



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD 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

August 17, 2012

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

RE: St. Alphonsus Regional Medical Center, CCN #13-0007

Dear Ms. Jeffcoat:

Based on the Medicare/Licensure survey completed at St. Alphonsus Regional Medical Center on July 31, 2012, by our staff, we have determined that **St. Alphonsus Regional Medical Center is out of compliance with the Medicare Hospital Conditions of Participation on Patient Rights (42 CFR 482.13)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused this condition to be unmet substantially limit the capacity of St. Alphonsus Regional Medical Center to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

Also enclosed is a CMS-2567B Form identifying previously cited deficiencies found to be in compliance during the July 31, 2012, survey. A similar form identifies state licensing deficiencies also found to be in compliance.

You have an opportunity to make corrections of those deficiencies which led to the finding of non-compliance with the Condition of Participation referenced above by submitting a written Plan of Correction/Credible Allegation of Compliance. **Such corrections must be achieved and compliance verified, by this office, before September 14, 2012. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 4, 2012.**

Sally Jeffcoat
August 17, 2012
Page 2 of 2

An acceptable Plan of Correction 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 each form.

Please complete your Allegation of Compliance/Plan of Correction and submit to this office by August 30, 2012.

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srm
Enclosures



August 29, 2012

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

RECEIVED
AUG 30 2012

FACILITY STANDARDS

Dear Ms. Creswell:

Attached please find Saint Alphonus Regional Medical Center's plan of correction (POC), which is intended to address deficiencies cited during a Medicare/Licensure survey concluded on July 31, 2012.

The hospital does not admit or concede to any deficiencies, but to the extent that any actual deficiencies do exist, Saint Alphonus Regional Medical Center is taking appropriate action to correct those deficiencies, including the steps outlined in the attached POC. This plan of correction addresses the Bureau of Facility Standards tags BB175, BB210, BB283, and BB553 and Medicare tags A115, A131, A144, A164, A166, A168, A169, A178, A185, A188, A450, A724, and A749.

We want to emphasize our absolute commitment to quality patient care and continued efforts to fulfill all regulatory requirements. We appreciate your thoughtful consideration of this plan of correction. We look forward to your acceptance of our plan and the revisit to verify our compliance. Please contact me at 367-2902, if you have any questions or concerns regarding these documents.

Respectfully submitted,

Handwritten signature of Aline Lee in cursive script.

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

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

PRINTED: 08/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2012
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706
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A 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the Medicare recertification and complaint investigation surveys of your hospital. Surveyors conducting the review were:</p> <p>Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Susan Costa, RN, HFS Rebecca Lara, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>CCU = Cardiac Care Unit CDC = Center for Disease Control and Prevention COPD = Chronic Obstructive Pulmonary Disease CVL = Central Venous Line dc = discontinue ED = Emergency Department EMR = Electronic Medical Record FMC = Family Maternity Center H&P = History and Physical IDAPA = Idaho Administrative Procedures Act inj = injury IPOC = Interdisciplinary Plan of Care IV = Intravenous LIP = Licensed Independent Practitioner NICU = Neonatal Intensive Care Unit NOC = night OR = Operating Room PA = Physician Assistant POC = Plan of Care PRN = as needed Pt = patient RN = Registered Nurse UAC = Umbilical Arterial Line UVC = Umbilical Venous Line</p>	A 000		
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RECEIVED
AUG 30 2012
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rolney J. Reiter</i>	TITLE COO	(X6) DATE 8.30.12
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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 115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: Based on staff interviews and review of medical records, hospital policies, and credentials files, it was determined the hospital failed to protect and promote patients' rights. This compromised the hospital's ability to keep patients safe and prevented staff from utilizing restraints in a consistent manner. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to A131 as it relates to the facility's failure to ensure patients were afforded the opportunity to make informed decisions. 2. Refer to A144 as it relates to the facility's failure to ensure patients were restrained in a safe manner. 3. Refer to A164 as it relates to the facility's failure to ensure restraints were used only when less restrictive interventions were determined to be ineffective. 4. Refer to A166 as it relates to the facility's failure to ensure patients' plans of care were modified to reflect the use of restraints. 5. Refer to A168 as it relates to the facility's failure to ensure restraints were utilized in accordance with orders of physicians or authorized LIPs. 6. Refer to A178 as it relates to the facility's failure to ensure patients who were restrained for violent behavior received a face to face 	A 115		

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A 115	Continued From page 2 examination by a qualified person. 7. Refer to A185 as it relates to the facility's failure to ensure a description of behavior was documented for restrained patients. 8. Refer to A188 as it relates to the facility's failure to ensure the response to restraint interventions used, including the rationale for continued use of the intervention, was documented. The cumulative effect of these negative systemic practices resulted in the inability of the hospital to promote and protect the rights of patients.	A 115		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on medical record review, staff interview and review of hospital policies, it was determined the hospital failed to ensure 6 of 39 inpatients (#7, #10, #11, #38, #47 and #48) whose records were reviewed, had the opportunity to make informed decisions about his or her health status. This also had the potential to impact all new born	A 131		

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A 131	<p>Continued From page 3</p> <p>patients. This failure had the potential to result in procedures being performed without fully executed informed consents. Findings include:</p> <p>The hospital's "CONSENT FOR MEDICAL TREATMENT" policy, dated 1/19/11, stated "It is the policy of [the facility] that a patient or patient representative shall give voluntary and informed consent for all care, treatment and services involving material risk." The policy also included "L.I.P. must document through a fully executed, timed and dated Consent Form that he or she has obtained Informed Consent from Patient prior to any Procedure..." Additionally, the policy documented "If a patient is unable to sign his or her name and is unable to make even a mark, such Patient must ask another person to sign his or her name. The Medical Employee must witness the execution of the Consent Form by such other person on behalf of Patient and must indicate on the Consent Form that he or she witnessed the third party sign at Patient's request."</p> <p>The "MEDICAL RECORDS" policy, undated, indicated each medical record would contain evidence of properly executed informed consents.</p> <p>Informed consents were incomplete as follows:</p> <ol style="list-style-type: none"> 1. Patient #7's medical record documented a 52 year old male who was admitted to the hospital on 7/19/12 at 12:36 AM for care related to respiratory failure. According to the "History and Physical," dictated on 7/19/12 at 2:01 AM, respiratory failure was secondary to severe COPD, interstitial lung disease (a group of disorders that cause progressive scarring of lung 	A 131		

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A 131	<p>Continued From page 4</p> <p>tissue, affecting the ability to move adequate oxygen into the bloodstream) and a higher than normal carbon dioxide level in the blood. The "History and Physical," also documented Patient #7 was transported by paramedics and admitted through the ED, where he was intubated and transferred to CCU for continued treatment.</p> <p>A "Critical Care Progress" note, dictated 7/20/12 at 11:38 AM, documented the physician planned a bronchoscopy (procedure that allows a physician to look at a patient's airway through a thin viewing instrument called a bronchoscope) for Patient #7. The note specifically stated, "I was able to arouse [the patient] and talk to him. I told him I needed to do a bronchoscopy through his tube. He has had these procedures before, and in fact, I have performed them on him before." The physician's progress note further stated Patient #7 was being maintained on a mechanical ventilator. A "Bedside Procedure Form," dated 7/19/12 at 11:21 AM, indicated Patient #7 underwent a bronchoscopy. An operative consent form signed by Patient #7 or Patient #7's designee could not be found in the medical record.</p> <p>The RN caring for Patient #7 at the time of the bronchoscopy was interviewed on 7/26/12, beginning at 8:30 AM. The RN stated she witnessed the physician obtaining a verbal consent for the procedure from Patient #7. She also stated Patient #7 was coherent and able to understand the situation. When asked to explain the hospital's process related to patients' who are unable to sign a surgical consent and do not have a representative present, the RN stated the hospital's practice was 2 RNs witnessed and</p>	A 131		
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A 131	<p>Continued From page 5</p> <p>signed the surgical consent form with the patient's verbal permission. The RN confirmed a surgical consent form was not reviewed and signed for Patient #7.</p> <p>The hospital failed to ensure a signed surgical consent form was in Patient #7's record for a bedside bronchoscopy.</p> <p>2. Patient #10 was a male admitted to the NICU, born 7/21/12 at 28 weeks gestation (12 weeks early). Patient #10 required required mechanical ventilation to assist with his breathing and multiple central lines. The medical record documented a UAC for monitoring purposes, a UVC for blood sampling and medication delivery, and a percutaneous CVL for medication administration when the umbilical lines were discontinued.</p> <p>The "CONSENT FOR TREATMENT AND PATIENT SERVICE AGREEMENT" dated 7/21/12, was signed by Patient #10's father. The consent stated "...no substantial medical procedure will be performed without my informed consent as required by law." Patient #10's record did not have consents for the intubation, UAC, UVC, or percutaneous CVL.</p> <p>A policy, titled "CONSENT FOR MEDICAL TREATMENT," dated 1/19/12, included types of procedures requiring informed consent that must be evidenced by a separate consent form. Examples of procedures requiring informed consent included central line insertion, intubation, and invasive monitoring such as an arterial line.</p> <p>During an interview on 7/23/12 beginning at 2:10</p>	A 131			

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A 131	<p>Continued From page 6</p> <p>PM, the NICU Charge Nurse reviewed Patient #10's record and confirmed there were no consents for the central lines, intubation and invasive monitoring.</p> <p>Informed consents for invasive procedures were not obtained for Patient #10.</p> <p>3. Patient #11 was a 7 week old male, born 5/29/12 at 30 weeks gestation (10 weeks early). According to the medical record Patient #11 required donor breast milk to meet nutrition needs.</p> <p>The "Donor Breast Milk" policy, dated 3/24/11, indicated in order to use donor breast milk, a signed hospital admission consent was required. However, the "CONSENT FOR TREATMENT AND PATIENT SERVICE AGREEMENT," was signed by Patient #11's mother but was not timed or dated. The consent was incomplete.</p> <p>During an interview on 7/23/12 beginning at 2:10 PM, the NICU Charge Nurse reviewed Patient #11's record and confirmed the admission consent was incomplete. The NICU Charge Nurse stated premature infants often needed breast milk, and if the mother was unable to provide an adequate supply, the baby would get donor breast milk. She stated use of donor breast milk was implied in the admission consent and there was not another specific consent obtained when donor breast milk was used.</p> <p>A complete admission consent was not obtained for Patient #11.</p> <p>4. Patient #47 was a 25 year old female admitted</p>	A 131		
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A 131	<p>Continued From page 7</p> <p>to the facility on 7/23/12 for a scheduled induction of labor. Her medical record contained a "CONSENT FOR INDUCTION OF LABOR," signed by the Midwife and Patient #47 on 7/03/12 at 1:45 PM, prior to the admission for delivery. The consent was lacking a signature, date and time for the witness portion of the consent.</p> <p>Patient #47 required a cesarean section to deliver her baby. A form, "ANESTHESIA EVALUATION," was completed by the anesthesiologist on 7/23/12 at 8:55 AM. The anesthesiologist noted Patient #47 was Russian speaking and the anesthesia consent was obtained with an interpreter. However, the "ANESTHESIA CONSENT," signed by both anesthesiologist and Patient #47 on 7/23/12 at 8:56 AM, was lacking a signature, date and time for the witness portion of the consent. There was no documentation on the consent that an interpreter was present while the consent was obtained.</p> <p>A policy titled "CONSENT FOR MEDICAL TREATMENT," dated 1/19/12, included "If a Patient cannot understand English, the LIP must convey the Required Information (and answer any questions of Patient) through a translator speaking Patient's language." Additionally, the policy stated "A Medical Employee must witness the execution of the Consent Form by Patient and confirm that Patient has no further questions regarding the Required Information or the Procedure."</p> <p>During an interview on 7/25/12 beginning at 3:00 PM, the Charge Nurse of the Family Maternity Center reviewed Patient #47's record and</p>	A 131		
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A 131	<p>Continued From page 8</p> <p>confirmed the consents were incomplete. The Charge Nurse stated she was unaware Patient #47 required the services of a translator.</p> <p>Informed consents were not complete for Patient #47.</p> <p>5. Patient #38 was a 34 year old female, admitted on 7/19/12 with pregnancy complicated by Systemic Lupus Erythematosus (an autoimmune disorder), and heart failure. Patient #38's medical record indicated she had a Caesarean Section on 7/21/12. An "Anesthesia Preoperative Assessment," dated 7/21/12 at 7:27 AM, included notation by the anesthesiologist that a consent was signed, and the procedure was discussed with the patient. However, Patient #38's medical record indicated she was intubated, and chemically paralyzed and therefore would have been unable to participate in the decision or the consent for anesthesia. The medical record did not contain an anesthesia consent.</p> <p>During an interview with on 7/24/12 beginning at 2:00 PM, the Anesthesiologist who provided the anesthesia, reviewed Patient #38's medical record and confirmed there was no anesthesia consent. He stated he had been in error regarding his documentation that Patient #38 had signed a consent.</p> <p>6. Patient #48 was a newborn male, born 7/24/12. His medical record did not include a "CONSENT FOR TREATMENT AND PATIENT SERVICE AGREEMENT."</p> <p>According to the "CONSENT FOR MEDICAL</p>	A 131		

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A 131	Continued From page 9 TREATMENT" policy, dated 1/19/11, "A patient or patient representative shall give voluntary and informed consent for all care, treatment and services." In addition, the policy specified that an admission to the medical facility required an informed consent. The "MEDICAL RECORDS" policy, undated, indicated each medical record would contain evidence of properly executed informed consents. During an interview on 7/25/12 beginning at 3:00 PM, the Charge Nurse of the Family Maternity Center reviewed Patient #48's record and confirmed there was no consent. She stated the facility did not obtain a consent for treatment for newborn patients. She confirmed an admission consent would not be found in any of the newborns' records.	A 131			
A 144	The facility failed to ensure that medical records contained properly executed informed consents. 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of medical records and user manuals, it was determined the hospital failed to ensure 1 of 2 patients in net bed restraints (#56), whose records were reviewed, was restrained in a safe manner. The use of unsafe restraint techniques had the potential to cause serious injury or death. Findings include: Patient #56's medical record documented a 57	A 144			

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A 144	<p>Continued From page 10</p> <p>year old male who was admitted to the hospital on 7/10/12 and was discharged on 7/20/12. Diagnoses included stroke and bipolar disorder. Physician orders, dated 7/13/12 at 5:33 PM, 7/14/12 at 3:46 PM, and 7/15/12 at 3:26 PM, all included "All Side Rails Up, Enclosure Bed/Net Bed, Soft Limb X2 [wrist restraints]." Nursing notes documented these restraints were utilized in accordance with the orders.</p> <p>The hospital utilized the same model of enclosure bed for all patients who needed one. The Regulatory Accreditation Coordinator accompanied the surveyor to the Rehabilitation Unit to observe an enclosure bed on 7/25/12 at 4:10 PM. A sign on the side of the bed contained a warning which stated to leave the side rails down in order "...to prevent side rail entrapment." The Regulatory Accreditation Coordinator provided a copy of the bed's user manual, not dated. The manual stated "Never leave side rails in the up position when the patient compartment is closed. A failure to follow this warning may result in serious injury or death from entrapment in the side rails, or between the mattress and the side rails."</p> <p>RN C was interviewed on 7/25/12 beginning at 4:35 PM. She stated she cared for Patient #56 while he was in the net bed. She stated the side rails were up when the bed was enclosed with the net. She stated she was not aware of the warning to avoid using side rails in conjunction with the enclosed bed.</p> <p>The hospital put Patient #56 at risk for injury by placing him in an enclosure bed with the side rails up.</p>	A 144		

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A 164	<p>482.13(e)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION</p> <p>Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.</p> <p>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 restraints were used only when less restrictive interventions had been determined to be ineffective. This affected the care of 2 of 7 restrained patients (#37 and #40) whose records were reviewed. The lack of patient assessment, including the evaluation of less restrictive interventions, had the potential to result in the unnecessary use of restraints. Findings include:</p> <p>1. Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall which resulted in a closed head injury. He was currently a patient as of 7/25/12.</p> <p>Patient #40's medical record contained a nursing "Handoff Form," dated 7/18/12 at 6:41 PM. The form stated "Sitter dc'd at NOC from 2300 to 0700, enclosure bed ordered, only to be zipped up during these times, not when sitter is present. Will need to initiate restraint orders at 2300 when enclosure bed zipped. Can order restraint as a verbal order per Dr...Pt calm and cooperative today."</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 11:30 PM on 7/18/12 and remained restrained through 6:00 AM on 7/19/12. The</p>	A 164		

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A 164	<p>Continued From page 12</p> <p>section labeled "Alternatives to Restraints Attempted," at midnight on 7/19/12 (the first note), stated "Bed Alarm, Frequent toileting, Increased observation, Moved closer to nurses' station, Promoted normal sleep pattern, Verbal reminders." The note stated Patient #40 was currently sleeping. The note did not explain the alternatives or state how they had been ineffective. For example, the note did not document when the last time was the bed alarm had been used or why it had not been effective. It appeared a sitter had been an effective alternative but this was not mentioned in the "Alternatives." The note did not define frequent toileting, increased observation, promoted normal sleep pattern, or verbal reminders. The note did not say how these related to the need for restraint for Patient #40. "Restraint Non-Violent Forms" documented Patient #40 was again placed in an enclosure bed restraint at 11:00 PM on 7/19/12 and remained restrained through 4:00 AM on 7/20/12. The section labeled "Alternatives to Restraints Attempted," at 11:00 PM on 7/19/12 stated "Bed Alarm, Environmental modification, Increased observation, Visually supervised, Other: close observation." Again, the medical record did not define these terms or explain how they had been ineffective.</p> <p>The Regulatory Accreditation Coordinator reviewed Patient #40's medical record with the surveyor on 7/24/12 beginning at 2:00 PM. She confirmed the medical record did not document an assessment of the need for restraints that included less restrictive interventions that had been tried and found ineffective.</p> <p>The hospital did not comprehensively assess the</p>	A 164			

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A 164	<p>Continued From page 13 need for restraint for Patient #40 including the effectiveness of less restrictive interventions.</p> <p>2. Patient #37's medical record documented a 24 year old male who was admitted to the hospital on 7/06/12 following a motor vehicle accident and a head injury. He was discharged to the Rehabilitation Unit on 7/18/12. Physician orders on 7/13/12, 7/14/12, and 7/15/12 called for the use of bilateral wrist restraints. "Restraint Non-Violent Forms" documented Patient #37 was restrained during those days. None of the forms stated what type of restraints were being used, although the "Restraint Non-Violent Form," dated 7/13/12 at 4:00 AM, documented "pt able to unclip right restraint and then left restraint." An assessment of the need for restraints including less restrictive interventions that had been attempted and that had been ineffective was not documented on 7/13/12, 7/14/12 and 7/15/12.</p> <p>Physician orders for restraints, dated 7/13/12 at 8:10 AM, 7/14/12 at 7:49 AM, and 7/15/12 at 11:04 AM, stated "Alternatives Tried: Counseling." No details were documented and no other less restrictive measures were documented.</p> <p>The Regulatory Accreditation Coordinator reviewed Patient #37's medical record with the surveyor on 7/25/12 beginning at 10:22 AM. She confirmed the medical record did not document an assessment of the need for restraints that included less restrictive interventions that had been tried and found ineffective.</p> <p>The hospital did not comprehensively assess the need for restraint for Patient #37 including the</p>	A 164		
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A 164 A 166	Continued From page 14 effectiveness of less restrictive interventions. 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 patient's plan of care. 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 plans of care were modified to provide direction to staff for 3 of 7 restrained patients (#37, #40 and #56) whose records were reviewed. The lack of care planning had the potential to interfere with a consistent approach in the care of patients who were restrained. Findings include: 1. Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall which resulted in a closed head injury. He was currently a patient as of 7/25/12. "Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 11:30 PM on 7/18/12 and remained restrained through 6:00 AM on 7/19/12. "Restraint Non-Violent Forms" documented Patient #40 was again placed in an enclosure bed restraint at 11:00 PM on 7/19/12 and remained restrained through 4:00 AM on 7/20/12. The nursing "Care Plans" document for Patient #40 contained a section dated 7/18/12 at 11:53 PM labeled "IPOC Risk of Injury to Self/Others: with/without restraints-risk for Inj: Restraint	A 164 A 166		

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A 166	<p>Continued From page 15</p> <p>Non-Beh [behavioral] (Initiated)." The plan listed "Outcomes" such as "Absence of Inadvertent Self Injury-Achieved or Progressing" and "Med interventions no longer necessary-Achieved or Progressing." "Achieved" or "Progressing" was then documented daily after the outcomes. No explanation of the terms achieved or progressing was listed. No direction to staff regarding caring for Patient #40 was included in the plan.</p> <p>The Regulatory Accreditation Coordinator reviewed Patient #40's medical record with the surveyor on 7/24/12 beginning at 2:00 PM. She confirmed the lack of a specific care plan.</p> <p>The hospital did not develop a specific POC for Patient #40.</p> <p>2. Patient #37's medical record documented a 24 year old male who was admitted to the hospital on 7/06/12 following a motor vehicle accident and a head injury. He was discharged to the Rehabilitation Unit on 7/18/12. Physician orders on 7/13/12, 7/14/12, and 7/15/12 called for the use of bilateral wrist restraints. "Restraint Non-Violent Forms" documented Patient #37 was restrained during those days. None of the forms stated what type of restraints were being used, although the "Restraint Non-Violent Form," dated 7/13/12 at 4:00 AM, documented "pt able to unclip right restraint and then left restraint."</p> <p>The nursing "Care Plans" document for Patient #37 contained a section dated 7/06/12 at 6:53 PM labeled "IPOC Risk of Injury to Self/Others: with/without restraints-risk for Inj: Restraint Non-Beh (Initiated)." The plan listed "Outcomes" such as "Absence of Inadvertent Self</p>	A 166			

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A 166	<p>Continued From page 16</p> <p>Injury-Achieved or Progressing" and "Med interventions no longer necessary-Achieved or Progressing." "Unchanged" or "Progressing" was then documented daily after the outcomes. No explanation of the terms achieved or progressing was listed. No direction to staff regarding caring for Patient #37 was included in the plan.</p> <p>The Regulatory Accreditation Coordinator reviewed Patient #37's medical record with the surveyor on 7/25/12 beginning at 10:22 AM. She confirmed the lack of a specific care plan.</p> <p>The hospital did not develop a specific POC for Patient #37.</p> <p>3. Patient #56's medical record documented a 57 year old male who was admitted to the hospital on 7/10/12 and was discharged on 7/20/12. Diagnoses included stroke and bipolar disorder. Physician orders, dated 7/13/12 at 5:33 PM, 7/14/12 at 3:46 PM, and 7/15/12 at 3:26 PM, all included "All Side Rails Up, Enclosure Bed/Net Bed, Soft Limb X2 [wrist restraints]." Nursing notes documented these restraints were utilized in accordance with the orders.</p> <p>The nursing "Care Plans" document for Patient #56 contained a section dated 7/11/12 at 8:08 PM labeled "IPOC Risk of Injury to Self/Others: with/without restraints-risk for Harm to Self/Others." The plan listed "Outcomes" such as "Absence of Harm to Self and/or Others-Achieved or Progressing" and "Absence of Inadvertent Self Injury-Achieved or Progressing." "Unchanged" or "Progressing" was then documented daily after the outcomes. No explanation of the terms achieved or progressing was listed. No direction</p>	A 166			

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A 166	Continued From page 17 to staff regarding caring for Patient #56 was included in the plan. The Regulatory Accreditation Coordinator reviewed Patient #56's medical record with the surveyor on 7/25/12 beginning at 3:20 PM. She confirmed the lack of a specific care plan.	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 staff interview and review of medical records, hospital policies, and credentials files, it was determined the hospital failed to ensure restraints were utilized in accordance with orders of physicians or authorized LIPs. This affected the care of 3 of 7 patients (#7, #37 and #40) who had been placed in restraints and whose records were reviewed. The use of restraints without proper authorization had the potential to result in the inappropriate use of restraints. Findings include: 1. Patient #37's medical record documented a 24 year old male who was admitted to the hospital on 7/06/12 following a motor vehicle accident and a head injury. He was discharged to the	A 168		

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A 168	<p>Continued From page 18</p> <p>Rehabilitation Unit on 7/18/12. A verbal order from PA A was documented on 7/15/12 at 11:04 AM for bilateral wrist restraints. The order was signed by the PA on 7/15/12 at 2:52 PM.</p> <p>PAs are not independent and must work under the supervision of a physician. The Idaho Board of Medicine (IDAPA 22.01.03010.07) defines a PA as a person licensed to render patient services under the direction of a supervising and alternate supervising physician.</p> <p>The hospital policy "Restraint and Seclusion," dated 7/03/12, stated the patient's physician or other "LIP" could order restraints. The term LIP was not defined. PAs were not specifically mentioned by the policy as being able to order restraints.</p> <p>PA A's "SCOPE OF PRACTICE AND SUPERVISING PHYSICIAN REQUEST FORM," dated 6/28/11, outlined parameters the hospital placed on the PA's practice. It stated the PA could conduct History and Physical examinations and discharge summaries which must be countersigned by the supervising physician. It also stated the PA could "diagnose and manage minor illnesses or conditions" and "manage the health care of the stable chronically ill patient in accordance with the medical regimen initiated by the supervising physician." The agreement did not state the PA could evaluate the need for and order restraints.</p> <p>The Regulatory Accreditation Coordinator reviewed the medical record on 7/25/12 beginning at 10:50 AM. She confirmed the order by the PA for restraints. She stated she thought</p>	A 168			

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A 168	<p>Continued From page 19</p> <p>PAs had privileges to order restraints but said she was not sure.</p> <p>In addition, the EMR documented Patient #37 had 4 side rails up on his bed on 7/13/12 at 8:00 PM, on 7/14/12 at midnight, 3:00 PM, and 8:00 PM, and on 7/15/12 at 7:00 AM. The use of all 4 side rails prevented Patient #37 from moving his arms and legs freely which met the definition of a restraint. Orders were not present in Patient #37's medical record which authorized the use of all 4 side rails.</p> <p>The Regulatory Accreditation Coordinator reviewed the medical record on 7/30/12 beginning at 3:30 PM. She confirmed the documentation and the lack of orders authorizing the use of the side rails.</p> <p>Restraints were utilized for Patient #37 without orders and restraints were also ordered by a person who was not authorized to provide those orders.</p> <p>2. Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall with a closed head injury. He was currently a patient as of 7/25/12. A verbal order from PA B was documented on 7/20/12 at 12:11 AM for an enclosure bed restraint.</p> <p>The PA B's "SCOPE OF PRACTICE AND SUPERVISING PHYSICIAN REQUEST FORM," dated 10/28/10, stated she could conduct History and Physical examinations and discharge summaries which must be countersigned by the supervising physician. It also stated the PA could</p>	A 168		
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A 168	<p>Continued From page 20</p> <p>"diagnose and manage minor illnesses or conditions" and "manage the health care of the stable chronically ill patient in accordance with the medical regimen initiated by the supervising physician." The agreement did not state the PA could evaluate the need for and order restraints.</p> <p>The Regulatory Accreditation Coordinator reviewed the medical record on 7/25/12 beginning at 10:50 AM. She stated she thought PAs were authorized to order restraints.</p> <p>Restraints were ordered for Patient #40 by a person who was not authorized to provide those orders.</p> <p>3. Patient #7's medical record documented a 52 year old male who was admitted to the hospital on 7/19/12 at 12:36 AM for care related to respiratory failure. According to the "History and Physical," dictated on 7/19/12 at 2:01 AM, respiratory failure was secondary to severe COPD, interstitial lung disease (a group of disorders that cause progressive scarring of lung tissue, affecting the ability to move adequate oxygen into the bloodstream) and a higher than normal carbon dioxide level in the blood. The "History and Physical," also documented Patient #7 was transported by paramedics and admitted through the ED, where he was intubated and transferred to CCU for continued treatment.</p> <p>An order from the physician was documented on 7/19/12 at 12:34 AM for soft, bilateral wrist restraints. The "Restraint Non-Violent Form," dated 7/19/12 at 1:12 AM documented Patient #7 was reaching for his intubation tube and IV lines. Documentation in the section of the form titled,</p>	A 168			

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A 168	Continued From page 21 "Type of Restraints," included the use of soft bilateral wrist restraints and all side rails raised. Orders were not found in Patient #7's medical record that authorized the use of side rails as a restraint. The Regulatory Accreditation Coordinator was interviewed on 7/26/12, beginning at 2:00 PM. She reviewed Patient #7's medical record and confirmed there was no order for the use of side rails as a restraint. Restraints were used for Patient #7 without an order.	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 staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure orders for the use of restraints were not written on an a prn basis for 1 of 7 restrained patients (Patient #40) whose records were reviewed. The use of restraints on a prn basis had the potential to result in the unnecessary use of restraints. Findings include: Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall with a closed head injury. He was currently a patient as of 7/25/12. Daily orders for "Enclosure Bed/Net Bed" restraints were documented beginning on 7/18/12 at 11:50 PM, 7/19/12, 7/20/12, 7/21/12, 7/22/12,	A 169			

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A 169	<p>Continued From page 22 and 7/23/12. The order dated 7/18/12 at 11:50 PM, stated to release Patient #40 "When awake and out of bed." The order dated 7/20/12 at 12:11 AM stated to release Patient #40 "When awake and out of bed, or when sitter available to be with patient."</p> <p>Patient #40's medical record contained a nursing "Handoff Form," dated 7/18/12 at 6:41 PM. The form stated "Sitter dc'd at NOC from 2300 to 0700, enclosure bed ordered, only to be zipped up during these times, not when sitter is present. Will need to initiate restraint orders at 2300 when enclosure bed zipped. Can order restraint as a verbal order per Dr...Pt calm and cooperative today."</p> <p>The Regulatory Accreditation Coordinator reviewed the medical record on 7/24/12 beginning at 2:00 PM. She confirmed the orders for the enclosure bed. She stated the restraint had been used for Patient #40 from 7/18/12 through 7/23/12. She stated the restraint had been used instead of a sitter from 11:00 PM until 7:00 AM.</p> <p>The hospital policy "Restraint and Seclusion," dated 7/03/12, stated "...as needed (PRN) restraint orders are not acceptable unless the patient is in and out of restraint as a normal part of daily treatment. Examples include...If a patient's status requires...an enclosure bed is used while the patient is in bed, a standing order or prn is permitted." The Regulatory Accreditation Coordinator, interviewed on 7/24/12 beginning at 2:00 PM, confirmed the hospital allowed the use of enclosure beds on a prn basis.</p>	A 169		
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A 169	Continued From page 23 The use of an enclosure bed for Patient #40 was based on the availability of sitters and staff to supervise the patient. It was not based on the behavior of the patient or on staff assessment of the need for restraint. The enclosure bed was used prn when staff were not available to supervise Patient #40.	A 169			
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the 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 2 patients (#39), who were restrained for violent behavior, received a face to face examination by a qualified person. This resulted in a lack of assessment to determine causes for the behavior and determination as to the appropriateness of the restraint. Findings include: Patient #39's medical record documented a 36 year old female who was admitted to the ED on 7/10/12 and was discharged on 7/11/12. She	A 178			

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A 178	Continued From page 24 was admitted for paranoid delusions and acute psychosis. A "Restraint/Seclusion Violent Form," dated 7/11/12 at 11:16 AM, stated hard restraints were applied to Patient #39's wrists and ankles at 10:30 AM. The form stated Patient #39 was "Attempting to strike out at others..." The restraints were discontinued at 11:00 AM that same day. Documentation of a face to face evaluation was not present in the medical record. The Regulatory Accreditation Coordinator reviewed the medical record on 7/24/12 beginning at 11:10 AM. She confirmed evidence of a face to face evaluation of Patient #39 within 1 hour of the time of restraint was not present in the medical record. A face to face evaluation of Patient #39 was not conducted.	A 178		
A 185	482.13(e)(16)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] A description of the patient's behavior and the intervention used. 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 a description of behavior was documented for 2 of 7 restrained patients (#40 and #56) whose records were reviewed. The lack of documentation interfered with the hospital's ability to justify care provided to patients. Findings include:	A 185		

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A 185	<p>Continued From page 25</p> <p>1. Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall which resulted in a closed head injury. He was currently a patient as of 7/25/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 11:30 PM on 7/18/12 and remained restrained through 6:00 AM on 7/19/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was again placed in an enclosure bed restraint at 11:00 PM on 7/19/12 and remained restrained through 4:00 AM on 7/20/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 8:00 PM on 7/21/12 and remained restrained through 6:00 AM on 7/21/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 10:00 AM on 7/21/12 and documented he was not restrained at 12:00 noon on 7/21/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 2:00 PM on 7/21/12 and documented he was not restrained at 4:00 PM on 7/21/12.</p> <p>The times Patient #40 was released from restraints was not documented.</p> <p>The "Restraint Non-Violent Forms" did not include a description of Patient #40's specific behavior at the time he was restrained except 7/19/12 at midnight, 7/19/12 at 2:00 AM, 7/19/12 at 6:00 AM, 7/19/12 at 11:00 PM, 7/20/12 at 2:00 AM, and 7/21/12 at 6:00 AM, when it was documented Patient #40 was sleeping.</p> <p>The Regulatory Accreditation Coordinator</p>	A 185		
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A 185	Continued From page 26 reviewed Patient #40's medical record with the surveyor on 7/24/12 beginning at 2:00 PM. She confirmed the lack of documentation related to specific behaviors Patient #40 exhibited that may have warranted the use of restraint. The hospital did not document specific behaviors while Patient #40 was restrained. 2. Patient #56's medical record documented a 57 year old male who was admitted to the hospital on 7/10/12 and was discharged on 7/20/12. Diagnoses included stroke and bipolar disorder. Physician orders, dated 7/13/12 at 5:33 PM, 7/14/12 at 3:46 PM, and 7/15/12 at 3:26 PM, all included "All Side Rails Up, Enclosure Bed/Net Bed, Soft Limb X2 [wrist restraints]." Nursing notes documented these restraints were utilized in accordance with the orders. The nursing "Restraint Non-Violent Forms," which contained the restraint assessments, did not document Patient #56's behavior from 7/13/12 at 6:00 AM to 7/14/12 at 10:00 AM (28 hours) except to state when he was asleep. From 7/14/12 at noon through 7/15/12 at 11:59 PM, the "Restraint Non-Violent Forms" did not document Patient #56's behavior. The Regulatory Accreditation Coordinator reviewed Patient #56's medical record with the surveyor on 7/25/12 beginning at 3:20 PM. She confirmed specific behaviors warranting the use of restrain for Patient #56 were not documented. The hospital did not document specific behaviors while Patient #40 was restrained.	A 185			
A 188	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT	A 188			

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A 188	<p>Continued From page 27 OR SECLUSION</p> <p>[there must be documentation in the patient's medical record of the following:]</p> <p>The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.</p> <p>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 the response to restraint interventions used, including the rationale for continued use of the intervention, was documented for 2 of 7 restrained patients (#40 and #56) whose records were reviewed. The lack of documentation interfered with the hospital's ability to justify the continued use of restraints. Findings include:</p> <p>1. Patient #40's medical record documented a 69 year old male who was admitted to the hospital on 7/13/12 following a fall which resulted in a closed head injury. He was currently a patient as of 7/25/12.</p> <p>"Restraint Non-Violent Forms" documented Patient #40 was placed in an enclosure bed restraint at 11:30 PM on 7/18/12 and remained restrained through 6:00 AM on 7/19/12. "Restraint Non-Violent Forms" documented Patient #40 was again placed in an enclosure bed restraint at 11:00 PM on 7/19/12 and remained restrained through 4:00 AM on 7/20/12. "Restraint Non-Violent Forms" documented Patient #40 was restrained in the enclosure bed at 8:00 PM on 7/20/12 and remained restrained through 6:00 AM on 7/21/12. "Restraint</p>	A 188			

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A 188	<p>Continued From page 28</p> <p>Non-Violent Forms" documented Patient #40 was restrained in the enclosure bed at 10:00 AM on 7/21/12 and documented he was not restrained at 12:00 noon on 7/21/12. "Restraint Non-Violent Forms" documented Patient #40 was restrained in the enclosure bed at 2:00 PM on 7/21/12 and documented he was not restrained at 4:00 PM on 7/21/12. The times the restraints were discontinued were not documented.</p> <p>The "Restraint Non-Violent Form," dated 7/19/12 at midnight, stated Patient #40 was sleeping when the restraint was applied. The "Restraint Non-Violent Forms," dated 7/19/12 at 2:00 AM and 7/19/12 at 6:00 AM, also documented Patient #40 was sleeping. The form, dated 7/19/12 at 4:00 AM, did not document Patient #40's behavior. The form, dated 7/19/12 at 4:00 AM, stated Patient #40's "Behavior for restraining continues" but it did not specify what that behavior was. The "Restraint Non-Violent Form," dated 7/19/12 at 11:00PM, stated Patient #40 was sleeping when the restraint was applied. The next "Restraint Non-Violent Form," dated 7/20/12 at 2:00 AM, also stated Patient #40 was sleeping. The next form, dated 7/20/12 at 4:00 AM, stated "Behavior for restraining continues" but it did not specify what that behavior was. The next form, dated 7/19/12 at 8:00 AM, stated Patient #40 was not restrained. The next "Restraint Non-Violent Form" that documented Patient #40 was restrained was dated 7/20/12 at 8:00 PM. It stated Patient #40's "Behavior for restraining continues" but it did not specify what that behavior was. The "Restraint Non-Violent Forms," dated 7/20/12 at 10:00 PM, as well as, 7/21 at midnight and 2:00 AM, stated "Behavior for restraining continues." The "Restraint</p>	A 188			

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A 188	<p>Continued From page 29</p> <p>Non-Violent Form," dated 7/21/12 at 4:00 AM, stated Patient #40 was released from restraint to have a snack in the dining room. The form stated he was placed back in the restraint at 3:15 PM. No behavior was documented. "Restraint Non-Violent Forms" stated Patient #40 was sleeping at 6:00 AM on 7/21/10 and was not restrained at 8:00 AM.</p> <p>The Regulatory Accreditation Coordinator reviewed Patient #40's medical record with the surveyor on 7/24/12 beginning at 2:00 PM. She confirmed the lack of documentation related to Patient #40's response to the restraints.</p> <p>The hospital did not document Patient #40's response to restraints.</p> <p>2. Patient #56's medical record documented a 57 year old male who was admitted to the hospital on 7/10/12 and was discharged on 7/20/12. Diagnoses included stroke and bipolar disorder. Physician orders, dated 7/13/12 at 5:33 PM, 7/14/12 at 3:46 PM, and 7/15/12 at 3:26 PM, all included "All Side Rails Up, Enclosure Bed/Net Bed, Soft Limb X2 [wrist restraints]." Nursing notes documented these restraints were utilized in accordance with the orders.</p> <p>The nursing "Restraint Non-Violent Forms," which contained the restraint assessments, did not document Patient #56's response to the restraints from 7/13/12 at 6:00 AM to 7/14/12 at 10:00 AM (28 hours) except to state when he was asleep. From 7/14/12 at noon through 7/15/12 at 11:59 PM, the "Restraint Non-Violent Forms" did not document Patient #56's response to the restraints.</p>	A 188		
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A 188	Continued From page 30	A 188		
A 450	<p>482.24(c)(1) MEDICAL RECORD SERVICES</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of medical records it was determined the facility failed to ensure that all medical record entries were complete for 7 of 39 inpatients (#11, #37, #38, #39, #45, #49 and #50) whose records were reviewed. Failure to ensure complete documentation resulted in lack of clarity of the course of hospital events and incomplete medical records. Findings include:</p> <p>1. Patient #45 was a 27 year old female admitted on 7/25/12 for a total laparoscopic hysterectomy. Her medical record contained the following discrepancies resulting in incomplete documentation:</p> <p>a. Patient #45's medical record contained documentation of an anesthesia preoperative assessment, completed and signed by the anesthesiologist on 7/25/12 at 8:53 AM. The assessment contained documentation that indicated the surgeon's H&P had been reviewed</p>	A 450		

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A 450	<p>Continued From page 31</p> <p>and anything different from that H&P would be documented in the anesthesia evaluation. The past medical history indicated Patient #45 was a smoker with occasional use of inhalers for asthma. The assessment contained a list of Patient #45's allergies and medications. The section of the assessment dedicated to the physical examination contained documentation of the initial set of vital signs, a description of Patient #45's mouth and airway and documentation that Patient #45 was oriented to person, place, time, and situation. In addition the anesthesiologist documented that Patient #45's breath sounds were equal bilaterally with no wheezing, rhonci, or rales and that her cardiac sounds indicated a regular rhythm without murmurs or gallops. The remainder of the assessment documentation included laboratory values, the anesthesia risk classification for Patient #45, and documentation of the discussion of the anesthesia plan with Patient #45.</p> <p>However, the documentation in the anesthesia preoperative assessment was not consistent with information presented upon interview with Patient #45 and the anesthesiologist.</p> <p>Patient #45 and her spouse were interviewed on 7/25/12 at 9:15 AM. She stated she met with her surgeon on the Friday prior to surgery. She explained that the surgeon reviewed the procedure, risks and benefits, but did not do a physical examination at that appointment. She confirmed that her surgeon had not been in to see her on 7/25/12 as of 9:15 AM. She stated the anesthesiologist had visited her that morning and explained the details of her anesthesia plan and reassured her of the safety of the anesthesia.</p>	A 450		
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A 450	<p>Continued From page 32</p> <p>She confirmed that the anesthesiologist did evaluate her mouth and oral cavity but did not listen to her heart or lungs with a stethoscope.</p> <p>The Anesthesiologist was interviewed on 7/25/12 at 9:20 AM. He stated it was the anesthesiologist's responsibility to update the H&P in the medical record. He stated the anesthesiologist does not redo the physical examination portion. He stated if the patient had any concerning symptoms, such as new symptoms since the history was completed by the surgeon, he completed a focused examination. He stated he may listen to the patient's heart and lungs with a stethoscope if they had any cardiopulmonary diagnoses. He did state that the RN's always completed the physical examination.</p> <p>A second surveyor interviewed the Anesthesiologist on 7/25/12, beginning at 9:25 AM. He stated there was a new, anesthesia-specific section of the hospital's EMR that went into effect recently. As he demonstrated the use of the new section of the EMR, the Anesthesiologist reviewed Patient #45's medical record. He stated he met with Patient #45 earlier that morning and explained the risks and benefits related to the use of general anesthesia. He said he performed a focused assessment, which consisted of an oral/airway examination. When asked if he assessed the heart and lungs, the Anesthesiologist stated the pre-operative nurse listened to the heart and lungs that morning during her physical examination of Patient #45. He went on to explain he would not listen to heart and lungs unless a condition change was reported after the physical assessment was completed by the</p>	A 450		
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A 450	<p>Continued From page 33</p> <p>surgeon. He then said he would listen to the patient's heart and lungs if they had any cardiopulmonary diagnoses. As the Anesthesiologist continued to review Patient #45's EMR, he read aloud that she had a significant history of smoking cigarettes and was diagnosed with asthma. When asked if he would alter his physical examination based on this information, the Anesthesiologist stated he would do so only if Patient #45 had reported concerning symptoms or a change in condition when he met with her that morning. He said based on the conversation he had with her that morning, Patient #45's condition was unchanged. He then said she was instructed to use her inhaler before arriving at the hospital, which was a typical practice for patients' with histories of asthma undergoing surgery.</p> <p>The medical record did not clearly reflect the anesthesia assessment of Patient #45's care.</p> <p>b. Patient #45's EMR contained a documented titled, "History & Physical." At the bottom of the form, beneath the name of the surgeon who dictated the report, was documentation which indicated the report was dictated on 7/25/12 at 12:35 AM, transcribed at 2:28 AM, and the date of service was 7/25/12. The H&P contained information regarding Patient #45's past medical and surgical history, a review of systems, and a physical examination which indicated Patient #45's lung sounds were "Clear to auscultation (listening with a stethoscope)," her heart rate was a regular rhythm, and the results of a pelvic examination.</p> <p>However, Patient #45 and her spouse were</p>	A 450		
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A 450	<p>Continued From page 34</p> <p>interviewed on 7/25/12 at 9:15 AM. She stated she met with her surgeon on Friday prior to surgery (7/20/12). She explained that the surgeon reviewed the procedure, risks and benefits, but did not do a physical examination at that appointment. She confirmed that her surgeon had not been in to see her on 7/25/12 as of 9:15 AM.</p> <p>The Preop RN was interviewed on 7/25/12 at 9:20 AM. She reviewed the electronic documentation in Patient #45's record. She reviewed the H&P for Patient #45. She stated she was unable to determine exactly when the H&P had been performed and confirmed that while the surgeon may have dictated the report after midnight on 7/25/12, the report did not clearly document when the physical examination had been conducted.</p> <p>The medical record did not clearly document the course of events of Patient #45's care.</p> <p>2. Patient #49 was a 60 year old female admitted on 7/22/12 for care of a post-operative infection following a hip joint replacement. Her medical record contained a document titled, "Post Operative Note." Documentation at the top of the form indicated it was a "Final Report." The "Post Operative Note" was completed and signed by the surgeon on 7/23/12 at 8:07 PM. The report indicated surgery was completed on 7/23/12 at 6:35 PM. Patient #49's record also contained an "Operative Report." The documentation indicated this was a "New version to correct visit, 7/24/12," and that this was a "Final Report." The "DATE OF PROCEDURE" was documented as 7/24/12.</p> <p>The Charge Nurse for the Orthopedic unit</p>	A 450			

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A 450	<p>Continued From page 35</p> <p>reviewed Patient #49's medical record on 7/25/12 at 2:45 PM. She confirmed that the surgical procedure was performed on 7/23/12 at 6:35 PM which is consistent with the "Post Operative Note." She confirmed that the dictated operative report indicated the surgery was completed on 7/24/12, which was not correct. She agreed the medical record did not correctly or consistently document the course of events for Patient #49.</p> <p>The medical record did not clearly reflect events of Patient #49's care.</p> <p>3. Patient #38 was a 34 year old female, admitted on 7/19/12 with pregnancy complicated by Systemic Lupus Erythematosus (an autoimmune disorder), and heart failure. Patient #38's record indicated she had a Caesarean Section on 7/21/12. An "Anesthesia Preoperative Assessment," dated 7/21/12 at 7:27 AM, included notation by the Anesthesiologist that a consent was signed, and the procedure was discussed with the patient. However, Patient #38's record indicated she was intubated and chemically paralyzed and therefore would have been unable to participate in the decision or the consent for anesthesia.</p> <p>During an interview with on 7/24/12 beginning at 2:00 PM, the Anesthesiologist who provided the anesthesia reviewed Patient #38's medical record and confirmed she did not sign a consent, and she was unable to participate in a discussion regarding anesthesia. He stated he had been in error regarding his documentation that Patient #38 had signed a consent. The Anesthesiologist stated the EMR contained a formatted screen for the Anesthesia Preoperative Assessment and</p>	A 450			

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A 450	<p>Continued From page 36</p> <p>included prompts, as well as, personalized preferences for each practitioner. He stated his personalized preferences had pre-populated data that could be modified. The sections related to the consent, including the statement "discussed with patient" were made in error.</p> <p>The medical record did not clearly reflect events of Patient #38's care.</p> <p>4. Patient #11 was a 7 week old male, born 5/29/12 at 30 weeks gestation (10 weeks early). His record contained the results of an umbilical cord sampling for a drug screen. The record included an order for the drug screen, however, there was no documentation to support the reasons for the test, and no documentation of parental consent.</p> <p>A hospital policy titled "NEWBORN TOXICOLOGY TESTING," dated 2/22/12, indicated the RN or LIP was to document in the newborn EMR the reasons for ordering drug screening of the newborn. In addition, staff were to document notifying the mother when a drug screen was ordered.</p> <p>During an interview on 7/23/12 beginning at 2:10 PM, the NICU Charge Nurse reviewed Patient #11's record and described the process for obtaining drug screens for neonatal patients. She stated certain criteria must be met before a drug screen could be ordered. She explained the criteria included such things as the mother's history of drug use, lack of prenatal visits, an abruption of the placenta, etc. She was unable to find documentation in the record that Patient #11's mother met any of the criteria for drug</p>	A 450		
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A 450	<p>Continued From page 37</p> <p>screening the newborn. The NICU Charge Nurse was unable to find documentation that Patient #11's mother had been informed of the drug testing of her infant.</p> <p>The medical record did not contain documentation required by policy to ensure a complete medical record for Patient #11.</p> <p>5. Patient #50 was a 62 year old male who was admitted to the hospital on 7/23/12 at 10:45 AM for surgery related to degenerative joint disease in the left hip. The "Operative/Procedure Report," dated 7/23/12 at 6:08 PM, documented Patient #50 had a left total hip arthroscopy (procedure performed through small incisions used to insert instruments and to insert a camera to visualize the inside of a joint).</p> <p>Patient #50's medical record was reviewed in the Orthopedic Unit on 7/25/12 at approximately 3:15 PM. An "Idaho Living Will and Durable Power of Attorney for Health Care" form was found in the record. The form documented that Patient #50 chose "Option 1" on the living will, which indicated he chose to receive "All treatment, Artificial Nutrition and Hydration" in the event that life sustaining measures became necessary during the hospitalization. The form also documented that Patient #50 designated an individual as his health care agent and durable power of attorney. Individuals chosen as first and second alternates were named on the document as well. The document was signed by Patient #50 and dated 7/27/12 (4 days after admission). Given that Patient #50 was admitted on 7/23/12, the document would not have been in effect as intended.</p>	A 450			

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A 450	<p>Continued From page 38</p> <p>The Charge Nurse for the Orthopedic Unit was interviewed on 7/25/12, beginning at 3:10 PM. She stated the living will and durable power of attorney should have been issued, explained to Patient #50, and reviewed for accuracy by the pre-operative nurse. The Charge Nurse then stated she would discuss the document with Patient #50 and allow him to make corrections if he chose to do so.</p> <p>The Director of Patient Safety and Regulatory Compliance was interviewed on 7/27/12, beginning at 8:10 AM. After researching the situation, she reported that a packet of pre-operative documents were mailed to Patient #50, and he brought the signed documents with him the date of surgery. She stated because the documents were already complete at the time of admission, Patient #50 did not go through the pre-operative screening process. She stated the responsibility for reviewing the admission documents then became the responsibility of the pre-operative nurse.</p> <p>A RN in the pre-operative unit was interviewed on 7/27/12, beginning at 8:55 AM. The RN confirmed the pre-operative nurse assigned to the patient on the day of surgery was responsible for reviewing admission documents for accuracy, including the "Idaho Living Will and Durable Power of Attorney for Health Care."</p> <p>The hospital did not ensure that the "Idaho Living Will and Durable Power of Attorney for Health Care" form was accurate in Patient #50's medical record.</p>	A 450		
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A 450	<p>Continued From page 39</p> <p>6. Patient #39's medical record documented a 36 year old female who was admitted to the ED on 7/10/12 and was discharged on 7/11/12. She was admitted for paranoid delusions and acute psychosis. A "Restraint/Seclusion Violent Form," dated 7/11/12 at 11:16 AM, stated hard restraints were applied to Patient #39's wrists and ankles at 10:30 AM. A "Restraint/Seclusion Violent Form," dated 7/11/12 at 11:32 AM, stated the restraints were discontinued at 11:00 AM.</p> <p>The order for the above restraint was written on 7/11/12 at 4:03 PM. A progress note by the physician who wrote the order was not documented.</p> <p>Patient #39's Physician was interviewed on 7/25/12 beginning at 8:45 AM. She stated she was present when Patient #39 was restrained and witnessed those behaviors. She confirmed she did not document the event or an examination of Patient #39.</p> <p>Events surrounding the restraint of Patient #39 were not documented.</p> <p>7. Patient #37's medical record documented a 24 year old male who was admitted to the hospital on 7/06/12 following a motor vehicle accident and a head injury. He was discharged to the Rehabilitation Unit on 7/18/12.</p> <p>Patient #37's record documented a "Progress Note" by the PA, dictated at 7/15/12 at 11:18 AM, which stated "The patient is severely agitated. We will do a trial of mitts with a Posey [vest] and restraints. If this does not work, we will consider getting a Vail bed."</p>	A 450		
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A 450	Continued From page 40 Patient #37's record documented a verbal order from the PA was on 7/15/12 at 11:04 AM for bilateral wrist restraints. The order was signed by the PA on 7/15/12 at 2:52 PM. The order did not include mitts or a Posey restraint. "Restraint Non-Violent Forms" for 7/15/12 and 7/16/12 were reviewed. They did not document Patient #37 was placed in mitts or in a Posey restraint. The next progress note by the PA was dictated 7/16/12 at 5:37 PM. The note stated Patient #37 was restrained but did not mention mitts or a Posey restraint. The Regulatory Accreditation Coordinator reviewed the medical record on 7/25/12 beginning at 10:50 AM. She confirmed the record did not document the status of the mitts or the Posey restraint.	A 450		
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observation 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	A 724		

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A 724	<p>Continued From page 41</p> <p>maintain a clean food storage and preparation environment had the potential to result in negative outcomes for patients, staff, and visitors. Findings include:</p> <p>1. During a tour of the hospital's kitchen, on 7/23/12 from 10:45 AM to 11:45 AM, accompanied by the Regulatory Accreditation Coordinator and Senior Food Service Director, the following concerns were noted:</p> <p>a. In the produce cooler, foods were not labeled with expiration date and were not disposed of after expiring as follows:</p> <p>i. There were buckets of blueberry, poppy seed, apple cinnamon, and chocolate muffin batter, dated 7/14/12. The Senior Food Service Director stated the mixes should have had a five day expiration date sticker on them. He stated the muffin batters had expired 7/19/12, which was four days before the survey and kitchen tour.</p> <p>ii. A container of citrus curry dressing was dated 7/13/12, and had no expiration date. The Senior Food Service Director stated the dressing should have had a five day expiration sticker in place and should have been discarded on 7/18/12.</p> <p>iii. On a rack directly under the container of citrus curry dressing, a large stainless steel bowl was noted to have a wrinkled and soiled plastic wrap covering. There was a sticky yellow substance on the sides of the bowl and on the plastic wrap. The bowl was identified by a piece of tape as containing leeks, and had no label to indicate when the leeks were prepared and would expire.</p>	A 724		
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A 724	<p>Continued From page 42</p> <p>iv. A gallon container of peeled shallots was not dated to indicate when it was opened or when it expired.</p> <p>b. The walk-in freezer posed the following safety issues:</p> <p>i. Packages of food were open and undated, including, pasta sheets, hash brown cubes and apple strudel.</p> <p>ii. The floor of the freezer had an area where an unidentified liquid had spilled and frozen over, this posed a safety hazard for kitchen staff. The Senior Food Service Director acknowledged the frozen spill. He did not offer an explanation how the slippery spill area could be cleaned, but stated the freezer floor could not be mopped.</p> <p>c. The dishwashing room posed the following safety issues:</p> <p>i. The floor was wet due to pooled water under the sink which extended beyond the rubber mats used for staff while working at the sink, posing a fall risk.</p> <p>The Senior Food Service Director confirmed the presence of pooled water in this location during the tour on 7/23/12.</p> <p>ii. The kitchen workers were observed rinsing the cooking utensils and stacking them on the floor. The dirty rinsed cookware was stacked resting against a rack which stored clean cookware and dishes.</p> <p>The Senior Food Service Director stated the dirty</p>	A 724		
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A 724	<p>Continued From page 43</p> <p>utensils were placed on the floor as there was insufficient counter space while waiting for the dishwasher. He confirmed the dirty utensils were resting against the clean cookware rack, and told a kitchen worker to move the wet soiled utensils.</p> <p>d. The fluorescent lights over the grill area were covered with a clear panel. The panels had a thick brown layer of grease.</p> <p>The Senior Food Service Director stated the panels were wiped down nightly, but confirmed the grease had not been removed during the cleaning process.</p> <p>e. The catering pantry had the following food storage and safety concerns:</p> <p>i. A pipe anchored to a wall had condensation dripping into a receiving drain on the floor. The drain was not covered or screened to prevent insect and or rodent entry.</p> <p>ii. The catering pantry had a counter with personal coffee cups, food, office supplies, a radio and personal hand lotion. The food and personal items were directly over a rack which held clean glasses and stemware.</p> <p>The Senior Food Service Director described the counter as an employee work area and requested a kitchen worker remove the rack with clean stemware.</p> <p>f. Sections of the kitchen floor had areas of residual from dried spills of food and/or liquid items. Small pieces of food and dust debris littered the floor behind the grill and oven unit, as</p>	A 724		

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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 724	Continued From page 44 well as, the pantry for dry food storage and clean cooking utensil racks. During the tour on 7/23/12, the Senior Food Service Director 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. The physical environment of the dietary department was not adequately maintained to ensure the safety and well-being of patients.	A 724			
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 communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on observation, interview, and review of policies and medical records, it was determined the facility failed to ensure implementation and monitoring of systems for mitigating potential infection control risks. This directly impacted 3 of 7 patients (#29, #45 and #57) for whom procedures were observed, 8 of 29 Departments/Units (Laboratory, Kitchen, Perioperative, Medical, Orthopedic, Telemetry, Neurology, and General Surgery) toured, and had the potential to impact all staff, visitors, and patients cared for at the facility. The failure to ensure implementation and monitoring of systems had the potential to expose patients and staff to infections. Findings include:	A 749			

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A 749	<p>Continued From page 45</p> <p>1. Biohazardous materials were not disposed of in a manner to minimize the risk of cross contamination as follows:</p> <p>The hospital's "Exposure Control Precautions," policy, dated 5/10/12, indicated, "All Regulated Waste will be placed in a red bag. Red bag waste will be placed in a red, rigid container with a biohazard label to be transported off-site for incineration."</p> <p>A housekeeper on the General Surgery Unit was interviewed on 7/23/12 at 11:10 AM. She stated that floor staff always placed biohazardous materials in the designated red biohazard bags. She explained that staff then placed the red bag on the floor next to the trash can in the patient's room and she would transport the red bag to the biohazard bin in the soiled utility room.</p> <p>A housekeeper on the Telemetry Unit was interviewed on 7/24/12 at 2:30 PM. She confirmed that floor staff typically placed biohazardous materials in the red biohazard bags. She stated that she would find the bags on the floor next to the trash can in the patient's room. She stated that if the red bag had not been tied closed by nursing staff she would not remove the bag, but if it was a closed bag she would transport it to the red biohazard bin in the soiled utility room.</p> <p>A housekeeper on the Neurology Unit was interviewed on 7/24/12 at 3:15 PM. She stated she did not have any concerns related to biohazardous materials placed in with the regular waste in the trash cans in patient's rooms. She</p>	A 749		
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A 749	<p>Continued From page 46</p> <p>stated staff placed biohazardous materials in the red biohazard bags and set the bags next to the trash can in the room. She explained that she transported the red bag to the biohazard bin in the soiled utility room.</p> <p>Infection Prevention Specialists A, B, and C were interviewed jointly on 7/27/12 at 11:05 AM. All three individuals stated they believed that nursing staff were transporting the red biohazard bags to the hard-walled biohazard container in the soiled utility room. Each confirmed the expectation that the biohazard bags be disposed of immediately and not placed on the floor to await housekeeping services.</p> <p>The facility failed to ensure that biohazardous materials were disposed of to minimize the risk of cross contamination.</p> <p>2. Blood glucose monitors were not cleaned to minimize the risk of cross contamination as follows:</p> <p>Patient #57 was a 21 year old female admitted on 7/22/12 for care of elevated blood glucose levels. An aide on the Medical Unit was observed to perform a blood glucose test on a Patient #57 on 7/24/12 at 11:20 AM. The aide removed the glucometer, inserted the test strip, and placed the glucometer on the patient's bed. She swabbed the patient's finger with alcohol and obtained the blood sample. She then placed the glucometer on a counter in the patient's room until the glucose level was read. She then removed the test strip and placed the glucometer back in the carrying case. She stated she cleaned the glucometer with Sani-wipes prior to docking it.</p>	A 749		

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A 749	<p>Continued From page 47</p> <p>She confirmed that she did not wipe down the glucometer between each patient use unless it was visibly soiled.</p> <p>An aide on the Orthopedic Unit was interviewed on 7/25/12, beginning at 3:30 PM, about cleaning glucometers used on multiple patients. The aide stated she cleaned the machine before placing it back in the docking station. When asked to explain the hospital's policy and practice, she stated she was uncertain, but thought the machine should be cleaned once per shift. The aide confirmed she was not cleaning the glucometer after each patient use.</p> <p>The hospital's "BLOOD GLUCOSE MONITORING" policy, dated 6/18/10, indicated the facility utilized the Precision Xceed Pro Glucometer for testing patients' blood glucose levels. According to the policy, the "Meter should be cleaned daily with Quality Control testing and as needed when exposed to patient blood, secretions or contaminates" and "Acceptable cleaning solutions include alcohol- and ammonia-based solutions (i.e. Sani-Cloth Plus wipes)." However, according to the CDC's website related to blood glucometer cleaning, last updated 5/02/12, "Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions."</p> <p>Infection Prevention Specialist B was interviewed on 7/27/12 at 11:05 AM. She confirmed that the facility's policy was to clean the blood glucometers on a daily basis.</p>	A 749		
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A 749	<p>Continued From page 48</p> <p>The facility failed to ensure that blood glucose meters were cleaned between each patient use to minimize the risk of cross contamination.</p> <p>3. The Perioperative area of the hospital was toured with Infection Prevention Specialist B on 7/25/12 from 9:15 AM to approximately 11:00 AM. The following infection control breaches were observed during the tour:</p> <p>a. Patient #45 was admitted on 7/25/12 for a total laparoscopic hysterectomy. Her care was observed from 9:15 AM to 11:00 AM. At 10:47 AM the Circulating RN was observed to apply the antiseptic skin preparation to Patient #45. The RN donned sterile gloves and applied the skin prep solution to the abdominal region using sponges, beginning at the umbilicus and moving in outward circles to clean the entire abdomen. The RN then began to clean the perineal and vaginal region. He was observed to wipe down the outer thigh region before moving in toward the vagina. The RN was not observed to change gloves following the completion of prepping the skin and prior to the insertion of the urinary catheter, a sterile procedure.</p> <p>The hospital's "Skin Antisepsis, Patient" policy was last reviewed 4/2012. The policy instructed staff to "Wear sterile gloves unless the antiseptic prep applicator is of sufficient length to prevent the antiseptic and patient's skin from coming in contact with the nonsterile glove." According to the policy, skin preparation of the perineum or vagina is as follows: "...Scrub the inner aspects of the thighs beginning at the labia majora and moving outward toward the knee, covering approximately the upper third of each</p>	A 749			

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A 749	<p>Continued From page 49</p> <p>thigh...Catheterization in conjunction with the perineal vaginal preparation...Complete the surgical prep...Remove and dispose of the prep gloves...Open the necessary catheter supplies...Don sterile gloves and insert a sterile catheter."</p> <p>The Circulating RN was interviewed on 7/25/12 at 4:07 PM. He reviewed the technique for cleaning the vaginal area and inserting the urinary catheter. He stated he believed his gloves were still sterile after prepping the skin and therefore he was able to insert the urinary catheter under sterile conditions.</p> <p>The Association of Surgical Technologists (AST), in an article titled, "Recommended Standards of Practice for Skin Prep of the Surgical Patient," noted the following standards of practice were "researched and authored by the AST Education and Professional Standards Committee and have been approved by the AST Board of Directors. They are effective October 20, 2008." The recommendations included, "The most important principle of skin prep is prepping always progresses from the clean to the dirty area...The paint solution should be applied with prep stick sponges, using the no-touch technique in order to avoid contamination from the gloves that came into contact with the prep-solution soaked sponges." In addition, "Abdominal-perineal and abdominal-vaginal procedures require separate skin preps since the perineal and vaginal areas are considered contaminated. The perineal or vaginal prep should be performed first in order to avoid splashing and contaminating the abdomen if it were to be prepped first."</p>	A 749			

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A 749	<p>Continued From page 50</p> <p>During an interview on 7/27/12 at 11:05, Infection Prevention Specialist B explained that when the above policy was written staff were not using sterile gloves to apply skin prep. She stated the facility changed practices to using sterile gloves with the application of the skin prep and, therefore, the urinary catheter was instered under sterile conditions. She confirmed the hospital's "Skin Antisepsis, Patient" policy did not reflect this current practice. She also confirmed that the appropriate method to prep the vaginal area was to work from the vagina outward to the thighs.</p> <p>b. On 7/25/12 at 11:00 AM, instruments were observed being removed from an OR after a completed operation. The equipment was loaded onto a cart with one side open, and much of the equipment was blood stained. One surveyor accompanied the OR Assistant as he transported the cart to the elevator designated for soiled equipment. The hallway through which the cart was transported had several clean hospital beds lined up against the wall. The open side of the cart faced these clean beds. The OR Assistant confirmed that the doors to the cart were not always closed to ensure containment, but that usually the open side of the cart faced away from the clean equipment occasionally stored in the hall way.</p> <p>According to the hospital's "Environmental Sanitation in Perioperative Areas" policy, dated 10/04/10, "Contaminated articles leaving the operating room will be contained or covered..."</p> <p>The facility failed to ensure infection control practices were followed to mitigate the risks of cross contamination in the Perioperative area.</p>	A 749		
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A 749	<p>Continued From page 51</p> <p>4. The Laboratory was toured on 7/24/12 from 9:40 AM to 10:45 AM with the Lab Director and the Regulatory Accreditation Coordinator. The following infection control breaches were observed during the tour:</p> <p>a. The sinks in the lab area each had multiple bottles of personal hand lotion.</p> <p>A hospital policy, titled "HAND HYGIENE IN THE PREVENTION OF INFECTION," dated 2/16/12, stated "The hospital will supply hand lotion to employees," and "only hospital-approved lotions may be used by staff on nursing units."</p> <p>b. Each sink, as well as, some of the work areas in the lab, had small plastic wash bottles containing a pale pink liquid. Some of the bottles were labeled, the dates on the bottles ranged from 12/2010 to 2011 and were written on faded tape. There was no indication if the date was a refill date or an expiration date, and the potency of the solution could not be determined.</p> <p>During the tour, the Lab Director explained the bottles contained a disinfectant solution that was used to clean the counters and work areas in the lab. She stated the solution was mixed and stored in the autoclave room and the wash bottles were refilled as needed.</p> <p>At 10:00 AM in the autoclave room, the Lab Director brought forth a plastic gallon container with "Isopropyl Alcohol" printed by the factory, and "Amphyl" written with a permanent marker. In addition, a line had been placed on the bottle to indicate a fill level. The Lab Director confirmed</p>	A 749		
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A 749	<p>Continued From page 52</p> <p>the bottle originally contained isopropyl alcohol. She was unsure of the amount, dilution, or contact time required for the Amphyl to be effective in cleaning of laboratory surfaces.</p> <p>The facility failed to ensure the environment in the laboratory was maintained to mitigate risks of cross contamination.</p> <p>5. During a tour of the hospital's kitchen, on 7/23/12 from 10:45 AM to 11:45 AM, accompanied by the Regulatory Accreditation Coordinator and Senior Food Service Director, the following infection control concerns were noted:</p> <p>a. In the produce cooler, foods were not labeled with expiration date and were not disposed of after expiring as follows:</p> <p>i. There were buckets of blueberry, poppy seed, apple cinnamon, and chocolate muffin batter, dated 7/14/12. The Senior Food Service Director stated the mix should have had a five day expiration date sticker on them. He stated the muffin batters had expired 7/19/12, which was four days before the survey and kitchen tour.</p> <p>ii. A container of citrus curry dressing was dated 7/13/12, and had no expiration date. The Senior Food Service Director stated the dressing should have had a five day expiration sticker in place and should have been discarded on 7/18/12.</p> <p>iii. On a rack directly under the container of citrus curry dressing, a large stainless steel bowl was noted to have a wrinkled and soiled plastic wrap covering. There was a sticky yellow substance</p>	A 749		
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A 749	<p>Continued From page 53</p> <p>on the sides of the bowl and on the plastic wrap. The bowl was identified by a piece of tape as containing leeks, and had no label to indicate when the leeks were prepared and would expire.</p> <p>iv. A gallon container of peeled shallots was not dated to indicate when it was opened or when it expired.</p> <p>b. In the walk in freezer packages of food were open and undated, including, pasta sheets, hash brown cubes and apple strudel.</p> <p>c. In the dishwashing room the kitchen workers were observed rinsing the cooking utensils and stacking them on the floor. The dirty rinsed cookware was stacked resting against a rack which stored clean cookware and dishes.</p> <p>The Senior Food Service Director stated the dirty utensils were placed on the floor as there was insufficient counter space while waiting for the dishwasher. He confirmed the dirty utensils were resting against the clean cookware rack, and told a kitchen worker to move the wet soiled utensils.</p> <p>e. The catering pantry had the following infection control concerns:</p> <p>i. A pipe anchored to a wall had condensation dripping into a receiving drain on the floor. The drain was not covered or screened to prevent insect and or rodent entry.</p> <p>ii. The catering pantry had a counter with personal coffee cups, food, office supplies, a radio and personal hand lotion. The food and personal items were directly over a rack which</p>	A 749		
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A 749	<p>Continued From page 54 held clean glasses and stemware.</p> <p>The Senior Food Service Director described the counter as an employee work area and requested a kitchen worker remove the rack with clean stemware.</p> <p>f. Small pieces of food and dust debris littered the kitchen floor behind the grill and oven unit, as well as, the pantry for dry food storage and clean cooking utensil racks.</p> <p>During the tour on 7/23/12, the Senior Food Service Director 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.</p> <p>The physical environment of the dietary department was not adequately maintained to ensure the safety and well-being of patients.</p> <p>6. Hand hygiene was not performed in accordance with policy to mitigate the risk of cross contamination as follows:</p> <p>a. During a tour of the Outpatient Lab area, from 10:10 to 10:30 AM, two phlebotomy procedures were observed. The first procedure was observed at 10:15 AM. The phlebotomist cleansed the patient's arm with alcohol, then palpated the site and performed the puncture without re-cleansing the site. After obtaining the sample, still wearing soiled gloves, she opened a drawer and removed the phlebotomy tubes for the sample. The phlebotomist removed her gloves and did not perform hand hygiene. She</p>	A 749		
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A 749	<p>Continued From page 55</p> <p>took the specimen tubes to a location in the lab area that had a computer and typed on the keyboard. After she entered information on the computer, the phlebotomist was observed to perform hand hygiene using hand sanitizer. The phlebotomist did not wipe down the computer keyboard or work area after she finished.</p> <p>The Lab Director confirmed the above observations during the tour. She stated she did not see fault when observing the phlebotomist wear gloves during the procedure, removing them, not performing hand hygiene then touching the computer and work areas.</p> <p>b. Patient #29 was a 56 year old male who was admitted to the hospital on 7/19/12, for treatment related to altered mental status and a recent history of a sacral (base of the spine) decubitus ulcer.</p> <p>Two RNs were observed while performing a dressing change of the decubitus ulcer, on 7/24/12 at 10:15 AM. The RNs reviewed the orders for the dressing change and assembled supplies for the dressing. After washing their hands and donning gloves, the RNs explained the procedure to Patient #29 and turned him on his left side in order to access the wound. There was no dressing found to be in place when Patient #29 was turned, but he was found to be soiled with feces. This required the nurses to clean the area before proceeding with the dressing change. Both RNs were observed to have exposed their gloved hands to the soiled area. The RNs then noticed they had failed to assemble supplies for cleaning the perineal area. While RN A remained with Patient #29, and assisted him to maintain</p>	A 749			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130007	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/31/2012
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NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706
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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 749	<p>Continued From page 56</p> <p>positioning, RN B obtained additional supplies from the closet in Patient #29's room. RN B was not observed to change her gloves prior to obtaining additional supplies, and therefore touched the closed doors and supplies inside the closet with soiled gloves. After cleaning Patient #29, both RNs' disposed of soiled materials, performed hand hygiene, and put on clean gloves before performing the dressing change.</p> <p>RN A and RN B were interviewed immediately after completing the dressing change. Both confirmed the hospital's practice was to remove the potentially soiled gloves and dispose of them prior to touching surfaces in the room.</p> <p>Infection Prevention Specialist C was interviewed on 7/27/12, beginning at 11:05 AM. She stated the facility has been working with the nursing staff to improve the practice of assembling all necessary supplies prior to beginning a treatment or procedure.</p> <p>The hospital's "Exposure Control Precautions" policy, dated 5/10/12, indicated hand hygiene was to be performed, "Before and after patient contact, after contact with the patient's environment, and after removing personal protective equipment (PPE) including gloves." In addition, "Hand hygiene is required after removal of gloves. Gloves must be removed immediately after completing procedure and hand hygiene performed prior to continuing other activities, for example, charting, use of telephone, computers, etc, and before leaving the work area."</p> <p>The facility failed to ensure the implementation and monitoring of systems for mitigating potential</p>	A 749		
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A 749	Continued From page 57 infection control risks throughout the hospital.	A 749			

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Tag	Plan of Correction	Completion Date
A115	Please refer to Tag A131, A144, A164, A166, A168, A178, A185 and A188	
A131	<p>Actions taken to correct these deficiencies include:</p> <ul style="list-style-type: none"> ▪ Flyers sent out to all medical staff, nursing units, and managers of procedural areas regarding expectations for Informed Consent, including the informed consent process, documentation of informed consent, how to document emergency procedures and use of interpreters on or before 8/28/2012 (Appendices A and B). Director of Patient Safety presented the information to Medical Executive Committee on 8/27/2012. ▪ Audits were completed by inpatient and outpatient managers to identify problem areas related to missing or incomplete consent forms. ▪ Audits will be completed by nurses on the inpatient units by 9/10/2012. The audit includes questions about consent, including presence of appropriate consents in the chart and correct signatures, dates, and times (Appendix C) ▪ Neonatal Intensive Care Unit (NICU) procedures requiring parent/guardian consent on a procedural consent form (central line placements, intubation, needle aspiration, chest tube, lumbar puncture) were defined by 8/1/2012. Education of all physicians and RNs in NICU was completed by 8/10/2012 by NICU manager. Follow up completed with RNs on 8/23/2012. Education included requirement of obtaining Informed Consent prior to all procedures, parent and witness signatures, dates, times, and documentation of emergent procedures if the parent is unavailable. NICU Charge nurse procedure audit tool developed and started on 8/10/2012 to confirm all procedures are supported with a procedural consent form (Appendix D). ▪ Education provided to all trauma surgeons, intensivists, and Intensive Care Unit (ICU) RNs by the ICU manager on or before 8/7/2012 including the requirement that consent forms are completed prior to all procedures, documentation of informed consent discussion with the patient, documentation of emergent cases, and requirement for patient and witness signature, date, and time. On 8/15/2012 ICU charge nurse began keeping a log of all procedures in ICU to ensure that all components of the consent are complete before the bedside nurse leaves at the end of the shift. Weekly auditing by ICU manager of all consents started on 8/15/2012 (surgical and procedural) for completion. ▪ Manager of the Coronary Care Unit (CCU) and Cardiovascular Intensive Care Unit (CVICU) discussed consent requirements in daily huddles, staff meetings, and charge nurse meetings and had 	9/4/2012

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	<p>direct discussions with Cardiac Surgeons regarding consent requirements and required verbiage in physician documentation on or before 8/27/2012.</p> <ul style="list-style-type: none"> ▪ Anesthesiologists were educated by Medical Director of Anesthesia regarding removing checks from irrelevant boxes in note templates in the EHR, the process for documenting emergent cases, and the process for documenting interpreter use on 8/2/2012 at a staff meeting. Pre-operative RNs and Anesthesiologists were educated about fully completing all consent forms, including patient and witness signature, date, and time on or before 8/29/2012. A space for interpreters to sign, date, and time the form are also being added. The changes will be finalized on or before 9/4/2012. Feedback and counseling of anesthesiologist that signed the Anesthesia Consent without a witness signature occurred on 7/30/2012 by the Medical Director of Anesthesia. The individual templates in the EHR will be changed by a Clinical Informatics Specialist to ensure that all anesthesiologists have an option to document “emergent” status if consent was not able to be obtained and to add an option to document interpreter use. Clinical Informatics Specialist will also educate each anesthesiologist with 1:1 education on or before 9/4/2012. ▪ Family Maternity Center (FMC) initiated a process on 8/23/2012 for nurses to check all consent forms for signatures, dates, and times upon completion. The unit clerk performs a second check prior to filing. FMC implemented a temporary process to obtain consent form for newborns on 8/1/12 involving manual printing of consent forms. On 8/23/2012 changes were made to print out a “Consent for Treatment” form for newborns automatically. Education to FMC staff regarding the requirement for Consent to Treatment forms for all newborns, and importance of required signatures, dates, and times was completed by 8/1/2012 by the FMC manager. ▪ Manager of Hospitality Services educated all interpreters in a meeting 8/23/2012 regarding signing, dating, and timing consent forms. <p>All education, document changes, process changes, double-checks, and auditing will ensure that consent is obtained when required and documented correctly for all patients. Informed Consent will be included in the Peer Review process where Anesthesia leadership regularly reviews charting. Ongoing Medical Record audits by the Health Information Management Department will detect incomplete or missing consent forms. The hospital should be fully compliant with all deficiencies by 9/4/2012.</p>	
A144	<p>Actions taken to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Decision was made by Chief Nursing Officer to only use enclosure beds on the rehabilitation unit. ▪ Specialty beds are ordered through “Bed Control,” and these nurses have been notified that enclosure 	8/1/2012

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	<p>beds should only be ordered on the rehab unit.</p> <ul style="list-style-type: none"> ▪ Rehabilitation nurses and support associates were trained on the correct use of Enclosure beds in June 2012, which included instructions to leave side rails down at all times. ▪ All new associates on the rehabilitation unit currently receive education on the proper use of all restraints including enclosure beds on hire. ▪ Education was provided to rehab staff on 8/10/12 to reinforce that side rails should not be used with enclosure beds. ▪ The Enclosure Bed Policy will be updated by 8/31/12 to indicate that beds will only be used on the rehab unit and to include the safety precaution that side rails should be down at all times. The updated policy will be sent out to rehab staff via e-mail on 8/31/12. <p>Limiting enclosure bed use to the rehab unit and staff education will ensure the beds are used correctly. No enclosure beds have been used outside of Rehab since 8/1/12 so the hospital has been in compliance since this time. Charge nurses on the rehabilitation floor will monitor for compliance on an ongoing basis and bring any concerns to the rehabilitation manager. The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A164	<p>Actions taken to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Implementation of “Restraint Champion” program on 8/8/2012 with 24/7 support by trained RNs until 9/17/2012. Restraint Champions participated in a three hour class regarding correct restraint use and documentation. One of the roles of Restraint Champions is to review all restraint documentation in the hospital with direct feedback to staff. One of the specific items the Restraint Champions review and educate staff about every shift includes correct documentation of less restrictive interventions. ▪ Reports are sent to the Staffing Office twice daily including a list of all patients in restraints over the past 24 hours. The Restraint Champions use the list to track compliance. In addition, a flyer was created and distributed to all units regarding the Restraint Champion program, including the requirement that the Restraint Champion be contacted when any restraint is initiated (Appendix E). ▪ Changes to the electronic health record (EHR) were implemented on 8/28/12. The changes will hardwire correct documentation for less restrictive measures by adding a mandatory free text box in the Restraint Initiation form with instructions for the RN to document what was tried, for how long, and why each alternative didn’t work prior to restraint initiation. The “Less Restrictive Alternatives Tried” section was removed from the Physician Order to avoid contradictions with nursing documentation and unexplained alternatives. The restraint assessment form includes a mandatory 	9/4/2012

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	<p>selection for nurses to indicate that restraint should be continued because it is the least restrictive method to keep patients safe. The discontinuation section includes a free text box for nurses to describe less restrictive interventions that were effective which allowed removal of restraint.</p> <ul style="list-style-type: none"> ▪ Education was created for physicians, LIPs, and physician assistants regarding restraint use in the form of two flyers, “CMS Survey—What Providers Need to Know about Restraint” (Appendix F) and “Updated PowerChart Restraint Orders” (Appendix G). The first flyer includes instructions for the provider to “collaborate with the RN caring for the patient to determine the least restrictive method to keep the patient safe.” Educational flyers and the Restraint and Seclusion policy were sent out via e-mail by the Medical Staff Office on 8/23/12 to all providers with an attestation form to be returned indicating receipt and understanding. The educational flyers were presented at a Medical Executive Committee meeting on 8/27/12. One to one contact was provided to the top 60 providers that order restraints by the medical staff office to give them the flyers and policy. ▪ Alternatives to Enclosure beds were identified by the Rehab manager and psychiatrists such as high-low beds, bed alarms, and Patient Safety Attendants for patients that are in and out of bed frequently by 8/10/2012. ▪ The Rehabilitation Manager educated all psychiatrists and rehab staff about documentation requirements for the use of Enclosure beds and alternatives to enclosure bed use on or before 8/10/2012. Education included documentation of less restrictive alternatives prior to use of Enclosure beds. <p>Changes to the EHR and widespread education will ensure that less restrictive alternatives are used and documented appropriately. All policy changes and education will be complete by 9/4/2012. Monthly restraint audits will be completed by the Regulatory Accreditation Coordinator. Charge nurses will audit all restraint patients’ charts to ensure ongoing compliance. All Medical Floor charge nurses will be trained to be restraint resources on a long-term basis (after the Restraint Champion program ends on 9/17/12). The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A166	<p>Actions taken to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Implementation of “Restraint Champion” program on 8/8/2012 with 24/7 support by trained RNs until 9/17/2012. Restraint Champions participated in a three hour class regarding correct restraint documentation. One of the roles of Restraint Champions is to review all restraint documentation in the hospital with direct feedback to staff. One of the specific items the Restraint Champions review and educate staff about every shift includes correct documentation of plans of care when restraints are 	9/4/2012

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	<p>initiated. This includes individualizing interventions to give more specific direction to staff and describing evaluations of outcomes.</p> <ul style="list-style-type: none"> ▪ Reports are sent to the Staffing Office twice daily including a list of all patients in restraints over the past 24 hours. The Restraint Champions use the list to track compliance. In addition, a flyer was created and distributed to all units regarding the Restraint Champion program, including the requirement that the Restraint Champion be contacted when any restraint is initiated, changed, or discontinued. ▪ EHR changes on 8/28/2012 included the addition of “type of restraint” to each restraint assessment form. ▪ “Tip of the Week” presented to all inpatient nurses 8/20/12-8/25/2012 during “huddles” included instructions for nurses to individualize interventions (to give nurses direction on how to care for the patient). It also included how to add a free text note to plan of care updates to indicate how the patient is progressing towards the plan’s goal (Appendix H). <p>Education, shift-to-shift auditing, and EHR changes will ensure that plans of care are documented correctly. All education was complete by 8/25/2012 and compliance should be obtained by 9/4/2012. Monthly restraint audits will be completed by the Regulatory Accreditation Coordinator. Charge nurses will audit all restraint patients’ charts to ensure ongoing compliance. All Medical Floor charge nurses will be trained to be restraint resources on a long-term basis (after the Restraint Champion program ends on 9/17/12). The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A168	<p>Actions taken to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Review of requirements that must be in place for physician assistants to evaluate the need for and order restraints in Idaho completed by 8/6/2012. ▪ Allied Health Plan portion of the Medical Staff Bylaws, which includes the physician assistant Scope of Practice, was changed to permit the ordering of restraints. The updates were approved by Medical Executive Committee on 8/10/12 and by the Quality Committee of the Board on 8/23/12. ▪ Delegation of Services agreements and Scope of Practice were updated, signed by physicians and physician assistants, and placed in the files of all physician assistants that ordered restraints in the last four months by 8/22/2012. All other physician assistants and supervising physicians have been contacted about the requirement to update Delegation of Service agreements and sign updated Scope of Practice to allow for ordering of restraints. They were also notified that physician assistants that do not have an updated and signed Delegation of Service agreement and Scope of Practice authorizing 	9/4/2012

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	<p>ordering of restraint are not authorized to order restraints, effective 8/23/12.</p> <ul style="list-style-type: none"> ▪ Restraint and Seclusion policy updated 8/23/2012 to indicate that physician assistants that are authorized by the medical staff office may evaluate the need for and order restraints. The policy outlines the requirements for physician assistants to order restraints. ▪ Physician Assistants received orientation on restraint use and ordering. ▪ The SARMC intranet homepage tab allows hospital-wide access to look up PA scope of practice. Those who have authorization to order restraints are identified per their approved Scope of Practice. ▪ Education was created for physicians, LIPs, and physician assistants regarding restraint use in the form of two flyers, “CMS Survey—What Providers Need to Know about Restraint” (Appendix F) and “Updated PowerChart Restraint Orders” (Appendix G) The first flyer included the requirements for restraint orders. Educational flyers and the Restraint and Seclusion policy were sent out via e-mail by the Medical Staff Office on 8/23/12 to all providers with an attestation form to be returned indicating receipt and understanding. The educational flyers were presented at a Medical Executive Committee meeting on 8/27/12. One to one contact was provided to the top 60 providers (including physician assistants) that order restraints by the medical staff office to give them the flyers and policy. <p>These actions will authorize physician assistants to evaluate the need for and order restraints, and ensure they have the knowledge to appropriately do so. Physician assistants will receive ongoing training on the use and ordering of restraints when reappointed and as needed. Physician, LIP, and physician assistant education will ensure that restraints are correctly ordered. The hospital should be in compliance by 9/4/2012. The Director of Medical Affairs is responsible for implementing this plan of correction.</p>	
A169	<p>Actions to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Alternatives to Enclosure beds were identified by the Rehab manager and physiatrists such as high-low beds, bed alarms, and Patient Safety Attendants for patients that are in and out of bed frequently by 8/10/2012. ▪ The Rehabilitation Manager educated all physiatrists and rehab staff about the correct use of Enclosure beds (cannot be used PRN), documentation requirements, and alternatives to enclosure bed use on or before 8/10/2012. ▪ The Restraint and Seclusion policy was updated on 8/23/2012 to remove enclosure beds as an acceptable exclusion for PRN restraint use. ▪ Implementation of “Restraint Champion” program on 8/8/2012 with 24/7 support by trained RNs until 9/17/2012. Restraint Champions participated in a three hour class regarding correct restraint 	9/4/2012

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	<p>documentation. One of the roles of Restraint Champions is to review all restraint documentation in the hospital with direct feedback to staff. One of the specific items the Restraint Champions review and educate staff about every shift includes correct documentation of restraint initiation and discontinuation.</p> <ul style="list-style-type: none"> ▪ Reports are sent to the Staffing Office twice daily including a list of all patients in restraints over the past 24 hours. The Restraint Champions use the list to track compliance. In addition, a flyer was created and distributed to all units regarding the Restraint Champion program, including the requirement that the Restraint Champion be contacted when any restraint is initiated, changed, or discontinued (Appendix E). <p>Education and shift-to-shift auditing will ensure that Enclosure beds are not used PRN and this is documented correctly. All education and policy changes were complete by 8/23/2012 and full compliance should be obtained by 9/4/2012. Monthly restraint audits will be completed by the Regulatory Accreditation Coordinator. Charge nurses will audit all restraint patients' charts to ensure ongoing compliance, on the rehab unit and all other inpatient units. All Medical Floor charge nurses will be trained to be restraint resources on a long-term basis (after the Restraint Champion program ends on 9/17/12). The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A178	<p>Actions taken to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ Decision made to limit face-to-face evaluations outside of the Behavioral Health Unit (BHU) to a small group of specially trained RNs (Restraint Champions) on 8/3/2012. The Restraint Champion program was implemented on 8/8/2012 and provides 24/7 coverage by trained RNs to complete Face-to-face evaluations until 9/17/2012 in all areas outside BHU. The Restraint Champions participated in a three hour class regarding correct restraint documentation. Part of this training included the completion and documentation of face-to-face assessments. The champions read an article titled "Clinical Practice Guideline: 1-Hour Face-to-Face Assessment of a Patient in a Mechanical Restraint" by Marlene Nader-Moodie published in the Journal of Psychosocial Nursing in 2009 (Appendix I). The champions completed a quiz and were required to answer 100% of the questions correctly to be authorized to complete Face-to-Face evaluations. BHU RNs also read the article and completed the quiz to ensure standard level of care. ▪ A flyer was created and distributed to all units regarding the Restraint Champion program, including the requirement that the Restraint Champion be contacted when any restraint is initiated (Appendix E). ▪ A decision was made on 8/23/2012 by the Nursing Leadership Council to provide special training to 	9/4/2012

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	<p>all Medical Floor and Emergency Department charge nurses to complete face-to-face evaluations in non-BHU areas. The training will be provided by the BHU manager and unit coordinator and the Regulatory Accreditation Coordinator and will include education regarding how a face-to-face evaluation should be performed and how to correctly document the assessment. A meeting was held 8/29/2012 to determine the details of this training and set up classes. A flyer will be created and distributed to staff when the Restraint Champion program ends and the Medical and ED charge nurses assume the role of face-to-face assessment completion.</p> <ul style="list-style-type: none"> ▪ A template was created on 8/3/2012 containing the components to be included in a face-to-face assessment, and Restraint Champions and BHU nurses have been instructed to complete and document the assessments within an hour of violent restraint initiation (Appendix J). The documentation will be entered into a Nursing Progress Note or ED Progress Note. ▪ A form is in the process of being created by the Trinity Restraint Team that will be part of the electronic health record. The implementation date is unknown at this time. <p>The Restraint Champion program will ensure compliance with the completion and documentation of face-to-face assessments. The hospital should be in full compliance with this standard by 9/4/2012. All Violent restraints that occur outside of BHU are reviewed by the Regulatory Accreditation Coordinator, and any non-compliant issues with the face-to-face assessments will be communicated to the staff nurse, manager, charge nurse that completed the face-to-face evaluation, and Chief Nursing Officer. This will ensure long term compliance. The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A185	<p>Actions to correct this deficiency include:</p> <ul style="list-style-type: none"> ▪ The Rehabilitation Manager educated all rehab RNs about the correct use of Enclosure beds and documentation requirements, including adequate documentation of the patient's behavior and response to restraints on or before 8/10/2012. ▪ The Restraint and Seclusion policy was updated on 8/23/2012 to remove enclosure beds as an acceptable exclusion for PRN restraint use. ▪ Implementation of "Restraint Champion" program on 8/8/2012 with 24/7 support by trained RNs until 9/17/2012. Restraint Champions participated in a three hour class regarding correct restraint documentation. One of the roles of Restraint Champions is to review all restraint documentation in the hospital with direct feedback to staff. One of the specific items the Restraint Champions review and educate staff about every shift includes correct documentation during initiation, assessment, and discontinuation of restraint, including specific patient behavior and response to restraints. 	9/4/2012

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	<ul style="list-style-type: none"> ▪ Reports are sent to the Staffing Office twice daily including a list of all patients in restraints over the past 24 hours. The Restraint Champions use the list to track compliance. In addition, a flyer was created and distributed to all units regarding the Restraint Champion program, including the requirement that the Restraint Champion be contacted when any restraint is initiated, changed, or discontinued. ▪ EHR changes on 8/28/2012 included mandatory free text boxes on the non-violent restraint Initiation and Assessment forms to document the patient's specific behavior requiring restraints. <p>Education, shift-to-shift auditing, and EHR changes will ensure that patient behavior and response to restraints is documented correctly in all patients' charts. All education and policy changes were complete by 8/23/2012 and full compliance should be obtained by 9/4/2012. Monthly restraint audits will be completed by the Regulatory Accreditation Coordinator. Charge nurses will audit all restraint patients' charts to ensure ongoing compliance, on the rehab unit and all other inpatient units. Charge nurses on the medical floor will be trained to be restraint resources on a long-term basis (after the Restraint Champion program ends on 9/17/12). The Chief Nursing Officer will be responsible for implementing this plan of correction.</p>	
A188	Please refer to Tag A185	9/4/2012
A450	<p>1.a. The Pre-Anesthesia Evaluation in the electronic health record will be revised to accurately reflect the care provided. These enhancements are: (1) The current "General Statement" will address lung and heart functions as assessed by the Anesthesiologist. (2) A new statement for "Lungs clear by Pre-Op RN examination" and "Regular heart rate and rhythms per Pre-Op RN". This medical record enhancement will allow the Anesthesiologist to accurately describe who performed portions of the physical examination and the documentation will reflect the patient's experience. Our Clinical Informatics specialist will add this enhancement to the Anesthesiologists electronic health record profile so it will be available to all Anesthesia providers. Anesthesiologists will be educated at the time the settings are changed in the electronic health record. Formal education will be conducted at the Anesthesia Department meeting on 9/6/2012.</p> <p>b. This issue has been determined to be an individual performance issue. The physician involved was informed of the issue by the Chief Quality Officer. The physician was counseled about the requirements and expected performance. The physician implemented changes to his office practice preop routine in order to ensure that an examination is performed within 30 days of surgery. The Director of Peri-Operative Services is responsible for this Plan of Correction, and compliance is expected by 9/4/2012.</p> <p>2. The physician dictated "today's date is 7/24/12" but did not say the procedure date was 7/23/12. Transcriptionist used date dictated as stated by surgeon as date of procedure. Transcription corrected this report</p>	9/4/2012

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to reflect the correct date of procedure immediately following the survey. Date of service errors are routinely corrected when brought to the attention of the transcription department. There is a process in place in Transcription to monitor "protocol" errors as part of the QA monitoring process for each transcriptionist, which has now become part of their quality score. The Health Information Management Director is responsible for this plan of correction and for continued monitoring of transcriptionist accuracy of visit and date of service entries. Full compliance is expected by 9/4/2012.

3. This particular case was an emergency C-section to be performed in ICU. The Anesthesia Preoperative Assessment form (an electronic form which is part of a new electronic charting process for Anesthesia that was implemented in July) contained pre-checked boxes "Consent signed-yes" and "Discussion with: Patient". In this case, these pre-checked fields should have been unchecked and the procedure should have been documented as emergent. Feedback and counseling were provided to this individual physician by the Anesthesia Medical Director immediately following the July survey. Education on this form, removing checks from irrelevant boxes in note templates in the EHR, the consent process, and documentation of emergent procedures was provided at the Anesthesia Department meeting by the Anesthesia Medical Director on 8/2/2012. The Anesthesia Preoperative Assessment form will be revised to include a field that will facilitate documentation of an emergent procedure. The Director of Peri-Operative Services and Anesthesia Medical Director are responsible for implementation of this plan of correction, and compliance should be obtained by 9/4/2012.

4. The screening criteria have been added in the form of a pick list into the electronic health record in the Family Maternity Center. This will facilitate nurses in clearly documenting the criteria for drug testing. Education on the requirements and changes in the documentation system were provided via email, posted in the unit, and discussed at a staff meeting on 8/14/12 by the FMC Manager. Auditing to ensure compliance will be conducted in one month by FMC manager. The screening criteria documentation process has been added to the new RN checklist. The Newborn Toxicology Testing policy was updated on 8/28/2012 to indicate the new process for documenting screening criteria. The Manager of the Family Maternity Center is responsible for implementation of this plan of correction, and compliance will be obtained by 9/4/2012.

5. The preoperative nursing staff received education on the importance of checking forms completed by patients prior to surgery for completion and accuracy, including dates, by the manager of this unit on 8/24/2012. In response to the finding that "The document was signed by Patient #50 and dated 7/27/12 (4 days after admission). Given that Patient #50 was admitted on 7/23/12, the document would not have been in effect as intended," we believe that, despite the dating error, the document would be in effect according to Idaho State law. Idaho State law says that the "last expressed wishes" of the patient are to be respected. In this case, despite

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	<p>the dating error, the completed document provided by the patient would be considered the “last expressed wishes” of the patient. The Director of Health Information Management is responsible for this plan of correction, and compliance is expected by 9/4/2012.</p> <p>6. Education was created for physicians, LIPs, and physician assistants regarding restraint use in the form of two flyers, “CMS Survey—What Providers Need to Know about Restraint (Appendix F)” and “Updated PowerChart Restraint Orders” (Appendix G). The first flyer included the expectation that providers complete an assessment regarding the need for restraints every day, and include the patient’s response to restraints in documentation. Educational flyers and the Restraint and Seclusion policy were sent out via e-mail by the Medical Staff Office on 8/23/12 to all providers with an attestation form to be returned indicating receipt and understanding. The educational flyers were presented at a Medical Executive Committee meeting on 8/27/12. One to one contact was provided to the top 60 providers (including physician assistants) that order restraints by the medical staff office to give them the flyers and policy. The Director of Medical Affairs is responsible for implementing this plan of correction. Compliance is expected by 9/4/2012.</p> <p>7. In addition to the education provided to all providers, the physician assistant mentioned in this deficiency was counseled by the manager of the rehabilitation unit regarding accurate restraint documentation. The Manager of the Rehabilitation unit is responsible for this plan of correction. Compliance is expected by 9/4/2012.</p> <p>All education, EHR changes, counseling, and auditing will ensure the hospital is compliant with this standard.</p>	
A724	<p>1. Food Service</p> <p>a. The Food Service labeling policy has been revised to more clearly define, in accordance with the Idaho Health Code, the proper labeling and dating process for perishable foods. New, water-soluble labels have been implemented. The labels contain pre-printed fields that standardize the information that is required on the label. Education has been provided to the food service staff on the labeling process by the Director of Food and Nutrition Services on or before 8/1/2012. The education has also been incorporated into the orientation for new staff. A daily audit process has been implemented, supervised by Food Service Manager/Patient Care Services. The Food Service Manager/Patient Care Services is responsible for implementation of this portion of the plan of correction and compliance was met 8/1/2012.</p> <p>b. i. In addition to the action plan on labeling described above, a new process for wrapping opened items that are returned to the freezer has been implemented. Clips will be used to seal open bags. The opened bags will be placed back in the box and the box will be labeled with the date that the bag was opened. Education has been provided to the food service staff by the Director of Food and Nutrition Services on the labeling/sealing process for returning items to the freezer by 8/1/2012. The education has also been</p>	9/4/2012

CMS Plan of Correction for Survey Completed July 31, 2012
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	<p>incorporated into the orientation for new staff. A daily audit process has been implemented, supervised by the Chef. ii. Please see plan of correction under f. Spill was cleaned up at the time of survey. Cleanliness of storage areas including store rooms, coolers, and freezers will be monitored every other day by the Chef. The Chef is responsible for implementation of this portion of the plan of correction and compliance was obtained 8/1/2012</p> <p>c. i. Staff was educated by the Director of Food and Nutrition on or before 8/1/2012 to squeegee any pools of water that extend past the mats. ii. The racks in the pot/pan washing room have been moved to clearly separate clean and soiled items. Staff was educated by 8/1/2012 by the Director of Food and Nutrition Services about a new practice that clearly requires that clean and soiled items are not to be stored in the same areas. The Job Coach for the developmentally disabled pot room attendant has been educated on the separation of clean and soiled items. The Job Coach will monitor for compliance with this daily as will the shift supervisors. The Food Service Manager/Patient Care Services is responsible for implementation of this portion of the plan of correction. Compliance was obtained 8/1/2012.</p> <p>d. The housing that holds the fluorescent light covers will be replaced to allow for easier removal and cleaning of the covers as soon as possible. The Director of Engineering is working on obtaining the covers, but they may need to be custom-made, so an installation date is unknown at this time. The Food Service Manager/Patient Care Services will supervise nightly cleaning of the covers once they are installed.</p> <p>e. i. A work order has been placed to install a screen on the drain. Installation will be complete by 9/4/12. The Facilities Manager is responsible for the implementation of this portion of the plan of correction. ii. The area under the counter in the catering pantry has been taped off to prevent placement of clean service ware in this area. The in-house catering staff received training on not storing items in this area on or before 8/1/2012. The Events Coordinator will monitor for compliance regularly, and is responsible for implementation of this portion of the plan of correction. Compliance will be obtained 9/4/2012.</p> <p>f. Environmental Services and Food Services developed a new Kitchen Cleaning Agreement which itemizes specific tasks and duties for which each department is responsible. With the implementation of this cleaning agreement, both departments now have a way to hold associates accountable to the cleaning process. The cleaning agreement lists the tasks that need to be addressed daily. For those areas under the responsibility of Environmental Services, monitoring will be done daily by the supervisor in charge of the kitchen cleaning program to ensure that the kitchen is getting cleaned to established standards. For those areas under the responsibility of Food Services, monitoring for cleanliness will be conducted every other</p>	
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CMS Plan of Correction for Survey Completed July 31, 2012
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	<p>day by Food Service Manager/Patient Care Services. The Director of Environmental Services and Food Service Manager/Patient Care Services are responsible for implementation of this plan of correction. Compliance was obtained by 8/1/2012.</p>	
<p>A749</p>	<p>Actions to correct this deficiency include:</p> <ol style="list-style-type: none"> 1. Clinical staff received education to take the red biohazard bags directly to soiled holding as soon as possible after completing patient care in the room. The education was provided through flyers (Appendix A and K), email and screensavers and completed by 8/27/2012. Nurse Managers are conducting observations and providing immediate feedback to staff if biohazard bags are found on the floor. To sustain the change, the Infection Preventionists will include observation of biohazard bag disposal in their rounding process. A question regarding biohazard bags on the floor in patient rooms has been added to monthly audits for RNs and Support Associates on the inpatient units. Audits are being conducted every shift, directed by the manager, on each inpatient unit. The Chief Nursing Officer is responsible for implementing this plan of correction. Compliance is expected to be obtained 9/4/2012. 2. Clinical staff received education on cleaning the blood glucose monitors between each patient use. The education was provided through flyers (Appendix A), email and posters. A small sign was placed in each blood glucose monitor case to remind staff to clean the monitor between patients. The policy "Blood Glucose Monitoring using the Precision Xceed Pro Bedside Glucometer" has been revised to include the requirement to clean the monitor between patients and describes the appropriate cleaning agent to be used. Infection Preventionists are monitoring the cleaning process through random observation of clinical staff during pre-meal glucose checks. A question regarding glucometer cleaning in between patients has been added to monthly audits for RNs and Support Associates on the inpatient units. The Infection Preventionist is responsible for implementing this plan of correction. Compliance is expected to be obtained by 9/4/2012. 3. Preoperative Area <ol style="list-style-type: none"> a) The Association of Operating Room Nurses (AORN) guidelines published in 2012 do not specify the sequence in which perineal and abdominal preps should be performed, and AORN guidelines were followed when updating the "Skin Antisepsis, Patient" policy in April 2012. The guidelines state that "Vaginal preps for procedures that include the abdomen should be performed in a manner to prevent splashing of antiseptic agent expelled from the vagina onto the prepped abdomen." Observations of gynecological surgeries were performed for a two week period. The deficiencies of not changing gloves prior to catheter insertion and prepping from the outer thigh region in to the vagina were confirmed to be 	<p>9/4/12</p>

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an individual performance issue. The RN has been educated and counseled on the proper procedure for completing a vaginal prep and changing gloves between the prep and urinary catheter insertion. We will continue to monitor his performance through impromptu observation and he will be held accountable to his performance on his annual evaluation. Although this was an individual issue, all OR staff were required to read and sign the "Skin Antisepsis, Patient" policy by 9/7/2012. Education on surgical preps and changing gloves will be provided at a staff meeting on 9/6/2012. The Surgery Director is responsible for the implementation of this plan of correction.

- b) OR staff were required to read and sign the "Environmental Sanitation in Perioperative Areas" policy by 9/7/2012. Education on ensuring that carts containing contaminated articles are contained and/or covered as they are transported out of the OR will be provided at a staff meeting on 9/6/2012. OR Managers will round regularly to ensure compliance with covering contaminated items during transport. The Surgery Director is responsible for the implementation of this plan of correction.

4.Laboratory

- a. All personal lotions have been removed from the laboratory and have been replaced with hospital-approved lotion as of 8/1/2012. The policy "General Standards of Personal and Laboratory Safety" was revised to state "only hospital approved hand lotions may be used in the laboratory" on 8/21/2012. The laboratory management conducted 1:1 training with each staff member on not using personal lotions by 8/28/2012. Observation audits of the laboratory for use of personal lotions will be conducted weekly for one month and then quarterly. The Laboratory Director is responsible for the implementation of this plan of correction. Compliance was obtained 8/28/2012.
- b. All containers containing Amphyl disinfecting solution have been labeled appropriately. Labels have been standardized so that they contain all required information. Laboratory management is conducting a product evaluation of germicidal wipes vs. solution. Factors included in the evaluation are product effectiveness, dwell time, convenience, accessibility and cost. The laboratory management is conducting 1:1 training with each staff member on labeling of decanted solutions. Observation audits of the laboratory for appropriate labeling will be conducted weekly for one month and then quarterly. The Laboratory Director is responsible for the implementation of this plan of correction. Compliance was obtained 8/23/2012.

5.Food Service

- a. The Food Service labeling policy was revised to more clearly define, in accordance with the Idaho Health Code, the proper labeling and dating process for perishable foods. New, water-soluble labels have been implemented. The labels contain pre-printed fields that standardize the information that is required on the

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	<p>label. Education has been provided to the food service staff on the labeling process by the Director of Food and Nutrition Services on or before 8/1/2012. The education has also been incorporated into the orientation for new staff. A daily audit process has been implemented, supervised by Food Service Manager/Patient Care Services. The Food Service Manager/Patient Care Services is responsible for implementation of this portion of the plan of correction and compliance was met 8/1/2012.</p> <p>b. In addition to the action plan on labeling described above, a new process for wrapping opened items that are returned to the freezer has been implemented. Clips will be used to seal open bags. The opened bags will be placed back in the box and the box will be labeled with the date that the bag was opened. Education was provided to the food service staff by the Director of Food and Nutrition Services on the labeling/sealing process for returning items to the freezer by 8/1/2012. The education has also been incorporated into the orientation for new staff. A daily audit process has been implemented, supervised by the Chef. The Chef is responsible for implementation of this portion of the plan of correction and compliance was obtained 8/1/2012</p> <p>c. The racks in the pot/pan washing room have been moved to clearly separate clean and soiled items. Staff was educated by 8/1/2012 by the Director of Food and Nutrition Services that clean and soiled items are not to be stored in the same areas. The Job Coach for the developmentally disabled pot room attendant has been educated on the separation of clean and soiled items. The Job Coach will monitor for compliance with this daily as will the shift supervisors. The Food Service Manager/Patient Care Services is responsible for implementation of this portion of the plan of correction. Compliance was obtained 8/1/2012.</p> <p>d. No finding listed.</p> <p>e. i. A work order has been placed to install a screen on the drain. Installation will be complete by 9/4/12. The Facilities Manager is responsible for the implementation of this portion of the plan of correction. ii. The area under the counter in the catering pantry has been taped off to prevent placement of clean service ware in this area. The in-house catering staff received training on not storing items in this area on or before 8/1/2012. The Events Coordinator will monitor for compliance regularly, and is responsible for implementation of this portion of the plan of correction. Compliance will be obtained 9/4/2012.</p> <p>f. Environmental Services and Food Services developed a new Kitchen Cleaning Agreement which itemizes specific tasks and duties for which each department is responsible. With the implementation of this cleaning agreement, both departments now have a way to hold associates accountable to the cleaning process. The cleaning agreement lists the tasks that need to be addressed daily. For those areas under the responsibility of Environmental Services, monitoring will be done daily by the supervisor in charge of the kitchen cleaning</p>	
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CMS Plan of Correction for Survey Completed July 31, 2012
Saint Alphonse Regional Medical Center

program to ensure that the kitchen is getting cleaned to established standards. For those areas under the responsibility of Food Services, monitoring for cleanliness will be conducted every other day by Food Service Manager/Patient Care Services. The Director of Environmental Services and Food Service Manager/Patient Care Services are responsible for implementation of this plan of correction. Compliance was obtained by 8/1/2012.

6. Hand Hygiene

- a. The Infection Preventionist conducted observations of work flow processes, hand hygiene and glove use in the Outpatient Phlebotomy area. Recommendations for product and work flow changes were provided to the Laboratory Director. The Laboratory Director created a detailed procedure for phlebotomy. Changes include: gathering supplies before donning gloves, palpating the vein prior to cleansing the patient's arm, placing supplies on a clean cloth for each patient, placing a clean cloth on the arm of the chair for each patient, using individually wrapped alcohol pledgets instead of cotton balls and an alcohol pump, performing hand hygiene after glove removal and prior to touching clean supplies or other work areas. The laboratory management is conducting 1:1 training with each phlebotomist. Observation audits of the phlebotomy process will be conducted weekly for one month and then quarterly. The new procedure, training, and auditing will ensure that infection control standards are met by phlebotomists in the lab. The Laboratory Director is responsible for the implementation of this plan of correction. Compliance was obtained by 8/27/2012.
- b. Nursing staff received education on performing hand hygiene prior to accessing clean supplies through flyers (Appendix A) and from Nurse Managers at the unit-based daily huddles. Monitoring for performing hand hygiene prior to accessing clean supplies will be added to the hand hygiene observer checklist. Infection Prevention staff will observe for appropriate hand hygiene during daily rounds. A question regarding hand hygiene prior to accessing supplies has been added to monthly audits for RNs and Support Associates on the inpatient units. The Infection Preventionists are responsible for this plan of correction. Compliance is expected by 9/4/2012.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDDK97	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2012
NAME OF PROVIDER OR SUPPLIER ST ALPHONSUS REGIONAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1055 NORTH CURTIS ROAD BOISE, ID 83706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the Idaho state licensure survey of your hospital. Surveyors conducting the review were: Gary Guiles, RN, HFS, Team Leader Aimee Hastriter, RN, HFS Susan Costa, RN, HFS Rebecca Lara, RN, HFS	B 000		
BB175	16.03.14.310.03 Patient Care Plans 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) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to A166 as it relates to the failure of the facility to ensure plans of care were modified to provide direction to staff regarding restraint use.	BB175		
BB210	16.03.14.320.09 Dietary Sanitation	BB210		

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Bureau of Facility Standards

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

TITLE
Rodney J. Reiter

(X6) DATE
8.30.12

Bureau of Facility Standards

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BB210	Continued From page 1 09. Dietary Sanitation. Sanitary standards for hospitals shall be those found in Idaho Department of Health and Welfare Rules, IDAPA 16.02.19, "Rules Governing Food Sanitation Standards Food Establishments (UNICODE)". (12-31-91) This Rule is not met as evidenced by: Refer to A-724 as it relates to food preparation and environmental concerns.	BB210		
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant	BB283		

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BB283	Continued From page 2 which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90)	BB283		

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BB283	Continued From page 3 ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to A450 as it relates to the failure of the facility to ensure patients' medical records 1) accurately and effectively described services provided to patients and patients' response to those services and 2) were complete.	BB283		
BB553	16.03.14.550.03 Garbage and Reguse Disposal 03. Garbage and Refuse Disposal. All garbage from the hospital shall be disposed of as follows: (10-14-88) a. All garbage and refuse shall be collected, stored, and disposed of in a manner that shall not permit the transmission of communicable disease, create a nuisance or fire hazard, or provide a breeding place for insects or rodents; and (10-14-88) b. When municipal garbage collection and disposal services are not available, garbage shall be disposed of by garbage grinders, incineration, burial sanitary fill, or other methods approved by the Department. (10-14-88) This Rule is not met as evidenced by: Based on observation, interview, and review of policies, it was determined the facility failed to ensure biohazardous refuse was stored and	BB553		

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BB553	<p>Continued From page 4</p> <p>disposed of to mitigate potential cross contamination of infectious diseases. This directly impacted 3 of 29 Departments/Units (Telemetry, Neurology, and General Surgery) toured, and had the potential to impact all staff, visitors, and patients cared for at the facility. The failure to ensure implementation and monitoring of systems had the potential to expose patients and staff to infections. Findings include:</p> <p>Biohazardous materials were not disposed of in a manner to minimize the risk of cross contamination as follows:</p> <p>The hospital's "Exposure Control Precautions," policy, dated 5/10/12, indicated, "All Regulated Waste will be placed in a red bag. Red bag waste will be placed in a red, rigid container with a biohazard label to be transported off-site for incineration."</p> <p>A housekeeper on the General Surgery Unit was interviewed on 7/23/12 at 11:10 AM. She stated that floor staff always placed biohazardous materials in the designated red biohazard bags. She explained that staff then placed the red bag on the floor next to the trash can in the patient's room and she would transport the red bag to the biohazard bin in the soiled utility room.</p> <p>A housekeeper on the Telemetry Unit was interviewed on 7/24/12 at 2:30 PM. She confirmed that floor staff typically placed biohazardous materials in the red biohazard bags. She stated that she would find the bags on the floor next to the trash can in the patient's room. She stated that if the red bag had not been tied closed by nursing staff she would not remove the bag, but if it was a closed bag she would transport it to the red biohazard bin in the soiled</p>	BB553		

Bureau of Facility Standards

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BB553	<p>Continued From page 5</p> <p>utility room.</p> <p>A housekeeper on the Neurology Unit was interviewed on 7/24/12 at 3:15 PM. She stated she did not have any concerns related to biohazardous materials placed in with the regular waste in the trash cans in patient's rooms. She stated staff placed biohazardous materials in the red biohazard bags and set the bags next to the trash can in the room. She explained that she transported the red bag to the biohazard bin in the soiled utility room.</p> <p>Infection Prevention Specialists A, B, and C were interviewed jointly on 7/27/12 at 11:05 AM. All three individuals stated they believed that nursing staff were transporting the red biohazard bags to the hard-walled biohazard container in the soiled utility room. Each confirmed the expectation that the biohazard bags be disposed of immediately and not placed on the floor to await housekeeping services.</p> <p>The facility failed to ensure that biohazardous materials were disposed of to minimize the risk of cross contamination.</p>	BB553		

State Plan of Correction for Survey Completed July 31, 2012
Saint Alphonsus Regional Medical Center

Tag	Plan of Correction	Completion Date
BB175	Please refer to Federal Tag A166.	
BB210	Please refer to Federal Tag A724.	
BB 283	Please refer to Federal Tag A450.	
BB553	Please refer to Federal Tag A749.	

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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
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September 12, 2012

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

Provider #130007

Dear Ms. Jeffcoat:

On **July 31, 2012**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005586

Allegation #1: The hospital did not follow patients' advance directives.

Findings #1: An unannounced visit was made to the hospital from 7/23/12 to 7/31/12. The investigation occurred in conjunction with a full Medicare recertification survey and state licensure survey. The medical records of 57 patients were reviewed. Hospital policies, personnel files, and administrative records were reviewed. Staff, patients, and family members were interviewed. Observations were conducted on the main campus as well as off site locations.

The medical records of 35 in-patients were reviewed, including 4 medical records of patients who had passed away. All of the adult in-patient records contained documentation regarding advance directives. None of the records reviewed indicated a patient's advance directive was not followed.

One medical record documented an 82 year old male who presented to the Emergency Department on 3/03/12. He was diagnosed with pneumonia and admitted to the telemetry floor. He had a Physician Orders for Scope of Treatment (POST) form which stated he did not wish to be resuscitated. He also had a living will stating he did not want treatment to prolong his life

under certain circumstances.

The patient's History and Physical (H&P), dated 3/03/12, stated he presented to the emergency department with respiratory symptoms. After a conversation between the physician and the patient's wife, the patient was placed on "comfort care" measures. This meant he was to be kept comfortable but no curative measures would be taken. The H&P stated the patient was then brought to a medical floor. It stated there was a mis-communication with the nurses about the patient's comfort care status. The nurses knew the patient had a Do Not Resuscitate order but did not yet know he had been placed on comfort care. When the patient arrived on the floor, he was breathing poorly. A nurse summoned the medical response team. The medical response team does not provide resuscitation. It is a team of nursing and other personnel who are specially trained to assess patients who may be deteriorating medically. The team does not have the authority to treat patients without the permission of a physician.

The medical response team had a cart. The patient's wife thought this was a treatment cart. The H&P stated the patient's wife became very upset. The H&P stated the physician arrived on the scene at the same time the medical response team arrived. The patient did not receive any treatment by the medical response team. The patient's advance directive was followed.

The above events were confirmed by interview with the patient's physician and the patient's wife.

Following this event, the hospital changed the way nurses on inpatient units were informed of comfort care measures.

No evidence was present that advance directives were not followed.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients or their legal representatives were not allowed to obtain copies of their medical records.

Findings #2: An unannounced visit was made to the hospital from 7/23/12 to 7/31/12. The investigation occurred in conjunction with a full Medicare recertification survey and state licensure survey. The medical records of 57 patients were reviewed. Hospital policies, personnel files, and administrative records were reviewed. Staff, patients, and family members were interviewed. Observations were conducted on the main campus as well as off site locations.

The system for release of medical records was reviewed. Policies and procedures were in place. A log was kept of requests and what documents were released. A procedure had been developed regarding patients who had died and what proof was required to release records to family or other

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patient representatives. The Director of Health Information reviewed the requests for release of the medical records of deceased patients prior to release of the records.

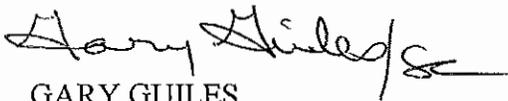
One medical record documented an 82 year old male who was admitted to the telemetry floor and died 5 days later. Administrative records showed his wife requested a copy of his medical record. The hospital requested evidence that she was entitled to the medical record. She provided this evidence and was given a copy of the medical record.

No evidence was found that patients or their legal representatives were prevented from obtaining copies of their medical records. The complaint could not substantiated.

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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm