January 5, 2015

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

Provider #130049

Dear Mr. Ness:

On July 25, 2014, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006544

Allegation #1: A child was sexually abused by a male roommate that was older than him while hospitalized in the Behavioral Health Center.

Findings #1: An unannounced visit was made to the hospital from 7/23/14 to 7/25/14. Nineteen patient medical records were reviewed. Staff interviews were conducted, as well as, observations of patient care.

One patient medical record documented a 10 year old male that was hospitalized for a 10 day period for psychiatric care related to bipolar disorder. The record also indicated the patient experienced bizarre thought content, perception disturbances, poor social skills, and inadequate control over sexual, aggressive, or frightening thoughts, feelings, and impulses.

During the first three days of his hospitalization, the patient's room assignment was changed twice, but he remained alone in those rooms. On the fourth day he was assigned to a room shared with a 10 year old male for 3 days. He was then moved to a room shared with a 9 year old male until he was discharged home.
The patient's medical record, including observation notes, nursing notes, and physician documentation was reviewed. The records of the male patients that he shared rooms with were reviewed, as well. The records did not include evidence of inappropriate contact during day or night hours. The patients were classified as level "C" for observation and monitoring during the times they shared rooms with the same individual.

Nursing and patient ratios were reviewed, as well as, observation level protocol. The patients were assigned levels for monitoring, with the following designations-

Observation level "A" would be assigned a staff member directly within arm's length and documentation every 15 minutes, "B" would be direct visual observation with documentation every 15 minutes, "C" would be direct visual observation with documentation every 30 minutes, "Routine" would be hourly visual observation with documentation hourly.

Four patient records of male patients that were hospitalized during the same 10 day period were reviewed. The observation notes and activity records were also reviewed. The documentation supported the assigned observation levels of the 4 patients. The records did not indicate suspicious or inappropriate behavior or activities occurred.

During an interview with the Director of Behavioral Health and the Program Manager, the routine for the day in the unit was reviewed. The Program Manager stated the boys and girls are separated, and room assignments were usually grouped within a 2 year age range. The day schedule was noted to be highly structured with minimal free time. She stated the night observation included a 30 minute minimum visual check, the doors were left partially open, and the staff used a flashlight to ensure appropriate visualization of the patients. Additionally, the Program Manager stated a work table was placed in the hall between patient rooms during night hours and a staff member was assigned to work at that location rather than the nursing station, to ensure closer monitoring of any patient activity during the night.

The Program Manager stated if inappropriate contact was noted between patients, they were separated and educated on personal boundaries.

Prior to the investigation another entity had brought the abuse allegation to the hospital's attention. The hospital responded appropriately by initiating its own investigation.

Records of current patients were reviewed and observations of patient activities were conducted. The patients were supervised, the milieu appeared quiet and relaxed. The patient to staff ratio appeared adequate.
The allegation of sexual abuse could not be verified through the investigative process.

**Conclusion:** Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care

SYLVIA CRESWELL  
Co-Supervisor  
Non-Long Term Care

SC/pmt
January 5, 2015

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Provider #130049

Dear Mr. Ness:

On July 25, 2014, a complaint survey was conducted at Kootenai Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006571

Allegation #1: Patients have catheters placed, and antipsychotic medications given, for staff convenience.

Findings #1: An unannounced complaint investigation was completed at the hospital on 7/24/14 through 7/25/14. Nineteen patient medical records were reviewed. Ten of the records reviewed were of patients on the medical floor. Staff interviews were, also, conducted.

One patient's medical record documented a 60 year old male who was admitted to the hospital on 6/29/14, from an assisted living facility with a diagnosis of "Acute Delirium." Additionally, the record indicated the patient had a history of subdural hematoma, fracture of his right leg, urinary retention, and alcohol related encephalopathy. His record indicated his right leg was in a cast and he was not to bear weight on the right leg for 12 weeks.

An Emergency Room Triage Assessment sheet dated 6/28/14 at 9:31 AM, stated Emergency Medical Services reported the patient had altered mental status, had been noted to be lethargic, and sat in his wheelchair overnight. While in the emergency room, a catheter was required to drain the patient's bladder and a urine specimen was sent to the lab. The results indicated he had a urinary tract infection. The physician determined the catheter should remain in place.
The patient was admitted to the medical unit of the hospital. In the admission assessment, dated 6/28/14 at 9:51 PM, the RN documented the patient refused to be assessed with the stethoscope, and "cannot/will not answer any questions."

Four hours later, on 6/30/14 at 2:10 AM, the RN noted the patient was restless and agitated. It also stated he had disconnected his catheter tubing and was pulling hard on the catheter.

In a nursing note, dated 6/30/14 at 10:56 AM, the RN documented the patient was hallucinating; claiming he saw bugs in the room and something at the end of his bed that was going to "get" him. Additionally, the patient stated he thought the hospital staff was going to blow him up. The note further stated that during that time, the patient became aggressive, was throwing things in his room, and pulled his IV (intravenous tubing) out. The nursing note documented the physician was called and ordered the patient be given an injection of Haldol. The foley catheter was subsequently discontinued. His medical record documented the staff monitored his ability to void and bladder scans were completed to determine if he was able to adequately empty his bladder. Based on the lab culture results from the urine specimen obtained on admission, the patient was placed in isolation and started on antibiotics.

In a nursing note, dated 7/03/14 at 4:25 AM, the RN noted the patient was unable to void. A bladder scan was completed and noted he had 600 ml of urine. He was catheterized and 700 ml of urine was removed. Later that day, he was again unable to void and a scan showed a large amount of urine in his bladder. At that point an indwelling catheter was placed.

In a nursing note, dated 7/05/14 at 5:40 PM, the RN noted the patient continued to be confused and have hallucinations. She documented that Haldol was administered with good results.

In preparation for discharge, the patient's parent was educated to perform straight catheterization. His record included a lengthy note which detailed the process of the discharge education that was provided, and the return demonstration by his parent. The documentation also included printed information related to catheterization.

The record included documentation that Haldol was discontinued on 7/20/14 as it was not needed as the last dose was given on 7/12/14.

No concerns related to the use of catheters, antipsychotic medications, or other intrusive interventions were identified in the other 18 patient records reviewed.

It could not be verified that catheters were placed and antipsychotic medications given for staff convenience.

**Conclusion #1:** Unsubstantiated. Lack of sufficient evidence.
Allegation #2: The hospital failed to protect patients from skin breakdown. Example includes: A patient developed bed sores on his lower back.

Findings #2: Ten records of current and discharged patients were reviewed for evidence of skin breakdown. Of the ten records reviewed, six patients were noted to have complications related to skin breakdown. Four of the patients were noted to have infections, as well. The six records of the patients with wounds documented early assessment and detection of wounds, and implemented interventions which included wound care/ostomy nurse assessment.

One patient's medical record documented a 60 year old male that was admitted from an assisted living facility on 6/29/14 with a diagnosis of Acute Delirium. An Emergency Room Triage Assessment sheet dated 6/28/14 at 9:31 AM, stated the EMS reported the patient to have altered mental status, had been noted to be lethargic, and sat in his wheelchair overnight.

The patient was admitted to the medical floor on 6/28/14 at 9:28 PM. Included in the admission plan of care was an identified problem of "Impaired Skin Integrity." The admission assessment included documentation by the admitting RN that the patient had redness in his chest area, "possibly from pressure from sleeping in the wheelchair," and redness and a blister in the lower back area.

In a nursing note dated 7/01/14, the nurse noted the patient had an area of concern, and noted a questionable sacral ulcer.

In a nursing note dated 7/12/14, his sacral ulcers were noted to be grade II, with some grade I skin changes.

In a "Wound Care Note," dated 7/18/14, the wound care nurse documented she had difficulty keeping him off his sacrum due to his being very active while in bed. His record noted he was frequently incontinent of stool, and was confused and disoriented.

In a "Wound Care Note," dated 7/19/14, the wound care nurse documented the patient was scooting in the bed. She noted that she reinforced to the patient that he needed to stay off his back, but he was confused and did not seem to understand.

In a nursing note, dated 7/20/14, the RN documented the patient was withdrawn and uncooperative. She stated he needed full assistance for turning.

In a nursing note dated 7/21/14, the RN noted the patient's sacral pressure ulcer had advanced to a stage III. His record documented he was receiving wound care from the wound care staff, and his position was changed every 2 hours. Additionally, the record indicated the patient required full assistance from staff to reposition in his bed. He was noted to be on a specialty pressure redistribution mattress, as well.
The patient was discharged to his home in the care of his mother and nephew on 7/24/14. His record indicated he was discharged against medical advice of the facility and of his attending physician.

During a tour of the medical floor on 7/25/14, the Charge Nurse discussed how nursing and support staff were assigned. She stated the patients with higher acuity or at risk for falls were in rooms that were close to the nursing station area for close monitoring.

It could not be verified through the investigative process that the worsening of the wound was related to inadequate or inappropriate care on the part of hospital staff.

**Conclusion #2:** Unsubstantiated. Lack of sufficient evidence.

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

Sincerely,

SUSAN COSTA  
Health Facility Surveyor  
Non-Long Term Care

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