



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
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PHONE 208-334-6626
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May 6, 2014

James Angle, Administrator
St Luke's Magic Valley RMC
P.O. Box 409
Twin Falls, ID 83301

RE: St Luke's Magic Valley RMC, Provider #130002

Dear Mr. Angle:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on April 25, 2014.

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

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

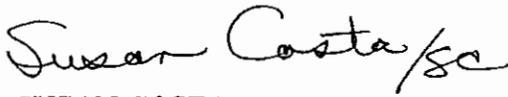
- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date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

James Angle, Administrator
May 6, 2014
Page 2 of 2

Whether you choose to provide a plan of correction or not, please sign and date the form and return it to our office by May 19, 2014. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

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

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt
Enclosures

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

PRINTED: 05/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130002	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/25/2014
NAME OF PROVIDER OR SUPPLIER ST LUKE'S MAGIC VALLEY RMC			STREET ADDRESS, CITY, STATE, ZIP CODE 801 POLE LINE ROAD WEST TWIN FALLS, ID 83301	
(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 A complaint investigation survey was completed at your hospital from 4/21/14 through 4/23/14. The Condition of Participation for Patient Rights, Nursing Services, Pharmacy Services, and Emergency Services were reviewed. Surveyors conducting the investigation were: Susan Costa, RN, HFS, Team Lead Nancy Bax, BSN, HFS Acronyms used in this report include: CN - Charge Nurse PSA - Patient Service Attendant RN - Registered Nurse The following deficiencies were cited.	A 000	Under the direction of the CNO/VP of Patient Care, the Shared Governance Safety and Quality Council is creating an escalation flowchart to assess the level of safety needs to be used for a patient, whom upon nursing assessment, is determined to be at risk for falls, to include the need for a constant observer (sitter). Nurse educators on each unit will educate staff to assess the patient for fall risk upon admission, every shift, and upon change in status; then document assessment determination and actions taken. To date, as part of our Falls Program, we have:	5-21-14
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, review of incident reports, hospital policies, and interviews with patient family members and staff, it was determined the hospital failed to ensure a safe environment was provided for patients who were at risk for falls. This directly impacted 3 of 5 patients with documented falls (#2, #5, and #7) whose records were reviewed, and had the potential to impact all patients at risk for falls. Findings include: 1. Patient #7 was a 95 year old male. On 2/27/14, he was brought to the emergency	A 144	<ul style="list-style-type: none"> constant observers a "falling star" sign placed on the door frame of the patient's room as an alert to all staff that the patient is at fall risk chair alarms bed alarms – analyzing the use of Hill-Rom beds as rental (rather than the KCI) as they can be integrated with our nurse call system. installing non-slip floor strips coming out of the shower/bathroom daily huddles to discuss fall events and lessons learned to prevent future events. 	

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MAY 19 2014
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: CEO (X6) DATE: 5/15/2014

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

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A 144	<p>Continued From page 1</p> <p>department by ambulance complaining of left hip pain after experiencing a fall in his home. Additional diagnoses included dementia, heart disease and diabetes. Patient #7 was admitted to the surgical unit with a diagnosis of left hip fracture.</p> <p>Patient #7's admission assessment on the surgical unit was completed by an RN on 2/27/14 at 11:45 AM. The documentation included a fall risk assessment that indicated Patient #7 had a high risk of falls. Fall prevention measures were documented, including "High risk flag system," "Room near nurse's station," "Bed alarm on," and "Sitter at bedside".</p> <p>Patient #7's medical record included RN assessments completed on 2/27/14, at 4:30 PM, 7:45 PM, 8:30 PM and 10:00 PM, and on 2/28/14 at 1:04 AM and 8:48 AM. All of the assessments included fall prevention measures of "Bed alarm on" and "Sitter at bedside".</p> <p>On 2/28/14 at 9:00 AM, an RN documented Patient #7 was transferred to the pre-operative area for surgery to his left hip.</p> <p>An RN note in Patient #7's medical record dated 2/28/14 at 6:27 PM, stated, "Patient back to the floor from surgery at 1330 (1:30 PM). Patient was combative and confused. Called charge for order for a sitter after surgery as well."</p> <p>On 2/28/14 at 6:29 PM, an RN noted Patient #7's fall prevention measures included "Bed alarm on" and "Sitter at bedside".</p> <p>Patient #7's medical record included RN assessments dated 2/28/14 at 8:30 PM and 11:43</p>	A 144			

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A 144	<p>Continued From page 2</p> <p>PM, and 3/01/14 at 7:45 AM. The assessments included fall risk assessments that indicated Patient #7 continued to have a high risk of falling. Fall prevention measures included "Bed alarm on", but did not include "Sitter at bedside".</p> <p>On 3/01/14 at 8:47 PM, an RN assessment noted Patient #7 had a high fall risk. Fall prevention measures did not include "Bed alarm on", or "Sitter at bedside".</p> <p>Patient #7's medical record included a patient note written by an RN and dated 3/02/14 at 1:16 AM. The note stated the RN went to check on Patient #7 on 3/01/14, around 11:20 PM, and found him lying on the floor next to his bed.</p> <p>A form titled "St. Luke's Health System Event Details" was reviewed. The form included the following statements:</p> <p>a. "Went into the patient room and he was lying on the floor. He had taken his dressing off of his surgical site. Patient was confused, which was his baseline, and stated he tried to get up to use the restroom."</p> <p>b. "RN stated that he set the bed alarm and thought it was working appropriately. When he went to check on patient he found him sitting on the floor. The patient was very confused, thought he was at home and did not realize he had surgery. The bed was pulled out of service and sent to engineering to check why bed alarm was not functioning appropriately. Sitter was obtained for patient."</p> <p>c. "The bed alarm was set, but apparently turned off after staff left. If the bed alarm was working</p>	A 144			

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A 144	<p>Continued From page 3 probably could have prevented the patient from falling."</p> <p>During an interview on 4/25/14 at 8:45 AM, the Surgical Department Director and the Surgical Department Team Leader reviewed Patient #7's record and the surgical department staffing record for 2/28/14 to 3/01/14. They stated the staffing record showed a sitter was assigned to Patient #7 following the RN's request after he returned from surgery on 2/28/14. However, the staffing records did not include a sitter for Patient #7 beginning at 7:00 PM on 2/28/2014.</p> <p>The Director and Team Leader stated patients are re-assessed by an RN every 4-8 hours to determine if the patient continues to require a sitter for constant observation. They confirmed Patient #7's record did not include documentation stating how it was determined he no longer required a sitter.</p> <p>The Director and Team Leader were asked how the staff ensured bed alarms are set and functioning properly. They stated when the alarm was turned on a tone sounded to indicate the alarm was set. They also stated a blinking light may indicate an alarm was not functioning on some, but not all, of the beds in the hospital.</p> <p>The hospital failed to ensure adequate fall prevention measures were in place for Patient #7.</p> <p>2. Patient #5 was a 47 year old male who was admitted to the facility on 4/08/14 for care related to alcohol withdrawal, hypertension, and critical hyponatremia (low sodium level). Patient #5's sodium level was 111 mEq/L. (According to Medline Plus, a normal sodium level is between</p>	A 144		

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A 144	<p>Continued From page 4</p> <p>135 and 145 mEq/L. Hyponatremia occurs when the sodium falls below 135 mEq/L. When the sodium level becomes too low, extra water enters the body's cells and causes them to swell. Swelling in the brain is especially dangerous. Complications from low sodium levels may include muscle weakness, seizures, confusion, unconsciousness, and coma).</p> <p>Patient #5's record documented he was transferred from another facility and directly admitted to the medical unit on 4/08/14 at 7:25 AM. An RN admission assessment, dated 4/08/14 at 7:45 AM, noted Patient #5 had weakness, was very shaky, and unsteady.</p> <p>His record indicated he was transferred from the ambulance stretcher into his bed and remained there until he was transported by stretcher to radiology for an ultrasound at 9:35 AM.</p> <p>An incident report documented on 4/08/14 at 10:25 AM, stated during a transfer from the stretcher to the chair, Patient #5 stepped on his pants and slipped, then fell. He hit his mid chest area on the edge of the armrest of the chair. The incident report noted a fall risk assessment had not been completed after his admission and before going downstairs for the ultrasound.</p> <p>Orders for transfer to the Intensive Medical Care Unit were written by Patient #5's physician on 4/08/14 at 10:45 AM. Included in the orders were "Bedrest and seizure precautions."</p> <p>Patient #5's admitting physician dictated a history and physical on 4/08/14 at 11:02 AM. Her dictated note included immediate plans to transfer him to intensive care for close monitoring</p>	A 144			

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A 144	<p>Continued From page 5</p> <p>and stated he was at risk for seizures. Her dictated note included documentation of increased anxiety, shakiness, and peripheral neuropathy (nerve damage, with weakness, numbness and pain in the hands and feet).</p> <p>During an interview on 4/25/14 at 8:55 AM, the Nursing Director of the medical unit reviewed Patient #5's records. She confirmed he fell during the process of getting off the stretcher and transferring to the chair. The Nursing Director confirmed there was no documentation that Patient #5's ambulatory status had been assessed by the admitting nurse before being transported to ultrasound. She confirmed the nurse had documented Patient #5 was shaky, weak, and unsteady. The Nursing Director confirmed the admitting diagnoses of alcohol withdrawal and hyponatremia were indicators of an increased risk for falls.</p> <p>A policy, titled "Fall Prevention Program," dated 9/02/11, noted "Adult and pediatric inpatients will be assessed upon admission using a fall risk assessment tool." The policy stated "Interventions will focus on specific areas of risk rather than a general risk score." This policy was not followed for Patient #5.</p> <p>Patient #5 was not adequately assessed for falls, and fall prevention measures were not in place at the time of his fall.</p> <p>3. Patient #2 was a 70 year old male admitted to the facility on 4/22/14 at 8:29 PM, for care related to lung cancer with metastasis and anemia. Additionally, Patient #2 had a stage 4 pressure ulcer on his coccyx. His record documented that shortly after his admission he was placed on</p>	A 144			

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A 144	<p>Continued From page 6</p> <p>Specialty Bed B. The website for the maker of Specialty Bed B, accessed 5/05/14, indicates it is a rotating bed designed for patients weighing up to 1,000 pounds. The website states the bed is used for obese patients to prevent pressure ulcers.</p> <p>An admission assessment completed by an RN on 4/23/14 at 12:30 AM, noted Patient #2 was disoriented, confused, and restless. The Fall Risk Screening Score was 23, indicating he was at high risk for falls (a score greater than 13 indicates a high fall risk). Patient #2's admission weight was noted as 162 pounds.</p> <p>In a "PATIENT CARE/INTERVENTIONS" note, dated 4/23/14 at 2:58 AM, the RN noted Patient #2 continued to be very restless, anxious, and grabbing at armbands to take them off. The RN noted she administered Ativan for agitation. The documentation included Patient #2 was on a rotating bed.</p> <p>Patient #2's record included a "CONTINUOUS ORDER SET, "Physicians Orders, Standing Orders for (Patient #2)." The Standing Orders were signed and dated 4/23/14 at 8:30 AM. The orders included that Patient #2 was to be placed on Specialty Bed A. The website for the maker of Specialty Bed A, accessed 5/05/14, indicates it is a rotating bed designed for patients weighing up to 350 pounds. The the bed is used to promote pulmonary function and prevent pressure ulcers.</p> <p>An incident report documented on 4/23/14 at 3:35 AM, indicated Patient #2 was found on the floor beside his bed. The individual who found Patient #2 on the floor documented "The pt's (patient's) air mattress was highly over inflated on one side</p>	A 144		
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A 144	<p>Continued From page 7</p> <p>and caused the pt to slide out of the bed." The incident report was reviewed by the Director of the Medical Unit on 4/24/14 at 7:34 AM. The Director documented the order was written for (Specialty Bed A) rotating bed, and the Charge Nurse made the decision to use the bariatric bed (Specialty Bed B) with the thought it would be more beneficial to Patient #2 instead of placing Patient #2 in a hospital bed until Specialty Bed A could be ordered.</p> <p>During a phone interview on 4/30/14 at 9:15 AM, the Service Manager/Technical Manager from the company who manufactures and distributes Specialty Bed B used by Patient #2, stated the company recommends Specialty Bed A for patients up to 300 pounds. He stated patients who weigh over 300 pounds up to 1,000 pounds should use Specialty Bed B. He stated using Specialty Bed B instead of Specialty Bed A for a 162 pound patient would be comparable to using a 4-wheel drive when a golf cart was indicated.</p> <p>A tour of the Medical Unit was conducted on 4/24/14 at 9:00 AM. During the tour of the unit, patients and family members were interviewed.</p> <p>Patient #2 was observed on Specialty Bed B that included an inflating air mattress overlay, and was set to rotate to 30 degrees. The bed had all 4 side rails up, which extended approximately 4 inches above the inflated mattress. A cushioned pad was inserted on the left side of the bed, spanning the open space between the left side rails, a safety measure to protect Patient #2 from a potential fall. During the observation of Patient #2's bed, he remained in a sleepy state, but his daughter was present in the room. She stated Patient #2 was admitted on 4/22/14, during the</p>	A 144			

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A 144	<p>Continued From page 8</p> <p>night, and she had requested a sitter to help monitor her father after she went home. Patient #2's daughter stated the nursing staff told her he would not need a sitter, as he was weak, was bedfast, and his room was located close to the nursing station for close visibility. Patient #2's daughter stated he fell out of bed, and was bruised with a large bump on his head. She stated Patient #2 had multiple recent hospitalizations and a sitter was provided during past hospitalizations. She stated a sitter was provided after her father fell on 4/23/14.</p> <p>A policy, titled "Patient Safety Attendant (Sitter)," dated 8/13/13, noted sitter duties would include constant patient observation.</p> <p>Specialty Bed A arrived for Patient #2 at 1:42 PM on 4/24/14.</p> <p>During an interview on 4/25/14 beginning at 8:30 AM, the Nursing Director of the Medical Unit stated the admitting RN and Charge Nurse would evaluate if a sitter was needed. She stated the RN providing care for Patient #2 on the shift the fall occurred was an experienced nurse and was confident she fully evaluated patient's need for a sitter. The Director stated she investigated the specialty bed documents, and was not able to find a minimum weight for (Specialty Bed B), but confirmed it was intended for bariatric usage.</p> <p>Patient #2 experienced a fall from his bed, after a fall risk assessment determined he was at high risk for falls. He was on a rotating bed designed for much larger patients. He was noted to be restless and confused. The facility did not ensure appropriate fall risk measures were implemented.</p>	A 144		
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May 6, 2014

James Angle, Administrator
St Luke's Magic Valley RMC
P.O. Box 409
Twin Falls, ID 83301

RE: St Luke's Magic Valley RMC, Provider #130002

Dear Mr. Angle:

On April 25, 2014, a complaint survey was conducted at St Luke's Magic Valley RMC. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006452

Allegation #1: The facility failed to ensure a safe environment for patients who were at risk for falls.

Findings #1: An unannounced, on-site complaint survey was conducted from 4/23/14 to 4/25/14. Clinical records and facility policies were reviewed, staff, patient and family interviews were conducted. Incident report logs from January 2014 through April 2014 were reviewed. Medical records of 5 patients who had experienced falls were reviewed for documentation of fall risk assessment and implementation of fall prevention measures for those patients.

Three of the 5 patient records reviewed reflected a lack of appropriate fall risk assessment and/or interventions.

One patient was a 70 year old male admitted to the facility on 4/22/14 at 8:29 PM, for care related to lung cancer with metastasis and anemia. Additionally, the patient had a stage 4 pressure ulcer on his coccyx. His record documented that shortly after his admission he was placed on Specialty Bed B, a specialty air inflation and rotation bed intended for patients weighing up to 1,000 pounds. An admission assessment completed by an RN on 4/23/14 at 12:30 AM, noted the patient was disoriented, confused, and restless. The Fall Risk Screening Score was 23, indicating he was at high risk for falls (a score greater than 13 indicates a high fall risk). The patient's admission weight was noted as 162 pounds.

James Angle, Administrator
May 6, 2014
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In a "PATIENT CARE/INTERVENTIONS" note, dated 4/23/14 at 2:58 AM, the RN noted the patient continued to be very restless, anxious, and grabbing at armbands to take them off. The RN noted she administered Ativan for agitation. The documentation included the patient was on a rotating bed.

The patient's record included a "CONTINUOUS ORDER SET, "Physicians Orders, Standing Orders for (Patient)." The Standing Orders were signed and dated 4/23/14 at 8:30 AM. The orders included that the patient was to be placed on Specialty Bed A, a rotating bed designed for patients weighing up to 350 pounds.

An incident report documented on 4/23/14 at 3:35 AM, indicated the patient was found on the floor beside his bed. The individual who found the patient on the floor documented "The pt's (patient's) air mattress was highly over inflated on one side and caused the pt to slide out of the bed." The incident report was reviewed by the Director of the Medical Unit on 4/24/14 at 7:34 AM. The Director documented the order was written for (Specialty Bed A) rotating bed, and the Charge Nurse made the decision to use the bariatric bed (Specialty Bed B) with the thought it would be more beneficial to the patient instead of placing the patient in a hospital bed until Specialty Bed A could be ordered.

During a phone interview on 4/30/14 at 9:15 AM, the Service Manager/Technical Manager from the company who manufactures and distributes Specialty Bed B used by the patient, stated the company recommends Specialty Bed A for patients up to 300 pounds. He stated patients who weigh over 300 pounds up to 1,000 pounds should use Specialty Bed B. He stated using Specialty Bed B instead of Specialty Bed A for a 162 pound patient would be comparable to using a 4 wheel drive when a golf cart was indicated.

A tour of the Medical Unit was conducted on 4/24/14 at 9:00 AM. During the tour of the unit, patients and family members were interviewed.

The patient was observed on Specialty Bed B that included an inflating air mattress overlay, and was set to rotate to 30 degrees. The bed had all 4 side rails up, which extended approximately 4 inches above the inflated mattress. A cushioned pad was inserted on the left side of the bed, spanning the open space between the left side rails, to prevent Patient #2 from falling out. During the observation of the patient's bed, he remained in a sleepy state, but his daughter was present in the room. She stated the patient was admitted on 4/22/14, during the night, and she had requested a sitter to help monitor her father after she went home. The patient's daughter stated the nursing staff told her he would not need a sitter, as he was weak, was bedfast, and his room was located close to the nursing station for close visibility. The patient's daughter stated he fell out of bed, and was bruised with a large bump on his head. She stated the patient had multiple recent hospitalizations and a sitter was provided during past hospitalizations. She stated a sitter was provided after her father fell on 4/23/14.

A policy, titled "Patient Safety Attendant (Sitter)," dated 8/13/13, noted sitter duties would include constant patient observation.

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During an interview on 4/25/14 beginning at 8:30 AM, the Nursing Director of the Medical Unit stated the admitting RN and Charge Nurse would evaluate if a sitter was needed. She stated the RN providing care for the patient on the shift the fall occurred was an experienced nurse and was confident she fully evaluated patient's need for a sitter. The Director stated she investigated the specialty bed documents, and was not able to find a minimum weight for (Specialty Bed B), but confirmed it was intended for bariatric usage.

The patient experienced a fall from his bed, after a fall risk assessment determined he was at high risk for falls. He was on a rotating bed designed for much larger patients. He was also noted to be restless and confused. The facility did not ensure appropriate fall risk measures were implemented.

A second patient admitted to the hospital in April 2014, was noted to be weak, very shakey, and unsteady, however, an admission fall risk assessment was not completed. The patient experienced a fall shortly after arriving at the hospital.

A third patient, admitted in February 2014, sustained a fall following hip surgery. The use of a sitter had been discontinued and the patient's bed alarm appeared to have been turned off.

The allegation was substantiated and a deficiency was cited at 42 CFR (Code of Federal Regulations) 482.13(c)(2), related to failure to provide care in a safe setting.

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

Allegation #2: The facility administered a narcotic drug that was included in the patient's list of allergies.

Findings #2: Eleven patient records were reviewed, including 5 who experienced falls. One patient's record noted he was allergic to morphine, (classified as an opiate), and specified it caused agitation. As per "Nursing 2014 Drug Handbook," agitation after the administration of morphine is considered an adverse reaction rather than an allergy, and should be used with caution in elderly and debilitated patients.

The patient's record noted he was hospitalized on 5 occasions during the past 6 weeks. Records were reviewed from each of those admissions for evidence that he received administration of morphine.

Each of the records contained a nursing review of allergies upon his admission. Each record contained documentation of his allergy to morphine.

There was no documentation in any of the 5 medical records reviewed for the patient that he received Morphine.

No evidence was found in the other 10 patient records reviewed that patients were administered drugs they were documented to be allergic to.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

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

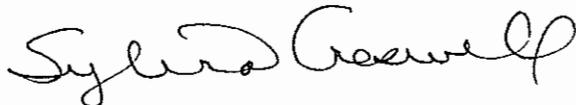
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

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,

Handwritten signature of Susan Costa in cursive, with the initials 'sc' at the end.

SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care

Handwritten signature of Sylvia Creswell in cursive.

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pmt