



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

CERTIFIED MAIL: 7007 3020 0001 4038 7624

January 14, 2013

Scott Tiffany, Administrator
Boise Behavioral Health Hospital
8050 Northview Street
Boise, ID 83704

RE: Boise Behavioral Health Hospital, Provider #134009

Dear Mr. Tiffany:

Based on the survey completed at Boise Behavioral Health Hospital, on December 28, 2012, by our staff, we have determined Boise Behavioral Health Hospital, is out of compliance with the following Conditions of Participation: **42 CFR 482.13 - Patient Rights (A115) and 42 CFR 482.21 - Quality Assessment and Performance Improvement (A263)**. 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 these conditions to be unmet, substantially limit the capacity of Boise Behavioral Health Hospital, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed also, is a similar form describing State licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

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;

Scott Tiffany, Administrator
January 14, 2013
Page 2 of 2

- 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.

Such corrections must be achieved and compliance verified by this office, before February 11, 2013. 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 January 30, 2013.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **January 22, 2013.**

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.

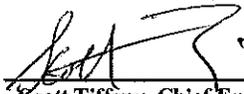
Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

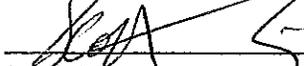
cc: Debra Ransom, R.N., R.H.I.T., Bureau Chief
Kate Mitchell, CMS Region X Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		RECEIVED MAR 4 2013 DIV. OF MEDICAID	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation surveys of your hospital. Surveyors conducting the investigation were: Rebecca Lara, RN, BA, HFS Team Leader Gary Guiles, RN, BS, HFS Libby Doane, RN, BSN, HFS Acronyms used in this report include: @ = At AV = Audio/Visual CEO = Chief Executive Officer DON = Director of Nursing H/I = Homicidal Ideation MMSE = Mini Mental Status Examination PI = Performance Improvement PTSD = Post Traumatic Stress Disorder Q or q = Every QAPI = Quality Assessment Performance Improvement RN = Registered Nurse S/I or SI = Suicidal Ideation Immediate Jeopardy was identified at A 144 and the facility was notified on 12/27/12 at 2:45 PM. The facility submitted an immediate Plan of Correction on 12/28/12 at 4:00 PM and the Immediate Jeopardy was abated.	A 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Boise Behavioral Health Hospital does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.  Scott Tiffany, Chief Executive Officer			
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on review of medical records,	A 115		RECEIVED MAR 04 2013 FACILITY STANDARDS		
		Pages: 1-2	A 115 482.13	3/8/13		

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

TITLE

(X6) DATE



CEO

3/4/2013

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: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 115

Continued From page 1
observation, staff interview and review of hospital policies, it was determined the hospital failed to ensure patients were provided a safe environment and protected from harm. The failure to implement appropriate safety precautions placed the safety of all patients admitted to the facility in immediate jeopardy. Findings include:

1. Refer to A 144 as it relates to the facility's failure to ensure patients' right to receive care in a safe setting was upheld and patients' health and safety were not placed in immediate jeopardy.

The cumulative effect of these negative systemic practices resulted in the inability of the hospital to keep patients safe from harm.

A 144

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 medical record review, observation, staff interview and review of hospital policies, it was determined the hospital failed to ensure adequate precautions were taken protect patients with suicidal ideations from self harm. Appropriate safety precautions were not implemented for 4 of 9 patients (#3, #5, #7 and #8) whose records were reviewed. This resulted in one patient (#5) attempting suicide in October of 2012 by using hospital gowns with the strings tied together in an effort to attempt suicide by strangulation. These failures left this patient, and all subsequent potentially suicidal patients admitted to the facility, vulnerable and in

A 115

See Response to Tag A 144

A 144

Pages:
2-17

A
144
482.13 (c)(2)

Action taken to correct the deficiency:

- I. A new "Safety Precautions and Categories of Observation" Policy and Procedure has been implemented. This policy was approved by the Governing Body on December 28th, 2012.
- II. Nursing and Direct Care Staff received education on this policy beginning December 28, 2012.
- III. Medical staff were educated on this policy on December 28th, 2012.

3/8/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 2 immediate jeopardy of serious harm, impairment, or death. Findings include:</p> <p>1. Patient #5's medical record documented a 69 year old male who was admitted to the facility on 10/20/12 at 4:00 PM. Diagnoses included bipolar disorder, PTSD by history, bulimia nervosa by history and borderline personality disorder.</p> <p>The "INITIAL PSYCHIATRIC EVALUATION," dated 10/20/12 at 7:20 PM and completed by a physician, documented Patient #5 attempted suicide twice within 30 days prior to admission on 10/20/12. The document stated Patient #5 tried to strangle himself with dental floss during late September of 2012 when he was a patient in another local psychiatric hospital. The evaluation also documented Patient #5 attempted suicide by overdose on 10/19/12, while sitting in the parking lot of a local medical/psychiatric facility. He was admitted to ICU. When he was medically stable, he was placed on a mental hold in order to determine mental competency. The document also included Patient #5 was admitted to the facility on 10/20/12 for "safety, further evaluation, and treatment on a hold... ..Disposition is unclear, it may be at [a state operated psychiatric facility]."</p> <p>The "ADULT ASSESSMENT," dated 10/20/12, untimed and signed by an RN, documented Patient #5's behaviors at the time of admission included "recent suicide attempts, depression and break up/separation with wife." The assessment described "breakup/separation w/wife" as a precipitating event. Additionally, documentation included Patient #5's refusal to discuss suicidal ideation/intent at the time of the assessment.</p>	A 144	<p>IV. All patients present at the time of the survey were reassessed according to this new policy at the time of the survey.</p> <p>V. Patients admitted subsequent to the new policy have been and will continue to be assessed according to this new policy.</p> <p>VI. All power cords have been removed from patient beds.</p> <p>VII. All hospital gowns have been removed.</p> <p>VIII. Safety Checks occur at least daily. This includes searching patient rooms and the group room for objects that could pose a risk for patients or staff.</p> <p><u>Description of how the actions will improve processes:</u></p> <p>I. The "Safety Precautions and Categories of Observation" Policy and Procedure contains a revised risk assessment, titled "High Risk Notification Alert". This assessment includes the following categories of risk: homicidal; suicidal; sexual-perpetration - acting out; sexual victimization; self-harm; falls; medically compromised; elopement; detoxification; and an "other" category. The policy further requires the assessment be completed based upon available admissions data; data collected from the patient; data collected from the referral source; ongoing assessment; data collected from the treatment team; and data from other reliable/competent persons associated with the patient.</p>	
-------	---	-------	---	--

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704	
(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	Continued From page 3 A document titled, "INITIAL SUICIDE ASSESSMENT," dated 10/20/12 at 4:00 PM, documented Patient #5 had "no apparent precipitating factor/event." The document also defined the 2 recent suicide attempts were "... Non-Lethal Attempt..." Written on the bottom of the form was "Patient is @ high.risk potential with 2 current suicide attempts. Both attempts at care facilities." Once the document was completed, correlating points were assigned, tallied and "LEVEL II" suicide precautions were implemented for Patient #5. (Levels refered to the amount of supervision patients received for safety.) On 10/20/12 at 10:00 PM, a nurse documented Patient #5 was found sitting on his bed with the strings of a hospital gown tied together. The note documented Patient #5 was "Holding very tight between hand in attempt to strangle himself." The progress note documented Patient #5 said "I just want to leave this world." A physician order, dated 10/20/12 at 9:00 PM, stated "Level I Suicide precautions 1/1 [staff supervision] d/t pt tying gown strings together in attempt to strangle himself." The DON was interviewed about safety precautions and the "INITIAL SUICIDE ASSESSMENT" form on 12/21/12, beginning at 9:23 AM. She reviewed the form and stated patients on "LEVEL II" suicide precautions were monitored/checked every 15 minutes. When asked the criteria for implementing 1:1 supervision, the DON said a patient should be actively suicidal, have a plan to commit suicide and have a history of prior suicide attempts.	A 144	II. Additionally, this policy defines three categories of patient observation: 1:1, Line of Sight, and 15 minute checks. The policy requires every patient be placed on one of these three categories of observation based upon an assessment of the patient. This initial category must be assigned as a part of the admission orders. III. Removal of the power cords will eliminate the potential risk these presented to patients. IV. Removal of gowns will eliminate the potential hazard presented by gown tie strings. <u>Procedure for implementing the plan of correction:</u> I. Nursing, Direct Care, and Medical Staff have been educated on this policy. Education was conducted by the Director of Nurses or a trained Designee for the Nursing and Direct Care staff and the Medical Director for the Medical Staff. II. A new "High Risk Notification Alert" form has been developed and implemented. III. Removal of the power cords from the patient beds was completed by the Maintenance Director. <u>Monitoring and Tracking Procedures:</u> I. A checklist has been developed to be completed by the charge RN at the time of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704	
(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	Continued From page 4 Appropriate safety precautions, based on Patient #5's initial assessment, were not implemented at the time of admission. 2. Patient #3's medical record documented a 37 year old male who was admitted to the facility on 12/06/12 at 8:30 PM. Diagnoses included mood disorder, rule out bipolar disorder, and major depressive disorder. The "INITIAL PSYCHIATRIC EVALUATION," dated 12/06/12 at 2:58 PM and completed by a physician, documented Patient #3 was admitted following an overdose on 12/05/12. According to documentation, he became unresponsive, was transported to a local ER and intubated to protect his airway. The documentation also indicated the trigger, or precipitating event, was a fight with his wife and adolescent daughter who ran away. Documentation also said Patient #3 initially denied he was suicidal, but then acknowledged he had been hospitalized approximately 7 times for suicidal thoughts. The evaluation also stated "He seems to have no insight into the seriousness of his attempt and he is at great risk for further harm to himself. ...He will be on q. 15 minute checks and suicidal precautions." The "ADULT ASSESSMENT," dated 12/07/12, untimed and signed by an RN, documented Patient #3's behaviors at the time of admission included a history of suicide attempt by overdose on prescription drugs. The assessment described a fight with his wife as the precipitating event for Patient #3's suicide attempt and resulting hospitalization.	A 144	admission. This checklist has spaces to check off if the "High Risk Notification Alert" form has been thoroughly completed based upon available information and that a Category of Observation has been assigned to the patient based on the patient's assessment. This will be used as an auditing tool. Education has been provided to the RNs by the DON on the use of this tool. II. An RN or designee is responsible for reviewing records to ensure safety precautions are reflected in the record and based upon the "High Risk Notification Alert". III. A "Stand-Up" meeting is held on business days. During this meeting, patient precautions are reviewed and adjusted if necessary based upon available and ongoing assessment information. IV. The Director of Nursing or a designee is reviewing records after admission to ensure the "High Risk Notification Alert" is thoroughly and accurately completed. Additionally, this review includes making sure an appropriate Category of Observation is ordered and that interventions taken are appropriate based on the assessment of the patient. V. The DON or a designee will monitor safety checks each business day to ensure they are occurring. <u>Person Responsible:</u>	

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO: 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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>A document titled, "INITIAL SUICIDE ASSESSMENT," dated 10/07/12 at 3:00 PM, documented Patient #3 had a "Minor Catastrophic Life Change" as the precipitating event. The document also defined the intensity of suicidal ideation as "Acute, recent onset with or without precipitant" and the lethality of the attempt as "Obvious Lethal Attempt with past 90 days." The 2 recent suicide attempts were "... Non-Lethal Attempt..." Once the document was completed, correlating points were assigned, tallied and "LEVEL II" suicide precautions were implemented for Patient #3. "Place level II with q 15 min checks" was written on the bottom of the document.</p> <p>On 12/19/12 at noon, a physician documented Patient #3 was informed that he would soon be transferred to a state operated psychiatric facility. Documentation also included "There is some concern given his impulsivity in the past that about hearing this news, there will be the possibility of self harm, however, staff is all aware of his history and the fact that he just heard this news and we are going to keep a very close eye on him and if there is any concern at all about his safety, we will put him on 1:1."</p> <p>The DON was interviewed on 12/21/12, beginning at 2:23 PM. She reviewed Patient #3's medical record and was unable to locate documentation that indicated the level of observation changed/was increased after the physician's progress note on 12/19/12. She was unable to explain what "keep a very close eye on him" meant for the nursing staff. The DON confirmed Patient #3 remained on 15 minute checks, but stated it would have been appropriate to maintain</p>	A 144	<p>I. The Director of Nurses will be responsible for implementing and monitoring this Plan of Correction.</p>	
-------	--	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 line of sight for Patient #3.</p> <p>Appropriate and clearly defined safety precautions were not documented for Patient #3.</p> <p>3. Patient #8's record documented a 30 year old male admitted to the facility on 12/23/2012 on an involuntary mental hold for a recent suicide attempt. The "INITIAL PSYCHIATRIC EVALUATION," dated 12/23/12, stated Patient #8 had a history of seizures, depression, bipolar disorder, schizophrenia and past suicide attempts in January and November of 2012 (attempted overdose.) According to the evaluation, the patient and his wife had an argument and she tried to close a door on him. The evaluation stated prior to admission the patient banged his head against the door finally breaking through the door, resulting in a laceration to his forehead. According to the evaluation, the patient then began to burn some pictures but his wife thought he was trying to burn the house down and the police were called. The evaluation stated that when the police arrived, Patient #8 had grabbed a butcher knife and held it to his stomach. The evaluation stated the patient was taken into custody and brought to the hospital.</p> <p>A document titled "INITIAL SUICIDE ASSESSMENT" was completed on 12/23/12 at 11:00 PM and signed by an RN. The instructions on the form indicated the RN was to "check the most applicable criterion and add the score. Divide by 4 to determine the assessed level. Circle the assessed level, date, time, and sign the assessment." According to the document, under the category "NATURE OF PRECIPITATING</p>	A 144			

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 7</p> <p>EVENT" the RN scored a 1 for "Minor Catastrophic Life Change." It was unclear what a "Minor Catastrophic Life Change" meant. Documentation indicated under the category "TIME SINCE PRECIPITATING EVENT" the RN scored a 3 for "One week or less." According to the document, under the category "INTENSITY OF SUICIDAL IDEATION" the RN scored a 3 for "Acute, recent onset with or without precipitant." According to the document, under "LETHALITY OF ATTEMPT" the RN scored a 1 for "Obvious Non-Lethal Attempt." Patient #8 was threatening himself with a knife. It was not clear what "Obvious Non-lethal Attempt" meant. The document indicated the "LEVEL II" was circled. The form was open to the interpretation of the RN.</p> <p>The "ADMISSION ORDERS" included "level II suicide precautions" handwritten on the document.</p> <p>In an interview on 12/21/12 beginning at 9:20 AM the DON explained the "INITIAL SUICIDE ASSESSMENT" forms were completed by the RN from the RN's perception of the patient's situation. The DON explained that a level I lead to one to one supervision, meaning the patient is within arms reach of staff. The DON stated one to one supervision is for a patient that is actively suicidal, has a plan, and has made suicide attempts. The DON stated a level II means the staff will check on the patient every 15 minutes. The DON stated a level II patient is a patient that is not currently suicidal and does not have a plan and a level III is for patients that are close to discharge. The DON stated supervision provided for level II and level III patients was the same.</p>	A 144		
-------	--	-------	--	--

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 8</p> <p>The DON stated that 15 minute checks were done for all patients except those requiring one to one supervision, regardless of the level the patient scores. The DON stated there were no assessments to evaluate for assault and elopement risk. The DON was asked how the level system keeps the patients in the facility safe and the DON replied "I know they are safe because the 15 minute checks are being done."</p> <p>According the "ADULT ASSESSMENT," dated 12/24/12, Patient #8 stated the reason he had been admitted was because he "was going to stab himself in the heart." The document titled "MASTER TREATMENT PLAN REVIEW" contained documentation from 12/27/12 that Patient #8 "remains depressed with active suicidal ideation w/specific scenarios." This document also stated Patient #8's "current symptoms of depression with SI (suicidal ideation) limited his ability to be safe at this time" and that Patient #8 is "on level II suicide precautions."</p> <p>Nursing notes dated 12/27/12 at 9:45 AM indicated the patient "reports positive suicidal ideation (with) plan to stab himself. Level II suicide precautions per (physician). Q 15 min (checks)." Nursing notes dated 12/27/12 at 10:00 PM stated "Pt did report suicidal ideation (with) plan to stab self paces on unit (continue) (with) q 15 (and) plan of care." Nursing notes dated 12/26/12 at 10:15 AM documented "pt (up) to counter reports he does have suicidal ideation but unsure of plan to harm self but gave several scenarios of other people attempts. Staff to monitor for (changes)." There was no documentation in the record to indicate the</p>	A 144		
-------	---	-------	--	--

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 9</p> <p>patient was on any other suicide precautions beside every 15 minutes checks.</p> <p>The document titled "PROGRESS NOTES FORM - SOCIAL SERVICES" dated 12/27/12 at 9:00 AM, stated "pt continues to have SI with multiple plans such as stabbing himself in the heart, overdosing on medications, or using a nailgun."</p> <p>Patient #8's medical record did not document the reason he was assigned a level II suicide precaution and did not document that his level of supervision was reassessed.</p> <p>The hospital did not clearly evaluate Patient # 8's suicide risk.</p> <p>4. Patient # 7's "INITIAL PSYCHIATRIC EVALUATION" recorded a 27 year old male admitted to the facility on 12/10/12 for depression with suicidal ideation. The evaluation stated the patient had a history of depression, schizo-affective disorder, post-traumatic stress disorder and substance abuse. According to the evaluation, Patient #7 was on probation and unable to leave the state, working a "dead-end job," had financial problems and problems with his family. The evaluation stated he was married but separated from his wife and lived in a halfway house. The evaluation stated Patient #7 had recently spoken with his wife which "was very upsetting to him." The evaluation stated he told his roommate he was going to kill himself. The evaluation stated "thought content was positive for suicidal thoughts with suicidal intention of killing himself once he was alone at night by cutting himself." According to the evaluation, Patient #7 had admitted to cutting himself in the</p>	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 10 past but had never attempted suicide before.</p> <p>The document titled "INITIAL SUICIDE ASSESSMENT" was completed and signed by an RN on 12/10/12 at 3:30 PM. The instructions on the form indicated the RN was to "check the most applicable criterion and add the score. Divide by 4 to determine the assessed level. Circle the assessed level, date, time, and sign the assessment." According to the document, under the category "NATURE OF PRECIPITATING EVENT" the RN scored a 0 for "No apparent precipitating factor." The document did not clearly define what precipitating factors were. According to the document, under the category "TIME SINCE PRECIPITATING EVENT" the RN scored a 3 for "One week or less." According to the document, under the category "INTENSITY OF SUICIDAL IDEATION" the RN scored a 3 for "Acute, recent onset with or without precipitant." According to the document, under "LETHALITY OF ATTEMPT" the RN scored a 1 for "Obvious Non-Lethal Attempt." The document did not clearly specify what qualified as lethal. The document stated the "LEVEL II" was circled however, according to the scoring instructions on the document, the patient actually scored 1.75 which would have made the patient a "LEVEL III." The document was open to the interpretation of the RN.</p> <p>There was no documentation of an order signed by a physician for level II precautions.</p> <p>In an interview on 12/21/12 beginning at 9:20 AM the DON explained the patient would be placed on "LEVEL II" suicide precautions automatically if there was no immediate order from the physician</p>	A 144		

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 11 stating a specific level of observation.</p> <p>A document titled "PROGRESS NOTES 2/12/12" dictated 12/12/12 at 6:14 PM and signed by the physician 12/14/12, stated that Patient #7's thought content was positive for suicidal thoughts. The note also stated "the patient is still at elevated [increased] risk of self harm." "PROGRESS NOTES 2/14/12" dictated 12/14/12 and signed by a physician on 12/18/12 recorded Patient #7's "thought content is positive for thoughts of cutting and suicidal thoughts." The progress notes also stated "the patient remains at elevated risk of self harm at this time." "PROGRESS NOTES 12/18/12" dictated 12/18/12 and signed by a physician 12/19/12, indicated Patient #7 "wishes he was not alive, he hates his life, and he feels 'so mad at this world.'" The note stated "he is having thoughts of overdosing on medications to end his life after he leaves the hospital." The note stated the patient "continues to be at elevated risk of self harm." It was not clear what was meant by "elevated risk of self harm." There was no documentation to indicate Patient #7's suicide observation level was reassessed.</p> <p>The DON was interviewed on 12/21/12 beginning at 9:20 AM. She reviewed the medical record and did not have an explanation about why the description of the patient's risk for self harm did not instigate a higher level of observation.</p> <p>A note written on 12/14/12 at 2:15 PM on the form titled "Interdisciplinary Progress Notes" contained documentation from a Certified Psychiatric Technician that Patient #7 "stated he was feeling like he wanted to hurt himself. He said...if he had</p>	A 144		

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 12</p> <p>a knife he would cut himself. Pt stated not sure what started his feeling like this but was having thought of being worthless." The note stated "staff reassured pt he was safe. Pt said he felt better after talking and went back to group after encouragement from staff to not be alone." A nursing note dated 12/14/12 at 3:00 PM stated "pt denies S/I, H/I or A/V hallucinations at this time but did report to pharm(asist) that he was hearing voices and seeing things (ie pencil) move by itself. No acute distress noted, will con't to monitor level II (with) q 15 min checks." There was no documentation that this encounter with Patient #7 was reported to an RN or physician or that Patient #7 was reassessed for a change in suicide precaution level.</p> <p>Patient #7's medical record did not document the reason he was assigned a level II suicide precaution and did not document that his level of supervision was reassessed.</p> <p>The hospital did not clearly evaluate Patient # 7's suicide risk.</p> <p>5. The policy manual on the nursing unit contained a policy titled "LEVELS OF OBSERVATION," dated 11/04/04. The policy stated patients would be assessed on admission for the appropriate level of precaution by a physician. The policy did not state the nurse's role in the assessment of patients in order to determine the level of observation required to keep patients safe from harm. The remainder of the policy listed the procedure for one to one observation and 15 minute observations.</p> <p>The "LEVELS OF OBSERVATION" policy further</p>	A 144		
-------	---	-------	--	--

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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)	
A 144	<p>Continued From page 13</p> <p>stated staff was to document the monitoring of patients on "Form NS 4a.3.3.1." The Director of Health Information was interviewed on 1/04/13 beginning at 11:50 AM. She stated there was no "Form NS 4a.3.3.1" and she did not know what document the policy referred to.</p> <p>A document titled "Suicide Precautions," not dated, was contained in a "Nursing Resource Manual" at the nursing station. It contained conflicting information from the above policy. It stated the RN assessed patients and notified the psychiatrist "...of a disturbed patient who may need initiation of suicide precautions..." It stated a physician's order for suicide precautions would be documented in the medical record when the procedure was implemented. The document described 3 levels of suicide precautions. Level I required one to one continuous nursing observation 24 hours a day. Level II was assigned to patients who "...present clinical symptoms that indicate a higher suicide potential than Level III. Nursing care for Level II patients was listed as "Continuous nursing observation in line of sight in a designated area and interaction 24 hours a day..." Level III was assigned to "Those patients who have suicidal ideations and, after assessment by the RN and/or psychiatrist, are assessed to be in minimal danger of actively attempting suicide." Level III required 15 minute checks and doors to remain open. The document stated "A no-harm contract will be signed daily and when the level of precaution changes."</p> <p>A document titled "OBSERVATION POLICY," not dated, was an extensive 7 page policy. The policy listed 3 levels of observation and outlined</p>	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 14</p> <p>staff's duties for each level. The policy did not specifically address precautions such as suicide, assault, or elopement precautions.</p> <p>The Charge Nurse was interviewed on 12/21/12 beginning at 11:00 AM. When asked to find the policy for observation of patients and levels of supervision, he produced the policy titled "LEVELS OF OBSERVATION," noted above. Later that morning, he stated he found the document titled "Suicide Precautions" in a "Nursing Resource Manual" at the nursing station. He stated these were the only 2 documents related to supervision levels he was aware of. He stated he was not aware of a policy addressing other precautions such as assault precautions and elopement precautions.</p> <p>The DON was interviewed on 12/21/12 beginning at 1:45 PM. She stated the hospital was using the policy "OBSERVATION POLICY." She described this policy as "current but not final." She confirmed the hospital policies did not address precautions other than suicide precautions.</p> <p>Hospital policies did not provide clear, consistent, comprehensive guidance related to levels of supervision required to maintain safety.</p> <p>NOTE: On Thursday 12/27/12 at approximately 2:45 PM, the CEO was notified of the immediate jeopardy related to the facility's failure to ensure valid, comprehensive patient assessments were completed and appropriate precautions implemented to protect the patients from immediate jeopardy. As a result of this failed practice, the safety of all subsequent patients</p>	A 144		
-------	---	-------	--	--

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 15 admitted to the facility was found to be at risk.</p> <p>A plan for immediate correction was received, reviewed, and accepted on 12/28/12 at approximately 2:30 PM. The plan included the development of a new "Safety Precautions and Categories of Observation" policy and procedure. The new policy documented that all patients admitted to the inpatient unit would be monitored in compliance with physician orders and prescribed protocols. The procedure provided the option of 3 categories of observation from which the physician could choose based on assessment and current condition of patients. The categories included 15 minute checks/observation, maintaining line of site and 1:1 observation. Also included was instruction to assess and obtain orders for precautions related to suicide, elopement, assault, behavioral, sexual perpetration, sexual victimization, self-harm, falls and seizures.</p> <p>A "High Risk Notification Alert" form was also implemented, which the policy indicated should be completed by the nurse at the time of admission and when a change related to safety precautions occurs. The form stated, "If any risk factors are checked, individualized precautions must be ordered to ensure patient safety." Possible risk factors listed on the form were "Homicidal, Suicidal, Sexual Perpetration - Acting Out, Risk of Being Sexually Victimized, Self Harm, Fall Risk, Medically Compromised, Elopement Risk and Detox."</p> <p>Education of the clinical staff about the new policy/procedure related to safety precautions and categories of observation was initiated on</p>	A 144		
-------	--	-------	--	--

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

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012	
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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	Continued From page 16 12/28/12. Education on the use of the "High Risk Notification Alert" form was included as well. The plan was to continue educating clinical staff before their next scheduled shift to work until all staff were educated. The DON and/or trained RN designee were responsible for providing training. Implementation of the above plan was verified through observation of training. The CEO was notified on 12/28/12 at approximately 4:00 PM, that the immediate jeopardy was abated. 6. Surveyors toured the facility on 12/19/12, beginning at 2:15 PM. Tour of patient rooms revealed electric hospital beds with exposed electrical cords. The cords were visible and long enough to extend from the electrical outlet and lay on the floor. The Building/Grounds Maintenance Manager and CEO was interviewed on 12/21/12, beginning at 1:45 PM. The Building Maintenance Manager confirmed that all patient beds in the facility except 2 were electric with attached, exposed cords. He and the CEO confirmed the exposed cords presented a potential risk to current and future patients who were admitted with suicidal ideation/intent. The hospital did not maintain a safe environment for patients at risk of self injurious behavior. 482.21 QAPI	A 144		
A 263	The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program.	A 263 Pages: 17-19	A 263 482.21 Boise Behavioral Health Hospital has hired	3/8/13

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 263	<p>Continued From page 17</p> <p>The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.</p> <p>The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.</p> <p>This CONDITION is not met as evidenced by: Based on staff interview and review of medical records, policies, meeting minutes, and QAPI documents, it was determined the hospital failed to ensure a data driven QAPI program had been developed, implemented, and monitored. This resulted in the inability of the hospital to evaluate its processes and practices. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to A266 as it relates to the failure of the hospital to ensure adverse patient events were analyzed and tracked. 2. Refer to A273 as it relates to the failure of the hospital to ensure a QAPI program had been developed and implemented that assessed processes of care and used data to monitor the effectiveness of services. 3. Refer to A283 as it relates to the failure of the hospital to ensure the QAPI program used data to evaluate and change systems to improve patient care. 4. Refer to A297 as it relates to the failure of the 	A 263	<p>a consultant from CareFix Management and Consulting, Inc. The consultant is working with the Boise Behavioral Health team to develop and implement a QAPI Plan, Performance Improvement processes, with a system of continuing assessment and evaluation. A consultant will remain on retainer throughout the year attending PI meetings to assure compliance, working with the QA Director, the Administrator, and department managers. The consultant will give support and direction regarding current goals and data collection for future goals. The consultant will also provide education to all staff as needed.</p> <p>See Responses to Tags A 266, A 273, A 283, A 297, and A 309.</p>	

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 266	<p>Continued From page 19</p> <p>number of incidents was conducted. She stated the data had not been used to analyze trends of certain events, such as falls, in order to change practices to decrease the number of events.</p> <p>2. Not all adverse patient events were documented in incident reports so the data could be captured and analyzed.</p> <p>Patient #5's medical record documented a 69 year old male who was admitted to the facility on 10/20/12 at 4:00 PM. Diagnoses included bipolar disorder, PTSD by history, bulimia nervosa by history and borderline personality disorder.</p> <p>The "INITIAL PSYCHIATRIC EVALUATION," dated 10/20/12 at 7:20 PM, documented Patient #5 attempted suicide twice within 30 days prior to admission on 10/20/12. The document stated Patient #5 tried to strangle himself with dental floss during late September of 2012 when he was a patient in another psychiatric hospital. The evaluation also documented Patient #5 attempted suicide by overdose on 10/19/12. He was admitted to the ICU at a local hospital and transferred to Boise Behavioral Health Hospital when he was medically stable.</p> <p>On 10/20/12 at 10:00 PM, a nurse documented Patient #5 was found sitting on his bed with the strings of a hospital gown tied together. The note documented Patient #5 was "Holding very tight between hand in attempt to strangle himself." The progress note documented Patient #5 said "I just want to leave this world."</p> <p>The DON was interviewed on 12/28/12, beginning at 11:15 AM. She stated an incident report had</p>	A 266	<p>reviewed from each department. (See attached Meeting Agenda for list of all topics reviewed and analyzed). If a trend is observed, the Performance Improvement Committee will initiate the steps of the QA/PI Plan to present a new project to the Governing Body for approval.</p> <p>IV. A new QAPI Plan has been adopted by the Governing Body. This plan outlines the steps and responsibilities for the Performance Improvement committee to track and analyze adverse patient events. Staff will receive training on this new policy. This training is scheduled to be completed by 3/8/13 for all inpatient staff. Inpatient staff not on duty prior to this date will be trained when they return to work.</p> <p>V. An offer has been made and accepted for a QAPI Director position. The QAPI Director began this role on 2/18/13. The person in this position will be responsible for overseeing the hospital-wide QAPI program.</p> <p>VI. The monthly report card process has been condensed to eleven key indicators. A threshold has been established for each of these indicators. The Performance Improvement Committee will monitor these key indicators at each regular monthly meeting and make recommendations for interventions or for Performance Improvement Projects as indicated.</p> <p><u>Description of how the actions will improve processes:</u></p>	

I. The Incident report policy includes the types of events for which an incident report is required. Re-educating nursing and direct care staff on the expectation to complete incident reports for all adverse patient outcomes will help ensure the Performance Improvement Committee has consistent data available to identify and reduce the potential of a medical error.

II. Notification to the DON at the time of an incident will allow the DON to begin an investigation in a timely manner and give immediate direction to the nursing staff. Presenting all adverse patient event incident reports to the Performance Improvement Committee will allow for complete analysis by all department managers. This will assist in the determination of need for improvements regarding safety, processes, and systems.

III. Reviewing adverse patient event incident reports will illuminate procedures, processes, or other factors that may be contributing factors. This will also ensure the Performance Improvement Committee will be able to analyze trends and make appropriate decisions regarding needed improvements.

IV. The QAPI Plan defines roles and responsibilities to ensure data and trends are analyzed and projects are presented to the Governing Body for approval, implementation, and evaluation.

V. The Director of QAPI will be dedicated to ensuring the hospital-wide QAPI Plan is implemented.

Procedure for implementing the plan of correction:

I. Nursing, Direct Care, and Medical Staff have been re-educated on the Incident Reporting policy. Re-education was conducted by the Director of Nurses or a trained Designee for the Nursing and Direct Care staff and the Medical Director for the Medical Staff. This was completed prior to 3/1/2013.

II. The Performance Improvement Committee will meet weekly through March 2013 to review changes in responsibilities, develop subcommittees, and refine strategies for achieving the newly adopted goals, the new QAPI Plan, and the new PI process. Following March 2013 these meetings will be scheduled monthly or more frequently as determined by the CEO.

III. Hospital staff will receive training on the new QAPI Plan. Continuing education and training is a part of the new QAPI Plan and PI process. This plan was reviewed and approved in the PI Committee meeting on 2/28/2013.

IV. An offer has been made and accepted for a QAPI Director position. The person in this position will be responsible for overseeing the hospital-wide QAPI program. This position was filled 2/18/2013.

Monitoring and Tracking Procedures:

I. The DON will keep a log of adverse patient event incident reports. This log will be presented to both the Performance Improvement Committee and the Governing Board for review and analysis. The Performance Improvement Committee and Governing Board Minutes will reflect a review of patient adverse event incident reports if/when they occur and a determination regarding the next steps to be taken when indicated.

II. All Nursing, Direct Care, and Medical staff will receive re-education on the Incident Reporting Policy, the QAPI Plan, and the PI Process. Documentation will be maintained in training records. This training will be completed by 3/8/13 for all inpatient staff who are scheduled to work the preceding week. Inpatient staff who are not scheduled to work between 3/4/13 and 3/8/13 will be trained when they return to work.

III. The Incident Reporting Policy, the QAPI Plan, and the PI Process will be included in new-employee orientation and will also be delivered annually.

IV. The QAPI Director will be responsible for ensuring the QAPI Plan is adhered to. Compliance will be reflected in monthly QAPI meeting minutes.

Person Responsible:

The QAPI Director and the CEO will be responsible for implementing and monitoring this Plan of Correction. The Consultant will be available for

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704	
(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 273	Continued From page 21 This STANDARD is not met as evidenced by: Based on staff interview and review of policies, meeting minutes, and QAPI documents, it was determined the hospital failed to ensure a QAPI program had been developed and implemented that assessed processes of care and used data to monitor the effectiveness of services. This resulted in the inability of the hospital to change its processes in response to patient outcomes. Findings include: The policy "Performance Improvement Policy and Procedure," not dated, stated each department would identify problems and bring them to the committee. The committee then was to identify the top 2 or 3 problems and assign subcommittees to address them. The subcommittees were to write and implement action plans to correct identified problems. No evidence was present that committees met on a regular basis and developed and implemented a comprehensive QAPI program. Examples include: 1. PI committee minutes for 2012 were requested from the DON. She provided "PERFORMANCE IMPROVEMENT MEETING MINUTES," dated 2/16/12. These were reviewed with her beginning at 9:15 AM on 12/28/12. She stated these were the only "PERFORMANCE IMPROVEMENT MEETING MINUTES" documented for 2012. The 11 page minutes discussed physical therapy audits, mainenance checks, and nursing record audit that had been completed prior to the meeting. The minutes did not discuss an assessment of problem areas nor	A 273	Model (Plan, Do, Study, Act) which is a circle of continuous quality improvement activity. II. The Performance Improvement Committee agenda has been modified (See Attached) to include an analysis of available data and discussion regarding need for additional Performance Improvement Projects. III. An offer has been made and accepted for a QAPI Director position. The QAPI Director began this role on 2/18/13. The person in this position will be responsible for overseeing the hospital-wide QAPI program. A consultant has been hired to work with the QAPI Director and the Performance Improvement Committee for at least the next 12 months. IV. The monthly report card process now includes eleven key indicators. A threshold has been established for each of these indicators. The Performance Improvement Committee will monitor these key indicators at each regular monthly meeting and make recommendations for interventions or for Performance Improvement Projects as indicated. <u>Description of how the actions will improve processes:</u> I. The QAPI Plan, as approved by the Governing Body, will provide a framework for the Performance Improvement Committee to operate within.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 273	<p>Continued From page 22</p> <p>did it set priorities to improve patient outcomes. The minutes did not include an overall plan for the QAPI program for 2012. The DON stated no other minutes of the PI Committee were documented for 2012. She stated a QAPI plan for 2012 was not documented. She stated she was not aware of the existence of a comprehensive QAPI plan, including the hospital's quality priorities. During the same interview, the DON stated the Coordinator of the QAPI program had left in January or February of 2012 and had not been replaced. She stated currently there was no person in charge of the hospital's QAPI program.</p> <p>2. The hospital continued to produce a "Report Card" which included data that had been gathered monthly from January through November 2012. The "Report Card" contained data for areas of patient satisfaction, employee monitors, risk management, medical record reviews, active treatment measures, outcomes, and financials. However, there was no evidence of changes made to hospital practices based on the the data. For example, the monthly "Fall Rate" between January 2012 through October 2012 ranged between 0 and 19.1. No documentation was present to explain what these rates meant or what, if any, steps were taken to reduce the number of falls. Also, the monthly delinquency rate for the completion of discharge summaries between January 2012 through November 2012 ranged between 0 and 6%. A goal for discharge summary delinquency rates was not specified and documentation of steps taken to decrease the number of late discharge summaries was not present.</p>	A 273	<p>II. Modifying the agenda will ensure an analysis of available data occurs at each monthly Performance Improvement Committee Meeting. The Committee can then make recommendations about additional Performance Improvement Projects based on a review and analysis of available data.</p> <p>III. A designated QAPI Director will ensure resources are continually directed to maintaining a focus on continuous quality improvement.</p> <p>IV. Consolidating the Report Card Data into key indicators and establishing thresholds for each will allow the Performance Improvement Committee to clearly determine when interventions are necessary to bring the measures within the established guidelines. The Performance Improvement Committee will have the ability to recommend Performance Improvement Projects to the Governing Body if this is determined to be necessary.</p> <p><u>Procedure for implementing the plan of correction:</u></p> <p>I. The new QAPI Plan defines roles and responsibilities with respect to tracking and analyzing data, implementation of projects and monitoring results. The QAPI Plan outlines the PDSA process which allows for a circle of continuous quality improvement activity. Hospital staff will receive training on this new plan. This training will be completed by 3/8/13 for all inpatient staff who are scheduled to work the preceding week. Inpatient staff who are not scheduled</p>		

to work between 3/4/13 and 3/8/13 will be trained when they return to work.

II. The chair of the Performance Improvement Committee will use the established agenda (See attached), working according to the new QAPI plan, to ensure a review and analysis of available data occurs at each monthly PI committee meeting.

III. An offer has been made and accepted for a QAPI Director position. The QAPI Director began this role on 2/18/13. The person in this position will be responsible for overseeing the hospital-wide QAPI program.

Monitoring and Tracking Procedures:

I. The Performance Improvement Committee minutes will reflect a review and analysis of available data at each monthly meeting. The chair will ensure this discussion occurs and verify documentation in the minutes.

II. The QAPI Director will monitor the PI projects and also monitor the use and analysis of data as it pertains to PI activities. The QAPI Director will compile a report to be presented to the Governing Board at least quarterly for evaluation and direction.

III. The minutes of the monthly Performance Improvement Committee will reflect an analysis of the established key indicators and recommendations for

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012	
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 273	<p>Continued From page 23</p> <p>The lack of data analysis was confirmed by interview with the DON on 12/28/12 beginning at 9:15 AM.</p> <p>3. Except for patient satisfaction indicators, the only listed quality indicators related to patient care on the "Report Card" were numbers of falls, assaults, medication errors and drug reactions, transfers, deaths, infections, restraints, and delinquent discharge summaries, the percentage of groups run as scheduled, and the percentage of patients who attended groups. A deeper examination of the systems that led to the numbers, such as such as nursing or pharmacy processes, was not included in QAPI documents.</p> <p>The lack of quality indicators and analysis of the data collected was confirmed by interview with the DON on 12/28/12 beginning at 9:15 AM.</p> <p>4. The DON was interviewed on 12/28/12 beginning at 9:15 AM. She was asked if any hospital processes had changed in the past year based on data gathered from the QAPI program. She stated she was not aware of any changes made as a result of the QAPI program.</p> <p>The hospital did not define its QAPI program, develop a current QAPI plan, or analyze data to assess its processes.</p>	A 273	<p>interventions or for additional Performance Improvement Projects as indicated.</p> <p>Person Responsible:</p> <p>The QAPI Director and the CEO will be responsible for implementing and monitoring this Plan of Correction. The Consultant will be available for continued assistance with QAPI. The Governing Board will be ultimately responsible for continued evaluation and direction.</p>	
A 283	<p>482.21(b)(1), (c) PROGRAM DATA, PROGRAM ACTIVITIES</p> <p>(b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement.</p>	<p>A 283 Pages 26-27</p>	<p>A 283 482.21(b)(1), (c)</p> <p>Action taken to correct the deficiency:</p>	3/8/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012	
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 283	<p>Continued From page 24</p> <p>(c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care.</p> <p>(3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the hospital failed to ensure the QAPI program used data to evaluate and change systems to improve patient care. This resulted in the inability of the hospital to methodically analyze its processes. Findings include:</p> <p>Only one set of minutes from the hospital's PI committee were documented for 2012. These "PERFORMANCE IMPROVEMENT MEETING MINUTES" were dated 2/16/12. The minutes included a report of QAPI activities at the hospital to date. The minutes did not identify high-risk, high-volume, and problem-prone areas nor did they suggest priorities for upcoming studies. Some data was included in the report such as numbers of incidents and percentages of physical therapy evaluations completed within 24 hours</p>	A 283	<p>I. The new QAPI Plan requires the Performance Improvement Committee to collect data, analyze the data in the PI meetings, and recommend PI projects to the Governing Board. The Governing Board meets at least quarterly to give direction and oversight to the Performance Improvement Committee and evaluate the hospital's QAPI processes. Monthly Performance Improvement Committee Minutes will reflect the following: a review and analysis of monthly report card data; identification of high-risk, high-volume, and problem-prone areas; and suggested priorities for performance improvement activities. These categories have been added to the agenda.</p> <p>II. A new Performance Improvement Plan has been adopted by the Governing Body. This plan outlines the steps and responsibilities for the PI committee including the collection of data, requirement to review and analyze monthly dashboard data; identify high-risk, high-volume, identifying problem-prone area, identifying opportunities for improvement.</p> <p>III. Staff will receive training on the new QAPI Plan. This training will be completed by 3/8/13 for all inpatient staff who are scheduled to work the preceding week. Inpatient staff who are not scheduled to work between 3/4/13 and 3/8/13 will be trained when they return to work.</p> <p>IV. An offer has been made and accepted for a QAPI Director position. The QAPI Director began this role on 2/18/13. The</p>	

person in this position will be responsible for overseeing the hospital-wide QAPI program. A consultant has been hired to work with the QAPI Director and the Performance Improvement Committee.

Description of how the actions will improve processes:

I. The QAPI Plan, as approved by the Governing Body, will provide a framework for the Performance Improvement Committee to operate within.

II. The QAPI Plan establishes requirements to review and analyze monthly dashboard data; identify high-risk, high-volume, and problem-prone areas; and suggest priorities for upcoming studies.

II. Training on the QAPI Plan will ensure staff have are aware of the new expectations and that the QAPI committee members understand their roles and responsibilities.

III. Changing the PI meeting agenda will ensure the committee covers the necessary topics at least monthly.

III. Hiring a QAPI Director will ensure an individual's primary role will be to oversee the QAPI plan, including ensuring the Performance Improvement Committee reviews and analyzes monthly dashboard data; identifies high-risk, high-volume, and problem-prone areas; and suggests priorities for upcoming studies. A designated QAPI

Director will ensure resources are continually directed to maintaining a focus on continuous quality improvement.

Procedure for implementing the plan of correction:

I. The Performance Improvement Committee agenda has been changed to include the requirement to review and analyze monthly report card data; identify high-risk, high-volume, and problem-prone areas; and suggest priorities for upcoming studies (see attached). The QAPI Director will ensure these topics are covered in each regular monthly meeting.

II. The QAPI Director will continually monitor all aspects of the QAPI Plan for compliance. The Performance Improvement Committee will review progress on projects at each monthly meeting. This will include a review to determine if baseline measures have been met and if not, making changes to the projects as determined necessary by the committee.

Monitoring and Tracking Procedures:

I. The Performance Improvement Committee minutes will reflect a review and analysis of monthly dashboard data; identification of high-risk, high-volume, and problem-prone areas; and suggestions for priorities for upcoming studies.

II. The Performance Improvement

Committee minutes will reflect continued monitoring of established Performance Improvement Projects; requests for corrective action plans if data indicates a target exceeded the established threshold and further refinement of plans if data continues to be outside the established baseline.

III. The Performance Improvement Committee Minutes will be reviewed at Governing Body meetings to ensure analysis of monthly dashboard data; identification of high-risk, high-volume, and problem-prone areas; and suggestions for priorities for upcoming studies is occurring. The Governing Board minutes will reflect the reporting process from the QAPI Director and the Governing Board's responses and direction given to the Performance Improvement Committee.

Person Responsible:

The QAPI Director and the CEO will be responsible for implementing and monitoring this Plan of Correction. The Consultant will be available for continued assistance with QAPI. The Governing Board will be ultimately responsible for continued evaluation and direction.

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704	
(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 283	Continued From page 25 but an analysis of the data was not documented. The minutes did not identify opportunities for improvement or changes to processes. No other PI committee meetings were documented. The DON was interviewed on 12/28/12 beginning at 9:15 AM. She stated a current QAPI plan that set priorities for its performance improvement activities and focused on high-risk, high-volume, and problem-prone areas had not been developed. She stated she was not aware of documents that included an analysis of QAPI data or set quality priorities for 2012.	A 283		
A 297	The hospital did not use data to improve its processes. 482.21(d) QAPI PERFORMANCE IMPROVEMENT PROJECTS As part of its quality assessment and performance improvement program, the hospital must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must be proportional to the scope and complexity of the hospital's services and operations. (2) A hospital may, as one of its projects, develop and implement an information technology system explicitly designed to improve patient safety and quality of care. This project, in its initial stage of development, does not need to demonstrate measurable improvement in indicators related to health outcomes. (3) The hospital must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.	A 297	Pages 26-27 A 297 482.21(d) <u>Action taken to correct the deficiency:</u> I. Four Performance Improvement Projects were approved by the Governing Body and the Performance Improvement Committee on February 28, 2013. Additional projects will be added on an as needed basis, based on the PDSA process and the direction of the Governing Body. II. The Performance Improvement Committee will monitor the effectiveness of	3/8/13

these Goals and Projects/Strategies. If subsequent data indicates the target of a Performance Improvement Project still exceeds the established target the Performance Improvement Committee will proceed with the PDSA process with the continued approval of the Governing Board.

III. The Performance Improvement Committee agenda has been modified to include a review of and discussion of the effectiveness of current Performance Improvement Projects.

IV. A new QAPI policy has been approved by the Governing Body. This policy delineates responsibilities, including the responsibility for the Performance Improvement Committee to establish teams to work on projects.

V. An offer has been made and accepted for a QAPI Director position. The QAPI Director began this role on 2/18/13. The person in this position will be responsible for overseeing the hospital-wide QAPI program.

Description of how the actions will improve processes:

I. The Performance Improvement has established four performance Improvement Teams, each to work on a specific project. Adopting, implementing, and monitoring these projects will ensure projects are conducted on an ongoing basis. Oversight from the QAPI Director will ensure continued compliance with the Plan.

II. A review of and discussion of the effectiveness of current projects at each monthly meeting will ensure continuous analysis of the effectiveness of current Performance Improvement Projects.

Procedure for implementing the plan of correction:

I. Performance Improvement Teams have been developed to adopt, implement, and monitor performance improvement projects.

II. The Performance Improvement Committee will review progress on these projects at the monthly meetings. The QAPI Director will monitor and give ongoing feedback to the PI Teams

III. Meeting minutes will reflect progress toward established targets and any changes in projects determined necessary by the team based on an ongoing review and analysis of data, with Governing Board approval.

Monitoring and Tracking Procedures:

I. The Performance Improvement Committee minutes will reflect an ongoing evaluation of the PI projects; requests for corrective action plans if data indicates a target exceeded the established threshold, and further refinement of projects if data continues to be outside the established baseline. The QAPI report to the Governing Board will reflect the continued oversight from the Governing Board. The Governing Board minutes will reflect the direction given to the Performance

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 297	<p>Continued From page 26</p> <p>(4) A hospital is not required to participate in a QIO cooperative project, but its own projects are required to be of comparable effort.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of policies and QAPI documents, it was determined the hospital failed to ensure the QAPI program included performance improvement projects. This resulted in the inability of the hospital to conduct in depth examination of its processes in order to determine the effectiveness of patient care. Findings include:</p> <p>No performance improvement projects were documented for 2012 in the "PERFORMANCE IMPROVEMENT MEETING MINUTES," the Report Card, or Governing Board meeting minutes.</p> <p>The policy "Performance Improvement Policy and Procedure," not dated, described the hospital's QAPI program. The policy did not mention performance improvement projects.</p> <p>The DON was interviewed on 12/28/12 beginning at 9:15 AM. She confirmed the policy and stated the hospital had not conducted performance improvement projects in 2012.</p> <p>The hospital failed to conduct performance improvement projects.</p>	A 297	<p>Improvement Committee.</p> <p>Person Responsible:</p> <p>The QAPI Director and the CEO will be responsible for implementing and monitoring this Plan of Correction. The Consultant will be available for continued assistance with QAPI. The Governing Board will be ultimately responsible for continued evaluation and direction.</p>	
A 309	<p>482.21(e) EXECUTIVE RESPONSIBILITIES</p> <p>The hospital's governing body (or organized group or individual who assumes full legal</p>	<p>A,309 Pages 27-30</p>	<p>A 309 482.21(e)</p>	3/8/13

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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 309	<p>Continued From page 27</p> <p>authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following:</p> <p>1) That an ongoing program for quality improvement and patient safety, including the reduction of medical errors, is defined, implemented, and maintained .</p> <p>(2) That the hospital-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety and that all improvement actions are evaluated.</p> <p>(5) That the determination of the number of distinct improvement projects is conducted annually.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes, it was determined the hospital failed to ensure the governing body assumed responsibility for implementing and monitoring the QAPI program. This resulted in the lack of a comprehensive QAPI program to analyze the hospital's systems and implement changes to improve patient care. Findings include:</p> <p>Five "Governing Board Committee Minutes" were documented from 12/01/11 through 12/26/12. These occurred on 12/13/11, 3/02/12, 6/21/12, and 9/11/12. In addition, a special ad hoc meeting was documented on 8/07/12 to discuss physician credentialing.</p> <p>The 12/13/11 "Governing Board Committee Minutes" documented a report on QAPI activities</p>	A 309	<p><u>Action taken to correct the deficiency:</u></p> <p>I. A new QAPI Plan has been adopted by the Governing Body. This plan outlines the steps and responsibilities for the PI committee including the requirement to review and analyze monthly dashboard data; identify high-risk, high-volume, and problem-prone areas; and suggest priorities for upcoming studies. This plan also reflects the data collection on the dimensions of performance will be directed by the Governing Body.</p> <p>II. The Governing Body met and adopted four Performance Improvement Projects on February 28, 2013.</p> <p>III. Baseline expectations have been established for these projects. The Performance Improvement Committee may require corrective action plans or make modifications to the Performance Improvement Projects if any month's data exceeds the established baseline.</p> <p>IV. A review of actions by and recommendations of the Performance Improvement Committee, through the QAPI Director report, will be conducted during regular Governing Body Meetings. Recommendations, if any, will be communicated to the Performance Improvement Committee.</p>	
-------	---	-------	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704
--	---

(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
--------------------	--	---------------	---	----------------------

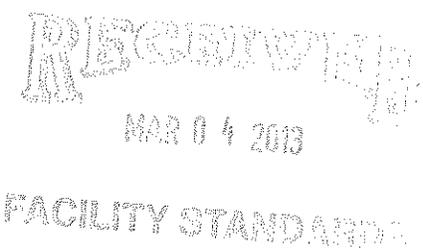
A 309	<p>Continued From page 28 throughout the hospital. The minutes did not discuss QAPI planning for 2012.</p> <p>The 3/02/12 minutes documented under "Risk Management/PI" the following: "One out-patient grievance: HIPPA violation was investigated. 1. Chemical/physical restraint: document face to face. 2. Strengths/attributes and intellectual functioning on all psychiatric evaluations. 3. Assure patient is appropriate for admission.: 1 to 17 MMSE."</p> <p>The 6/21/12 minutes documented under "PI/Risk Management" the following: "[The administrator] summarized the last quarter for both meetings."</p> <p>The 8/07/12 minutes did not address quality.</p> <p>The 9/11/12 minutes documented under "PI/Risk Management" the following: "[staff name] quarterly compliance. He suggested that we focus on safety issues, facility wide."</p> <p>The corporate Regional Vice President for the Behavioral Health Region was interviewed on 12/28/12 beginning at 2:50 PM. She stated she attended most of the Governing Board meetings. She confirmed the meeting minutes and the lack of documentation of direction and monitoring by the Governing Board. She stated the Board talked about quality a lot but it was not documented. She stated the administrator was new to the position. She stated the previous administrator had more documentation on quality and she would look for it on 12/30/12. The DON was contacted on 1/02/13 at 9:00 AM. She stated staff had looked for more documentation related to the Governing Board and quality but</p>	A 309	<p><u>Description of how the actions will improve processes:</u></p> <p>I. The Performance Improvement Committee will be responsible for monitoring performance against established targets. If data exceeds the established threshold, the Performance Improvement Committee will proceed with the steps of PDSA.</p> <p>II. The Governing Body will review progress toward established targets and direct efforts, if needed, to help achieve the Performance Improvement Goals.</p> <p>III. Establishment of a Performance Improvement Plan by the Governing Body provides a consistent framework and clearly defines the expectations of the Performance Improvement Program.</p> <p><u>Procedure for implementing the plan of correction:</u></p> <p>I. Regular meetings of the Governing Body will include a review of Progress toward Performance Improvement Projects. This will be reflected in the meeting minutes.</p> <p>II. As indicated by a review of available data, the Governing Body may make changes or additions to the Performance Improvement Committee's Projects.</p> <p><u>Monitoring and Tracking Procedures:</u></p> <p>I. The Governing Body minutes will reflect a review of progress toward Performance Improvement Projects. The minutes will</p>	
-------	---	-------	--	--

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

PRINTED: 01/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134009	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 309	Continued From page 29 none had been found. The Governing Board did not assume responsibility for direction and oversight of the QAPI program.	A 309	also reflect any directions to the Performance Improvement Committee to modify projects based on available data. Person Responsible: The QAPI Director and the CEO will be responsible for implementing and monitoring this Plan of Correction. The Consultant will be available for continued assistance with QAPI. The Governing Board will be ultimately responsible for continued evaluation and direction.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: ID5ENT	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/28/2012
NAME OF PROVIDER OR SUPPLIER BOISE BEHAVIORAL HEALTH HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 8050 NORTHVIEW STREET BOISE, ID 83704		
(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 state deficiency was cited during the complaint investigation survey of your hospital. Surveyors conducting the investigation were: Rebecca Lara, RN, BA, HFS Team Leader Gary Guiles, RN, BS, HFS Libby Doane, RN, BSN, HFS	B 000		
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on staff interview and review of medical records, policies, meeting minutes, and QAPI documents, it was determined the hospital failed to ensure ensure that there was an effective, hospital-wide quality assurance program to evaluate the provision of care. Refer to A263 as it relates to the lack of a comprehensive quality assurance program.	BB124 Page 1 State Only	 BB 124 Idaho Code 16.03.14.200.10 <u>Action taken to correct the deficiency:</u> I. A new Performance Improvement Plan has been adopted by the Governing Body. This plan outlines the steps and responsibilities for the PI committee including the requirement to review and analyze monthly dashboard data; identify high-risk, high-volume, and problem-prone areas; and suggest priorities for upcoming studies. This plan also reflects the data collection on the dimensions of performance will be directed by the Governing Body. II. The Governing Body met and adopted four Performance Improvement Projects. These projects have also been adopted by the Performance Improvement Committee.	3/8/13

Bureau of Facility Standards

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

TITLE

CEO

(X6) DATE

3/4/2013



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

January 17, 2013

Scott Tiffany, Administrator
Boise Behavioral Health Hospital
8050 Northview Street
Boise, ID 83704

Provider #134009

Dear Mr. Tiffany:

On **December 28, 2012**, a complaint survey was conducted at Boise Behavioral Health Hospital. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005496

ALLEGATION:

A patient successfully committed suicide while he was admitted as an in-patient to the facility. The hospital failed to keep the patient safe from self harm.

FINDINGS:

An unannounced survey was conducted at the hospital from 12/19/12 through 12/28/12. Surveyors reviewed hospital policies, incident reports, death review documents, quality assessment/performance improvement documents, nursing staff as-worked schedules, grievance logs and administrative documents. Surveyors also reviewed 5 current patient records and 4 closed patient records. Staff and patients were interviewed and nursing staff was observed while providing care to patients.

It was found the hospital did not implement appropriate safety precautions for 4 of 9 patients whose records were reviewed.

Scott Tiffany, Administrator
January 17, 2013
Page 2 of 2

Issues identified include:

- Patients were not clearly evaluated for suicide risk upon admission.
- Patients' suicide risk factors were not reassessed, as appropriate, during their inpatient stay.
- Patients were not provided the level of supervision necessary to ensure their safety
- The hospital lacked clear and consistent policies and procedures related to suicide.

These failures resulted in one patient attempting suicide in October of 2012 by using hospital gowns with the strings tied together in an effort to attempt suicide by strangulation. They also left all subsequent potentially suicidal patients admitted to the facility, vulnerable and in immediate jeopardy of serious harm, impairment, or death.

Based on investigative findings, the facility did not ensure adequate supervision/precautions were implemented to protect patients with suicidal ideations from self harm. Deficiencies were cited at 42 CFR 482.13 and 42 CFR 482.13 (c)(2) for failure to provide care in a safe setting for potentially suicidal patients.

CONCLUSION:

Substantiated. Federal and State deficiencies related to the allegation are cited.

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

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

Sincerely,



REBECCA LARA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

sc/