



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

RE: Kootenai Medical Center, Provider #130049

Dear Mr. Ness:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on December 4, 2012.

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

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

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

Jon Ness, Administrator

December 18, 2012

Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by **December 28, 2012**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

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

Sincerely,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/sc

Enclosures



2003 Kootenai Health Way  
Coeur d'Alene, Idaho 83814  
208.666.2000 tel  
www.kootenaihealth.org

December 27, 2012

Rebecca Lara  
Health Facility Surveyor  
Idaho Department of Health and Welfare  
Bureau of Facility Standards  
3232 Elder Street  
Boise, ID 83720

Dear Rebecca,

Attached is the Plan of Correction for the Medicare deficiencies A118, Patient's Rights: Grievances and A144, Patient Rights: Care in a Safe Setting. The findings have been addressed and corrected as of 12.17.2012. If you have any questions or need further information, please contact me.

Sincerely,

A handwritten signature in cursive script that reads 'Lorraine Olsheski'.

Lorraine Olsheski  
Executive Director of Quality and Risk Management

Cc Jon Ness

RECEIVED

DEC 27 2012

FACILITY STANDARDS

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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/04/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  KOOTENAI MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

A 000	<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>Rebecca Lara, RN, BA, HFS Team Leader Susan Costa, RN, HFS Libby Doane, RN, BSN, HFS Gary Gulles, RN, BS, HFS Aimee Hastriter, RN, BSN, HFS</p> <p>Acronyms used in this report include:</p> <p>AMA = Against Medical Advice ED = Emergency Department RN = Registered Nurse</p>	A 000	<p>RECEIVED DEC 27 2012 FACILITY STANDARDS</p>	
A 118	<p>482.13(a)(2) PATIENT RIGHTS: GRIEVANCES</p> <p>The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review, staff interview, and review of hospital policies and grievances, it was determined the hospital failed to ensure grievances were identified and promptly resolved for 1 of 11 patients (Patient #22) whose grievances were reviewed. This resulted in delayed investigation of a patient's concerns regarding a staff person's behavior toward patients. Findings Include:</p> <p>Patient #22's medical record documented a 15 year old male who was admitted to the adolescent psychiatric unit on 9/19/12. He presented to the ED with suicidal ideation and</p>	A 118	<p>Education in tracing all AMA cases had occurred in investigating all AMA's as possible grievances.</p> <p>All AMA reports through the event notification system have been monitored by the Pt. Advocacy Manager &amp; will be ongoing</p> <p>Mother of Patient #22 met w/ Director of BH &amp; manager of Youth Acute Unit Complaint clarified, investigated w/ resolution</p>	<p>12-17-12 12-17-12 11-12-12 12-17-12</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lorraine K. Oleschki TITLE: Executive Director of Quality & Risk Mgmt (X8) DATE: 12-27-12

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

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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/04/2012
NAME OF PROVIDER OR SUPPLIER  KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(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 118	<p>Continued From page 1</p> <p>depression. Patient #22 was discharged AMA to the care of his parents on 9/23/12.</p> <p>On 9/23/12 at 7:53 PM, an RN documented a conversation with Patient #22 and his parents. The note included the parents dissatisfaction with the treatment their son had received. The note documented the parents indicated the unit was not what they expected and stated "their son was admitted for suicidal ideation, not behavior issues." The note also said Patient #22's parents expressed concern about a specific male staff member who they reported had glared at them several times. The nurse's note also included Patient #22's complaint that the male staff member had singled him out and yelled at him. Documentation indicated Patient #22 was released AMA to the care of his parents as a result of their dissatisfaction with care.</p> <p>The Patient Advocacy Manager was interviewed on 11/30/12, beginning at 10:30 AM. He stated the incident related to Patient #22 was initially documented and reported as an AMA discharge, but not a grievance. He went on to report that as a result of a recently revised process, he was reviewing reports of AMA discharges to ensure all grievances would be investigated. He stated the AMA discharge documentation for Patient #22 would have been considered a grievance. He stated the investigation process, including phone contact with the family, should have been initiated approximately 2 weeks prior to the survey, but the facility had failed to do so. The 2 week time frame was based on the date the facility identified the grievance.</p> <p>Patient #22 and his parents voiced their</p>	A 118	Letter attached - Exhibit A	



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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 12/04/2012
NAME OF PROVIDER OR SUPPLIER  KOOTENAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(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 144	<p>Continued From page 3</p> <p>including nurses, mental health specialists, the physician and the therapist. She spoke of a male staff member who she identified by name. She described the male staff member as "a mean person who didn't treat patients with respect or understanding." She went on to say "He was working with the little kids one night this week, and he was yelling at them until he made someone cry. It almost made me cry to listen to him."</p> <p>b. A randomly selected male adolescent patient on the psychiatric unit was interviewed on 11/29/12, beginning at 2:00 PM. The patient stated the Mental Health Specialist, noted above, was mean and had a gruff angry manner. The patient was not able to articulate any specific threatening behavior by the Mental Health Specialist but he was clearly bothered by the employee. The patient stated when he had to interact with the employee, he would think, "Please let him be nice this time. Please let him be nice this time." This interfered with the patient's ability to focus on his therapy.</p> <p>The Director of Behavior Health was interviewed on 11/29/12, beginning at 2:45 PM. Results of the interview with both adolescent patients were discussed. She stated she was unaware of the on-going inappropriate and unprofessional behavior exhibited by the male Mental Health Specialist and indicated she would follow up immediately.</p> <p>Patients did not feel emotionally safe on the adolescent psychiatric unit.</p> <p>2. A closed record documented the</p>	A 144		

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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/04/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  KOOTENAI MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814
---	--

(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 144	<p>Continued From page 4</p> <p>dissatisfaction of a patient and his parents, indicating the patient did not feel emotionally safe and the patient and family were not treated with respect.</p> <p>Patient #22's medical record documented a 15 year old male who was admitted to the adolescent psychiatric unit on 9/19/12. He presented to the ED with suicidal ideation and depression. Patient #22 was discharged AMA to the care of his parents on 9/23/12.</p> <p>On 9/23/12 at 7:53 PM, an RN documented a conversation with Patient #22 and his parents. The note included the parents dissatisfaction with the treatment their son had received. The note documented the parents indicated the unit was not what they expected and stated "their son was admitted for suicidal ideation, not behavior issues." The note also included that Patient #22's parents identified and expressed concern about a specific male staff member, identified as the same individual spoken of by the current patients, who they reported had passed by and glared at them several times during the visit. The nurses note also stated Patient #22's complained the male staff member had singled him out and yelled at him. Documentation indicated Patient #22 was released AMA to the care of his parents as a result of their dissatisfaction with care.</p> <p>Patient #22 and his parents did not feel they were treated appropriately and with respect.</p> <p>3. The personnel file of an employee identified during current patient interviews and in Patient #22's medical record documented a pattern of unprofessional and inappropriate behavior.</p>	A 144		
-------	--	-------	--	--

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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>130049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/04/2012</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>KOOTENAI MEDICAL CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814</b>
--	--

(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 144	<p>Continued From page 5</p> <p>The personnel file of a male Mental Health Specialist was reviewed with the Director of Behavioral Health on 11/28/12, beginning at 3:15 PM. The file included documentation of incidents that resulted in disciplinary action as follows:</p> <p>An "EMPLOYEE EVENT RECORD," dated 4/04/07, documented 3 patient grievances had been reported. The document also included co-worker observations of inappropriate behavior toward patients, including inappropriate language, provoking behavior and lack of empathy related to patients' problems. An action plan to improve the employee's performance was implemented.</p> <p>A document titled, "Notice of Performance and/or Job Related Behavior Concerns," dated 4/09/11 was reviewed. Areas of performance concern included:</p> <ul style="list-style-type: none"> <li>- Lack of empathy</li> <li>- Joking about patient problems</li> <li>- Swearing</li> <li>- Tone of voice - harsh and abrasive</li> <li>- Harsh statements to patients</li> </ul> <p>A "Notice of Performance - Intent to Terminate," dated May 5/05/11, was reviewed. The document discussed 6 incidents that were reported between 4/07/07 and 5/02/11. Areas of performance concern included:</p> <ul style="list-style-type: none"> <li>- Breach of patient confidentiality</li> <li>- Crossed professional and ethical boundaries</li> <li>- Lack of empathy</li> <li>- Argumentative with patient's family</li> </ul>	A 144		
-------	--	-------	--	--

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

PRINTED: 12/10/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/04/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  KOOTENAI MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814
---	--

(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 144	<p>Continued From page 6</p> <p>Additionally, the document stated the employee was expected to meet specific standards of employee conduct and ethics included in the facility's "Code of Ethics and Conduct." Documentation included the employee was expected to provide a safe work place and protect the environment."</p> <p>The performance notice also discussed a plan of action. The action plan included the employee was expected to "meet and sustain" the performance and behavioral expectations of a Mental Health Specialist employed by the facility. Another point in the plan of action indicated that failure to meet and sustain performance and/or behavioral standards of the facility would result in termination of employment.</p> <p>The Director of Behavioral Health was interviewed on 11/28/12, beginning at 3:15 PM. She confirmed this Mental Health Specialist had a history of inappropriate interactions with patients and crossing professional/ethical boundaries.</p> <p>The facility failed to consistently provide an emotionally safe and supportive environment for patients.</p>	A 144		
-------	--	-------	--	--



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005737**

**Allegation #1:** The facility failed to provide an emotionally supportive and safe environment for patients.

**Findings #1:** An unannounced survey was conducted at the hospital from 11/26/12 through 11/30/12. Surveyors reviewed medical records, hospital policies related to patient rights and nursing services, personnel files, grievance logs and administrative documents. Surveyors also interviewed patients and staff on the adolescent/child psychiatric unit and observed the nursing staff providing care to and interacting with patients.

Three current patients on the adolescent/child psychiatric unit were separately interviewed during the survey about the care they had received and interactions with staff. All patients who were interviewed spoke favorably of the program and majority of the staff. However, two patients identified the same male staff member and indicated he behaved in an unprofessional manner when interacting with patients. The two patients also indicated the male staff member did not treat patients with respect and failed to provide an emotionally supportive, safe environment.

Jon Ness, Administrator  
December 18, 2012  
Page 2 of 4

One medical record that was reviewed documented a 15 year old male who was admitted to the adolescent psychiatric unit on 9/19/12 for suicidal ideation and depression. The record documented he was discharged against medical advice to the care of his parents on 9/23/12.

A nurses note, dated 9/23/12, documented a visit by the parents and indicated they were dissatisfied with the care their son had received. The note stated the parents admitted their son for treatment of depression and suicidal ideation, not behavioral problems. The note also documented the patient and parents concern about a particular male staff member who the patient stated singled him out and yelled at him. The nurses note said the patient's parents informed the nurse that the male staff member had passed by and glared at them several times during the visit. Documentation finally indicated the patient was discharged to his parents against the medical advice.

The personnel file of the male staff member identified during patient interviews and in the medical record discussed earlier was reviewed. A pattern of unprofessional behavior and resulting disciplinary action was documented in the personnel file. A disciplinary action plan that addressed the employee's inappropriate and unprofessional behavior had been implemented and remained in effect at the time of the survey.

Results of the investigation were discussed with the Director of Behavioral Health on 11/29/12. She stated she was unaware of the on-going and recent complaints of inappropriate and unprofessional behavior exhibited by the male staff member. She then stated she planned to follow up immediately.

The hospital did not ensure all staff working on the adolescent/child psychiatric unit treated patients with respect or consistently provided an environment that fostered feelings of emotional safety. Therefore, the allegation was substantiated and deficiencies were cited.

Conclusion #1: Substantiated. Federal deficiencies related to the allegation are cited.

**Allegation #2:** The facility failed to provide status updates to the parents of adolescent psychiatric patients.

**Findings #2:** An unannounced survey was conducted at the hospital from 11/26/12 through 11/30/12. Surveyors reviewed medical records, hospital policies related to patient rights and nursing services, personnel files, grievance logs and administrative documents. Surveyors also interviewed patients and staff throughout the hospital, including the adolescent/child psychiatric unit.

Jon Ness, Administrator  
December 18, 2012  
Page 3 of 4

Three current patients hospitalized at the time of the survey were interviewed about their families and/or designees ability to obtain updates about their condition. All patients were aware that in order for someone to obtain information about them during the time they were hospitalized, the facility had to have documented approval from the patient or patient's designee. On the adult and adolescent/child psychiatric units, family members/designees and friends had be able to convey an appropriate identification number and their names had to be included on a parent/guardian approved list.

One medical record that was reviewed documented a 15 year old male who was admitted to the adolescent psychiatric unit on 9/19/12 for suicidal ideation and depression. The record documented he was discharged against medical advice to the care of his parents on 9/23/12.

The medical record documented permission for the staff to release information to the parents about their son. Documentation of five telephone conversations between various staff and the patient's mother were also contained in the medical record.

Staff on the adolescent/child psychiatric units were interviewed during the survey. All staff offered similar responses when questioned about releasing information about a patient by telephone. All staff understood they were allowed to release updated information to a caller if approval/consent by the patient/patient designee was documented in the medical record.

Hospital policies related to release of information were reviewed and found to be appropriate. When questioned, staff on the adolescent/child psychiatric unit were aware of the policies and the process for releasing information to a caller. Staff stated there have been times when parents called requesting to speak to a physician or therapist and they have not been available. When that situation occurred, staff stated they took a message and notified the physician or therapist as soon as possible. Additionally, staff was observed communicating with parents by phone and providing updates during the survey.

Due to a lack of sufficient evidence, the allegation that the facility failed to provide updates to the parents of an adolescent who was hospitalized could not be substantiated.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

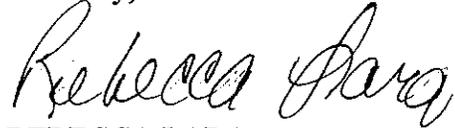
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208)

Jon Ness, Administrator  
December 18, 2012  
Page 4 of 4

334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/nw



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005487**

**Allegation #1:** Patients were not involved in their plan of care for treatment and recommended diagnostic procedures.

**Findings #1:** An unannounced complaint investigation was conducted 11/26/12 through 12/04/12. Medical records were reviewed and patients and staff were interviewed.

The medical records of 24 patients who received care on the medical or surgical unit were reviewed. Eight records were for current patients and 16 records were for patients who had been discharged. All records were reviewed for documentation of patient/patient representative involvement in the plan of care including appropriate consent. The records indicated that patients or representatives were informed of the plans for their course of treatment, including diagnostic testing and recommended procedures.

Eleven patients who received care on the medical or surgical units were interviewed between 11/27/12 and 11/30/12. Each patient stated they were aware of the plan for their course of care and felt satisfied with the plan for recommended testing and procedures.

In addition, Emergency Department (ED) records were reviewed and current patients were

interviewed. Two current patients' records and eleven records of discharged patients, contained documentation that patients were involved in decisions for care, including the diagnostic testing recommended during their evaluation. Two current patients in the ED were interviewed on 11/29/12 during their stay. Each patient stated they were involved in the decisions related to their course of care in the ED. Each confirmed they were aware of, and approved the plan, for proposed testing and procedures.

The ED record of one discharged patient indicated the patient experienced sudden onset of weakness, dizziness, confusion, and was unable to repeat simple phrases. The record indicated the patient arrived to the ED via ambulance. A nursing note, completed by a Registered Nurse (RN) within 15 minutes of arrival to the ED, indicated that the patient was alert and oriented and the weakness, dizziness, and difficulty speaking had resolved. In the ED physician report, the physician documented that the patient had recently been discharged from the hospital where he had been treated for an infection. The physician documented potential causes for the patient's symptoms included an infection or a stroke. The medical record contained results of laboratory testing, a chest x-ray, and a Computed Tomography scan of the head. The physician documented the results of the tests were discussed with the patient and spouse. The record indicated that patient instructions related to stroke symptoms were given to the patient upon discharge and that the patient was discharged in the care of the spouse.

The Director of the ED was interviewed on 11/29/12. She stated that all patients received care, including recommendations for diagnostic testing and treatments, based on their presenting symptoms.

It could not be determined that patients were not involved in the plan for care or treatment, including recommended testing or procedures.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Staff failed to protect patients from infectious diseases.

Findings #2: An unannounced complaint investigation was completed from 11/26/2012 to 12/04/2012. Staff and patients were interviewed. Policies and medical records were reviewed for evaluation of infectious disease processes and for isolation precaution initiation.

The medical records of 24 patients who received care on the medical or surgical unit were reviewed. Eight records were for current patients and 16 records were for patients who had been discharged. Out of the 24 records, only three patients' records indicated patients had a history of, or symptoms related to, infectious diseases. The medical records of these three patients contained documentation to support appropriate testing for infectious diseases based on

presenting symptoms. Two of these patients presented with symptoms in the Emergency Department (ED) and were tested accordingly. The third patient developed symptoms later in the admission and was tested at that time. The medical records indicated each patient tested negative for an infectious disease and therefore no isolation precautions were implemented. Thirteen additional ED records were reviewed, including two patients who presented to the ED during the survey on 11/29/12. None of the records indicated patients had symptoms which required testing to rule out infectious diseases or required isolation.

One of the inpatient records for a discharged patient indicated the patient was admitted for a planned surgical procedure. This patient had a history of antibiotic use for three weeks prior to this admission. The documentation indicated that on the second day of admission the patient developed diarrhea. On the morning of the third day of admission the documentation indicated the patient's doctor ordered stool specimens be sent for *Clostridium difficile* (*C. difficile*) testing. (Information obtained from the facility's CareNotes System defined *C. difficile* as an infection of the colon caused by bacteria with the most common symptom being frequent diarrhea. According to the documentation, one of the risk factors for contracting a *C. difficile* infection is prolonged antibiotic use.) The initial results of the testing were negative for *C. difficile* and a more sensitive form of testing was ordered. The more sensitive test results were available on the fourth day of hospitalization and indicated the patient was positive for *C. difficile*. The record also indicated on the fourth day of admission the patient was placed on isolation precautions and antibiotics were initiated.

The hospital policy, "Isolation Guidelines for *Clostridium Difficile* (C Diff)," dated 9/01/10, indicated, "All patients with *Clostridium Difficile* will be placed on Contact Isolation until asymptomatic." According to the policy, patients on contact isolation are placed in a private room, staff are required to wear gowns and gloves when entering the room and must remove these when leaving. In the case of a *C. difficile* infection, hands were to be washed with soap and water upon leaving the patient's room.

The patient was discharged the day following the *C. difficile* diagnosis. The record indicated the patient was discharged with a three day supply of antibiotics and that a prescription was called in to the patient's pharmacy for an additional eleven days of antibiotics. Instructions about *C. difficile* care at home were also given to the patient and the patient signed a form acknowledging receipt of this information.

The Supervisor for Infection Prevention was interviewed on 11/28/12. She explained that patients diagnosed with an infectious disease while in the hospital were evaluated to determine whether or not the infection was caused by a deficient infection control practice within the hospital. She stated she reviewed the above medical record and determined the *C. difficile* infection was related to the extended course of antibiotics the patient had been taking prior to the

admission, and was not considered a hospital acquired infection.

An ED record for the above patient was reviewed. According to the record, four days after discharge the patient was admitted to the ED via the ambulance for a sudden onset of weakness, dizziness, confusion and the inability to repeat simple phrases. The ED triage nurse documented that the patient had a recent hospital admission and a diagnosis of *C. difficile*. The ED physician's note contained a gastrointestinal assessment in which the physician documented "there has been diarrhea, which has essentially dissipated as the patient is being treated for *C. difficile*."

The Director of the ED and a Charge Nurse from the ED were interviewed on 11/29/2012. They both verbalized that patients were asked on admission about symptoms related to infectious disease. They stated if the patient had symptoms present to cause suspicion for an infectious disease, the patient was immediately placed on isolation precautions. The Charge Nurse explained that isolation precautions included hanging a large yellow bag on the outside of a patient's door that contained gowns, gloves, masks, and chemically treated wipes to clean equipment. The Charge Nurse explained the bag also contained a notice to remind staff to wash hands with soap and water when the isolation precautions were initiated for *C. difficile*. The large yellow bag was one of the signals to other staff that a patient had a known or suspected infectious disease.

On 11/29/12, isolation precautions were observed to be in place for two patients on the surgical unit. Nursing and aide staff were observed to use personal protective equipment and complete hand hygiene in accordance with facility policy. On 11/29/12 patient care in the ED was observed. Isolation precautions were not required for any patient in the ED, but universal precautions (use of gloves and hand hygiene) were observed to be used appropriately with patient care.

It could not be determined that staff failed to protect patients from exposure to infectious diseases.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** Staff failed to assess, monitor, and address patients' nursing and hygiene needs.

Finding #3: An unannounced complaint investigation was completed from 11/26/2012 to 12/04/2012. Staff and patients were interviewed. Medical records were reviewed.

The medical records of 24 patients who received care on the medical or surgical unit were reviewed. Eight records were for current patients and 16 records were for patients who had been

discharged. All records were reviewed for documentation of nursing assessments and timely interventions in response to patients' changing needs. The records were also reviewed for documentation of nursing and nurse aide assistance with hygiene and toileting needs. All records contained documentation of assessments of patients on a routine basis. In addition, the records indicated that nursing staff responded in a timely manner to changes in a patient's condition. The records contained documentation that patients were assisted with hygiene and toileting needs.

One record indicated the patient was admitted for a planned surgical procedure, had a history of diabetes and was being treated for an infection. Nursing documentation indicated the patient developed diarrhea on the second day. Nursing staff documented the patient had a red coccyx and that barrier gel was applied on at least two occasions. An RN documented that the patient was placed on a pressure redistribution mattress and that the patient was repositioned every two hours to alleviate pressure on the coccyx.

On the 3rd day of admission, nursing documentation indicated the patient continued to have diarrhea and a red coccyx. By mid-day the physician had ordered a stool sample to be sent and the lab reported the patient was negative for *C. difficile*. Per the physician's order, a second, more sensitive test was performed on the stool sample. In the evening, an RN documented that the patient was experiencing frequent loose stools and had extremely red skin in the peri-rectal area. The RN documented the application of the fecal incontinence pouch and barrier cream to the coccyx.

The medical record indicated staff received the results of the second test for *C. difficile* on the morning of the fourth day. The patient was determined to be positive for *C. difficile* and was placed in isolation. The physician ordered antibiotics. A Certified Wound Care Nurse (CWCN) was consulted to assess the patient and determine the best approach to protecting the red and excoriated peri-rectal area. The CWCN documented removal of the fecal incontinence pouch, cleansing the area, and recommending Xenaderm ointment to protect the skin from frequent stooling. The CWCN documented that if the patient experienced an incontinent episode, a dry chux (a large disposable pad) could be placed under the patient as a barrier until staff could assist with hygiene needs. In the evening an RN documented that the patient had not experienced any diarrhea since starting antibiotics.

Early in the morning on the 5th day, the RN documented that the excoriation to the peri-rectal area was "greatly improved" with the application of Xenaderm ointment and barrier cream and that the patient voiced feeling much better with the absence of the diarrhea. The patient was discharged later on the 5th day.

An RN who cared for patients on the surgical unit was interviewed on 11/29/12. She explained that any time patients have diarrhea, and especially with a diagnosis of *C. difficile*, staff made an

Jon Ness, Administrator  
December 18, 2012  
Page 6 of 6

extra effort to protect skin integrity. She stated the first line of defense was to prevent episodes of incontinence as much as possible. She stated the staff also had a protective barrier cream that could be applied to the rectal area following each stool. She stated if there was a concern for impaired skin integrity, nursing staff used a special chux that improved air circulation and decreased moisture contact with skin. The RN also explained that patients with skin care concerns were placed on a pressure redistribution bed and turned frequently. The RN was asked about staffing on the surgical unit. She stated that there were aides to assist with patient care and the Charge Nurse as well as the Manager of the unit were available and willing to respond to call lights.

As-worked staffing schedules for the medical unit were reviewed for the time period from 11-01-12 through 11-17-12. The medical unit utilized a staffing algorithm which defined how many nurses and nursing assistants were assigned based on the patient census. The staffing schedules documented this algorithm had been followed.

Care on the surgical unit was observed on 11/29/12 from 1:40 PM to 3:30 PM. Staff were observed to respond to call lights in a timely fashion. Five current patients on the surgical unit were interviewed. Each patient stated that staff responded to the call light and addressed their needs within a reasonable timeframe. An additional six current patients on the medical unit were interviewed. All of the patients, from both units, indicated satisfaction with staff assessment and monitoring of their needs. Each patient indicated that hygiene needs were met and skin care concerns were addressed.

It could not be determined that staff failed to assess, monitor, and address patients' nursing and hygiene needs.

Conclusion #3: 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,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/nw



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005428**

**Allegation #1:** The facility refused to release information about a patient's condition to a family member.

**Findings #1:** An unannounced survey was conducted at the hospital from 11/26/12 through 11/30/12. Surveyors reviewed medical records, hospital policies, grievance logs and administrative documents. Staff and patients were interviewed during the survey as well.

Several current patients throughout the facility, including patients on the adult psychiatric unit were interviewed about patient rights and release of information to family/friends. All patients understood the need to document the names of the family and friends to whom they would allow the facility to release information. On the adult psychiatric unit, patients explained the need to complete a communication document that included their consent to release information to specified individuals. The patients were also aware that family and friends must be aware of patients' identification numbers before information would be released.

One medical record that was reviewed documented a 25 year old female who was admitted to the facility on 2/14/12 and discharged on 2/15/12. She was re-admitted on 2/16/12 and discharged

on 2/19/12. Diagnoses for both admissions included suicidal ideation, borderline personality disorder and PTSD.

The medical record from the 2/14/12 admission contained documentation of a conversation between hospital staff and the patient's mother. Documentation of a discussion with the patient's grandmother was present in the medical record as well.

During the 2/16/12 admission, a telephone conversation between nursing staff and the patient's mother was documented on 2/16/12. Additionally, documentation included 2 on site visits by the patient's mother. One visit was on the 2/16/12 date of admission. The second visit was documented on 2/17/12. On 2/19/12, the medical record stated the patient was discharged, and the patient's mother would transport her home.

Several staff members were interviewed during the survey, including staff on the adult psychiatric unit. Staff on the adult psychiatric unit explained they were instructed to check for patient authorization and obtain a patient identification number before releasing information about a patient to a caller.

No evidence could be found supporting the allegation that the facility refused to release information to a family member. Therefore, the allegation could not be substantiated.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The facility/medical staff discharged a patient who was still experiencing suicidal ideation, then refused to re-admit the patient a day later when she returned voicing suicidal ideation.

**Findings #2:** An unannounced survey was conducted at the hospital from 11/26/12 through 11/30/12. Surveyors reviewed medical records, hospital policies, grievance logs and administrative documents. Staff and patients were interviewed during the survey as well.

Current patients on the adult and adolescent psychiatric units who were admitted for suicidal ideation were interviewed during the survey. All patients who were interviewed stated they were immediately assigned 1:1 supervision and were admitted to the facility once they voiced suicidal intent. All were satisfied with their care and voiced no concerns about the admitting process. Additionally, patients who were interviewed said they felt their physicians listened to them and followed up appropriately during the admission process.

Several current and closed medical records were reviewed during the survey. Eight records documented patients admitted to the facility for suicidal ideation. All eight medical records

Jon Ness, Administrator  
December 18, 2012  
Page 3 of 3

documented an appropriate admission process. All patients were evaluated by a physician, admitted to a psychiatric unit and 1:1 observation was ordered.

One medical record that was reviewed documented a 25 year old female who was admitted to the facility on 2/14/12 and discharged on 2/15/12. She was re-admitted on 2/16/12 and discharged on 2/19/12. Diagnoses for both admissions included suicidal ideation, borderline personality disorder and PTSD.

Documentation of the 2/14/12 admission included physician evaluation of a patient who arrived with suicidal ideation and was admitted and placed on 1:1 observation/suicide precautions. Documentation also indicated the patient's condition improved, and she no longer voiced suicidal intent by the time she was discharged on 2/15/12. Discharge documentation stated the patient was seeing a counselor on an out patient basis. Appointments were confirmed, and the patient was instructed to follow up as scheduled. The patient was discharged to her grandmother.

The 2/16/12 admission documentation stated the patient was again admitted for suicidal ideation. Documentation indicated she was evaluated by a physician, admitted and 1:1 observation was ordered. When the patient was discharged on 2/19/12, the medical record stated she was no longer experiencing suicidal ideation.

Due to a lack of sufficient evidence, the allegation that the facility discharged a patient who was suicidal, then refused to re-admit the same patient when she presented with suicidal ideation the following day could not be substantiated.

Conclusion #2: 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,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/nw



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005442**

**Allegation #1:** Patient was assaulted by a nurse.

**Findings #1:** An unannounced complaint survey was conducted on 11/26/12 to 12/04/12. Clinical records and facility policies were reviewed, staff and patient were interviewed, and observations were conducted.

Clinical records were reviewed for documentation related to patients with neurological conditions such as stroke, altered mental status, seizure disorder, and cataplexy.

Hospital complaint and grievance logs were reviewed for allegations of physical abuse by staff towards patients.

One complaint alleged a patient had been assaulted by a nurse during a neurological assessment. The record documented the patient had a specific neurological condition and experienced multiple episodes during the hospitalization. The record indicated the patient had taken measures to educate the staff and increase awareness of how to respond appropriately if and when an episode occurred. During one episode the Rapid Response Team was called to assist

the nurse that was providing care for the patient. A neurological assessment was performed as part of the patient assessment during that episode. The assessment included an examination by the Rapid Response Nurse of the patient's pupils, attempts to elicit a pain response by rubbing her knuckles on the patient's sternum and direct pressure on the patient's nail bed. The patient complaint stated the neurological assessment and painful stimuli was felt to be an assault, and should not have occurred.

Current patients were interviewed to assess perception of staff response to cares provided. Each patient who was interviewed reported staff was appropriate and did not feel as if they were assaulted or injured in any way.

During the investigation staff was observed to perform multiple aspects of patient care. There were no observed instances of improper technique with assessment or patient contact.

While the staff that provided direct care to the patient was aware of the precautions and plan of care for the specific neurological condition, the Rapid Response team member had not been informed of the medical condition and performed a neurological assessment. The assessment activity performed was not a deficient practice on the part of the staff member.

It could not be verified the nursing staff member assaulted the patient.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The facility failed to ensure nursing staff were educated regarding a medical condition of a patient and how to respond appropriately.

Findings #2: One record documented a patient with a neurological condition manifested by frequent episodes of a sudden loss in muscle tone as well as the inability to speak. The patient would remain cognitively alert but unable to respond. The episodes could be triggered by stress, fatigue and bright lights. Supportive measures would be to ensure an airway was maintained and provide minimal stimulation until the patient returned to normal baseline.

The patient had provided documentation that was placed in the record for appropriate measures to take if an episode occurred. The record documented the patient experienced multiple episodes during the hospitalization. One episode was longer in duration and the patient appeared to be responding differently than others the nurse had witnessed. The nurse called for the Rapid Response Team to assist in assessment of the patient. A neurological assessment was performed by the Rapid Response Nurse of the patient's pupils, as well as attempts to elicit a pain response by rubbing her knuckles on the patient's sternum and direct pressure on the patient's nail bed. The patient later filed a complaint which stated the neurological assessment and painful stimuli

Jon Ness, Administrator  
December 18, 2012  
Page 3 of 3

should not have occurred. The patient had provided education materials in advance that directed the staff to provide supportive measures only, and no noxious stimuli be performed.

While the staff that provided direct care to the patient was aware of the precautions and plan of care for that specific neurological condition, the Rapid Response team member had not been informed of the medical condition and performed a neurological assessment as directed by established protocol. The assessment activity performed was not a deficient practice on the part of the staff member.

Conclusion #2: 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,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/nw



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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005406**

**Allegation #1:** Patients with diabetes were not appropriately managed.

**Findings #1:** An unannounced visit was made to the hospital on 11/26/12 to 11/30/12. The medical records of 54 patients were reviewed. Eleven patients/family members were interviewed from the medical and surgical floors. Hospital policies, nursing staffing schedules, patient grievances, hospital contracts, and physician credentials files were reviewed.

The medical records of 5 inpatients with diabetes were reviewed. Documentation showed all of these patients had physician orders for the treatment of their diabetes. All 5 patients had their blood glucose levels monitored appropriately and all received glucose lowering medications per physician orders.

One medical record documented an 84 year old female who was admitted to the hospital on 12/17/11 and was discharged on 12/22/11. One of her diagnoses was insulin dependent diabetes. Her blood glucose levels were monitored as ordered and were also checked at other times per her request. Nurses administered insulin as ordered per a sliding scale except for 3 times when the patient refused her insulin. Her insulin and glucose testing orders were changed in response

Jon Ness, Administrator  
December 18, 2012  
Page 2 of 3

to her wishes and her condition.

Care was provided appropriate to patients' needs.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** The hospital did not respond promptly to call lights.

Findings #2: Eleven inpatients from the medical and surgical floors were interviewed during the survey. Two of these patients stated on 1 occasion they had to wait as long as 20 minutes for assistance. These patients did not experience adverse outcomes. The other 9 patients stated staff were readily available and were prompt in responding to call lights.

As-worked staffing schedules for the medical floor were reviewed for the time period from 11-01-12 through 11-17-12. The medical floor utilized a staffing algorithm which defined how many nurses and nursing assistants were assigned based on the patient census. The staffing schedules documented this algorithm had been followed.

An observation on 11/28/12 beginning at 9:55 AM revealed a patient census of 27. At that time, 6 registered nurses plus a charge nurse were on duty. In addition, 4 nursing assistants were on duty. This was the staffing level specified in the algorithm.

Two registered nurses were interviewed on the morning of 11/28/12. Both nurses stated they felt the floor was well staffed and they had sufficient time to attend to their patients. They also stated if it got too busy they were able to call in extra staff.

While there may have been delays in assisting patients at times, the hospital appeared sufficiently staffed to meet patient needs. No deficient practice was found.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

**Allegation #3:** The hospital used a portable commode for multiple patients without cleaning it between patients.

Findings #3: Eleven inpatients from the medical and surgical floors were interviewed during the survey. All stated the facility and equipment were clean and no problems were noted.

Observations of the medical and surgical floors on 11/27/12 and 11/28/12 did not reveal any unclean equipment.

Jon Ness, Administrator  
December 18, 2012  
Page 3 of 3

Two registered nurses were interviewed on the morning of 11/28/12. Both nurses stated the hospital had procedures for obtaining equipment and its care. They stated only clean equipment was used for patients.

No deficient practice was found.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

**Allegation #4:** The hospital did not allow patients' primary care physicians to care for them in the hospital.

Findings #4: The hospital employed hospitalists, who are physicians who specialize in rendering care for inpatients. Staff interview and physician contract review revealed family practice physician groups had the option to admit and follow all of their group's patients in the hospital or to allow the hospitalists to admit and follow all of the group's inpatients.

One family practice physician was interviewed on the morning of 11/30/12. He stated his physician group had decided to have the hospitalists follow their adult patients. In addition, he stated his group had contracted with a group of pediatricians to follow juvenile patients. He stated his physician group had chosen to not follow their patients in the hospital.

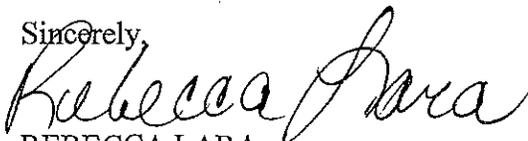
The physician who was interviewed stated the hospital did notify him when his patients were admitted to the hospital and when his patients were discharged.

The shift to hospitalists caring for inpatients is part of a national trend. The decision to transfer patient care to hospitalists is a business decision and does not violate state or federal regulations.

Conclusion #4: 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,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/nw



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

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

DEBRA RANSOM, R.N., R.H.L.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

December 18, 2012

Jon Ness, Administrator  
Kootenai Medical Center  
2003 Kootenai Health Way  
Coeur D'Alene, ID 83814

Provider #130049

Dear Mr. Ness:

On **December 4, 2012**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00005530**

**Allegation #1:** The patient received medication that she claimed to be allergic to.

**Findings #1:** An unannounced complaint survey was conducted on 11/26/12 to 12/04/12. Clinical records and facility policies were reviewed, staff and patients were interviewed, and observations were conducted.

Outpatient records were reviewed for documentation related to patients with drug allergies.

One record contained documentation the patient was allergic to Morphine, the reaction to which caused nausea and "flu-like" symptoms. During the recovery period after a surgical procedure in Outpatient Surgery the patient received Morphine for pain, and was also prescribed Morphine to take for pain after being discharged home.

The Director of Pharmacy reviewed the facility's process of releasing medications for patient administration. He stated patient allergies were documented in the pharmacy software program. If a medication was ordered by a physician that the patient claimed to be allergic to, the system would require a pharmacist over-ride to allow the medication to be released for administration.

The Pharmacist stated nausea and "flu-like" symptoms from Morphine was a side effect, rather than an allergy, and would be approved for patient administration. The Director of Pharmacy provided multiple documents which demonstrated the review of medications and over-ride process before allowing those medications to be administered.

While the patient claimed to be allergic to Morphine, the Pharmacist had determined the drug was safe for administration to the patient.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

**Allegation #2:** Patient was discharged from Outpatient Surgery before she was fully awake.

Findings #2: Six medical records from Outpatient Surgery were reviewed, four of which were orthopedic procedures. The medical records were reviewed for documentation of recovery and readiness for discharge.

The "PACU Discharge Criteria" policy included a scoring tool to assist in the determination of patient condition for discharge. The tool included assessment criteria of: activity, respiration, circulation, consciousness, oxygen saturation, wound dressing appearance, pain level, ability to ambulate, tolerance to drinking fluids, and ability to use the bathroom. Each category would receive a score of 0-2, a total score of 18-20 would indicate readiness for discharge.

One Outpatient record documented the patient was moved from the operating room to the Post Anesthesia Recovery Unit (PACU) at 2:07 PM. The record contained an order written by the anesthesiologist to discharge the patient when discharge criteria were met per policy. An Outpatient PACU Nurse reviewed the record and stated the patient met discharge criteria of 18/20 at 5:45 PM. The documentation stated the IV was removed at that time and the patient and family member were provided discharge instructions. The record indicated the patient was discharged at 6:15 PM in stable condition. The record contained documentation the patient was contacted on the following day as part of a post surgical follow up program, and stated the patient had no concerns and was doing well.

Although the patient met criteria for discharge and was noted to be drowsy after the effects of anesthesia, the facility required the assistance of a family member or friend to receive discharge instructions and to accompany the patient home. It could not be determined the patient was discharged home prematurely.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the

Jon Ness, Administrator  
December 18, 2012  
Page 3 of 3

courtesies and assistance extended to us during our visit.

Sincerely,



REBECCA LARA  
Health Facility Surveyor  
Non-Long Term Care



SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

RL/aa