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 9, 2013

COPY

Steve Proctor, Administrator
Safe Haven Hospital Of Treasure Valley
8050 Northview Street
Boise, ID 83704

RE: Safe Haven Hospital Of Treasure Valley, Provider #134009

Dear Mr. Proctor:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on July 2, 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:

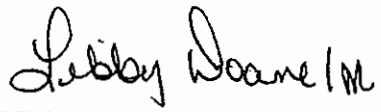
An acceptable plan of correction (PoC) contains the following elements:

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

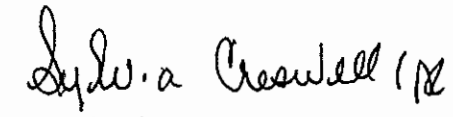
After you have completed your Plan of Correction, return the original to this office by **July 21, 2013**, and keep a copy for your records.

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,



LIBBY DOANE
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LD/pt
Enclosures

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 9, 2013

Steve Proctor, Administrator
Safe Haven Hospital Of Treasure Valley
8050 Northview Street
Boise, ID 83704

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Provider #134009

Dear Mr.. Proctor:

On **July 2, 2013**, a complaint survey was conducted at Safe Haven Hospital Of Treasure Valley. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005854

Allegation #1: Patients' families were not involved in discharge planning.

Findings #1: An unannounced visit was made to the hospital on 7/01/13 through 7/02/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 65 year old male admitted to the hospital on 7/17/12 on a mental hold for attempted suicide. On 7/19/12 at 8:30 AM, a Designated Examiner documented on a "CERTIFICATE OF DESIGNATED EXAMINER" that she found the patient no longer met the criteria for a hold. In a progress note from 7/24/13 at 9:00 AM, a social worker stated that the certificate was not in the patient's chart and requested a copy be sent again. The social worker also documented that a social worker will discuss disharge plans with the patient.

A "DISCHARGE ORDERS" form, signed by the social worker on 7/24/12 at 4:06 PM, documented that the patient's wife had requested that she be the one to schedule follow up appointments with the patient's psychiatrist. The form also documented the patient had phsyical therapy services in place and the pateint's wife requested she be the one to schedule those appointmetns as well. A nursing note dated 7/24/12 at 5:30 PM documented the patient and his wife verbalized understanding of the discharge instructions.

The social worker that signed the discharge orders reviewed the pateint's record and was interviewed on 7/02/13 at 11:20 AM. He confirmed the form "DISCHARGE ORDERS" was given to the patient and his wife at discharge. He also stated that when a patient is notified he or she is being discharged, the patient is encouraged to make the phone call to notify his/her family that the patient is being discharged and ready to be picked up. The social worker stated that this encouraged responsibility and allowed the patient to participate in the discharge plan.

It could not be verified through the investigation process that patients' families were not involved in the discharge process.

Conclusion #1: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients are discharged based on insurance coverage rather than condition.

Findings #2: An unannounced visit was made to the hospital on 7/01/13 through 7/02/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 65 year old male admitted to the hospital on 9/12/12 for homicidal and suicidal ideation. The patient was discharged from the hospital on 9/22/12.

A physician "PROGRESS NOTES," dictated 9/21/12 at 3:31 PM and signed by the physician on 10/04/12 at 10:00 AM, stated the patient had resolved his homicidal and suicidal ideation and was doing "quite well" and was ready to be discharged. The physician documented the patient had requested to be placed in an assisted living facility initially but after much discussion had agreed to be discharged to home with home health services. The progress note stated the plan to be discharged to home was "agreeable" to both the patient and his wife and the patient would be "discharged tomorrow and the patient understands."

A progress note from the social worker on 9/21/12 at 2:00 PM documented that she spoke to the patient about his and discharge plans. The social worker documented that she had informed the patient his insurance was covering the hospitalization through 9/21/12. The social worker also documented the patient's doctor felt he was ready to be discharged to home the following day. She documented that the patient stated he did not feel he could be discharged to home and wanted instead to be placed in an assisted living facility. The social worker documented that she had called the physician to notify him of the patient's desire for assisted living placement. She documented that the physician wished to continue with the plan to discharge the patient to home with home health. She documented that she spoke with the patient's wife who also agreed to this arrangement and looked forward to her husband returning home.

The social worker reviewed the record and was interviewed on 7/2/13 beginning at 8:55 AM. She stated the decision to discharge a patient was made by the physician, not insurance coverage.

She stated she does frequently update patients on their insurance coverage but that did not factor into the decision to discharge a patient.
The Director of Nursing was interviewed on 7/1/13 at 2:50 PM. She stated that the decision to discharge a patient was made by the physician in coordination with the treatment team, which includes nurses and social workers, and the patient. She stated insurance coverage was not a factor in determining a patient's readiness for discharge.

The hospital policy "Discharge, Anticipated," reviewed 5/01/13, stated "Though discharge planning starts on the patient's admission, a Social Worker will initiate formal discharge planning as soon as the physician approves a patient's discharge."

It could not be verified through the investigative process patients were discharged based on insurance coverage.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospital did not coordinate services for home health and psychiatric management prior to discharge.

Findings #3: An unannounced visit was made to the hospital on 7/01/13 through 7/02/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 65 year old male admitted to the hospital on 9/12/12 for homicidal and suicidal ideation. The patient was discharged from the hospital on 9/22/12.

"DISCHARGE ORDERS," signed by the social worker and physician on 9/21/12, documented an appointment had been made for the patient to follow-up with his primary care physician on 10/08/12 at 10:20 AM. There was also documentation that a message had been left with the patient's psychiatrist to schedule a follow-up appointment. The orders included a phone and fax number for the home health agency the patient would be using.

An "INDIVIDUAL ACCOUNTING OF DISCLOSURES" form contained documentation that information had been sent to the home health agency on 9/21/12, including nursing notes, progress notes and physician orders. There was also documentation on this form that indicated orders were sent again on 9/24/12.

A physician "PROGRESS NOTES," dictated 9/21/12 at 3:31 PM and signed by the physician on 10/04/12, stated the home health agency had arranged to come to the patient's home on Monday.

A "NARRATIVE NOTE" made by the nurse at 11:15 AM on 9/22/12 stated that home health was scheduled to come to patient's home on Monday. It also stated discharge medications had

been faxed to the patient's pharmacy and that the patient and his wife verbalized understanding of the discharge instructions.

The social worker that arranged the patient's discharge reviewed the record and was interviewed on 7/02/13 at 8:55 AM. She confirmed the home health agency had been called and the information had been sent to, including the orders, on 9/21/12. She confirmed the orders were sent again on 9/24/12. She stated she had tried to reach the patient's psychiatrist to schedule a follow up appointment but could only leave messages.

The hospital policy "Discharge Planning," reviewed 5/01/13, stated "Prior to discharge the Social Worker will contact the appropriate facility or individuals responsible to care for the patient following discharge from the hospital. All necessary treatment interventions that must cross over to new care givers will be coordinated via Social Service discharge planning."

It could not be verified though the investigative process that the hospital did not coordinate services for home health and psychiatric management prior to discharge.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: The hospital lost patients' belongings.

Findings #4: An unannounced visit was made to the hospital on 7/01/13 through 7/02/13. During the complaint investigation, hospital policies were reviewed and staff were interviewed. Surveyors reviewed 8 patient records.

One medical record documented a 65 year old male admitted to the hospital on 9/12/12 for homicidal and suicidal ideation. The patient was discharged from the hospital on 9/22/12.

A nursing "NURSING PROGRESS NOTES," documented on 9/22/12 at 11:15 stated the patient was discharged to home with his wife and that "all belongings returned (to the patient) except for drivers license." There was no documentation in the medical record listing the items the patient had brought to the hospital when he was admitted.

The medical record contained a letter from the patient's wife dated 11/03/12 asking for reimbursement for the lost drivers license.

The Director of Nursing reviewed the medical record and was interviewed on 7/01/13 at 2:50 PM. She confirmed there was no documentation to indicate what items the patient had in his possession at the time of admission. She confirmed this made it difficult to determine whether the patient had brought a drivers license with him or not. She also confirmed it was difficult to determine if the patient had been reimbursed in any way for the drivers license, as requested in the letter written by the patient's wife.

The Director of Nursing also stated that the since the patient's admission in 2012, the hospital had changed the form that documented items in the patients' possession at discharge. She stated the old form, that would have been used in 2012, was unclear as to what items the patient came in with and what items were returned. In addition, the new form allowed the patient to sign for his belongings where as in 2012, the belongings were just returned without a signature. She stated that if a patient item is unaccounted for, an incident report is to be completed and the patient will be reimbursed for the cost of the item. There was no documentation of an incident report related to the patient's drivers license.

It could not be verified in the investigation process that the patient's driver's license was lost by the hospital.

Conclusion #4: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

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

Sincerely,

Libby Doane/pt
LIBBY DOANE
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell/pt
SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

LD/pt

July 17, 2013

Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
P.O. Box 83720
Boise, ID 83720

RECEIVED
JUL 17 2013
FACILITY STANDARDS

Dear Ms. Doane:

The staff at Safe Haven Hospital of Treasure Valley appreciates the feedback that you gave us during your visit on July 1 and July 2, 2013. It goes without saying that I am relieved that the complaint allegations portion of your survey was unsubstantiated. I also appreciate your staff's Statement of Deficiencies feedback, as this has factored into our changing certain priorities, as we continue to meet the numerous challenges that come with a transition period, which is secondary to a change of ownership. As an Administrator new to this Facility, it is my opinion that our staff have done an incredible job taking care of patients since the change of ownership that occurred on May 1, 2013, all the while ensuring that standards of clinical practice have been held in high regard.

Enclosed, please find Form CMS-2567 with our Plan of Correction, which I have signed. If you have any questions or concerns, please feel free to call me at 208-233-0170; this is my work cell number and the fastest and easiest way to reach me.

Respectfully submitted,

Steve Proctor, Administrator
Safe Haven Hospital of Treasure Valley

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	ID5ENT		C 07/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN HOSPITAL OF TREASURE VALLI	8050 WEST NORTHVIEW STREET BOISE, ID 83704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiency was cited during the complaint investigation at your hospital. Surveyors conducting the review were: Libby Doane, RN, HFS, Team Leader Donald Sylvester, RN, HFS Susan Costa, RN, HFS Acronyms used in this report are as follows: DON- Director of Nursing RN-Registered Nurse	B 000	Preparation and execution of this Plan of correction is not an admission of guilt nor does the provider agree with the conclusions set forth in the Statement of Deficiencies rendered by the Bureau. The Plan of Correction is prepared and executed simply as a requirement of federal and state law. We maintain that the alleged deficiencies so not individually, or collectively, jeopardize the health and safety of our patients, nor are they of such character as to limit this provider's capacity to render adequate patient care. Furthermore, the provider asserts that it is in substantial compliance with regulations governing the operation and licensure of an acute psychiatric hospital and this document, in its entirety, constitutes this providers claim of compliance. Completion dates are provided for the procedural procession purposes to comply with the state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in compliance with requirements or that corrective action was necessary.	
BB179	16.03.14.310.07 Policies and Procedures 07. Policies and Procedures. Written policies supported by written procedures shall be available for all nursing staff which includes all areas for delivery of nursing services and shall be consistent with generally accepted nursing practice. The following shall be included with all other policies and procedures for nursing services: (10-14-88) a. There shall be a written procedure for reporting and processing incidents/accidents to patients; and (10-14-88) b. There shall be a written procedure for reporting and processing medication errors. (10-14-88) This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the hospital failed to ensure staff had access to current policies. This had the potential for a lack of guidance in providing nursing care for psychiatric patients. Findings include: 1. In an interview on 7/2/2013 at 9:00 AM, the	BB179		

RECEIVED
JUL 17 2013
FACILITY STANDARDS

Bureau of Facility Standards

Steve Proctor — Administrator — TITLE — (X6) DATE 7/17/13

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

Bureau of Facility Standards

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BB179	Continued From page 1 DON stated there had been a change of ownership that occurred on 5/01/2013. The hospital currently was using two sets of policies, printed and online. The printed policies were from before the change of ownership, and the online policies were with the new corporation. The DON stated she was in the process of reviewing and adapting policies from both sets. She stated the nursing staff had access to policy binders for written policies and may request printed copies of the policies that were online from the unit secretary. The staff was not provided with guidance as to which policies were to be followed. 2. In an interview on 7/02/2013 at 9:55 AM, the Charge RN was not able to locate specific patient care policies. He searched the binder stored at the nursing station without success. The Charge RN then stated "I cannot get online to see those policies as I do not have a computer password." He confirmed he was unable to have access to policies. The hospital failed to ensure availability of policies for staff.	BB179	**Patient Specific:** All patients could have been affected by the citation. **Hospital Systems:** The necessary Policy and Procedure binders are located at the Nurse's Station. Nursing Staff and direct care staff have been re-educated by the Director of Nursing on which policies are to be used until the Safe Haven Hospital Policy and Procedure can be fully enforced in its entirety by September 1, 2013. A mandatory meeting is scheduled for July 18, 2013, during which staff will be educated on how to access current Policy's and Procedures electronically. Direct Care staff will be directed to speak with the Charge RN, Director of Nursing Services or Chief Administrative Officer for immediate guidance when searching for speeific policies and procedures. Charge Registered Nurses have been given computer access and have been educated on how to access Safe Haven Hospital's Policy and Proeedure electronically and correctly. The Incident reporting policy includes the types of events which an incident report is required and is located at the Nurse's Station. The current policy is Sun Health's policy and will be replaced by September 1, 2013.	

Bureau of Facility Standards

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BB179		BB179	Nursing staff, direct care staff and medical staff will be re-educated on the Incident Report Policy of Safe Haven Hospital by September 1, 2013. The medication reporting and processing policy is located at the Nurse's Station. The current policy is Sun Health's policy and will be replaced by September 1, 2013. Nursing staff, direct care staff and medical staff will be re-educated on the medication reporting and processing policy of Safe Haven Hospital by September 1, 2013. All polices will be reviewed and approved by the Medical Director, Chief Administrative Officer and Director of Nursing Services. At the monthly Performance Improvement Committee meeting, policy and procedure compliance will be reviewed from each department. If a trend and inconsistency is observed, the Performance Improvement Committee will initiate steps of the QAPI plan to present a new project to the Governing Body for approval. The newly created Performance Improvement Sub Committee will meet July 18, 2013 and weekly until September 1, 2013, then monthly thereafter. The Sub Committee will review changes in responsibilities and refine strategies for achieving implementation of newly adopted Policy and Procedures.	

Bureau of Facility Standards

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BB179		BB179	**Monitoring:** The Ward Clerk will conduct a daily audit on Nursing staff, direct care staff and medical staff regarding accessibility to policies and procedures daily for the next 2 months and will be audited every six months after that. The Director of Nursing Services will conduct a random audit on Nursing Staff, direct care staff and medical staff regarding the ability to access policies and procedures for the next 6 months. The tracking log will be reviewed monthly at the Performance Improvement Meeting and by the Sub Committee meetings if a trend of inconsistency is observed, the Performance Improvement Committee will initiate steps of the QAPI plan to present a new project to the Governing Board for approval. **Person Responsible:** The Chief Administrative Officer, Director of Nursing Services, and QAPI Director will be responsible for implementing this plan of correction. The Governing Board and Chief Administrative Officer will ultimately be responsible for continued evaluation and direction.	