4/19/12, for suicidal ideation and depression. A medical "History and Physical Examination" was completed by the physician on 4/19/12. The

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Suzi Costa Hospital Administrator 6-20-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 396	<p>Continued From page 1</p> <p>physician documented Patient #4 had chronic restrictive versus obstructive lung disease and chronic back pain. The physician ordered medications to treat the conditions.</p> <p>On 4/19/12 at 4:50 PM, the physician ordered Oxygen 1-2 lpm to be used to keep her Oxygen saturation levels above 90%. The Oxygen was to be used at night and as needed during the day and her Oxygen saturation levels were to be checked and documented each shift to indicate how much Oxygen she was using at the time of the assessment. The following day, 4/20/12 at 4:51 PM, the physician ordered CPAP with warm humidification. On 4/30/12 at 1:10 PM, a physician order indicated that Patient #4 would be able to receive a less restrictive level of observation provided she was adherent to her Oxygen order for 24 hours.</p> <p>Nursing notes indicated Patient #4 was occasionally noncompliant with her use of supplemental oxygen and would experience decreased Oxygen saturation levels. For example, on 4/26/12 at 8:09 PM, the RN documented that Patient #4 presented to the front desk complaining of shortness of breath with an Oxygen saturation level of 84% on room air. The RN documented that Patient #4 told him she did not want to wear her Oxygen. On 5/14/12 at 6:38 PM, the RN documented Patient #4 "was observed without her supplemental O2 [Oxygen] again this shift. She had been non-compliant earlier as she ambulated the halls following a clinic appt [appointment] that did not meet pt [patient] expectations r/t [related to] her care." The Physical Therapist working with Patient #4 documented in a progress note, on 5/12/12 at</p>	A 396		

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A 396	<p>Continued From page 2</p> <p>2:18 PM, that "pt mentioned getting busted not having [sic] her O2 on and [physician name] saw her."</p> <p>Patient #4's medical record contained a "MASTER TREATMENT PLAN" completed by multiple disciplines including physicians, nursing staff, the clinician, and pharmacy staff on 5/02/12, 13 days after Patient #4's admission. According to the documentation on the treatment plan, the next "Review Date" was 5/30/12. The treatment plan addressed Patient #4's depression, her danger to herself, chronic pain, and COPD. Each section addressed contained a description of the problem, long-term and short-term goals, and treatment interventions.</p> <p>The section related to Patient #4's chronic pain indicated she experienced "chronic pain at times in her back and legs. She is moderately adherent to her medical care." Only one treatment modality was listed, "Medications as prescribed for treatment of chronic pain." The plan did not address non-pharmacological measures that were currently being used to assist Patient #4 in managing her pain such as heat/ice, distraction, or physical therapy exercises.</p> <p>The section related to Patient #4's COPD indicated she "currently requires the use of supplemental oxygen and a CPAP at night. She is moderately adherent to medial care." Two treatment interventions were listed, patient education related to the understanding of the treatment for COPD and testing as ordered by the physician for diagnosis and treatment of COPD. Treatment interventions did not address how much oxygen was to be used, physical therapy's</p>	A 396			

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A 396	<p>Continued From page 3</p> <p>role in providing education on proper breathing techniques, medication management for her respiratory needs, the use of CPAP with oxygen supplementation at night, and the required oxygen saturation monitoring.</p> <p>The DON and the Nurse Manager for Patient #4's unit on 5/24/12 were interviewed on 5/24/12 at 3:47 PM. The DON confirmed that a "MASTER TREATMENT PLAN" was completed within 14 days of a patient's admission and was based on the admitting physician's initial assessment. He stated that a specific nursing care plan was not generated but nursing needs were incorporated to the "MASTER TREATMENT PLAN." He stated nursing medical interventions, prior to the development of the treatment plan, were found in the "Plan" section of the physician's "History and Physical Examination." The Nurse Manager stated that the facility viewed the nursing assessments and documentation as the nursing care plan which guided staff in providing interventions and monitoring. The DON confirmed the "MASTER TREATMENT PLAN" did not include all interventions related to Patient #4's nursing needs and was not initiated as soon as possible after admission.</p> <p>A nursing care plan was not thoroughly developed upon Patient #4's admission.</p> <p>2. Patient #1 was a 49 year old female admitted on 4/05/11 for panic disorder and depression. A medical "History and Physical Examination" was completed by the physician on 4/05/11. The Physician documented Patient #1 had obstructive sleep apnea. The Physician wrote an order on 4/05/11 at 11:27 PM for Patient #1 to have 1 lpm</p>	A 396			

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A 396	<p>Continued From page 4 of Oxygen as needed while sleeping to maintain Oxygen saturation levels above 90%.</p> <p>The RN completed an assessment on 4/05/11 and documented Patient #1 was being treated for diabetes. In addition, the RN documented a fold of skin on her lower abdomen with a yeast-like rash and included she was placing washcloths in the fold of skin at night.</p> <p>Patient #1's medical record contained a "MASTER TREATMENT PLAN" completed by multiple disciplines, which included the psychiatrist, physician's assistant, clinical supervisor, nurse manager, recreational therapist, clinician, treatment coordinator, and direct care staff on 4/14/12, nine days after Patient #1's admission. The treatment plan addressed Patient #1's depression, her danger to herself, and sleep apnea. Each section addressed contained a description of the problem, long-term and short-term goals, and treatment interventions. The only intervention related to sleep apnea was to provide education to Patient #1 regarding the treatment of sleep apnea. Patient #1's Oxygen use was not addressed on the treatment plan.</p> <p>A nursing care plan was not developed upon admission to address nursing interventions for Patient #1's diabetes, sleep apnea, or impaired skin integrity.</p> <p>In an interview on 5/25/12 at 9:30 AM, the DON reviewed Patient #1's medical record and confirmed a nursing care plan was not developed after the nursing assessment. He stated the "MASTER TREATMENT PLAN" was developed</p>	A 396			

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A 396	<p>Continued From page 5</p> <p>within 14 days of admission and information from the nursing assessment was used to develop a portion of the plan.</p> <p>A complete and timely nursing care plan was not developed for Patient #1.</p> <p>3. Patient #2 was a 58 year old male admitted on 6/22/11 for bi-polar disorder and threatening suicide. In addition, a "HISTORY AND PHYSICAL EXAMINATION," completed by a physician assistant on 6/22/11, documented Patient #2 had type 2 diabetes, sleep apnea, COPD, and a history of stroke.</p> <p>Patient #2's medical record contained a nursing assessment, dated 6/22/11, that included documentation of arthritis pain in his back, knees and feet. Patient #2's pain was assessed on a scale of 1-10, with 10 being the greatest pain level. His pain level at the time of the assessment was 7/10.</p> <p>Patient #2's medical record contained a "MASTER TREATMENT PLAN" completed by multiple disciplines which included the psychiatrist, physician's assistant, clinical supervisor, nurse manager, recreational therapist, clinician, treatment coordinator, and direct care staff on 7/05/11, 13 days after Patient #2's admission. The treatment plan addressed Patient #2's depression, his danger to himself, and COPD. Each section addressed contained a description of the problem, long-term and short-term goals, and treatment interventions. The only treatment intervention documented for COPD was education regarding understanding COPD.</p>	A 396		

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A 396	Continued From page 6 The treatment plan did not include nursing interventions such as Oxygen therapy for COPD and pain interventions for his arthritis. In an interview on 5/25/12 at 9:40 AM, the DON reviewed Patient #2's medical record and confirmed a nursing care plan was not developed after the nursing assessment. A complete and timely nursing care plan was not developed for Patient #2 on admission. 4. Patient #5 was a 59 year old female admitted on 12/22/11 for Alzheimer's Disease and schizoaffective disorder. A "PHYSICIAN PROGRESS NOTE - MEDICAL CLINIC," dated 2/10/12 at 2:25 PM, documented Patient #5 had pneumonia. On 2/10/12 at 2:18 PM, the physician ordered 1-2 lpm of Oxygen as needed to keep Oxygen saturation levels above 90%. Oxygen saturations levels were also ordered to be checked and documented every shift. Patient #5's medical record contained additional physician progress notes related to the lung infection. On 3/06/12, the Physician Assistant documented Patient #5 remained on Oxygen. On 3/13/12, the Physician Assistant documented Patient #5 was no longer using Oxygen. A physician order, dated 3/14/12 at 1:18 PM, directed staff to check Patient #5's Oxygen saturation levels every hour while awake and not to use Oxygen if her saturation levels were above 90% on room air. Additional "PHYSICIAN PROGRESS NOTE - MEDICAL CLINIC" notes, dated 4/03/12, 4/10/12,	A 396			

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A 396	<p>Continued From page 7 and 5/01/12, reflected Patient #5's continued treatment for pneumonia, such as nebulizer treatments and follow-up chest X-rays.</p> <p>Patient #5's medical record contained a "MASTER TREATMENT PLAN" completed by multiple disciplines on 1/10/12, and again on 3/21/12. Forty days had elapsed between the diagnosis of pneumonia and the review of the treatment plan. The treatment plan addressed Patient #5's psychological and cognitive impairment, inadequate treatment involvement, grave disability and dangerousness to self and others, chronic encephalopathy, cachexia, ataxia, anorexia, and spasticity. Each section of the treatment plan contained a description of the problem, long-term and short-term goals, and treatment interventions.</p> <p>Patient #5's pneumonia, use of Oxygen and nebulizers, and frequent Oxygen saturation level checks were not included on the plan.</p> <p>The Assistant DON was interviewed on 5/25/12 at 9:30 AM. He reviewed Patient #5's medical records and stated a specific nursing care plan was not generated. He stated nursing needs were incorporated in the "MASTER TREATMENT PLAN," which was completed within 14 days of a patient's admission. He stated nursing medical interventions, prior to the development of the treatment plan, were found in the "Plan" section of the physician's "HISTORY AND PHYSICAL EXAMINATION." The Assistant DON stated the facility used the nursing assessments and progress notes as the nursing care plan to guide staff in providing interventions and monitoring. The Assistant DON stated the "MASTER</p>	A 396			

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A 396	<p>Continued From page 8</p> <p>TREATMENT PLAN" did not include all interventions relevant to Patient #5's nursing needs and was not initiated as soon as possible after admission.</p> <p>The facility did not ensure a timely nursing care plan was developed and kept current for Patient #5.</p> <p>5. Patient #6 was a 36 year old female admitted on 5/02/12 for depressive disorder and homicidal ideation. A medical "HISTORY AND PHYSICAL EXAMINATION" was completed by the Physician on 5/02/12 at 1:31 PM. The Physician documented Patient #6 had obstructive sleep apnea. On 5/02/12 at 2:27 PM, the Physician ordered treatments for this condition, including biPAP or, if no biPAP available, 1-2 lpm of Oxygen with the head of bed at a 45 degree angle. The Physician also ordered Oxygen saturation level checks every shift while walking and with sleeping.</p> <p>Patient #6's medical record contained a "MASTER TREATMENT PLAN" completed by multiple disciplines on 5/15/12, 13 days after Patient #6's admission. The treatment plan addressed Patient #6's depression, dangerousness to self and others, and polysubstance dependence. Each section of the treatment plan contained a description of the problem, long-term and short-term goals, and treatment interventions.</p> <p>Patient #6's use of biPAP, Oxygen as needed and Oxygen saturation checks while walking and sleeping were not included on the plan.</p>	A 396		

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A 396	Continued From page 9 The Assistant DON was interviewed on 5/25/12 at 9:30 AM. He reviewed Patient #6's medical records and stated a specific nursing care plan was not generated, but nursing needs were incorporated in the "MASTER TREATMENT PLAN," which was completed within 14 days of a patient's admission. He stated nursing medical interventions, prior to the development of the treatment plan, were found in the "Plan" section of the physician's "HISTORY AND PHYSICAL EXAMINATION." The Assistant DON stated the facility used the nursing assessments and progress notes as the nursing care plan to guide staff in providing interventions and monitoring. The Assistant DON stated the "MASTER TREATMENT PLAN" did not include all interventions relevant to Patient #6's nursing needs and was not initiated as soon as possible after admission. The facility did not ensure a complete and timely nursing care plan was developed for Patient #6.	A 396	See attached Corrective Action Plan For Tag A-396		

Corrective Action Plan for Tag A 396

Action and Procedures

- State Hospital South staff will initiate a Nursing Care Plan- Interim within 72 hours of admission beginning 8/1/2012. The Nursing Care Plan- Interim will be based on assessments conducted by various disciplines. The Nursing Care Plan-Interim in conjunction with Initial Impressions and Plans identified in the Psychiatric Evaluation and the History and Physical will guide the treatment of the patient until the Master Treatment Plan is developed.
- The Nursing Care Plan- Interim will be completed in the electronic medical record; allowing all treating staff accessibility and flexibility to keep the plan current with patient needs.
- Training with Physicians, Mid-level Providers, Nurse Managers, and Charge RN's will be completed by 8/1/2012 in the Mental Health Suite electronic treatment planning program.
- Nursing medical problems will be formulated from the nursing report obtained for the transfer from the discharging community treatment facility, History and Physical, Admission Nursing Assessment, Psychiatric Evaluation and ongoing medical and nursing assessments.
- Nursing medical problems, long and short term goals, and interventions will be identified and entered into the electronic medical record.
- A General Wellness problem will be entered on all patients to monitor general health issues and to connect ongoing monitoring to the Nursing Care Plan-Interim, the Master Treatment Plan, and the Weekly/Monthly Nursing Note.
- The Nursing Care Plan- Interim will be reviewed and assessed by nursing staff in the Weekly/Monthly Nursing Note.
- The Nursing Care Plan- Interim will be expanded into the Master Treatment Plan within 14 days of admission, and reviewed by the Treatment Team every 30 days thereafter.
- The Treatment Plan will be developed, implemented and kept current throughout the patient's hospitalization.

Completion Date for Plan of Correction

- 8/1/2012

Monitoring

- Monitoring and tracking of the timeliness and content of the Nursing Care Plan-Interim will be conducted through the Performance Improvement Department.

Responsible Person for Implementation

- Director of Nursing

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDOI7N	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/25/2012
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NAME OF PROVIDER OR SUPPLIER STATE HOSPITAL SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221
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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) COMPLETE DATE
B 000	<p>16.03.14 Initial Comments</p> <p>The following deficiencies were cited during the complaint investigation survey of your hospital. The surveyors conducting the investigation were:</p> <p>Suzi Costa RN, HFS, Team Lead Aimee Hastriter RN, BS, HFS Karen Dewey RN, BSN, HFS</p> <p>The following acronyms were used in this report:</p> <p>biPAP - bilevel Positive Airway Pressure COPD - Chronic Obstructive Pulmonary Disease CPAP - Continuous Positive Airway Pressure DON - Director of Nursing H&P - History and Physical lpm - liters per minute RN - Registered Nurse</p>	B 000	<p style="text-align: center;">RECEIVED JUN 21 2012 FACILITY STANDARDS</p>	
BB175	<p>16.03.14.310.03 Patient Care Plans</p> <p>03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88)</p> <p>a. Nursing care treatments required by the patient; and (10-14-88)</p> <p>b. Medical treatment ordered for the patient; and (10-14-88)</p> <p>c. A plan devised to include both short-term and long-term goals; and (10-14-88)</p> <p>d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88)</p> <p>e. A description of socio-psychological needs of the patient and a plan to meet those needs.</p>	BB175		

Bureau of Facility Standards



(X6) DATE 6-20-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM 6899 7L6Q11 If continuation sheet 1 of 2

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDO17N	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/25/2012
NAME OF PROVIDER OR SUPPLIER STATE HOSPITAL SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 700 EAST ALICE STREET BLACKFOOT, ID 83221		
(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) COMPLETE DATE	
BB175	Continued From page 1 (10-14-88) This Rule is not met as evidenced by: Refer to A 396 as it relates to the facility's failure to develop and keep current nursing care plans.	BB175	See Corrective Action Plan for Tag A-396		

COPY



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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July 6, 2012

Ms. Tracey Sessions, Administrator
State Hospital South
700 East Alice Street
Blackfoot, ID 83221

Provider #134010

Dear . Sessions:

On **May 25, 2012**, a complaint survey was conducted at State Hospital South. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005479

Allegation #1: Hospital staff did not attend to a patient's medical need for oxygen and C-PAP.

Findings #1: An unannounced complaint investigation was made to the hospital on May 24 and 25, 2012. During the investigation, surveyors reviewed six patient records, including three records of discharged patients and three records of current patients. Patient and staff interviews were conducted, and policy and procedures were reviewed.

One record reviewed was that of a patient who had a history of COPD and sleep apnea. The record documented the patient had refused to use the hospital provided CPAP (Continuous Positive Airway Pressure) and was placed on continuous oxygen shortly after admission to the hospital. Nursing progress notes documented oxygen saturations were recorded with vital sign assessments at night. The discharge summary stated the patient responded well to medication changes and was taken off continuous oxygen. The summary stated the combination of discontinuing oxygen and medication changes resulted in a marked change in his mental status in which he became clearer and organized in his thinking. At the time of discharge, the patient was on oxygen only at night.

The Director of Nursing was interviewed and stated the hospital had a contract with a vendor that

Ms. Tracey Sessions, Administrator
July 6, 2012
Page 2 of

provided CPAP units for patient use. He stated the specific design of the CPAP provided by the vendor had been determined to be safe for the patient population at the facility.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Hospital staff did not notify the patient's primary physician of his admission to the hospital, even though the spouse requested they do so.

Findings #2: An unannounced complaint investigation was made to the hospital on May 24 and 25, 2012. During the investigation, surveyors reviewed six patient records, including three records of discharged patients and three records of current patients. Patient and staff interviews were conducted, and policy and procedures were reviewed.

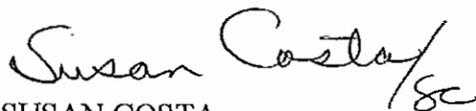
One record reviewed was that of a patient who had been transferred from another facility. The record documented a family member had brought in medical records from previous facilities the patient had been in. The medical record documented family visits and included a conversation with a family member which addressed four specific concerns. There was no documentation that the family member requested notification of the patient's admission to the primary physician.

The Director of Nursing was interviewed, and stated if a patient or family members requested notification of the physician, they had the patient sign a consent form, and then the physician could be notified. The Director of Nursing stated the physician would not be able to participate in the care provided to the patient unless the physician had privileges at the facility.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm