



I D A H O D E P A R T M E N T O F
HEALTH & WELFARE

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

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

CERTIFIED MAIL: 7012 1010 0002 0836 1406

August 28, 2014

Charles Lloyd, Administrator
Mountain View Center For Geriatric Psychiatry
500 Polk Street East
Kimberly, ID 83341

RE: Mountain View Center For Geriatric Psychiatry, Provider #13-4014

Dear Mr. Lloyd:

Based on the survey completed at Mountain View Center For Geriatric Psychiatry, on August 11, 2014, by our staff, we have determined Mountain View Center For Geriatric Psychiatry, is out of compliance with the Medicare Hospital **Condition of Participation of Patients' Rights (42 CFR 482.13)**. To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies, which caused the condition to be unmet, substantially limit the capacity of Mountain View Center For Geriatric Psychiatry, to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). Enclosed, also, is a similar form describing State licensure deficiencies.

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

An acceptable Plan of Correction contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;

Charles Lloyd, Administrator
August 28, 2014
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- 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 both forms.

Such corrections must be achieved and compliance verified by this office, before September 25, 2014. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than September 17, 2014.

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **September 10, 2014.**

Failure to correct the deficiencies and achieve compliance will result in our recommending that CMS terminate your approval to participate in the Medicare Program. If you fail to notify us, we will assume you have not corrected.

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208) 334-6626.

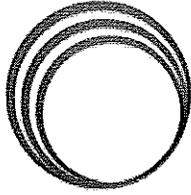
Sincerely,



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/

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



**MOUNTAIN VIEW CENTER
FOR GERIATRIC PSYCHIATRY**
A BRP Health Management Care Center

RECEIVED
SEP 15 2014
FACILITY STANDARDS

September 10, 2014

Sylvia Creswell
Co-Supervisor
Non-Long Term Care
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

Dear Ms. Creswell,

Enclosed is the plan of correction for cited deficiencies for the complaint survey that was conducted at Mountain View Center for Geriatric Psychiatry on August 11, 2014.

If you have any other questions please call me at (208) 736-1050.

Sincerely,

Charles D. Lloyd, Jr., MBA/HCM
Administrator
Mountain View Hospital for Geriatric Psychiatry

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

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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A 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited during the complaint investigation survey at your hospital from 8/07/14 through 8/11/14. Surveyors conducting the investigation were:</p> <p>Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Laura Thompson, RN, HFS</p> <p>Acronyms used in this report include:</p> <p>EHR - electronic health record MAR - medication administration record NP - Nurse Practitioner QAPI - quality assessment and performance improvement</p>	A 000	<p>RECEIVED</p> <p>SEP 15 2014</p> <p>FACILITY STANDARDS</p>	
A 115	<p>482.13 PATIENT RIGHTS</p> <p>A hospital must protect and promote each patient's rights.</p> <p>This CONDITION is not met as evidenced by: Based on staff interviews and review of medical records, meeting minutes, and quality documents, it was determined the hospital failed to protect and promote patients' rights. This resulted in adverse patient outcomes and the potential for similar events to occur in the future. Findings include:</p> <p>Refer to A144 as it relates to the failure of the hospital to ensure patients received care in a safe setting.</p> <p>The inability of the hospital to protect patients from harm, seriously impeded the ability of the hospital to provide services of sufficient scope</p>	A 115	<p>Mountain View Center for Geriatric Psychiatry mission is to protect and promote each patient's rights while providing quality of care and services in a safe setting. We believe our plan of correction set forth in this document is evidence of our mission. All resources have been brought to bear, including the hiring of an outside consulting firm to assist with action plan development and implementation. Please refer to A144.</p>	9/17/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> MBA/HCM	TITLE Administrator	(X6) DATE 9/10/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 115	Continued From page 1 and quality.	A 115			
A 144	<p>482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING</p> <p>The patient has the right to receive care in a safe setting.</p> <p>This STANDARD is not met as evidenced by: Based on review of medical records, facility policies, accident and incident reports, and staff interviews, it was determined the hospital failed to ensure 4 of 8 patients (#1, #2, #4, and #7) whose records were reviewed, received care in a safe setting. This resulted in the inability of the hospital to ensure hospital staff correctly administered medications, monitored patients, and protected patients from injury. Findings include:</p> <p>1. A facility policy, "ADMINISTRATION OF MEDICATIONS," revised 2/2013, stated</p> <p>Medication orders must include:</p> <ul style="list-style-type: none"> - Date and Time, - Patient Name, - Drug Name, - Route of Administration, - Dose, - Frequency. <p>The policy also stated "Order Clarification, The nurse is ultimately responsible to clarify unclear/incomplete medication orders with the physician. The pharmacist may assist in this process as needed. The nurse taking a telephone order must repeat the order back to the physician to ensure the accurate order was</p>	A 144	<p>The following actions are being taken relating to the citation at A144:</p> <p>1) The facility medication administration policies are being updated to include more specific information concerning processes to follow with telephone orders and additional measures to decrease our medication error rate. A number of resources are being used to update these policies that include the National Patient Safety Commission and the National Coordinating Council for Medication Error Reporting and Prevention. The policies will be updated and available for staff training as described below. We feel this action will assist in developing clarity for our staff with regards to our policies for medication administration by outlining specific processes and algorithms to follow as well as their role and responsibilities in ensuring accuracy when taking orders and administering medications.</p>	9/17/14	

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A 144	<p>Continued From page 2 taken."</p> <p>This policy was not followed. Examples include:</p> <p>a. Patient #7 was a 79 year old male admitted to the facility on 4/04/14 for dementia, unspecified psychosis, and hypertension.</p> <p>His record documented he was transferred from Mountain View Center for Geriatric Psychiatry to an acute care hospital on 4/06/14 until 4/08/14, as a result of an inadvertent dose of Thorazine.</p> <p>A nursing note, dated 4/06/14 at 4:00 PM, was the first nursing entry for the day shift (7:00 AM to 7:00 PM). The note documented Patient #7 received Thorazine 200 mg at 11:30 AM. The RN wrote she held all of Patient #7's 8:00 AM and 12:00 PM medications due to his sleeping and combative behavior. The RN did not indicate the route of administration.</p> <p>In a nursing note at 6:00 PM on 4/06/14, the same RN described Patient #7's agitated behaviors of spitting, biting, and hitting at staff. The RN documented at that time the psychiatrist was notified and "Thorazine & Ativan IM ordered." The nurse wrote "...these were given in the R [right] dorso gluteal, Ativan given in the L [left] dorso gluteal. Pt [patient] continues [with] physical & verbal aggression." The nurse did not document in her notes what time the medications were administered, or the doses delivered.</p> <p>In a nursing note at 7:00 PM on 4/06/14, the same RN wrote "Pt [patient] transferred out of facility for further monitoring." It did not include further details of why Patient #7 was transferred. Patient #7's record did not include documentation</p>	A 144	<p>2) We have contracted with an outside consulting firm to assist with Medication Administration training for 100% of our Licensed Staff. A series of webinars are being provided; training will be completed by September 6, 2014 and will include the following: General and specific processes / standards in the administration of medication by various routes; Pharmacology including drug properties, interactions, and adverse consequences; Drug therapy in the elderly; Common drug classifications and their actions; Common causes and prevention of errors; how to transcribe orders; how and what to document; facility policies and procedures; reporting errors and follow-up investigations; providing for prn medications and subsequent assessments that may be needed and documented. A written examination will be provided after the training with the expectation licensed staff will pass with a 95%. The training is now part of our orientation program. We feel outside training by professionals is a more effective way of delivering training as well as creating focus for our staff. The training will be utilized for orientation on an ongoing basis. We feel this will assist with decreasing medication errors by providing a clear and consistent method for training all staff on hire and annually.</p>		

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A 144	<p>Continued From page 3 for hospital transfer, or physician orders for the transfer.</p> <p>A form titled "DOCTOR'S ORDERS AND PROGRESS NOTES," included an entry by Patient #7's psychiatrist on 4/06/14 at 6:30 PM: "[Patient Name] became more & more agitated & refused oral meds X 2, and started hitting & trying to bite staff. I ordered Haldol 10 mg IM & Ativan 2 mg IM. The nurse gave it and the Team Control Positioning was required for less than 30 seconds for both injections. When I arrived to evaluate him he was sitting quietly on the bedside & did not require more physical restraints." Patient #7's record did not include a verbal order or written order for Haldol, Thorazine, or Ativan. The record did not include a physician's order for Patient #7's transfer or notes written by his physician indicating why a transfer would be indicated.</p> <p>Review of Patient #7's medication administration records did not include documentation Thorazine, Haldol, or Ativan were administered that evening.</p> <p>An admission History and Physical from the hospital where Patient #7 was transferred to, dated 4/06/14, noted he received the Thorazine and Ativan dose at 6:25 PM.</p> <p>Patient #7's Discharge Summary from Mountain View Center for Geriatric Psychiatry, dictated 6/06/14, dictated by his Psychiatrist, documented that on 4/06/14, Patient #7 received Haldol 10 mg and Ativan 2 mg IM, then was transported to the hospital for evaluation and returned 4/08/14. The discharge summary was not accurate as it indicated Haldol was administered, although Patient #7 received Thorazine. The discharge summary did not include the reason for the</p>	A 144	<p>3) Once training as described above is completed, 100% of all licensed staff will be observed passing medications. Process outcome measures and a new competency evaluation will be utilized to determine a medication error that may not exceed 5%. Any licensed nurse that exceeds the goal of 5% medication error on observation will be re-educated and observed again and / or taken off the schedule. The medication pass competency will be placed in the employee file. Monitoring and tracking of competencies: Observations will occur on hire, annually and / or whenever a medication error occurs. Competency testing or process outcomes are the best way to determine the capability and capacity of your staff with this complex procedure. We believe this is the most effective way (after training) to decrease our medication error rate.</p> <p>4) Monitoring and Tracking of medication errors: In collaboration with our pharmacist and our contracted consultants, a new process will be implemented as part of our Quality Assurance and Performance Improvement (QAPI) Plan that will include completion of investigations for all identified medication errors – the causes of errors will be identified and appropriate actions taken. We have defined medication errors using the</p>		

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A 144	<p>Continued From page 4 hospital transfer, and did not reference the medication adverse event.</p> <p>The DON was reported to have conducted an investigation regarding the medication error, but was unavailable during the survey. During an interview on 8/08/14 beginning at 11:15 AM, the Admissions Coordinator reviewed Patient #7's record and stated she was familiar with the incident. She stated she was covering for the DON during her absence, and provided a packet of papers she described as the DON's investigation of the incident.</p> <p>The investigation packet included Progress notes and Nursing notes, however, they were undated and/or unsigned, as follows:</p> <p>i. An undated and unsigned Progress note, timed 7:55 PM, indicated a phone order was obtained from the psychiatrist. The writer of the progress note documented administration of Thorazine and Ativan. The progress note stated a phone order was obtained from the psychiatrist for Patient #7's transport to the acute care hospital.</p> <p>ii. A dated and timed, but unsigned, Nurse's notes with Patient #7's name, date and time, however the notes did not have a signature to indicate the authors. Dated and timed, but unsigned, Nurse's notes with Patient #7's name on them, were written by 2 different individuals. This was evidenced by the use two different writing instruments and two different handwriting styles. These included:</p> <p>- A Nurse's note, dated 4/06/14 at 7:30 PM, was a three page description of the medication administration, written as a narrative of how the</p>	A 144	<p>definition as published by the National Coordinating Council for Medication Error Reporting and Prevention. All medication errors will be tracked and trended. An analysis will be performed and presented to the committee on a quarterly basis. QAPI initiatives create improved quality of care that is sustainable.</p> <p>5) We are developing new processes for accident and incident investigations that include root cause analysis utilizing specific information to identify the actual and potential causes of the fall so effective interventions can be implemented.</p> <p>6) Monitoring and Tracking of accident and incidents (falls and other incidents): All falls will be tracked, trended, and analyzed monthly. We are establishing a goal utilizing information from the National Patient Safety Commission. Should a goal not be reached, a performance improvement team will assist with further analysis and an action plan. Results will be reported to the QAPI Committee quarterly. We believe a good investigation process will assist with the identification of good preventions measures that will lead to decrease of falls, in-particular repeat falls. QAPI initiatives create improved quality of care that is sustainable.</p> <p>7) We have implemented new</p>		

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A 144	<p>Continued From page 5</p> <p>individual (an RN,) assisted Patient #7's nurse. The writer of the Nursing note stated she drew up two 5 ml syringes of Thorazine, (which would be a total dose of 500 mg). She wrote that the other nurse drew up the Ativan 2 ml, (which would be a dose of 4 mg). The writer documented the Ativan and 5 ml of Thorazine was administered into Patient #7's left gluteal region by the other nurse, and she administered Thorazine 5 ml into his right gluteal region. She documented the injections were administered at 6:40 PM. Additionally, the RN documented Patient #7's physician came in to see him and wrote orders at 6:30 PM.</p> <p>- A Nurse's note dated 4/06/14 at 7:40 PM, was a three page description of the events surrounding the medication administration and transfer of Patient #7. The note appeared to have been written by the nurse who took care of Patient #7 on 4/06/14, however, the note was not signed. The writer stated Patient #7 was combative on 4/06/14 shortly after 11:00 AM, and Thorazine 200 mg was administered orally. The nurse documented that Patient #7 got up at 5:45 PM, was belligerent, and difficult to redirect. She wrote that she attempted to call the psychiatrist twice, then he called back and "...gave order for Thorazine 10 ml IM and Ativan 2 ml." The writer stated another nurse offered assistance, and she delegated the nurse to draw up the Thorazine. The writer stated she was questioned by the other nurse regarding the volume, and they decided to divide the medication into two syringes of 5 ml each. The writer documented the injections were administered at 6:45 PM, and vital signs were taken at 6:40 and 6:50 PM, and were within normal limits.</p>	A 144	<p>guidelines for assessments and documentation of changes of status. All licensed staff has been educated. Monitoring and Tracking: We are checking assessments and documentation daily Monday through Friday at morning meeting to ensure comprehensive assessments that include Vital Signs per our guidelines. Any failures will result in documented education for the nurse(s) involved.</p> <p>The Administrator and the Director of Nursing have overall responsibility in ensuring these above actions are implemented.</p> <p>Please note: We have conducted an investigation with regards to the citation for Patient 4 and the medication Rocephin. The medication was delivered and provided at 11:00 pm on 10/24/13 – only 30 minutes after the order came from the physician. Through our investigation we found the nurse documented the medication as being given on the wrong day (meaning 10/25/13). We understand this does not mitigate a nurse's responsibility to document accurately and does not mitigate our responsibility to conduct investigations in order to improve our systems and our processes.</p>	

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A 144	<p>Continued From page 6</p> <p>During an interview on 8/08/14 beginning at 11:15 AM, the Admission Coordinator (an RN who was covering in the DON's absence) reviewed Patient #7's record and confirmed the times of the medication administration differed in each different document. The administration times ranged from 6:25-6:45 PM. She also confirmed there was no order for Haldol, Thorazine, or Ativan written the evening of 4/06/14, by either the psychiatrist, or the nurse who received the orders. Additionally, the medication administration was not documented on Patient #7's Medication Administration Records. The Admission Coordinator confirmed the Discharge Summary and Physician's notes included information Patient #7 received Haldol and Ativan, although he was documented by the nurse as receiving Thorazine and Ativan. She confirmed the discrepancy in documentation.</p> <p>During an interview on 8/08/14 at 9:00 AM, the RN who was the charge nurse who provided care to Patient #7, and who administered the Thorazine/Ativan injections, reviewed her process for obtaining medications from the pharmacy. She stated the charge nurse had access to the key for the pharmacy. The RN unlocked the door of the pharmacy and demonstrated where the medication was stored, and stated the only dose of Thorazine the facility carried was in 2 ml glass ampules of 50 mg Thorazine. She stated 10 ml would mean 5 of the ampules would be used.</p> <p>During an interview on 8/08/14 at 1:40 PM, the facility Pharmacist reviewed Patient #7's record and confirmed it was Thorazine 10 ml (500 mg total dose), and Ativan 2 ml (4 mg total dose) that Patient #7 received. He confirmed there were no written orders for either medication. The</p>	A 144		

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A 144	<p>Continued From page 7</p> <p>Pharmacist stated he did not perform an analysis of the incident, as he felt it was a nursing incident and not related to pharmacy. He was questioned about monitoring of inventory, and how he reconciled counts of medications if the orders did not match what was used. He stated the Thorazine and Ativan was not ordered, and it was not on the medication administration records, so it would not be possible to track where it went. The Pharmacist stated he did not review Patient #7's record during the monthly medication audits that he performed.</p> <p>During a phone interview on 8/11/14 beginning at 12:40 PM, the DON stated the nurse who administered the Thorazine and Ativan was an experienced nurse with the hospital. She stated she reviewed the nurse's competencies and annual performance evaluations. The DON stated the nurse was counseled after the incident, she had been assigned "Homework," and had to complete a PowerPoint and med-pass audit before she was able to return to patient care. The DON stated the incident was reviewed with the hospital physicians and the administrator.</p> <p>b. Patient #4 was a 79 year old male admitted to the facility on 9/20/13, for dementia and aggression. Additional diagnoses included acute dystonia secondary to drugs. Patient #4 was transferred to an acute care hospital for a higher level of care on 10/26/13, and died on 11/06/13.</p> <p>Patient #4's medical record included a signed verbal order dated 10/24/13 at 10:35 PM, for blood to be drawn for labwork and to start antibiotics. Rocephin 2 gm IM was ordered "now," as the initial dose, and was to be followed by 1 gm every 24 hours for the next 5 days. The</p>	A 144			

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A 144	<p>Continued From page 8</p> <p>order did not include a time when the physician authenticated the order, or when the nurse noted the order.</p> <p>A Medication Administration Record included documentation Patient #4 received the first dose of Rocephin 2 gm on 10/25/13. The medication sheet did not include a time of administration.</p> <p>A nursing note dated 10/26/13 at 4:00 AM, was unclear, as multiple events were described, but no time was provided when they occurred. The note lacked clarity of what time the first dose of Rocephin was administered, and if he received an additional dose as follows: "Rocephin 2 gm IM initial dose, then Rocephin 1 gm IM q [every] 24 hours X 5 d [days]. Pt breathing labored, noted Rhonci." The nursing note, also under the 4:00 AM entry, included "Pt VS [vital signs] recheck after Rocephin given @ approx (sic) 2300 [11:00 PM]." The nurse documented Patient #4's blood pressure was 100/52.</p> <p>In a nursing note on 10/26/13 at 4:55 AM, the nurse documented Patient #4 was transferred to an acute care hospital.</p> <p>During an interview on 8/08/14 beginning at 11:15 AM, the Admission Coordinator, (an RN who was covering in the DON's absence,) reviewed Patient #4's record and confirmed the medication order was written on 10/24/13. She verified the MAR documented Patient #4 received the first dose of Rocephin on 10/25/13, and the time was not noted on the MAR. She confirmed the RN documented she gave the IM Rocephin injection to Patient #4 at 11:00 PM on 10/25/14.</p> <p>During an interview on 8/08/14 beginning at 1:40</p>	A 144			

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A 144	<p>Continued From page 9</p> <p>PM, the facility Pharmacist reviewed Patient #4's record and confirmed the medication administration record indicated his first dose of Rocephin 2 gms was administered on 10/25/13. He was asked about medication errors, and if this was identified as a medication error. The Pharmacist stated he did not think Patient #4's record was reviewed for medication errors. He stated that most medication errors are self disclosed, meaning the nursing staff identifies an error and will complete an incident report. The Pharmacist stated he chooses 3 random records for medication review each month. From the review of the 3 records, he stated, he then is able to determine the percentage of medication errors for the facility each month.</p> <p>Antibiotics for Patient #4 were ordered to be given "Now," on 10/24/13 at 10:35 PM. The facility failed to administer his first dose until 24 hours later, on 10/25/13 at 11:00 PM. Five hours later he was transferred to a higher level of care facility where he later died.</p> <p>The facility failed to fully investigate medication errors, failed to ensure accuracy of documentation by the physician and nursing staff, and failed to ensure verbal orders for medications were written and authenticated as per the facility's policy and commonly understood nursing standards of practice.</p> <p>2. Patient #1 was a 53 year old male admitted to the hospital on 5/1/14 for Schizoaffective Disorder.</p> <p>A form titled "Medication Sheet" indicated Patient #1 had an elevated temperature of 102 on 5/6/14 at 7:00 PM. At 7:30 PM on 5/6/14 a verbal order</p>	A 144			

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A 144	<p>Continued From page 10</p> <p>was received to give him Tylenol "now" and recheck Patient #1's temperature along with vital signs in one hour, then to call the NP back to inform them of the results. However, this order was not followed. One and a half hours later at 9:00 PM on 5/6/14, on a form titled "Patient Vitals Data," the nurse documented Patient #1's temperature as 101. One hour later, at 10:00 PM on 5/6/14, the nurse documented contacting the NP and Patient #1's temperature was 102. A temperature of 101 and administration of Tylenol was documented on the "Medication Sheet" at 1:30 AM on 5/7/14, three and half hours later. Patient #1's temperature was not documented again until 5:00 AM on 5/7/14, three and half hours after the Tylenol was given. His temperature at that time was 101.2.</p> <p>Vital signs were not documented in a consistent location in Patient #1's record for monitoring of changes in his condition and effectiveness of medications administered. Elevated temperatures were not rechecked in a timely manner after medications were given.</p> <p>Patient #1 was, subsequently, transferred to an acute care hospital on 5/08/14.</p> <p>The facility did not have a policy related to vital signs, and this was confirmed by the Director of Medical Records and Health Information on 8/08/14 at 10:00 AM.</p> <p>During an interview on 8/08/14 at 11:15 AM, the Admission Coordinator reviewed Patient #1's record and confirmed his temperature was elevated, and the documentation of vital signs was in multiple locations in his record. She</p>	A 144		

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A 144	<p>Continued From page 11</p> <p>stated the frequency of his vital signs should have been increased, and his temperature monitored more closely. The Admission Coordinator stated she was not aware of the lack of a policy related to vital signs.</p> <p>3. Patient #2 was a 92 year old female admitted to the facility on 4/30/14 for care related to dementia, aggressive behavior, HTN, and irregular heart rhythm. A fall risk assessment was performed on 5/01/14, with a score of 9. The worksheet used by the facility noted "TOTAL SCORES ABOVE 10 REPRESENTS A HIGH RISK."</p> <p>An incident report documented Patient #2 fell out of her wheelchair on 5/06/14, at approximately 6:13 PM. The report indicated there were no witnesses to the fall. It stated the recording was reviewed, and Patient #2 was observed attempting to stand up from the wheelchair and reaching for the dining room table. The incident report documented the review of the recording showed Patient #2 falling backwards, landing on her buttocks, back, and head. Additionally, the report documented her wheelchair was not locked. On 5/07/14, Patient #2's fall risk assessment was re-evaluated, and the score was 16. A care plan related to falls was implemented on 5/06/14.</p> <p>During an interview on 8/08/14 beginning at 11:30 AM, an RN who identified herself as an Admissions Coordinator, and was covering for the DON, reviewed Patient #2's record. She stated Patient #2 was considered a risk for falls, although her score on admission was less than 10. She stated the wheelchair should have been</p>	A 144			

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A 144	<p>Continued From page 12</p> <p>locked, and was not able to explain why the fall was unwitnessed as it was during mealtime.</p> <p>Patient #2 experienced a fall when she attempted to stand up from an unlocked wheelchair.</p> <p>The facility did not ensure patients received care in a safe setting.</p> <p>4. Falls:</p> <p>The minutes of 4 Medical Executive Committee meetings were documented between 8/01/13 and 8/7/01. Medical Executive Committee meeting minutes, dated 8/27/13, stated "There have been 15 falls during the 2nd quarter, of which (1) was addressed as being preventable. Goal not met." The 15 falls were not specifically addressed.</p> <p>Medical Executive Committee meeting minutes, dated 12/10/13, stated "There have been 22 falls during the 3rd quarter, of which (0) were addressed as being preventable. Goal met." The 22 falls were not specifically addressed.</p> <p>Medical Executive Committee meeting minutes, dated 2/25/14, stated "There have been 34 falls during the 4th quarter [of 2013], of which (3) were addressed as being preventable. There was a annual total of 84 falls, of which 4, (5%) were addressed as being preventable. The annual goal was not met."</p> <p>Medical Executive Committee meeting minutes, dated 5/20/14, stated "There have been 62 falls during the 1st quarter [of 2014] of which 10 were addressed as being preventable. The 1st quarter rate is 5.3%, so the quarterly goal is not met." The meeting minutes stated the hospital had a</p>	A 144		

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A 144	<p>Continued From page 13</p> <p>"Goal of 2% or < fall rate." This was the first mention of a 2% fall rate. The rationale for this change was not documented. No specific actions or recommendations to reduce the fall rate were documented.</p> <p>The Administrator was interviewed on 8/08/14 at 9:25 AM. He confirmed the data for 2013 and 2014.</p> <p>The Administrator was interviewed again on 8/15/14 at 2:25 PM. He stated changes to the hospital's fall prevention program had been implemented but were not documented for the year prior to survey. The Administrator stated the hospital had not analyzed fall data beyond the total number or percentage of falls. He stated the hospital's QAPI program had not measured the effects of efforts to reduce falls.</p> <p>The hospital did not take actions to prevent falls and protect patients from harm.</p> <p>5. Medication Errors:</p> <p>The "QAPI REPORT FOR THE YEAR OF 2013," not dated, stated the medication error rate for 2013 was 4.51%. The document stated this was higher than the hospital's goal of 3.5%. Medical Executive Committee meeting minutes, dated 2/25/14, stated the medication error rate for the fourth quarter of 2013 was 7.35% which did not meet the 3.5% goal. The FORM "QAPI MEDICATION ERRORS FOR APRIL 2014" stated the error percentage rate was 1.2%. The FORM "QAPI MEDICATION ERRORS FOR MAY 2014" stated the error percentage rate was 4.1%. The FORM "QAPI MEDICATION ERRORS FOR JUNE 2014" stated the error percentage rate was</p>	A 144		

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A 144	<p>Continued From page 14 6.1%.</p> <p>Raw data showed the medication error rate was determined based on the pharmacist's review of 3 randomly chosen medical records per month. This brought into question the accuracy of the data as it was solely dependent on which records were chosen for review. The severity of medication errors was not tracked. Also, causal analysis of the errors was not done. No review of systems for prescribing, transcribing, and administering medications had been conducted.</p> <p>Medical Executive Committee meeting minutes from 8/01/14 to 8/07/14 documented the hospital's QAPI actions. The only actions documented to reduce medication errors were to "educate" staff who passed medications.</p> <p>The pharmacist was interviewed on 8/08/14 beginning at 1:40 PM. He stated the medication error rate was determined by his review of 3 randomly chosen medical records per month. He stated incident reports were not completed for the medication errors that were identified.</p> <p>The pharmacist stated the error rate was determined by the number of errors identified divided by the number of doses ordered. He stated the data used to determine the error rate was not broken down into sub-categories such as the severity of the errors or the type of errors identified, i.e. prescription errors, transcription errors, etc. He stated causal analyses of medication errors was not conducted.</p> <p>The administrator was interviewed on 8/08/14 at 9:25 AM. He confirmed the data for 2013 and the first quarter of 2014. He stated other than</p>	A 144			

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A 144	Continued From page 15 educating staff to be more careful, the hospital had not taken specific measures to reduce the medication error rate for at least one year prior to the survey. The hospital did not take action to reduce the number of medication errors and protect patients from harm.	A 144		
A 283	6. Refer to A283 as it relates to the failure of the facility ensure its QAPI program effectively monitored falls and medication errors by implementing quality improvement processes, tracking progress, analyzing results, and revising ineffective processes. 482.21(b)(2)(ii), (c)(1), (c)(3) QUALITY IMPROVEMENT ACTIVITIES (b) Program Data (2) [The hospital must use the data collected to -] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to	A 283	We have taken the following actions: 1) We are reviewing and updating our entire QAPI plan to include identification of measures that are high priority, high risk and high volume or problem-prone areas – these measures will include falls, medication errors, skin issues and more. The update will include a QAPI calendar to outline those areas scheduled for review by the QAPI committee, goals in each of the measures, root cause analysis tools, performance improvement teams, and documented action plans. We are developing specific tools and data based programs to assist with trending and analysis.	9/17/14

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A 283	<p>Continued From page 16 ensure that improvements are sustained.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and review of meeting minutes and QAPI documents, it was determined the hospital failed to take actions aimed at performance improvement when it failed to meet quality goals. This affected the care of 1 of 2 sample patient who sustained a fall and whose record was reviewed (Patient #7) and had the potential to affect all patients at the hospital. This prevented the hospital from reaching those quality goals and decreasing adverse patient outcomes. Findings include:</p> <p>1. Falls:</p> <p>The Administrator was interviewed on 8/08/14 at 9:25 AM. He stated the Medical Executive Committee was also the hospital's QAPI Committee. He stated the Medical Executive Committee minutes served for both committees.</p> <p>The minutes of 4 Medical Executive Committee meetings were documented between 8/01/13 and 8/7/01. Medical Executive Committee meeting minutes, dated 8/27/13, stated the "Objective" for the hospital was "No avoidable or preventable patient fall incidents, ensuring that all appropriate fall precautions are implemented and adhered to." The minutes stated "There have been 15 falls during the 2nd quarter, of which (1) was addressed as being preventable. Goal not met." The 15 falls were not specifically addressed. The Action column stated "Preventable fall assessment form is to be completed on all fall incidents and reported at the monthly QAPI</p>	A 283	<p>2) Any recommendations by the QAPI committee will be well documented.</p> <p>3) Education on our QAPI plan will be provided to all members of the committee, and hospital staff. QAPI education will be provided on hire and annually.</p> <p>4) We are establishing a QAPI communication board that will provide information to staff on measures and results.</p> <p>5) Monitoring and Evaluation: We are developing a self-assessment tool to assess the QAPI program on an annual basis. We will first evaluate where we are today, implement our new plan, and will then conduct an additional evaluation in three months for the purpose of assessing overall implementation.</p> <p>The Administrator and Director of Nursing have overall responsibility in the collection of data, comparing it to a set measure, and then action plans as well as the monitoring and evaluation of the program overall.</p>	

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A 283	<p>Continued From page 17</p> <p>meeting, break down time and complete trending. Assess the root cause of what the patient was trying to accomplish before the fall. Individualize care plan and educate staff to follow care plan."</p> <p>Medical Executive Committee meeting minutes, dated 12/10/13, stated the "Objective" of for the hospital was "No avoidable or preventable patient fall incidents, ensuring that all appropriate fall precautions are implemented and adhered to." The minutes stated "There have been 22 falls during the 3rd quarter, of which (0) were addressed as being preventable. Goal met." The 22 falls were not specifically addressed. The Action column stated "Preventable fall assessment form is to be completed on all fall incidents and reported at the monthly QAPI meeting, break down time and complete trending. Assess the root cause of what the patient was trying to accomplish before the fall. Individualize care plan and educate staff to follow care plan."</p> <p>Medical Executive Committee meeting minutes, dated 2/25/14, stated the "Objective" of for the hospital was "No avoidable or preventable patient fall incidents, ensuring that all appropriate fall precautions are implemented and adhered to." The minutes stated "There have been 34 falls during the 4th quarter [of 2013], of which (3) were addressed as being preventable. There was a annual total of 84 falls, of which 4, (5%) were addressed as being preventable. The annual goal was not met." The Action column stated "Preventable fall assessment form is to be completed on all fall incidents and reported at the monthly QAPI meeting, break down time and complete trending. Assess the root cause of what the patient was trying to accomplish before the fall. Individualize care plan and educate staff</p>	A 283			

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A 283	<p>Continued From page 18 to follow care plan."</p> <p>Medical Executive Committee meeting minutes, dated 5/20/14, stated the "Objective" of for the hospital was "No avoidable or preventable patient fall incidents, ensuring that all appropriate fall precautions are implemented and adhered to. Goal of 2% or < fall rate." This was the first mention of a 2% fall rate. The rationale for this change was not documented. This was the last documented meeting by the Medical Executive Committee.</p> <p>The 5/20/14 minutes stated "There have been 62 falls during the 1st quarter [of 2014] of which 10 were addressed as being preventable. The 1st quarter rate is 5.3%, so the quarterly goal is not met." The "Action" listed was "Preventable fall assessment form is to be completed on all fall incidents and reported at the monthly QAPI meeting, break down time and complete trending. Assess the root cause of what the patient was trying to accomplish before the fall. Individualize care plan and educate staff to follow care plan. Therapy to screen for any patients with greater than 2 falls. Establish a fall rate goal of 2% or less based on monthly census."</p> <p>The Administrator was interviewed on 8/08/14 at 9:25 AM. He stated data regarding falls had not been presented for the 2nd quarter of 2014. He confirmed the data for 2013 and the first quarter of 2014.</p> <p>Medical Executive Committee meeting minutes stated the total number of falls and then told how many of those falls were "preventable." The minutes stated one objective was to have "No avoidable or preventable patient fall incidents."</p>	A 283			

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A 283	Continued From page 19 The Administrator was interviewed on 8/15/14 at 10:20 AM. He stated the hospital did not have a definition of preventable falls. The Administrator was not able to state how the number of preventable falls was determined . All of the Medical Executive Committee meeting minutes mentioned above stated one of the actions to prevent falls was to "Assess the root cause of what the patient was trying to accomplish before the fall." However, the incident reports used to record falls did not include a section to assess the root cause of patients' behavior before falls. For example, Patient #7 had an incident report for a fall on 5/31/14. The incident report contained identifying information, a description of the incident, and corrective action taken. The form did not ask for or include information regarding what Patient #7 was trying to accomplish prior to his fall. The Administrator was interviewed on 8/15/14 at 2:25 PM. He stated for at least 1 year prior to the survey on 8/11/14, the incident reports had not changed. He stated they did not request information regarding the root cause of what the patient was trying to accomplish before the fall. During the same interview, the Administrator stated actions had been taken to prevent falls such as using specific colors to identify patients at high risk for falls. He stated these actions had not been included in the QAPI program and no data had been gathered to determine if the actions had been successful. The administrator stated staff had always utilized measures to prevent falls such as low bed positions and bed alarms. He stated, other than measures to allow	A 283			

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A 283	<p>Continued From page 20</p> <p>staff to easily identify patients at risk for falls, no new actions had been implemented to prevent falls in the past year.</p> <p>The hospital did not take actions when it failed to meet goals for fall prevention.</p> <p>2. Medication Errors:</p> <p>The "QAPI REPORT FOR THE YEAR OF 2013" document, not dated, stated the medication error rate for 2013 was 4.51%. The document stated this was higher than the hospital's goal of 3.5%. The report stated "we will continue to educate everyone who passes meds so that they can become familiar and confident when passing meds."</p> <p>Medical Executive Committee meeting minutes, dated 2/25/14, stated the medication error rate for the fourth quarter of calendar year 2013 was 7.35% which did not meet the 3.5% goal. The "Recommendations" section of the minutes stated "Continue to encourage everyone to explain anything out of the ordinary on the back of the MAR. Ensure that all drugs are pulled and recorded as given on the MARs. Continue to alert those who pass meds on how to improve. Include known medication errors in the QAPI process. Use PCC [a type of software] as EHR for immediate real time communication when it goes live."</p> <p>Medical Executive Committee meeting minutes, dated 5/20/14, stated the medication error rate for the first quarter of 2014 was 4.3% which was higher than the goal. The recommendations were "Continue to encourage everyone to explain anything out of the ordinary on the back of the</p>	A 283			

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A 283	<p>Continued From page 21</p> <p>MAR. Ensure that all drugs are pulled and recorded as given on the MARs. Continue to alert those who pass meds on how to improve. Include known medication errors in the QAPI process. Use PCC [a type of software] as EHR for immediate real time communication when it goes live."</p> <p>The FORM "QAPI MEDICATION ERRORS FOR APRIL 2014" stated the error percentage rate was 1.2%. The FORM "QAPI MEDICATION ERRORS FOR MAY 2014" stated the error percentage rate was 4.1%. The FORM "QAPI MEDICATION ERRORS FOR JUNE 2014" stated the error percentage rate was 6.1%.</p> <p>The Pharmacist was interviewed on 8/08/14 beginning at 1:40 PM. He stated the medication error rate was determined by his review of 3 randomly chosen medical records per month. The pharmacist stated the error rate was determined by number of errors identified by the number of doses ordered. He stated the data used to determine the error rate was not broken down into sub-categories such as the severity of the errors or the type of errors identified, i.e. prescription error, transcription error, etc. He stated he did not use incident reports to identify a medication error rate. He stated causal analyses of medication errors was not conducted.</p> <p>The Administrator was interviewed on 8/08/14 at 9:25 AM. He confirmed the data for 2013 and the first quarter of 2014. He stated the hospital had not reviewed the way the medication error rate was determined or the way data was used in the past year. He stated other than educating staff to be more careful, the hospital had not taken specific measures to reduce the medication error</p>	A 283			

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A 283	Continued From page 22 rate for at least one year prior to the survey.	A 283			
A 405	The hospital did not take action when it failed to meet goals for medication errors. 482.23(c)(1), (c)(1)(i) & (c)(2) ADMINISTRATION OF DRUGS (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on record review, staff interview, and policy review, it was determined the hospital failed to ensure drugs were administered in accordance with accepted standards of practice for 2 of 8 patients (Patient #4 and #7) whose records were reviewed. The negative practices had the potential to affect all patients in the	A 405	We have taken the following actions: 1) Education and supervision is being provided to all licensed staff on documentation / assessments / evaluations overall; and when to complete an incident report. Increased supervision by reviewing documentation and actions taken by the nurse is being reviewed for actions and the accuracy of these assessments. 2) Monitoring evaluations: Our plan is to review documentation in patient records daily at our early morning reading. Assistance will be provided to the employee related to competency. 3) We have implemented a new electronic assessments and tools. 4) In collaboration with the pharmacist, we are examining the drug order and delivery system to identify areas which lead to difficulty in expediting the delivery of medications. We believe a more comprehensive review of the system	9/17/14	

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A 405	<p>Continued From page 23</p> <p>facility. This resulted in patients receiving medications that were not ordered and adverse patient outcomes resulting in transfer to an acute care hospital. Findings include:</p> <p>A facility policy, "ADMINISTRATION OF MEDICATIONS," revised 2/2013, stated</p> <p>Medication orders must include:</p> <ul style="list-style-type: none"> - Date and Time, - Patient Name, - Drug Name, - Route of Administration, - Dose, - Frequency. <p>The policy also stated "Order Clarification, The nurse is ultimately responsible to clarify unclear/incomplete medication orders with the physician. The pharmacist may assist in this process as needed. The nurse taking a telephone order must repeat the order back to the physician to ensure the accurate order was taken."</p> <p>The following examples include errors related to a failure to document written medication orders, a failure to ensure the correct medication, and dose was administered, and recorded as given, and inaccurate documentation of the medication as it related to timing and related activities:</p> <p>a. Patient #7 was a 79 year old male admitted to the facility on 4/04/14 for dementia, unspecified psychosis, and hypertension.</p> <p>His record documented he was transferred from Mountain View Center for Geriatric Psychiatry to</p>	A 405	<p>identify areas which lead to difficulty in expediting the delivery of medications. We believe a more comprehensive review of the system may assist with declines in those areas that would be counted as drug errors.</p> <p>5) We are developing new processes for drug ordering and delivery. Our pharmacist, our DON and our nurse consultant will assist with the development of these processes.</p>	

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A 405	<p>Continued From page 24</p> <p>an acute care hospital on 4/06/14 until 4/08/14, as a result of an inadvertent dose of Thorazine.</p> <p>A nursing note, dated 4/06/14 at 4:00 PM, was the first nursing entry for the day shift (7:00 AM to 7:00 PM). The note documented Patient #7 received Thorazine 200 mg at 11:30 AM. The RN wrote she held all of Patient #7's 8:00 AM and 12:00 PM medications due to his sleeping and combative behavior. The RN did not indicate the route of administration.</p> <p>In a nursing note at 6:00 PM on 4/06/14, the same RN described Patient #7's agitated behaviors of spitting, biting, and hitting at staff. The RN documented at that time the psychiatrist was notified and "Thorazine & Ativan IM ordered." The nurse wrote "...these were given in the R [right] dorso gluteal, Ativan given in the L [left] dorso gluteal. Pt [patient] continues [with] physical & verbal aggression." The nurse did not document in her notes what time the medications were administered, or the doses delivered.</p> <p>In a nursing note at 7:00 PM on 4/06/14, the same RN wrote "Pt [patient] transferred out of facility for further monitoring." It did not include further details of why Patient #7 was transferred. Patient #7's record did not include documentation for hospital transfer, or physician orders for the transfer.</p> <p>A form titled "DOCTOR'S ORDERS AND PROGRESS NOTES," included an entry by Patient #7's psychiatrist on 4/06/14 at 6:30 PM: "[Patient Name] became more & more agitated & refused oral meds X 2, and started hitting & trying to bite staff. I ordered Haldol 10 mg IM & Ativan 2 mg IM. The nurse gave it and the Team Control</p>	A 405			

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A 405	<p>Continued From page 25</p> <p>Positioning was required for less than 30 seconds for both injections. When I arrived to evaluate him he was sitting quietly on the bedside & did not require more physical restraints." Patient #7's record did not include a verbal order or written order for Haldol, Thorazine, or Ativan. The record did not include a physician's order for Patient #7's transfer or notes written by his physician indicating why a transfer would be indicated.</p> <p>Review of Patient #7's medication administration records did not include documentation Thorazine, Haldol, or Ativan were administered that evening.</p> <p>An admission History and Physical from the hospital where Patient #7 was transferred to, dated 4/06/14, noted he received the Thorazine and Ativan dose at 6:25 PM.</p> <p>Patient #7's Discharge Summary from Mountain View Center for Geriatric Psychiatry, dictated 6/06/14, dictated by his Psychiatrist, documented that on 4/06/14, Patient #7 received Haldol 10 mg and Ativan 2 mg IM, then was transported to the hospital for evaluation and returned 4/08/14. The discharge summary was not accurate as it indicated Haldol was administered, although Patient #7 received Thorazine. The discharge summary did not include the reason for the hospital transfer, and did not reference the medication adverse event.</p> <p>The DON was reported to have conducted an investigation regarding the medication error, but was unavailable during the survey. During an interview on 8/08/14 beginning at 11:15 AM, the Admissions Coordinator reviewed Patient #7's record and stated she was familiar with the incident. She stated she was covering for the</p>	A 405			

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A 405	<p>Continued From page 26</p> <p>DON during her absence, and provided a packet of papers she described as the DON's investigation of the incident.</p> <p>The investigation packet included Progress notes and Nursing notes, however, they were undated and/or unsigned, as follows:</p> <p>i. An undated and unsigned Progress note, timed 7:55 PM, indicated a phone order was obtained from the psychiatrist. The writer of the progress note documented administration of Thorazine and Ativan. The progress note stated a phone order was obtained from the psychiatrist for Patient #7's transport to the acute care hospital.</p> <p>ii. A dated and timed, but unsigned, Nurse's notes with Patient #7's name, date and time, however the notes did not have a signature to indicate the authors. Dated and timed, but unsigned, Nurse's notes with Patient #7's name on them, were written by 2 different individuals. This was evidenced by the use two different writing instruments and two different handwriting styles.</p> <p>- A Nurse's note, dated 4/06/14 at 7:30 PM, was a three page description of the medication administration, written as a narrative of how the individual (an RN,) assisted Patient #7's nurse. The writer of the Nursing note stated she drew up two 5 ml syringes of Thorazine, (which would be a total dose of 500 mg). She wrote that the other nurse drew up the Ativan 2 ml, (which would be a dose of 4 mg). The writer documented the Ativan and 5 ml of Thorazine was administered into Patient #7's left gluteal region by the other nurse, and she administered Thorazine 5 ml into his right gluteal region. She documented the injections were administered at 6:40 PM.</p>	A 405			

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A 405	<p>Continued From page 27</p> <p>Additionally, the RN documented Patient #7's physician came in to see him and wrote orders at 6:30 PM.</p> <p>- A Nurse's note dated 4/06/14 at 7:40 PM, was a three page description of the events surrounding the medication administration and transfer of Patient #7. The note appeared to have been written by the nurse who took care of Patient #7 on 4/06/14, however, the note was not signed. The writer stated Patient #7 was combative on 4/06/14 shortly after 11:00 AM, and Thorazine 200 mg was administered orally. The nurse documented that Patient #7 got up at 5:45 PM, was belligerent, and difficult to redirect. She wrote that she attempted to call the psychiatrist twice, then he called back and "...gave order for Thorazine 10 ml IM and Ativan 2 ml." The writer stated another nurse offered assistance, and she delegated the nurse to draw up the Thorazine. The writer stated she was questioned by the other nurse regarding the volume, and they decided to divide the medication into two syringes of 5 ml each. The writer documented the injections were administered at 6:45 PM, and vital signs were taken at 6:40 and 6:50 PM, and were within normal limits.</p> <p>During an interview on 8/08/14 beginning at 11:15 AM, the Admission Coordinator, (an RN who was covering in the DON's absence,) reviewed Patient #7's record and confirmed the times of the medication administration differed in each different document. The administration times ranging from 6:25-6:45 PM. She also confirmed there was no order for Haldol, Thorazine, or Ativan written the evening of 4/06/14, by either the psychiatrist, or the nurse who received the orders. Additionally, the medication</p>	A 405			

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A 405	<p>Continued From page 28</p> <p>administration was not documented on any of Patient #7's Medication Administration Records. The Admission Coordinator confirmed the Discharge Summary and Physician's notes included information Patient #7 received Haldol and Ativan, although he was documented by the nurse as receiving Thorazine and Ativan. She confirmed the discrepancy in documentation.</p> <p>During an interview on 8/08/14 at 9:00 AM, the RN who was the charge nurse who provided care to Patient #7, and who administered the Thorazine/Ativan injections, reviewed her process for obtaining medications from the pharmacy. She stated the charge nurse had access to the key for the pharmacy. The RN unlocked the door of the pharmacy and demonstrated where the medication was stored, and stated the only dose of Thorazine the facility carried was in 2 ml glass ampules of 50 mg Thorazine. She stated 10 ml would mean 5 of the ampules would be used.</p> <p>During an interview on 8/08/14 at 1:40 PM, the facility Pharmacist reviewed Patient #7's record and confirmed it was Thorazine 10 ml (500 mg total dose), and Ativan 2 ml (4 mg total dose) that Patient #7 received. He confirmed there were no written orders for either medication. The Pharmacist stated he did not perform an analysis of the incident, as he felt it was a nursing incident and not related to pharmacy. He was questioned about monitoring of inventory, and how he reconciled counts of medications if the orders did not match what was used. He stated the Thorazine and Ativan was not ordered, and it was not on the medication administration records, so it would not be possible to track where it went. The Pharmacist stated he did not review Patient #7's record during the monthly medication audits</p>	A 405			

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A 405	<p>Continued From page 29 that he performed.</p> <p>During a phone interview on 8/11/14 beginning at 12:40 PM, the DON stated the nurse who administered the Thorazine and Ativan was an experienced nurse with the hospital. She stated she reviewed the nurse's competencies and annual performance evaluations. The DON stated the nurse was counseled after the incident, she had been assigned "Homework," and had to complete a PowerPoint and med-pass audit before she was able to return to patient care. The DON stated the incident was reviewed with the hospital physicians and the administrator.</p> <p>b. Patient #4 was a 79 year old male admitted to the facility on 9/20/13, for dementia and aggression. Additional diagnoses included acute dystonia secondary to drugs. Patient #4 was transferred to an acute care hospital for a higher level of care on 10/26/13, and died on 11/06/13.</p> <p>Patient #4's medical record included a signed verbal order dated 10/24/13 at 10:35 PM, for blood to be drawn for labwork and to start antibiotics. Rocephin 2 gm IM was ordered "now," as the initial dose, and was to be followed by 1 gm every 24 hours for the next 5 days. The order did not include a time when the physician authenticated the order, or when the nurse noted the order.</p> <p>A Medication Administration Record included documentation Patient #4 received the first dose of Rocephin 2 gm on 10/25/13. The medication sheet did not include a time of administration.</p> <p>A nursing note dated 10/26/13 at 4:00 AM, was unclear, as multiple events were described, but</p>	A 405		

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A 405	<p>Continued From page 30</p> <p>no time was provided when they occurred. The note lacked clarity of what time the first dose of Rocephin was administered, and if he received an additional dose as follows: "Rocephin 2 gm IM initial dose, then Rocephin 1 gm IM q [every] 24 hours X 5 d [days]. Pt breathing labored, noted Rhonci." The nursing note, also under the 4:00 AM entry, included "Pt VS [vital signs] recheck after Rocephin given @ approx (sic) 2300 [11:00 PM]." The nurse documented Patient #4's blood pressure was 100/52.</p> <p>In a nursing note on 10/26/13 at 4:55 AM, the nurse documented Patient #4 was transferred to an acute care hospital.</p> <p>During an interview on 8/08/14 beginning at 11:15 AM, the Admission Coordinator, (an RN who was covering in the DON's absence,) reviewed Patient #4's record and confirmed the medication order was written on 10/24/13. She verified the MAR documented Patient #4 received the first dose of Rocephin on 10/25/13, and the time was not noted on the MAR. She confirmed the RN documented she gave the IM Rocephin injection to Patient #4 at 11:00 PM on 10/25/14.</p> <p>During an interview on 8/08/14 beginning at 1:40 PM, the facility Pharmacist reviewed Patient #4's record and confirmed the medication administration record indicated his first dose of Rocephin 2 gms was administered on 10/25/13. He was asked about medication errors, and if this was identified as a medication error. The Pharmacist stated he did not think Patient #4's record was reviewed for medication errors. He stated that most medication errors are self disclosed, meaning the nursing staff identifies an error and will complete an incident report. The</p>	A 405			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/11/2014
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PSYCHIATRY			STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341		
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A 405	Continued From page 31 Pharmacist stated he chooses 3 random records for medication review each month. From the review of the 3 records, he stated, he then is able to determine the percentage of medication errors for the facility each month. Antibiotics for Patient #4 were ordered to be given "Now," on 10/24/13 at 10:35 PM. The facility failed to administer his first dose until 24 hours later, on 10/25/13 at 11:00 PM. Five hours later he was transferred to a higher level of care facility where he later died. The facility failed to fully investigate medication errors, failed to ensure accuracy of documentation by the physician and nursing staff, and failed to ensure verbal orders for medications were written and authenticated as per the facility's policy and commonly understood nursing standards of practice.	A 405			
A 454	482.24(c)(1) CONTENT OF RECORD: ORDERS DATED & SIGNED All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all orders were dated, timed, and authenticated for 1 of 8 patients (#7) whose records were reviewed. This resulted in orders that were not transcribed,	A 454	Please refer to A144. In addition, a new system and processes are being developed to assist the nurses with how to document concisely and effectively.	9/17/14	

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A 454	<p>Continued From page 32</p> <p>medications administered without a physician order, lack of authentication of physician orders, medication and treatment errors, as well as lack of clarity about the course of patient care. Findings include:</p> <p>1. Patient #7 was a 79 year old male admitted to the facility on 4/04/14 for dementia, unspecified psychosis, and hypertension.</p> <p>His record documented he was transferred to an acute care hospital, where he was on observation for 2 days as a result of an inadvertent dose of Thorazine.</p> <p>In a nursing note dated 4/06/14 at 6:00 PM, the RN described Patient #7's agitated behaviors of spitting, biting, and hitting at staff. The RN documented at that time the Psychiatrist was notified by phone and "Thorazine & Ativan IM ordered." The nurse wrote "...these were given in the R [right] dorso gluteal, Ativan given in the L [left] dorso gluteal. Pt [patient] continues [with] physical & verbal aggression."</p> <p>In a nursing note on 4/06/14 at 7:00 PM, the same RN wrote "Pt [patient] transferred out of facility for further monitoring." It did not include further details of why Patient #7 was transferred. Patient #7's record did not include a physician order for the transfer.</p> <p>A form titled "DOCTOR'S ORDERS AND PROGRESS NOTES," included an entry by Patient #7's psychiatrist on 4/06/14 at 6:30 PM: "[Patient Name] became more & more agitated & refused oral meds X 2, and started hitting & trying to bite staff. I ordered Haldol 10 mg IM & Ativan 2 mg IM. The nurse gave it and the Team Control</p>	A 454			

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A 454	Continued From page 33 Positioning was required for less than 30 seconds for both injections. When I arrived to evaluate him he was sitting quietly on the bedside & did not require more physical restraints." Patient #7's record did not include a verbal order or written order for Haldol, Thorazine, or Ativan. The record did not include a physician's order for Patient #7's transfer or notes written by his physician indicating why a transfer would be indicated. During an interview on 8/08/14 beginning at 11:15 AM, the Admissions Coordinator reviewed Patient #7's record and stated she was familiar with the patient and the event that occurred on 4/06/14. She confirmed the record did not include either verbal or written orders for Thorazine, Haldol, or Ativan. She confirmed the record did not include either verbal or written orders for Patient #7's transfer to another facility. The facility did not ensure verbal orders were written and authenticated.	A 454			
A 465	482.24(c)(4)(iv) CONTENT OF RECORD: COMPLICATIONS [All records must document the following, as appropriate:] Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia. This STANDARD is not met as evidenced by: Based on review of facility policies, record review, and staff interview, it was determined the	A 465	Please refer to A144 – medication policies and DON training. Medical Providers who dictate discharge summaries will be in-serviced about the required information that is needed in a discharge summary. The in-servicing will also include the specifics behind this citation (i.e Medication Error, reason for transfer to another hospital). Policies surrounding discharge summaries will be updated to ensure all required information is included to meet regulatory compliance for a comprehensive discharge summary.	9/17/14	

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A 465	<p>Continued From page 34</p> <p>facility failed to ensure medical records included documentation of complications, hospital acquired infections and unfavorable reactions to drugs for 1 of 8 patients (#7) whose records were reviewed. This had the potential for patients to have an inaccurate health care record of their hospitalization. Findings include:</p> <p>1. Patient #7 was a 79 year old male admitted to the facility on 4/04/14 for dementia, unspecified psychosis, and hypertension.</p> <p>In a nursing note at 6:00 PM on 4/06/14, an RN described Patient #7's agitated behaviors of spitting, biting, and hitting at staff. The RN documented the Psychiatrist was contacted by phone and "Thorazine & Ativan IM ordered." The nurse wrote "...these were given in the R [right] dorso gluteal, Ativan given in the L [left] dorso gluteal. Pt [patient] continues [with] physical & verbal aggression." The nurse did not document in her notes what the doses of the medications were that were administered.</p> <p>In a nursing note at 7:00 PM on 4/06/14, the same RN wrote "Pt [patient] transferred out of facility for further monitoring."</p> <p>His record included an admission note from an acute care hospital dated 4/06/14. It noted he was transferred from Mountain View Center for Geriatric Psychiatry as a result of an inadvertent dose of Thorazine on 4/06/14. He remained at the hospital until 4/08/14, when he was returned to Mountain View Center for Geriatric Psychiatry.</p> <p>In Patient #7's discharge summary, dictated 6/06/14, his Psychiatrist documented that on 4/06/14, Patient #7 received Haldol 10 mg and</p>	A 465			

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A 465	<p>Continued From page 35</p> <p>Ativan 2 mg IM, then was transported to an acute care hospital for evaluation and returned 4/08/14. The discharge summary was not accurate as it indicated Haldol was administered, although Patient #7 received Thorazine. The discharge summary did not include the reason for the hospital transfer, and did not include the complication related to a medication error.</p> <p>During an interview on 8/08/14 beginning at 11:15 AM, the Admission Coordinator, (an RN who was covering in the DON's absence,) reviewed Patient #7's record and confirmed the discharge summary did not include documentation of the medication error and complication which required additional hospitalization at another facility.</p> <p>The facility did not include critical medical patient information in Patient #7's discharge summary.</p>	A 465			

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PS	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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B 000	16.03.14 Initial Comments The following state licensure deficiency was cited during the complaint investigation survey at your hospital from 8/07/14 through 8/11/14. Surveyors conducting the investigation were: Gary Guiles, RN, HFS, Team Leader Susan Costa, RN, HFS Laura Thompson, RN, HFS	B 000		
BB283	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)	BB283	See P.O.C. A144 and A465 RECEIVED SEP 15 2014 FACILITY STANDARDS	9/17/14

Bureau of Facility Standards
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature] MBA/HCM

TITLE
Administrator

(X6) DATE
9/10/14

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 134014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW CENTER FOR GERIATRIC PS	STREET ADDRESS, CITY, STATE, ZIP CODE 500 POLK STREET EAST KIMBERLY, ID 83341
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BB283	<p>Continued From page 1</p> <ul style="list-style-type: none"> 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) f. Reports of special examinations including but not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) <ul style="list-style-type: none"> ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) <ul style="list-style-type: none"> i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) <ul style="list-style-type: none"> i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) <ul style="list-style-type: none"> i. Name and affiliation of requestor; and (3-1-90) 	BB283		

Bureau of Facility Standards

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

MOUNTAIN VIEW CENTER FOR GERIATRIC PS 500 POLK STREET EAST
KIMBERLY, ID 83341

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BB283	<p>Continued From page 2</p> <p>ii. Name and relationship of requestee; and (3-1-90)</p> <p>iii. Response to request; and (3-1-90)</p> <p>iv. Reason why donation not requested, when applicable. (3-1-90)</p> <p>This Rule is not met as evidenced by: Refer to A454 as it relates to the failure of the hospital to ensure orders were documented and complete.</p>	BB283		



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

November 19, 2014

Charles Lloyd, Administrator
Mountain View Center For Geriatric Psychiatry
500 Polk Street East
Kimberly, ID 83341

Provider #134014

Dear Mr. Lloyd:

On August 11, 2014, a complaint survey was conducted at Mountain View Center For Geriatric Psychiatry. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006334

Allegation #1: The hospital had a high number of falls.

Findings #1: An unannounced visit was made to the hospital on 8/07/14-8/11/14. Eight medical records were reviewed. Quality Assessment/Performance Improvement documents and meeting minutes were reviewed. Patients were observed. Staff were interviewed.

The Medical Executive Committee also served as the hospital's Quality Improvement Committee. The minutes of 4 Medical Executive Committee meetings were documented between 8/01/13 and 8/07/14. The number of falls was consistently above the goal set by the hospital. No documentation was present that the hospital investigated the high fall rate or took steps to decrease the number of falls.

One medical record documented a 53 year old female who was admitted to the hospital on 8/23/13 for diagnoses of dementia with behavioral changes and psychosis. She was transferred to an acute care hospital on 9/17/13. Her "HISTORY AND PHYSICAL," dated 8/24/13, stated she was admitted for "...agitated, anxious, non-redirectable, vocally disruptive with nighttime disturbances."

On 9/12/13 at 7:40 PM, Nursing Notes stated the patient had fallen twice by leaning forward too far in her chair. The Nurse Practitioner and the patient's husband were notified. Neurological checks were ordered for 24 hours and were completed by nurses. Staff supervision and the amount of staff assistance during transfers was increased. However, an investigation of the causes of the falls was not documented.

Charles Lloyd, Administrator
November 19, 2014
Page 2 of 3

No changes in condition were noted until the morning of 9/15/13 when the patient had difficulty swallowing. That evening her level of consciousness decreased. On 9/17/13, a CT scan of her head was performed which was negative. She was admitted to an acute care hospital later on 9/17/13 for aspiration pneumonia.

The Administrator was interviewed on 8/15/14 at 2:25 PM. He stated changes to the hospital's fall prevention program had been implemented but were not documented for the year prior to survey. The Administrator stated the hospital had not analyzed fall data beyond the total number or percentage of falls. He stated the hospital's QAPI program had not measured the effects of efforts to reduce falls.

The hospital did not take actions to prevent falls and protect patients from harm. A deficiency was cited at 42 CFR Part 482.13 related to the failure of the hospital to keep patients safe.

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

Allegation #2: Physicians ordered frequent medication changes that were detrimental to patients' health.

Findings #2: An unannounced visit was made to the hospital on 8/07/14-8/11/14. Eight medical records were reviewed. Quality Assessment/Performance Improvement documents and meeting minutes were reviewed. Patients were observed. Staff were interviewed.

All eight medical records documented frequent medication changes.

One medical record documented a 53 year old female who was admitted to the hospital on 8/23/13 for diagnoses of dementia with behavioral changes and psychosis. She was transferred to an acute care hospital on 9/17/14 for aspiration pneumonia. The patient's medications were frequently changed during her hospitalization, however, a direct causal relationship between the medication changes and the decline in the patient's health could not be proven through the investigative process.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients were not appropriately monitored and treated for urinary tract infections.

Findings #3: An unannounced visit was made to the hospital on 8/07/14-8/11/14. Eight medical records were reviewed. Quality Assessment/Performance Improvement documents and meeting minutes were reviewed. Patients were observed. Staff were interviewed.

One medical record documented a 53 year old female who was admitted to the hospital on 8/23/13 for diagnoses of dementia with behavioral changes and psychosis. She was transferred to an acute care hospital on 9/17/13. Her "HISTORY AND PHYSICAL," dated 8/24/13, stated she was admitted for "...agitated, anxious, non-redirectable, vocally disruptive with nighttime disturbances."

Charles Lloyd, Administrator
November 19, 2014
Page 3 of 3

The patient was incontinent of urine on admission. Prior to being admitted on 8/23/13, a urine culture was performed. On 8/25/13 at 6:15 PM, the culture was positive and she was prescribed Amoxicillin for a urinary tract infection. On 8/30/14, she was placed on a bladder training program. A physician progress note, dated 9/10/13, stated the patient complained of a "...sense of urinary frequency secondary to neurogenic bladder." The physician ordered nurses to catheterize the patient two times a day. The catheterizations were documented. No evidence of a urinary tract infection was noted after the first one was treated. On 9/14/13 at 6:15 PM, an LPN progress note stated the patient was catheterized and her urine was clear and bright yellow.

Issues related to monitoring for urinary tract infections were not identified in the other patient records reviewed.

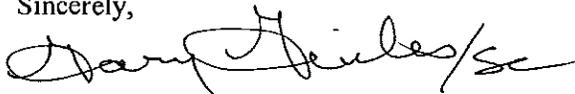
It could not be proven through the investigative process that patients were not monitored and treated for urinary tract infections.

Conclusion #3: Unsubstantiated. Lack of sufficient evidence.

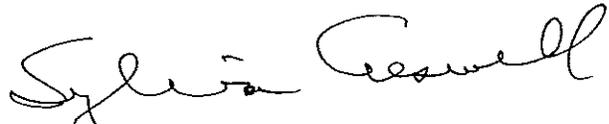
Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it will be addressed in the Plan of Correction.

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



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/pmt