

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



IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 20, 2013

Jon Ness, CEO
Kootenai Medical Center
2003 Kootenai Health Way
Coeur d'Alene, ID 83814

CMS Certification Number: 13-0049

Re: Complaint survey completed 06/10/2013
CoP Patient Rights Not Met
Placed on 90-day termination track starting 06/10/2013

Dear Mr. Ness:

After careful review of the facts, the Centers for Medicare and Medicaid Services (CMS) has determined that Kootenai Medical Center no longer meets the requirements for participation as a provider of services in the Medicare program established under Title XVIII of the Social Security Act. Kootenai Medical Center is now placed on a 90-day termination track based on the date of June 10, 2013. This is to notify you that effective **September 8, 2013**, the Secretary of the Department of Health and Human Services intends to terminate its provider agreement with Kootenai Medical Center. We will publish a legal notice in the local newspaper 15 days prior to the termination date.

I. BACKGROUND

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services. When a hospital is found to be out of compliance with the Medicare Conditions of Participation, the facility no longer meets the requirements for participation as a provider of services in the Medicare program.

The Social Security Act Section 1866(b) authorizes the Secretary to terminate a hospital's Medicare provider agreement if the hospital no longer meets the regulatory requirements for a hospital. Regulations at 42 CFR § 489.53 authorize the Centers for Medicare and Medicaid Services to terminate Medicare provider agreements when a provider, such as Kootenai Medical Center, no longer meets the Conditions of Participation.

On June 10, 2013, the Idaho Bureau of Facility Standards (State survey agency) completed a complaint survey at your facility. This survey found that the Medicare Condition of Participation (CoP) at Patient Rights (42 CFR § 482.13) was not met. These deficiencies limit the capacity of Kootenai Medical Center to furnish services of an adequate level and quality. The details of the above deficiencies are listed on the enclosed Statement of Deficiencies and Plan of Correction (Form CMS 2567).

II. PUBLIC NOTICE OF TERMINATION AND OPPORTUNITY TO CORRECT

In accordance with 42 CFR § 489.53(d), legal notice of our action will be published in the local newspaper 15 days before the termination date.

Kootenai Medical Center can avoid the 90-day termination action by correcting the deficiencies prior to the effective date of the termination. CMS must receive and approve a credible allegation of compliance, in sufficient time to verify, with an unannounced revisit by the State survey agency, that the deficiencies have been corrected. Complete your plan of correction in the space provided on the CMS-2567 within the next 10 calendar days. An acceptable plan of correction, which includes acceptable completion dates, must contain the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving 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;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

CMS strongly encourages Kootenai Medical Center to have its plan of correction fully implemented by no later than **July 15, 2013**. Please send your corrective actions to the State survey agency and to:

**CMS – Division of Survey and Certification
Attention: Kate Mitchell (Mail stop RX-48)
2201 Sixth Avenue
Seattle, WA 98121**

III. APPEAL RIGHTS

Kootenai Medical Center has the right to appeal this determination by requesting a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR § 498.40 et seq. A written request for a hearing must be filed not later than 60 days after the date you receive this letter. Such a request may be made to:

Chief, Civil Remedies Division
Departmental Appeals Board
MS 6132
Cohen Building, Room 637-D
330 Independence Avenue, SW
Washington, D.C. 20201

Please also send a copy to:

Chief Counsel
Office of General Counsel, DHHS
2201 Sixth Avenue, M/S RX-10
Seattle, WA 98121-2500

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which Kootenai Medical Center disagrees. The request should also specify the basis for contending that the findings and conclusions are incorrect. Evidence and arguments may be presented at the hearing and you may be represented by legal counsel at your own expense.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432 or by email at Catherine.mitchell@cms.hhs.gov.

Sincerely,


for

Steven Chickering, Associate Regional Administrator
Western Division of Survey & Certification

Enclosure

cc: Idaho Bureau of Facility Standards
Office of General Counsel, DHHS
Joint Commission



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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

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

June 21, 2013

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

COPY

RE: Kootenai Medical Center, Provider #130049

Dear Mr. Ness:

This is to advise you of the findings of the complaint survey at Kootenai Medical Center, which was concluded on June 10, 2013.

A copy of a Statement of Deficiencies/Plan of Correction, Form CMS-2567 was forwarded to you by CMS Region X office on 06/20/2013.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

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

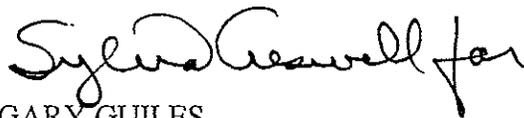
Jon Ness, Administrator
June 21, 2013
Page 2 of 2

- plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by July 3, 2013, and keep a copy for your records.

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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESTWELL
Co-Supervisor
Non-Long Term Care

GG/pt

Enclosures

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

June 27, 2013

CMS – Division of Survey and Certification
Kate Mitchell
2201 Sixth Avenue, RX – 48
Seattle, WA 98121

RECEIVED

JUL - 1 2013

FACILITY STANDARDS

Dear Kate,

Attached is the Plan of Correction for the Conditions of Participation as well as the Credible Allegation of Compliance for A-115 482.13 Patient Rights, A-115, 145, 154, 166, 168, 169, 171, 174, 187, 188, Use of Restraints or Seclusion.

Kootenai Health's core commitment is to provide quality healthcare to all people. Our mission, values and vision uphold our Service Excellence Standards, including privacy, patient rights, and professional behavior.

Corrective actions to address all areas of deficiencies under A-115 482.13 will have been put into place within the 35 day time period. Systems and processes have been implemented in order to ensure ongoing compliance and quality of care in meeting the Conditions of Participation.

If you have any questions regarding the report submitted, please contact me at 208-666-2278.

Sincerely,



Lorraine Olsheski, Executive Director of Quality and Risk Management

cc: **Sylvia Creswell**
Co-Supervisor
3232 Elder Street
P.O. Box 83720
Boise, ID 83720

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint investigation at your hospital. Surveyors conducting the review were: Gary Gules, RN, HFS, Team Leader Libby Doane, RN, HFS Donald Sylvester, RN, HFS Acronyms used in this report include: DQRM - Director of Quality and Risk Management ED - emergency department EMR - Electronic Medical Record GLF - Ground Level Fall h - Hour IM - Intramuscular LIP - licensed independent practitioner MAR - Medication Administration Record mg - milligram Neurocheck - Neurologic Check POC - plan of care PRN - As Needed q - Every	A 000		
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 staff interviews and review of medical records, hospital policies, and grievance documents, it was determined the hospital failed to protect and promote patients' rights. This resulted in patients restrained 1) without evidence of necessity to protect the patient or other from	A 115		

RECEIVED
JUL - 1 2013
FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Louanne Cleber *Exec. Director of Quality & Risk Management* TITLE
6-27-13 (X6) DATE

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: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 115	<p>Continued From page 1</p> <p>harm 2) without physician authorization 3) on an as-needed basis 4) longer than necessary and/or permitted 5) and without incorporating the intervention into each patients' POC. It also resulted in delayed investigation of a patient's allegations of mistreatment by hospital employees. Findings include:</p> <ol style="list-style-type: none"> 1. Refer to A145 as it relates to the hospital's failure to ensure a process had been developed for the prompt reporting and investigation of allegations of abuse. 2. Refer to A154 as it relates to the hospital's failure to ensure restraint was only imposed to ensure the immediate physical safety of the patient or others and/or was discontinued at the earliest possible time. 3. Refer to A166 as it relates to the hospital's failure to ensure patients' written plans of care were modified to reflect the use of restraints. 4. Refer to A168 as it relates to the hospital's failure to ensure restraints were utilized in accordance with physician orders. 5. Refer to A169 as it relates to the hospital's failure to ensure orders for chemical restraints were not written on an a prn basis. 6. Refer to A171 as it relates to the hospital's failure to ensure orders for restraint used for the management of violent or self-destructive behavior were renewed every 4 hours. 7. Refer to A174 as it relates to the hospital's failure to ensure restraints were discontinued at 	A 115		
-------	--	-------	--	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
A 145	<p>Continued From page 3</p> <p>ED stay, Patient #2 became increasingly combative and attempted to hit security staff with a metal stool. The note documented that Patient #2 was then physically restrained by security staff and given an injection of an antipsychotic medication. The note stated that Patient #2 was to be transferred to the behavioral health unit of the hospital but would remain in the ED until a bed became available. Patient #2 was transferred to the behavioral health unit on 1/27/13 at approximately 1:55 PM.</p> <p>On 1/27/13 at 9:42 PM, a Mental Health Specialist documented that Patient #2 believed he had been abused by security during his time in the ED and wanted to meet with administration to file a grievance. The note went on to state that Patient #2 felt undue force had been used on him causing injuries to his arm and back and he felt the security staff was laughing at him. There was no documentation to indicate the Mental Health Specialist had reported this incident or responded to Patient #2's request to file a grievance. A grievance was later filed by the manager of the behavioral health unit on 1/31/13, four days after the initial allegation of abuse by Patient #2, and an investigation was initiated at that time.</p> <p>The Mental Health Specialist referenced above was interviewed at 11:25 AM on 6/07/13. She stated that she had not reported the incident nor had she responded to Patient #2's request to file a grievance. She stated that she had not been told to report these kinds of allegations. She also stated that she did not think he really had been abused and therefore did not feel the need to report it. She stated that if she had thought Patient #2 had been abused, she would have</p>	A 145	<p><i>Policy modification & changes completed. 6-26-13</i></p> <p><i>Education & follow-up completed with all Behavioral Health staff as well as internal newsletter communications 6-17-13</i></p> <p><i>owner: Director of Behavioral Health</i></p>

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 145	Continued From page 4 reported it to her supervisor and the house supervisor. She also stated that because the incident did not happen on her unit, she felt her only responsibility was to document it in the record. The policy "Abuse and Neglect of Patients at Kootenai Medical Center," dated 5/13/13, stated "All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the employee's director and in accordance with state law." The policy did not address when or how to report allegations of abuse nor did it outline a process for staff to follow when reporting abuse. The DQRM was interviewed at 11:05 AM on 6/07/13. She confirmed there was no written process to provide direction to staff regarding the reporting of abuse allegations. The hospital did not have a process for reporting abuse.	A 145	<i>Policy modifications have been completed to reflect expected timeframes in reporting any alleged Abuse or neglect. see attachment <u>C</u> policy. attachment <u>D</u> guidelines</i>	6-26-13	
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by: Based on medical record review and staff	A 154			

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 154	<p>Continued From page 6 that he was a threat to himself or others from 11:20 PM through 3:15 AM.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7 was restrained while he was asleep and he did not appear to be a threat to himself or others.</p> <p>There was no documentation to support that Patient #7 was restrained to protect himself or others.</p> <p>2. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and discharged on 3/18/13. Diagnoses included progressive dementia and GLF (Ground level fall).</p> <p>A physician order, dated 3/09/13 at 10:00 PM, called for Patient #3 to be placed in "four point soft restraints." The order did not state what specific behaviors Patient #3 exhibited that construed a threat to safety.</p> <p>On 3/09/13 at 9:36 PM, a nursing progress note included wrists and legs were restrained. The note did not include the specific behaviors which may have warranted the restraints. At 1:30 AM on 3/10/13, Patient #3's nursing note stated " ...IS SLEEPING ON AND OFF, WHEN AWAKE PT HAS TO BE REDIRECTED FROM HIS WRIST RESTRAINTS, ONLY WRIST RESTRAINTS ARE APPLIED." There was no nursing documentation to indicate when the leg restraints were discontinued. Subsequent nursing notes included no further reference to Patient #3 being restrained. No documentation was found to indicate when the restraints were discontinued or</p>	A 154	<p>6) Modifications made to violent, non-violent, chemical restraint process maps & algorithms as a user friendly resource for staff & physicians to clarify process expectations</p> <p>attachments L - algorithms attachment M - maps</p> <p>7) Revision completed to EHR screens (Meditech) to support prompt documentation expectations</p> <p>attachment N - screen prints</p> <p>8) Re-education & training of all direct care givers in which standards apply to ensure overall competencies in use of restraint & seclusion.</p> <ul style="list-style-type: none"> - documentation standards; - plan of care expectations - order set compliance - nursing protocol elements - use of process maps - types of restraints 	6-24-13 7-13-13 6-12-13 14 24 25
-------	---	-------	---	---

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 154	Continued From page 7 the rationale for the restraints. The DQRM was interviewed at 6/05/13 at 12:40 PM. She reviewed Patient #3's medical record and confirmed there was no documentation to indicate Patient #3 was physically aggressive or exhibited violent behavior, requiring the use of restraints. There was no documentation to support that Patient #3 was restrained to protect himself or others.	A 154	Continued - Specific talking points for all training stations. attachment <u>O</u> - posting attachment <u>P</u> - materials & tools.	
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure treatment plans reflected the use of restraints and seclusion for 3 of 4 patients (#3, #7, and #8) whose records were reviewed and who were restrained and/or secluded. This resulted in a lack of direction to staff regarding ways to decrease restraint usage and ways to keep the patient safe. Findings include: 1. Patient #8 was a 51 year old male admitted to the hospital through the ED on 5/15/13 for severe intoxication and suicidal behavior. He was discharged on 5/18/13. An RN assessment note, dated 5/15/13 at 3:52 PM, stated Patient #8 had been placed in soft wrist and ankle restraints due to his intoxication	A 166	9.) Information & training packets developed for all clinical managers, directors, supervisors to assist with their own staff training & expectations: Reviewed with clinical leadership group. Contact: Steps to meet compliance Process maps. Order sets. Audit tools algorithms types of restraints policies attachment <u>R</u> - packet.	7.24.13
			10.) SABA (Electronic online training software) module development 7.13.13 & roll-out to all clinical staff addressing COP compliance	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 166	<p>Continued From page 8</p> <p>level and increasing combativeness. A "RESTRAINT NON-VIOLENT/SELF DESTRUCTIVE (MEDICAL) PHYSICIAN ORDERS," signed by the ED physician on 5/15/13 at 5:00 PM, documented orders for soft ankle and wrist restraints. A nursing note dated 5/15/13 at 7:25 PM documented that Patient #8 had been removed from restraints and was calm and cooperative. A plan of care that included the restraints was not documented in Patient #8's medical record.</p> <p>The DQRM was interviewed on 6/10/13 beginning at 12:40 PM. She stated POCs, including POCs for restraints, were not documented for Patient #8.</p> <p>Patient #8's plan of care was not reflective of the use of restraints.</p> <p>2. Patient #2 was a 50 year old male admitted through the ED on 1/26/13 for schizophrenia. He was discharged on 1/31/13.</p> <p>The ED physician's progress note, dictated 1/26/13 at 10:55 PM, stated Patient #2 had been physically restrained after attempting to hit security staff with a metal stool.</p> <p>In addition, a "Case Report," completed by security staff on 1/27/13 at 11:50 PM, documented that security officers were in place at the door to Patient #2's room to "make sure (patient) didn't leave or injure himself." The security officer that documented the report was interviewed on 6/07/13 at 7:35 AM and confirmed he and another officer stood at the door of Patient #2's room and did not allow him to leave to</p>	<p>11) A 166</p>	<p>Re-education of physicians w/ focus on intensivists, ED, Cardiology, selected Surgeons & Hospitalists</p> <p>Newly developed education packets distributed.</p> <p>Re-introduced at quarterly General Staff meeting</p> <p>Patient Care (Quality) Comm. 6-17-13</p> <p>Medical Executive Comm. 6-18-13</p> <p>6-20-13</p> <p>Acknowledgment form signed 6-24-13 by each physician & filed for future reference</p> <p>attachment 5 packet.</p>	
		<p>12)</p>	<p>Daily audits conducted on all restraints to ensure 100% compliance to standards</p> <p>Audit tracking database developed in order to compile weekly reports for clinical managers use, training & info</p> <p>attachment I audit tools</p>	<p>ongoing</p>

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 166	<p>Continued From page 9</p> <p>protect Patient #2 and ED staff. The medical record did not document the length of time the security gaurds were positioned at Patient #2's doorway to prevent him from leaving.</p> <p>In an interview with the Manager of Patient Advocacy on 6/06/13 at 8:45 AM, he confirmed the security guards did not allow Patient #2 to leave the room and this qualified as seclusion, in addition to the physical restraint by security staff. A plan of care that included physical restraints and seclusion was not documented.</p> <p>The DQRM was interviewed on 6/10/13 beginning at 12:40 PM. She stated POCs, including POCs for restraints, were not documented for Patient #2.</p> <p>Patient #2's plan of care was not reflective of the use of restraints.</p> <p>3. Patient #7's medical record documented a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder.</p> <p>At 9:07 PM on 5/10/13, a nursing progress note stated Patient #7 was placed in 4 point restraints. At 12:00 midnight on 5/11/13, a nursing progress note stated "right upper and lower leather restraints removed." At 2:55 AM on 5/11/13, a nursing progress note stated only Patient #7's left arm was restrained. At 3:30 AM on 5/11/13, a nursing progress note stated Patient #7's last restraint was removed. A plan of care that included restraints was not documented in his</p>	A 166	<p><i>attachment U</i></p> <p><i>database elements</i></p> <p><i>owner: Elements #1-12 Core Team.</i></p>		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 166	Continued From page 10 medical record. The DQRM was interviewed on 6/10/13 beginning at 12:40 PM. She stated POCs, including POCs for restraints, were not documented for Patient #7. A POC that included the use of restraints was not documented in Patient #7's medical record. 4. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF. At 9:36 PM on 3/09/13, a nursing progress note stated Patient #3 was placed in 4 point restraints. A POC that included restraints was not documented in Patient #3's medical record. The DQRM was interviewed on 6/05/13 beginning at 12:40 PM. She stated POCs, including POCs for restraints, were not documented.	A 166			
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by:	A 168			

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 168	Continued From page 11 Based on medical record review and staff interview, it was determined the hospital failed to ensure restraint was used in accordance with the order of a physician or an authorized licensed independent practitioner for 4 of 4 patients (#2, #3, #7, and #8) whose records were reviewed and who were restrained. This resulted in the use of restraints without orders. Findings include: 1. Patient #2 was a 50 year old male admitted through the ED on 1/26/13 for schizophrenia. He was discharged on 1/31/13. The ED physician's progress note, dictated 1/26/13 at 10:55 PM, stated Patient #2 had been physically restrained after attempting to hit security staff with a metal stool. There were no orders documented for the physical restraint. In addition, a "Case Report," completed by security staff on 1/27/13 at 11:50 PM, documented that security officers were in place at the door to Patient #2's room to "make sure (patient) didn't leave or injure himself." The security officer that documented the report was interviewed on 6/07/13 at 7:35 AM and confirmed he and another officer stood at the door of Patient #2's room and did not allow him to leave to protect Patient #2 and ED staff. The medical record did not document the length of time the security officers were positioned at Patient #2's doorway to prevent him from leaving. In an interview with the Manager of Patient Advocacy on 6/06/13 at 8:45 AM, he confirmed the security guards did not allow Patient #2 to leave the room and this qualified as seclusion. He confirmed there were no orders in the medical	1) A 168	Order sets modified to include addressing change in restraint status attachment <input checked="" type="checkbox"/> order set.	6.21.13
		2)	Nursing protocol update to reflect need for new order of change in restraint status. attachment <input type="checkbox"/> Old set.	6.21.13
		3)	Re-education completed in training sessions Refer to pg 7 of 39 for details.	6.12.13 14 24 25
		4)	Re-education to clinical staff regarding immediate need to complete order forms according to standards & policy compliance. Enforcement stressed in training sessions. Refer to pg 8 of 39 for details	6.12.13 14 24 25

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 168	<p>Continued From page 12 record for seclusion. He also confirmed that there were no orders for the physical restraint.</p> <p>Patient #2 was physically restrained and placed in seclusion without an order.</p> <p>2. Patient #8 was a 51 year old male admitted to the hospital through the ED on 5/15/13 for severe intoxication and suicidal behavior. He was discharged on 5/18/13.</p> <p>An RN assessment note, dated 5/15/13 at 3:52 PM, stated Patient #8 had been placed in soft wrist and ankle restraints due to his intoxication level and increasing combativeness. The RN also documented that a valid order for restraints was in the chart.</p> <p>A "RESTRAINT NON-VIOLENT/SELF DESTRUCTIVE (MEDICAL) PHYSICIAN ORDERS," signed by the ED physician on 5/15/13 at 5:00 PM, documented orders for soft ankle and wrist restraints as well as chemical restraints, one hour and eight minutes after Patient #8 had been placed in restraints. The order form contained a place for the RN who initiated the restraints to sign, date, and time when restraints had been placed. This portion of the form was left blank. There was no documentation to explain why the order was delayed after initiating the restraints.</p> <p>The DQRM was interviewed on 6/06/13 at 4:15 PM. She confirmed the documentation indicated Patient #8 had been placed in restraints prior to the ED physician's order.</p> <p>Patient #8 was physically restrained without an</p>	A 168 <i>owner</i>	<i>cleans #1-4 Core Team.</i>		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 168	<p>Continued From page 13 order.</p> <p>3. Patient #7's medical record documented a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder.</p> <p>A physician's order, dated 5/10/13 at 9:10 PM, called for Patient #7 to be placed in "four point leather restraints."</p> <p>Patient #7's nursing notes, beginning at 9:07 PM on 5/10/13, stated these restraints were in place. At 12:00 midnight on 5/11/13, a nursing progress note stated "right upper and lower leather restraints removed." At 2:55 AM on 5/11/13, a nursing progress note stated only Patient #7's left arm was restrained. At 3:30 AM on 5/11/13, a nursing progress note stated Patient #7's last restraint was removed.</p> <p>An order was not present in the medical record for the 2 point restraints which were documented at 12:00 midnight on 5/11/13 or the 1 point restraint which was documented at 3:30 AM on 5/11/13.</p> <p>Also, a nursing progress note dated 5/11/13 at 8:00 AM stated Patient #7 had a "trunk" restraint. The trunk restraint was also documented in place on 5/11/13 at 10:00 AM, 12:00 noon, 1:42 PM, and 5:00 PM. An order for the trunk restraint was not documented.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7's medical</p>	A 168		
-------	---	-------	--	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 168	Continued From page 14 record did not include orders for the restraints. Patient #7 was placed in restraints which were not in accordance with the orders of a physician or other LIP. 4. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF. A physician order, dated 3/09/13 at 10:00 PM, called for Patient #3 to be placed in "four point soft restraints." On 3/09/13 at 9:36 PM, a nursing progress note included wrists and legs were restrained, it did not include any specific behaviors. At 1:30 AM on 3/10/13, Patient #3's nursing note, stated " ...IS SLEEPING ON AND OFF, WHEN AWAKE PT HAS TO BE REDIRECTED FROM HIS WRIST RESTRAINTS, ONLY WRIST RESTRAINTS ARE APPLIED." There was no nursing documentation to indicate when Patient #3's ankle restraints were removed. The medical record did not contain an order for wrist restraints only. The DQRM was interviewed on 6/05/13 beginning at 3:40 PM. She acknowledged a specific order for Patient #3 to be in wrist restraints only was not documented. Patient #3 did not have a specific order for wrist restraints.	A 168			
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION	A 169			

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 169	<p>Continued From page 15</p> <p>Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure orders for chemical restraints were not written on a prn basis for 1 of 4 patients (#3) who were restrained and whose medical records were reviewed. This resulted in the potential for patients to be unnecessarily restrained. Findings include:</p> <p>Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF.</p> <p>An order titled "RESTRAINT/SECLUSION VIOLENT/SELF-DESTRUCTIVE(BEHAVIORAL) INITIAL PHYSICIAN ORDERS AND ASSESSMENT," dated 3/09/13 at 9:33 PM, stated "medication: Haldol + Ativan." A subsequent order, dated 3/10/13 at 12:29 AM, stated "Ativan 1 mg IV/IM/PO Q1h PRN agitation, Haldol 1-4 mg IV/IM PRN agitation."</p> <p>Patient #3's MAR indicated PRN Haldol was given 3/09/13 at 9:33 PM and at 3/10/13 at 4:17 PM. Patient #3's MAR indicated PRN Ativan was given on the following dates and times for "AGITATION":</p> <p>- 3/09/13 at 10:51 PM</p> <p>- 3/10/13 at 9:17 AM, 11:39 AM, 12:37 PM, 3:28</p>	A 169	<p>1) order sets modified to address "NO PRN" medication orders are ^{NOT} to be written as standing orders. owner: Core Team Attachment X order set 6-21-13</p> <p>2) Physician re-education Refer to #11 pg 9 of 39 for details owner: Exec. Director Quality & Risk 6-24-13</p> <p>3) Focused enforcement with physicians & clinical staff conducted during audits in documenting specific symptoms that warrants the use restraints or seclusion owner: Core Team oversight 6-30-13</p> <p>ongoing</p>	
-------	--	-------	---	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 169	Continued From page 16 PM, 6:33 PM, 9:53 PM, 11:33 PM. The DQRM was interviewed on 6/13/13 beginning at 2:00 PM. She confirmed Patient #3's medical record contained orders for PRN chemical restraints. PRN chemical restraints were ordered for Patient #3.	4.) A 169	<i>ongoing daily audits conducted to ensure 100% compliance related to prn orders. Any physician out of compliance is notified by CMO or Chief of Staff Core Team.</i>	<i>Ongoing</i>
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure orders for restraint used for the management of violent or self-destructive behavior were renewed every 4 hours for 1 of 4 adult patients (#7) who were restrained for violent and destructive behavior and whose records were reviewed. This resulted in the use of restraint without continued authorization. Findings include: 1. Patient #7's medical record documented a 59 year old male who was admitted to the hospital	owner: A 171	1) Refer to pg 7 of 39 for details #8 regarding re-education Pol. 2) Refer to pg 9 of 39 for details # 12 regarding daily audits. 3) Ensure compliance through daily audits in documentation supporting symptoms & reason for use of restraints	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 171	Continued From page 17 through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder. A physician order, dated 5/10/13 at 9:10 PM, called for Patient #7 to be placed in "four point leather restraints." Patient #7's nursing notes, beginning at 9:07 PM on 5/10/13, stated these restraints were in place. At 12:00 midnight on 5/11/13, a nursing progress note stated "right upper and lower leather restraints removed." At 2:55 AM on 5/11/13, a nursing progress note stated only Patient #7's left arm was restrained. At 3:30 AM on 5/11/13, a nursing progress note stated Patient #7's last restraint was removed. Patient #7 was restrained from at least 9:07 PM on 5/10/13 until 3:30 pm on 5/11/13, a total of 6 hours and 23 minutes. No orders for restraints were documented after 5/10/13 at 9:10 PM. The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed restraint orders for Patient #7 were not renewed after 4 hours. Restraint orders for Patient #7 were not renewed after 4 hours.	A 171	Feedback given to staff & physicians in real time after audits complete if indicated for re-educating & training improvement. Core Team	ongoing
A 174	482.13(e)(9) PATIENT RIGHTS: RESTRAINT OR SECLUSION Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order. This STANDARD is not met as evidenced by:	A 174		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 174	<p>Continued From page 18</p> <p>Based on medical record review and staff interview, it was determined the hospital failed to ensure restraints were discontinued at the earliest possible time for 1 of 4 patients (#7) who were restrained and whose records were reviewed. This resulted in the continued use of restraint that was not necessary to keep the patient and others safe. Findings include:</p> <p>Patient #7's medical record documented a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder.</p> <p>A physician order, dated 5/10/13 at 9:10 PM, called for Patient #7 to be placed in "four point leather restraints."</p> <p>Patient #7's nursing notes, beginning at 9:07 PM on 5/10/13, stated these restraints were in place. At 12:00 midnight on 5/11/13, a nursing progress note stated "right upper and lower leather restraints removed." At 2:55 AM on 5/11/13, a nursing progress note stated only Patient #7's left arm was restrained. At 3:30 AM on 5/11/13, a nursing progress note stated Patient #7's last restraint was removed.</p> <p>Nursing notes documented 30 minute checks while Patient #7 was restrained. The notes documented Patient #7 "Appears to sleep" on 5/10/13 at 11:20 PM, 11:50 PM, and on 5/11/13 at midnight, 12:25 AM, 12:55 AM, 1:16 AM, 1:45 AM, 2:15 AM, 2:45 AM, and 3:15 AM. Patient #7 was restrained for 3 hours and 50 minutes while he was asleep. A reason why the restraints were</p>	A 174	<p>1) Refer to pg 7 of 39 for details # 8 Regarding re-education POC.</p> <p>2) Refer to pg 9 of 39 for details # 12 Regarding daily audits</p> <p>3) Ensure compliance through daily audits to ensure ongoing compliance with documentation standards related to reason patient remains in restraints</p> <p>4) Feedback given to staff & physicians in real time after daily audit complete if indicated for re-education & training enforcement.</p> <p>owner: Core Team.</p>	<p>ongoing</p> <p>ongoing</p>

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 174	Continued From page 19 not discontinued when Patient #7 was asleep and did not present a danger to himself or others was not documented. The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7 was restrained while he was asleep.	A 174			
A 187	482.13(e)(16)(iv) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] The patient's condition or symptom(s) that warranted the use of the restraint or seclusion. This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure medical records documented the symptoms that warranted the use of restraint for 3 of 4 patients (#2, #3 and #7) who were restrained and whose records were reviewed. This resulted in the inability of the hospital to justify the use of restraints. Findings include: 1. Patient #7's medical record documented a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder. A nursing progress note dated 5/11/13 at 7:38 AM stated Patient #7 was "...very restless [with] lap	A 187	1) Refer to pg 7 of 39 for details #8 regarding re-education POC 2) Refer to pg 9 of 39 for details #12 regarding daily audits. 3) Ensure compliance through daily audits to ensure documentation supports justification for use of restraints	ongoing	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 187	<p>Continued From page 21</p> <p>Patient #2's room to "make sure (patient) didn't leave or injure himself." The "Case Report" was an internal report and was not part of the medical record.</p> <p>The security officer that documented the report was interviewed on 6/07/13 at 7:35 AM. He confirmed he and another officer stood at the door of Patient #2's room on the evening of 1/26/13 and did not allow the patient to leave in order to protect Patient #2 and ED staff. The length of time the security guards were positioned at Patient #2's doorway to prevent him from leaving was not documented. There was no nursing documentation to include the rationale for the seclusion of Patient #2.</p> <p>In an interview with the Manager of Patient Advocacy on 6/06/13 at 8:45 AM, he confirmed the security guards did not allow Patient #2 to leave the room and this qualified as seclusion. He confirmed there was no nursing documentation to include the rationale for seclusion of Patient #2</p> <p>Patient #2's medical record did not contain the rationale for seclusion.</p> <p>3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF.</p> <p>On 6/05/13 at 9:25 AM, Patient #3's medical record was reviewed. Patient #3's Emergency Admit note, section Emergency Department Course stated, "He has been violent with other</p>	A 187			

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 187	Continued From page 22 staff at (assisted living) earlier, but has not been so yet with the emergency department. He was given Haldol IM in the emergency department. As this was not effective enough, he was given 1 mg Ativan IM." The medical record did not document that Patient #3 was violent or combative at the hospital. A physician order titled "RESTRAINT/SECLUSION VIOLENT/SELF-DESTRUCTIVE(BEHAVIORAL) INITIAL PHYSICIAN ORDERS AND ASSESSMENT," dated 3/09/13 at 10:00 PM, stated "medication: Haldol + Ativan." The order also stated to place Patient #3 in 4 point soft restraints. The order stated Patient #3 was a danger to himself and others. However, the order did not state what specific behaviors Patient #3 exhibited that construed a threat to safety. There was no documentation in nursing notes to indicate Patient #3 was violent or combative. The DQRM was interviewed at 6/05/13 at 12:40 PM, she reviewed Patient #3 medical record and confirmed there was no documentation to indicate Patient #3 was physically aggressive or combative. Patient #3's medical record did not include documentation to support the need for the restraints.	A 187		
A 188	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.	A 188		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 188	<p>Continued From page 24</p> <p>was restrained for 3 hours and 50 minutes while he appeared to be asleep. The rationale for continued use of the restraints while Patient #7 was asleep was not documented.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7's medical record did not document the reason for his continued restraint while he was sleeping.</p> <p>Patient #7's medical record did not document the rationale for continued use of the restraints .</p> <p>2. Patient #8 was a 51 year old male admitted to the hospital through the ED on 5/15/13 for severe intoxication and suicidal behavior. He was discharged on 5/18/13.</p> <p>An RN assessment note, dated 5/15/13 at 3:52 PM, stated Patient #8 had been placed in soft wrist and ankle restraints due to his intoxication level and increasing combativeness. The RN also documented the clinical justification for restraints, less restrictive alternatives used prior to restraints and that an assessment and observation of Patient #8 had been done. The next assessment and observation was documented by the RN at 5:42 PM, one hour and 50 minutes after the first assessment. There was no documentation during this time of the rationale for the continued use of restraints.</p> <p>The policy "Non-Violent/Self Destructive Restraint and Seclusion (Non-Behavioral)," revised March 2013, stated "Direct observation must be performed at a minimum of every one-hour."</p> <p>The DQRM was interviewed on 6/06/13 at 4:15</p>	A 188		
-------	---	-------	--	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 188	Continued From page 25 PM. She confirmed the documentation indicated Patient #8 had not been directly observed every hour in accordance with hospital policy. She also confirmed the lack of documentation for the continued use of restraints.	A 188		
A 438	<p>482.24(b) FORM AND RETENTION OF RECORDS</p> <p>The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to ensure medical records were properly retained and accessible for 7 of 8 ED patients (#2-#8) whose medical records were reviewed. This failure resulted in an inability to review the complete medical record and had the potential to prevent medical providers from obtaining information about courses of treatment. Findings include:</p> <p>1. The Medical Records Manager was interviewed in 6/05/13 at 1:30 PM. She stated that the hospital had a scheduled downtime period of the EMR in order to change servers. The downtime was scheduled to end on the morning of 5/30/13. However, the servers stayed</p>	A 438	<p>1.) Patients records reviewed 5 of the reviewed had an Electronic Legal Record (eChart) intact & accessible eChart made available 6-12-13 for all records.</p> <p>2.) 2 of the patients records reviewed had an eChart that did not contain requested patient information & data</p>	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 438	<p>Continued From page 26</p> <p>down for several more hours and as a result, certain data within the EMR from the period of 10/01/12 to the time of the survey had been lost. Some data had been retrievable, but ED physician orders and narrative notes were not.</p> <p>The DQRM confirmed in an interview on 6/05/13 at 11:40 AM that clinical data could not be pulled from the EMR. While attempting to review the EMR of Patient #6, the DQRM was unable to access nursing or physician notes, orders, and other clinical data. She stated that some of this information was available in the legal record, but could not be accessed by using the EMR. She confirmed that the ED physicians orders and some ED nursing notes were not retrievable, even in the legal record. She also confirmed that staff could not access the legal record easily from computer portals. The DQRM also stated the hospital could not access lists or logs that were generated by the EMR, such as the restraint log, as a result of the server crash. The number and name of patients that had been restrained could only be determined by examining each handwritten note completed by the house supervisors over a 24 hour period.</p> <p>The complete medical record could not be accessed for the following patients:</p> <p>a. Patient #2 was a 50 year old male admitted through the ED for schizophrenia on 1/26/13 and discharged on 1/31/13. His medical record was missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p>	A 438	<p>2.) <i>cont.</i> Further analysis records had been over-written upon "compiling" the medical recording HLM using the "compiling" function resulted in the eChart presenting without patient data.</p> <p>3.) The EHR Vendor (Meditech) was able to retrieve the eChart of the missing patient data & information</p> <p>4.) A Meditech "lock down" of the eChart has been put into place to prevent the "compiling" function so that the missing eChart is not overridden</p> <p>5.) ALL patients affected echarts from May 29 downtime have been copied & unalterable</p>	6-14-13 6-14-13 6-14-13 6-10-13

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 438	<p>Continued From page 27</p> <p>b. Patient #8 was a 51 year old male admitted through the ED for extreme intoxication and suicidal behavior on 5/13/13 and discharged on 5/18/13. His medical record was missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>c. Patient #6 was a 27 year old female admitted to the ED for a suicide attempt on 3/04/13. She was discharged on 3/07/13. Her medical record was missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>d. Patient #4 was a 61 year old male admitted to the hospital on 4/25/13 for alcohol intoxication, aspiration pneumonia, and hepatitis. He was discharged on 5/08/13. His medical record was missing ED physician orders, ED nursing notes, and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>e. Patient #5 was a 28 year old female admitted to the hospital on 4/25/13 for an acute drug overdose. She was discharged on 4/28/13. Her medical record was missing ED physician orders, ED nursing notes, and nursing POCs.</p>	<p>6.) A 438</p>	<p>Access to eCharts has been evaluated & put into place to expand access to appropriate end users in patient care areas so access is available to providers as needed.</p> <p>Health Unit Coordinators Quality Staff have been educated & trained</p> <p>attachment <u>Y</u> training screens</p> <p>7.) Training in access & use of echart will be provided to other identified users as needed.</p> <p>8.) All future back-ups of the electronic record are being restored & validated by EHR Vendors to ensure back-ups are</p>	<p>6-21-13</p> <p>7.13.13</p>
-------	--	----------------------	---	-------------------------------

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 438	<p>Continued From page 28</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed the missing documentation.</p> <p>f. Patient #7 was a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy, alcohol abuse, and seizure disorder. He was discharged on 5/08/13. His medical record was missing ED physician orders, ED nursing notes, and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed the missing documentation.</p> <p>g. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included Progressive Dementia and GLF. His medical record was missing ED physician orders, ED nursing notes, and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed the missing documentation.</p>	<p>B.) A 438</p> <p>owner:</p>	<p>cont are valid + usable CIO is information operations Director</p>	
A 439	<p>The complete medical record was not accessible.</p> <p>482.24(b)(1) FIVE-YEAR RETENTION OF RECORDS</p> <p>Medical records must be maintained in their original or legally reproduced form for a period of at least 5 years.</p> <p>This STANDARD is not met as evidenced by:</p>	A 439		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 439	<p>Continued From page 29</p> <p>Based on staff interview and review of medical records, it was determined the hospital failed to ensure the medical records of 7 of 8 patients (#2-#8) whose records were reviewed were maintained for a period of at least 5 years. This prevented the hospital from promptly retrieving the complete medical records of patients. Findings include:</p> <p>1. The Medical Records Manager was interviewed on 6/05/13 beginning at 1:30 PM. She stated the national servers which stored electronic medical records for the hospital had been corrupted on 5/29/13. She stated medical record information may have been lost for all patients treated at the hospital from October 2012 through 5/29/13. She stated electronic physician orders in the ED, nursing POCs, and some nursing notes had been lost. She stated this information may be lost forever as the corrupted servers were back-up servers and no servers contained usable data.</p> <p>2. Medical records of Patients #2-#8 were reviewed on 6/5/13 and 6/17/13. All of these records were of patients who had been admitted through the ED and had been admitted as inpatients for more than 24 hours. All of these records were missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed regarding each of the above medical records from 6/05/13 to 6/07/13. She confirmed each record contained missing information.</p> <p>The hospital did not maintain complete medical records for at least 5 years.</p>	A 439	<p><i>Refer to pgs 26-29 of 39 #1-9 of A-438 for details of PoC</i></p>		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 449	<p>482.24(c) CONTENT OF RECORD</p> <p>The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.</p> <p>This STANDARD is not met as evidenced by: Based on medical record review and staff interview, it was determined the hospital failed to ensure medical records contained sufficient information to describe the progress and response to services for 3 of 8 patients (#3, #7, and #8) whose records were reviewed. This resulted in incomplete medical records. Findings include:</p> <p>1. Patient #7's medical record documented a 59 year old male who was admitted to the hospital through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder.</p> <p>A physician's order, dated 5/10/13 at 9:10 PM, called for Patient #7 to be placed in "four point leather restraints." The medical record documented the restraints were applied. At 12:00 midnight on 5/11/13, a nursing progress note stated "right upper and lower leather restraints removed." The left side remained restrained. At 2:55 AM on 5/11/13, a nursing progress note stated only Patient #7's left arm was restrained. At 3:30 AM on 5/11/13, a nursing progress note stated Patient #7's last restraint was removed. No orders were present in the record to utilize either 1 or 2 extremity restraints. No nursing documentation was present explaining why</p>	A 449			

Refer to pp 26-29 of 39 #1-8 of A-438 for details of POC

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 449	<p>Continued From page 31</p> <p>Patient #7 was placed in 2 point restraints and then in 1 point restraint. In addition, a nursing POC was not present in Patient #7's medical record.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7's medical record did not include orders for the use of 1 or 2 extremity restraints. She confirmed Patient #7's medical record did not include a rationale for the different types of restraints. She was interviewed again on 6/10/13 beginning at 12:40 PM. She confirmed Patient #7's nursing POC was not present in the medical record. She stated, due to a computer problem, ED physician orders and nursing POCs written between 10/12/12 and 5/29/13 were not accessible by the hospital.</p> <p>Patient #7's medical record did not contain complete documentation of services and the rationale for them.</p> <p>2. Patient #2 was a 50 year old male admitted through the ED on 1/26/13 for schizophrenia. He was discharged on 1/31/13.</p> <p>The ED physician's progress note, dictated 1/26/13 at 10:55 PM, stated Patient #2 had been physically restrained after attempting to hit security staff with a metal stool. There were no orders documented for the physical restraint and no nursing notes documented the behaviors that led to the restraint or the restraint itself. The length of time Patient #2 was restrained was not documented.</p> <p>A "Case Report," completed by security staff and dated 1/27/13 at 11:50 PM, documented that</p>	A 449		
-------	--	-------	--	--

Refer to pgs 6-10 of 39 #1-12 A-166 for details of PIC

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 449	<p>Continued From page 32</p> <p>security officers were in place at the door to Patient #2's room to "make sure (patient) didn't leave or injure himself." The "Case Report" was an internal report and was not part of the medical record.</p> <p>The security officer that documented the report was interviewed on 6/07/13 at 7:35 AM. He confirmed he and another officer stood at the door of Patient #2's room on the evening of 1/26/13 and did not allow the patient to leave in order to protect Patient #2 and ED staff. This seclusion of Patient #2 to his ED room was not documented. The length of time the security guards were positioned at Patient #2's doorway to prevent him from leaving was not documented.</p> <p>In an interview with the Manager of Patient Advocacy on 6/06/13 at 8:45 AM, he confirmed the security guards did not allow Patient #2 to leave the room and this qualified as seclusion. He confirmed there were no orders in the medical record for seclusion. He also confirmed that there were no orders for the physical restraint.</p> <p>Patient #2's medical record did not completely describe interventions and his responses to them.</p> <p>3. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF. Patient #3's medical record contained the following:</p> <p>a. A physician order, dated 3/09/13 at 10:00 PM, called for Patient #3 to be placed in "four point soft restraints."</p>	A 449			

Refer to pgs 6-10 of 39 #1-2 A-166 for details of POC

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 449	<p>Continued From page 33</p> <p>Patient #3's nursing notes, beginning at 9:36 PM on 3/09/13, stated his wrists and legs were restrained. A nursing note, dated 3/10/13 at 1:30 AM stated Patient #3 " ...IS SLEEPING ON AND OFF, WHEN AWAKE PT HAS TO BE REDIRECTED FROM HIS WRIST RESTRAINTS, ONLY WRIST RESTRAINTS ARE APPLIED." Subsequent nursing notes did not state Patient #3 was restrained. It was not documented when the restraints were discontinued. Nursing notes did not include specific behaviors that justified the use of restraints.</p> <p>Patient #3's Emergency Admit note dictated, dated 3/09/13 at 11:20 PM stated, he had been violent at an assisted living facility earlier that day but he had not been violent in the emergency department. The note stated Patient #3 was given Haldol IM in the emergency department and then was given Ativan IM as chemical restraints.</p> <p>The medical record did not document that Patient #3 was violent or combative in the hospital. The medical record did not document the rationale for the use of restraints.</p> <p>The DQRM was interviewed at 6/05/13 at 12:40 PM. She reviewed Patient #3 medical record and confirmed there was no documentation of physically aggressive behavior. She was also interviewed on 6/05/13 beginning at 3:40 PM. She acknowledged an order for the decrease in Patient #3's extremity restraints from 4 to 2 was not documented. She confirmed specific behaviors to justify the use of restraints were not documented.</p>	A 449	<p><i>Refer to pg 6-10 of 39 #1-12 A-166 & pg 17 of 39 A-171 #1-4 for details of PoC</i></p> <p><i>Refer to pg 6-10 of 39 #1-12 A-166 & pg 17 of 39 A-171 #1-4 for details of PoC</i></p>	
-------	---	-------	---	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
A 449	Continued From page 34 b. At 5:28 PM on 3/15/13, Patient #3's physician's progress note stated "This afternoon (Patient #3) was left unattended in the bathroom and sustained a GLF. There was no loss of consciousness." There was no documentation by nursing that Patient #3 had fallen. Prior to Patient #3's fall, the physician had ordered a 1:1 staff sitter for patient safety on 3/11/13, untimed. There was no documentation in the nursing notes on 3/15/13, the day Patient #3 fell, that he was accompanied by a sitter at all times After Patient #3 sustained the fall, neurochecks were ordered by the physician on 3/15/13 at 12:22 PM. The medical record did not include documentation that neurochecks had been done. The DQRM was interviewed on 6/05/13 beginning at 12:40 PM. She confirmed the medical record was missing nursing documentation that Patient #3 had fallen. She also confirmed the medical record was missing documentation related to the 1:1 staff sitter and neurochecks being performed as ordered. She stated the missing documentation was the result of nursing staff's failure to document rather than the server crash. Patient #3's medical record did not include documentation verifying services provided and his response to those services.	A 449	<i>Documentation expectations reinforced with all clinical staff. Daily fall audits are being conducted as well as any fall reported is reviewed in real time attachment Z</i>	6-21-13	
A 467	482.24(c)(2)(vi) CONTENT OF RECORD - OTHER INFORMATION [All records must document the following, as appropriate:]	A 467	<i>Feedback given to staff in real time after audit complete if indicated for re-education & training enforcement. owner: Fall Team Chair</i>	<i>Fall audit too ongoing</i>	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 467	<p>Continued From page 35</p> <p>All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.</p> <p>This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined the hospital failed to ensure medical records contained all practioners orders, nursing notes, and POCs for 7 of 8 ED pateints (#2-#8) whose records were reviewed. This failure resulted in an incomplete medical record and had the potential to prevent medical providers from obtaining information about courses of treatment. Findings include:</p> <p>The Medical Records Manager was interviewed in 6/05/13 at 1:30 PM. She stated that the hospital had a scheduled downtime period of the EMR in order to change servers. The downtime was scheduled to end on the morning of 5/30/13. However, the servers stayed down for several more hours and as a result, certain data within the EMR from the period of 10/01/12 to the time of the survey had been lost. Some data had been retrivable, but ED phsyician orders and narrative notes were not. In addition, the restraint log and other logs that were generated in the EMR were no longer accessible. The following medical records did not contain ED orders as a result of the servers going down:</p> <p>1. Patient #2 was a 50 year old male admitted through the ED for schizophrenia on 1/26/13 and discharged on 1/31/13. His medical record was missing ED physican orders and nursing POCs.</p>	A 467	<p>Refer to pgs 26-29 of 39 #1-8 A-438 for details of POC</p>	
-------	---	-------	---	--

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 467	<p>Continued From page 36</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>Patient #2's medical record was missing information.</p> <p>2. Patient #8 was a 51 year old male admitted through the ED for extreme intoxication and suicidal behavior on 5/13/13. His medical record was missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>Patient #8's medical record was missing information.</p> <p>3. Patient #6 was a 27 year old female admitted to the ED for a suicide attempt on 3/04/13. She was discharged on 3/07/13. Her medical record was missing ED physician orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>Patient #6's medical record was missing information.</p> <p>4. Patient #3's medical record documented a 74 year old male who was admitted to the hospital on 3/09/13 and was discharged on 3/18/13. Diagnoses included progressive dementia and GLF. His medical record was missing ED</p>	A 467		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 467	<p>Continued From page 37 physican orders and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>Patient #3's medical record was missing information.</p> <p>5. Patient #4 was a 61 year old male admitted to the hospital on 4/25/13 for alcohol intoxication, aspiration pneumonia, and hepatitis. He was discharged on 5/08/13. His medical record was missing ED physician orders, ED nursing notes, and nursing POCs.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 8:15 AM. She confirmed the missing documentation.</p> <p>Patient #4's medical record was missing information.</p> <p>6. Patient #5 was a 28 year old female admitted to the hospital on 4/25/13 for an acute drug overdose. She was discharged on 4/28/13. Her medical record was missing ED physician orders and ED nursing notes.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed the missing documentation.</p> <p>Patient #5's medical record was missing information.</p> <p>7. Patient #7's medical record documented a 59 year old male who was admitted to the hospital</p>	A 467		

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 130049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

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

A 467	<p>Continued From page 38 through the ED at 9:03 PM on 5/10/13. He was discharged on 5/12/13. His diagnoses included encephalopathy (degeneration of brain function), alcohol abuse, and seizure disorder.</p> <p>Patient #7's medical record did not contain ED physician orders and nursing notes from the ED.</p> <p>The DQRM was interviewed on 6/06/13 beginning at 3:40 PM. She confirmed Patient #7's medical record was not complete.</p>	A 467		
-------	---	-------	--	--

June 27, 2013

Idaho Department of Health and Welfare
Bureau of Facility Standards
Sylvia Creswell
Co-Supervisor
PO Box 87320
Boise, ID 83720

RECEIVED

JUL - 1 2013

FACILITY STANDARDS

Dear Sylvia,

Attached is the Plan of Correction for the State licensure deficiencies, BB278, 280,283 and 458 regarding Medical Records and Patient's Right's

Kootenai Health's core commitment is to provide quality healthcare to all people. Our mission, values and vision uphold our Service Excellence Standards, including the retention of medical records and patient's rights.

Corrective actions to address all areas of deficiency have been put into place with the 35 day time period. Systems and processes have been implemented in order to ensure ongoing compliance and quality of care in meeting the State licensure requirements.

If you have any questions regarding the report submitted, please contact me at 208.666.2278

Sincerely,



Lorraine Olsheski
Executive Director of Quality and Risk Management.

cc: Kate Mitchell, CMS Region Office

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDVUMG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
--	--	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint investigation at your hospital. Surveyors conducting the review were: Gary Guiles, RN, HFS, Team Leader Libby Doane, RN, HFS Donald Sylvester, RN, HFS	B 000		
BB278	16.03.14.360.07 Retention 07. Retention. Records shall be retained to conform with Section 39-1394, Idaho Code. (10-14-88) This Rule is not met as evidenced by: Refer to A439 as it relates to the retention of medical records.	BB278	1.) Patients records reviewed 5 of the reviewed record had an Electronic Legal Record (eChart) intact & accessible.	
BB280	16.03.14.360.09 Identification and Filing 09. Identification and Filing. A system of identifying and filing to ensure prompt retrieval of patient's records shall be maintained as follows: (10-14-88) a. Any system shall bear at least the name, address, birthdate, medical record number, dates of admission and discharge; and (10-14-88) b. Each record shall be maintained so that both in and outpatient records for treatment are readily retrievable. (10-14-88) This Rule is not met as evidenced by: Refer to A438 as it relates to the inability to retrieve medical records.	BB280	eChart made available for all medical records. 2.) 2 of the patients medical records reviewed had an eChart that did not contain requested patient information & data. Further analysis; Records had been overwritten	6-12-13

RECEIVED
JUL - 1 2013
FACILITY STANDARDS

Bureau of Facility Standards
Lorraine Oleshenki *Gen. Director of Quality & Risk Management*
 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE
 6-27-13

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IDVUMG	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/10/2013
NAME OF PROVIDER OR SUPPLIER KOOTENAI MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2003 KOOTENAI HEALTH WAY COEUR D'ALENE, ID 83814		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB283 BB283	Continued From page 1 16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88)	BB283 BB283	#2 cont upon "compiling" the medical record in HIM using the "compiling" function resulted in the eChart presenting without patient data 3.) The EHR Vendor (Meditech) was able to retrieve the eChart of the missing patient data & information 4.) A Meditech "lock down" of the eChart has been put into place to prevent the "compiling" function so that the existing eChart is not overridden.	6-14-13 6-14-13



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

July 19, 2013

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

COPY

Provider #130049

Dear Mr. Ness:

On **June 10, 2013**, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006027

Allegation #1: Patients reports of abuse in the Emergency Department were not act upon.

Findings #1: An unannounced visit was made to the hospital on 6/05/13 through 6/07/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 50 year old male admitted to the Emergency Department, or ED, for schizophrenia on 1/26/13 and was discharged 1/31/13.

The ED physician dictated a progress note on 1/16/13 at 10:55 PM that stated the patient presented to the emergency room hearing voices and having thoughts about harming others. The note stated that during his stay in the ED, the patient became increasingly combative and attempted to hit security staff with a metal stool. The note documented that the patient was then physically restrained by security staff and given an injection of an antipsychotic medication. The note stated that the patient was to be transferred to the behavioral health unit of the hospital but would remain in the ED until a bed became available. The patient was transferred to the behavioral health unit on 1/27/13 at approximately 1:55 PM.

On 1/27/13 at 9:42 PM, a Mental Health Specialist documented that the patient believed he had been abused by security during his time in the ED and wanted to meet with administration to file

Jon Ness, Administrator
July 19, 2013
Page 2 of 8

a grievance. The note went on to state the patient felt undue force had been used on him, causing injuries to his arm and back. He also felt the security staff was laughing at him. There was no documentation to indicate the Mental Health Specialist had reported this incident or responded to the patient's request to file a grievance. A grievance was later filed by the manager of the behavioral health unit on 1/31/13, four days after the initial allegation of abuse by the patient, and an investigation was initiated at that time.

The Mental Health Specialist was interviewed at 11:25 AM on 6/07/13. She confirmed that she had not reported the incident nor had she responded to the patient's request to file a grievance. She stated that she had not been told to report these kinds of allegations. She also stated that she did not think he really had been abused and therefore did not feel the need to report it. She stated that if she had thought the patient was abused, she would have reported it to her supervisor and the house supervisor. She stated that because the incident did not happen on her unit, she felt her only responsibility was to document it in the record.

The policy "Abuse and Neglect of Patients at Kootenai Medical Center," dated 5/13/13, stated "All alleged violations involving mistreatment, abuse or neglect will be thoroughly investigated by the facility under the direction of the employee's director and in accordance with state law." The policy did not address when to report allegations of abuse nor did it outline a process for staff to follow when reporting abuse.

The Director of Quality and Risk Management was interviewed at 11:05 AM on 6/07/13. She confirmed there was no process for reporting abuse, stating that staff would take the allegations up through the chain of command or take them directly to risk management.

A deficiency was cited at 42 CFR 482.13(c)(3) related to the hospital's failure to ensure a process was in place for the prompt reporting and investigation of abuse.

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

Allegation #2: Staff withheld medications requested by patients in the Emergency Department.

Findings #2: An unannounced visit was made to the hospital on 6/05/13 through 6/07/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 50 year old male admitted to the Emergency Department, or ED, for schizophrenia on 1/26/13 and was discharged 1/31/13. The ED physician documented that the patient came to the ED hearing voices and having thoughts of hurting people. He documented that the patient was taking Depakote and Lexapro, but doses were not documented. He also documented that the patient refused to talk to him, except to say that he was "crazy" and needed to be admitted. The patient then refused to talk any further. There was no

Jon Ness, Administrator

July 19, 2013

Page 3 of 8

documentation that the patient told the physician he wanted medications.

The Behavioral Health Case Manager attempted to interview the patient on 1/26/13 at 10:03 PM. He documented that the patient seemed very angry and demanded to go to the behavioral health unit. He also documented that the patient was threatening staff and security and making statements about hurting people. The Behavioral Health Case Manager was interviewed on 6/06/13 at 3:55 PM. He stated that the patient had been screaming for medication but would not say what medication he wanted.

The nurse who cared for the patient in the ED was interviewed on 6/06/13 at 4:30 PM. She stated that the patient was asking for medications but would not tell anyone what medications he wanted.

A note written by a behavioral health nurse on 1/27/13 at 4:21 PM documented that the patient took Lexapro and Depakote but was unable to verify these medications and the doses because the patient's pharmacy was closed. An "Admission Order Medication Profile," dated 1/27/13 at 4:20 PM, contained the patient's home medications. The medication profile included an Albuterol inhaler four times a day as needed for shortness of breath, Depakote ER- 500 mg twice a day, and Lexapro 10 mg daily. The physician gave a verbal order on 1/27/13 at 6:00 PM for the patient to begin taking these medications.

A "MEDICATION DISCHARGE SUMMARY REPORT" documented the patient received 500 mg of Depakote ER on 1/27/13 at 9:26 PM, on 1/28/13 at 8:09 AM, on 1/28/13 at 2:07 PM, and on 1/29/13 at 9:30 AM.

"PHYSICIAN ORDERS" signed by the physician on 1/29/13 at 1:40 PM changed the dose of Depakote ER to 500 mg in the morning and 1000 mg at bedtime. The patient was given 1000 mg of Depakote ER on 1/29/13 at 8:22 PM. He was then given 500 mg in the morning and 1000 mg at bedtime on 1/30/13. He was given 500 mg of Depakote ER the morning of 1/31/13 and was discharged later that afternoon.

The seven other medical records that were reviewed documented patients were receiving medications as ordered.

There was no evidence that staff withheld medications.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Jon Ness, Administrator
July 19, 2013
Page 4 of 8

Allegation #3: Power of Attorney was not honored for patients admitted to the hospital through the Emergency Department with a psychaitric problem.

Findings #3: An unannounced visit was made to the hospital on 6/05/13 through 6/07/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 50 year old male admitted to the Emergency Department, or ED, for schizophrenia on 1/26/13 and was discharged 1/31/13. The patient had an advanced directive, signed by the patient and notarized on 8/17/12, naming his girlfriend as his durable power of attorney or healthcare agent. This authorized his girlfriend to make healthcare decisions, which meant "consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical condition" if the patient were incapacitated. The advanced directive stated the healthcare agent was authorized to make decisions related to "obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures..." The patient did not have a psychiatric advanced directive. A psychiatric advanced directive allows the patient to name a person authorized to make decisions for the patient if he or she is deemed legally incompetent to make his/her own choices.

There was no documentation in the patient's medical record to indicate he required life-sustaining care during this admission that would necessitate the use of his power of attorney. Furthermore, the patient signed his own admission paperwork in the ED on 1/26/13 at 6:55 PM. The ED physician documented in his progress note, dictated 1/26/13 at 10:55 PM, that the patient had been placed on a physician hold due to the patient's combativeness and making statements of wanting to leave the emergency department to harm others. The note also dictated that the patient would remain in the emergency department until a bed became available in the behavioral health unit.

The Behavioral Health Case Manager who was present during the patient's time in the emergency department was interviewed on 6/6/13 at 3:55 PM. He stated that when patients are placed on a physician hold in the ED, visitors are not allowed to be with the patient for the safety of the visitor. He stated that visitors are only allowed once the patient is transferred to the behavioral health unit or the physician hold is lifted. The patient was transferred to the behavioral health unit at approximately 2:00 PM on 1/27/13. A nursing note on 1/27/13 at 4:21 PM stated that the patient's power of attorney had been called and she was on her way to the hospital to see the patient.

On 1/27/13, untimed, a Designated Examiner documented she had examined the patient and found he did not lack "the capacity to make informed decisions about his treatment." She also found that the patient was no longer a danger to himself or others or gravely disabled and the physician hold was lifted.

Jon Ness, Administrator
July 19, 2013
Page 5 of 8

On 1/28/13 at 5:01 PM, a Behavioral Health Case Manager documented that he had updated the patient's power of attorney on the patient's condition. He documented that the power of attorney requested she be called immediately for treatment or medication changes and when "medical issues arise." He documented that he notified the charge nurse of this and would notify the rest of the staff on 1/29/13.

A "PHYSICIAN PROGRESS NOTE," dated 1/29/13 and dictated at 10:26 PM, stated that the physician spent 45 minutes speaking to the patient, 20 of which was "spent in supportive psychotherapy with the patient and his girlfriend, the person with medical power of attorney, at his request." The physician went on to document that he planned to make changes to the patient's medications and that this was discussed with, and agreed to by, the patient and his power of attorney.

There was no evidence the hospital did not include the power of attorney in the patient's care.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Patients are being abused by security staff in the Emergency Department.

Findings #4: An unannounced visit was made to the hospital on 6/05/13 through 6/07/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 50 year old male admitted to the Emergency Department, or ED, for schizophrenia on 1/26/13 and was discharged 1/31/13. An ED physician's admission note, dated 1/26/13 at 6:55, documented that the patient presented to the ED hearing voices and having thoughts of hurting people. The physician documented that the patient refused to be evaluated by behavioral health and demanded to leave the ED with plans to "hurt someone." The physician documented that the patient was placed on a physician hold to prevent him from leaving and causing harm to others. The note stated that the patient had been yelling at security staff and had picked up a stool and "was in the process of hitting them with it when he had to be (physically) restrained..." The note documented that the patient was then given an antipsychotic medication and it caused the patient to become sedated. The note ended by stating the patient would be kept in the ED until a bed became available on the behavioral health unit.

The security officer that was present during the patient's time in the ED documented a report of the incident on 1/27/13 at 11:50 PM. In the report, he stated that he and another officer were called to the patient's room because the patient was very agitated and staff did not feel safe. Upon arrival to the patient's room, staff informed security that the patient was now becoming aggressive. The security officer documented that the CNA assisted the patient to change into a gown and secured all his belongings. The security officer documented that at approximately 9:50 PM the patient started to yell and demanded to be released from the ED and taken to the

behavioral health unit. The security officer documented that the patient became so loud that patients in adjoining rooms became fearful. The officer documented that at 10:00 PM the nurse came to explain to the patient that the behavioral health unit was full and the patient would have to stay in the emergency room until a bed became available. The officer documented that the patient became angry and began kicking chairs and throwing equipment around the room. The security officer documented that he and the other officer stood at the doorway to the patient's room to make sure he did not injure himself or try to leave the ED. The officer documented that the patient made several aggressive movements toward security staff. The patient then picked up a stool and attempted to hit security with it. The security officer documented that the patient was then physically restrained by the two officers. The patient was walked to the stretcher and physically restrained there until he was calm and then the security guards released him. The nurse then entered the room to give the patient a shot and asked the patient to lay on his stomach. The officer documented that the patient refused and had to be "physically assisted" to lay on his stomach to receive the shot. The officer documented that the patient was held in a secure position until the patient stated he was calm and could feel the medication working. The officer documented that the patient was then released by security.

The officers that were present during the incident were interviewed on 6/07/13 at 7:35 AM. They confirmed the above report was accurate. The officers explained that when they had physically restrained the patient, they had held his arms close to his body because the patient was attempting to punch them. They stated that the patient was resisting violently. They stated that they walked him over to the stretcher and held him on the stretcher for 2 to 3 minutes until he calmed down, at which point they released him. The officers stated that the patient was sitting on the side of the bed when the RN came into the room and told the patient about the shot (of antipsychotic medication). They stated the patient became very agitated and again had to be restrained for the nurse to give the shot. They stated they restrained the patient on the bed for "a few minutes" and released him and left the room. The security staff monitored the patient from outside the door of his room. The security officers stated that nothing unusual had happened during the restraint of this patient.

The Behavioral Health Case Manager that had attempted to evaluate the patient on 1/26/13 was interviewed on 6/06/13 at 3:55 PM. He stated that the patient was screaming, posturing, acting like he was going to charge security staff. The case manager stated that he and security staff were standing outside of the patient's room. The case manager stated that the patient then picked up the stool and security physically restrained him. He stated that security staff moved the patient to the bed where the patient was allowed to readjust himself and the patient was given an injection of medication. The case manager stated that it took the patient 2 or 3 minutes to calm down and then the patient was released. He stated there was nothing unusual about the way security restrained the patient.

The nurse that provided care for the patient while in the ED was interviewed at 4:30 PM on 6/06/13. The nurse stated that upon admission to the ED, the patient was acting very strange and she felt afraid to be in the room alone with him. She said she called security to stand by. She

stated that the ED was very busy that night and there were several people standing in the hallways. She stated that the patient became aggressive and began throwing things and that she had to move two elderly ladies out of the hallway to avoid being hit by the things the patient was throwing. She stated she was not in the room when the patient picked up the stool and was restrained by security the first time. She stated she did not recall doing a full physical assessment of the patient after he was restrained by security but she said she did not note any injuries to the patient when she saw him the rest of the night.

A late entry nursing note was documented on 1/31/13 at 12:50 PM. The note stated that on 1/27/13 the patient showered with staff assistance and was able to raise arms above head to wash his hair and bend over to pick up his clothes. The note stated that the patient's skin was "free of bruising and had no visible signs of injury."

A nursing note from 1/31/13 at 5:18 PM stated patient was making his bed and "talking and gesturing with both arms for an extended amount of time, without visible signs of discomfort. no discoloration or swelling was noted."

It could not be verified through the investigative process that patients were abused by security.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Patients were restrained inappropriately in the Emergency Department.

Findings #5: An unannounced visit was made to the hospital on 6/05/13 through 6/07/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records. Four of these records documented patients had been restrained. The medical records contained the following:

-One medical record documented a 50 year old male admitted to the Emergency Department, or ED, for schizophrenia on 1/26/13 and was discharged 1/31/13. The patient's medical record documented the patient was shouting and became aggressive towards staff, throwing objects and kicking chairs. The patient was physically restrained for a short period on a stretcher after attempting to hit security staff with a metal stool. The patient was physically restrained a second time in order for nursing staff to administer an antipsychotic medication to the patient. After the medication was administered and the patient verbalized feeling calm, the patient was released from the physical restraint. However, the patient's medical record did not contain physician orders for the use of the restraints. The medical record also did not include documentation of the time the patient was placed in restraints and the time of his release from them. The use of the restraint was not included in the patient's plan of care.

The other 3 medical records reviewed also identified the following additional concerns related to restraint use:

Jon Ness, Administrator
July 19, 2013
Page 8 of 8

- One patient's medical record contained documentation that indicated restraints were not used solely to ensure the immediate safety of the patient or others. The medical record also documented that the restraints were not discontinued on the patient at the earliest possible time.

-One patient's medical record contained documentation that restraint orders were written for an as needed basis, resulting in the potential for the patient to be restrained unnecessarily.

-Two patients' medical records contained documentation that restraint orders were not renewed every 4 hours, resulting in the use of restraints on the patients without continued authorization.

-Two patients' medical records did not contain documentation of the patients' symptoms that warranted the use of restraints.

-Two patients' medical records did not contain documentation for the rationale for the continued use of restraints on the patients.

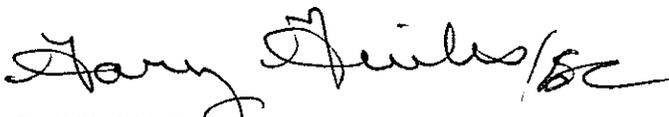
Additional issues related to restraints were noted during the investigation. Seven deficiencies were cited related to restraints, as well as the Condition of Participation of Patient Rights at 42 CFR 482.13.

Conclusion #5: 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,



GARY GUILLES
Health Facility Surveyor
Non-Long Term Care



SLYVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pt