DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Western Division of Survey and Certification
Seattle Regional Office
2201 Sixth Avenue, RX-48
Seattle, WA 98121

IMPORTANT NOTICE – PLEASE READ CAREFULLY

November 23, 2012

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

CMS Certification Number: 13-0007

Re: Restore "deemed" status through Joint Commission accreditation

Dear Ms. Jeffcoat:

The Idaho Bureau of Facility Standards (State survey agency) completed a full health and life safety code survey on July 31, 2012 and determined that the Condition of Participation (CoP) at Patient Rights (42 CFR § 482.13) was not met. Following submission of a Plan of Correction, the State survey agency conducted a revisit survey on October 30, 2012 and determined that St Alphonsus Regional Medical Center has met all the Medicare Hospital Conditions of Participation.

As a result of St Alphonsus Regional Medical Center's compliance with federal requirements, the Centers for Medicare and Medicaid Services (CMS) will reinstate the hospital's Medicare "deemed" status through The Joint Commission and remove the hospital from the State survey agency's survey jurisdiction. Copies of this letter are being provided to the State survey agency and the Joint Commission.

If you have any questions, please contact me at (206) 615-2432.

Sincerely,

Kate Mitchell

Kate Mitchell, Health Insurance Specialist
Division of Survey and Certification - Seattle

cc: Idaho Bureau of Facility Standards
The Joint Commission

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

November 1, 2012

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

RE: St Alphonsus Regional Medical Center, Provider #130007

Dear Ms. Jeffcoat:

On October 30, 2012, a follow-up visit of your facility, St Alphonsus Regional Medical Center, was conducted to verify corrections of deficiencies noted during the survey of July 31, 2012.

We were able to determine that the Condition of Participation of Patient Rights is now met.

Your copy of a Post-Certification Revisit Report, Form CMS-2567B, listing deficiencies that have been corrected is enclosed.

Thank you for the courtesies extended to the surveyors during their visit. If we can be of any help to you, please call us at (208) 334-6626.

Sincerely,

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srm
Enclosures
ec: Kate Mitchell, CMS Region X Office

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November 1, 2012

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

Provider #130007

Dear Ms. Jeffcoat:

On **October 29, 2012**, a complaint survey was conducted at St Alphonsus Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005772

Allegation #1: A patient was pressured to sign an informed consent without understanding the risks and benefits of the proposed surgery.

Findings #1: An unannounced compliant investigation was completed from 10/29/12 through 10/30/12. Four records of discharged surgical patients and facility policies were reviewed. Patients were interviewed.

Six patients cared for on the Orthopedic Unit were interviewed. Five patients confirmed that staff explained the risks and benefits of the treatment they received. They stated they were satisfied with the discussions about surgery or proposed surgery. Each of the five patients expressed feeling comfortable with the process by which consents were obtained, for both planned and unplanned surgeries.

One patient stated they felt pressured to sign consent for surgery without understanding the risks and benefits of the procedure. The patient stated he told staff he was not able to understand the risks and benefits of the procedure and explained that he was in a significant amount of pain. His medical record contained a consultation report completed by the orthopedic surgeon at 6:22 AM

the morning of the patient's admission. The surgeon documented discussing the risks and benefits of the required procedure and noted the patient "understood all these risks and wished to proceed. All questions were answered and informed consent was obtained." The RN documented a nursing assessment at 4:00 PM. She documented the patient was receiving morphine via a patient controlled pump and that the patient stated that he had no pain. The RN noted the patient was alert and oriented to person, place, time, and situation, responded appropriately, displayed sound judgement, and that the patient's memory was intact. The RN documented the patient was appropriate, calm, and cooperative. His medical record indicated his consent for surgery was signed by the patient and a witness at 4:05 PM.

Three additional medical records of surgical patients were reviewed. Each contained documentation that that consents for admission for care and surgery were signed by appropriate individuals. Two medical records contained consents signed prior to elective surgery. One trauma record contained consents signed by the patient's representative after the patient received sedative medication and was deemed not capable of giving his own consent.

It could not be determined that patients were pressured to sign informed consents without understanding the risks and benefits of the proposed surgery.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients' hygiene needs were not attended to.

Findings #2: An unannounced compliant investigation was completed from 10/29/12 through 10/30/12. Four records of discharged surgical patient were reviewed and patients were interviewed.

Six patients who were cared for on the Orthopedic Unit were interviewed. Five patients stated staff helped, or offered to help, complete hygiene cares throughout their stay. Each patient confirmed they felt staff were readily available when needed and they were happy with the care they received.

One patient stated that he was not assisted with his hygiene needs during his stay. He stated that he was assisted with oral care but was not offered assistance with bathing.

The patient's medical record was reviewed. According to the medical record the patient was admitted to the hospital through the Emergency Department at 1:12 AM and was discharged two days later at 7:00 PM in the evening. The medical record indicated the patient had surgery late in the evening of the first day of admission. Nursing notes indicate that on the first post-operative day, at 8:05 AM, the patient was set up for oral care and had bed linens changed, but refused

pericare at this time. At 10:41 AM the same day, the patient was set up for bathing (soap, warm water, towels). At 11:52 AM, staff documented the patient completed a bed bath independently. At 8:00 PM, the patient was set up for oral care. The patient was discharged at 7:00 PM the following day. There was no documentation of hygiene care for this day.

Three additional medical records of surgery patients were reviewed. Each record contained frequent documentation of either assistance with, or completion of, hygiene care such as bathing, oral care, and linen changes. The medical records also documented when patients declined assistance with hygiene needs.

It could not be determined that patients' hygiene needs were not attended to.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: A patient's medical record contained inaccurate documentation related to discharge information.

Findings #3: An unannounced compliant investigation was completed from 10/29/12 through 10/30/12. Four records of discharged surgical patients were reviewed. Staff and patients were interviewed.

Four records were reviewed for discharge information. Each record contained documentation of medications which had been prescribed for use at home, educational material related to these medications, follow up instructions for care related to the specific surgery performed, and instructions on when and how to contact physician for any questions or concerns.

Six patients cared for on the Orthopedic Unit were interviewed. Five patients stated they were involved in their discharge planning process and were aware plans for care at home. Each patient confirmed they were comfortable with the discharge plans and who to contact if they had any questions or concerns.

One patient expressed concern that the discharge documentation did not accurately represent the medications dispensed at discharge. According to the patient, the patient received two prescriptions upon discharge, Lovenox (an anticoagulant given via subcutaneous injection) and Oxycodone (a pain medication). The patient stated the discharge documentation indicated four prescriptions and a bottle of pills were dispensed upon discharge.

The patient's medical record was reviewed. The discharge information contained documentation that the patient received prescriptions for Oxycodone, Xarelto (an anticoagulant in pill form), Valium (sedative), and Phenergan (anti-nausea medication). There was no documentation the

patient received a bottle of pills upon discharge.

An RN from the Orthopedic Unit reviewed the above medical record and was interviewed on 10/30/12.

She stated medications were not typically given to patients at discharge, rather prescriptions were given for medications to be filled at the patient's pharmacy. She stated that on rare occasions small amounts of medications, usually 10 days worth or less, could be dispensed upon discharge as part of a patient assistance program. She stated to obtain medications in this manner, the Case Manager worked with the patient to complete financial paperwork to demonstrate need. She confirmed there was no documentation that this patient received medications through a patient assistance program.

It could not be determined that a patient's medical record contained inaccurate documentation related to discharge information.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Surgery was delayed resulting in a negative patient outcome.

Findings #4: An unannounced compliant investigation was completed from 10/29/12 through 10/30/12. Medical records were reviewed and patients were interviewed.

Six patients who were cared for on the Orthopedic Unit were interviewed. Three patients had surgeries that were scheduled prior to their admission. Three patients were seen in the ED (###) and required surgery as a result of decisions based on assessments. One patient stated the surgeon was waiting for his condition to stabilize before performing surgery and a second patient stated that surgery had been performed in a timely manner.

A third patient stated that during follow up visit with his surgeon, the surgeon indicated that based on the injuries surgery should have been completed much sooner than it was. The patient stated that he suffered negative outcome because of the delay in surgery.

This patient's medical record was reviewed. The medical record contained documentation that the patient arrived in the ED at 1:12 AM. The ED physician completed a thorough assessment of the patient and notified the orthopedic surgeon that the patient would be admitted and required a consultative evaluation. The ED physician documented that the patient suffered an injury at 9:00 PM (approximately 4 hours before arriving to the ED) and that the orthopedic surgeon would "likely schedule in the next day or 2."

The orthopedic surgeon documented a consultation with the patient at 6:22 AM. The orthopedic surgeon documented completing a thorough assessment of the patient and review of the diagnostic imaging. The orthopedic surgeon documented the patient "will be scheduled for surgery this afternoon." The medical record indicated the patient was in the operating room from 7:56 PM to 11:03 PM that night. The medical record did not contain documentation to indicate the patient suffered negative outcome as a result of having surgery 23 hours after the initial injury.

It could not be determined surgery was delayed resulting in a negative patient outcome.

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.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

AH/sc