IDAHO DEPARTMENT OF HEALTH & WELFARE

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

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BUREAU OF FACILITY STANDARDS
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January 16, 2015

Todd Hurt, Administrator
State Hospital North
300 Hospital Drive
Orofino, ID 83544

Provider # 43506

Dear Mr. Hurt:

On **September 18, 2014**, a complaint survey was conducted at State Hospital North. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00005211

Allegation: Patients were given medications they were allergic to and staff did not accommodate their medication requests.

Findings: An unannounced visit was made to the hospital on 9/17/14 and 9/18/14. Medical records for 10 patients, including 4 current patients, were reviewed. Seven current patients were interviewed. Patients were observed. Facility documents were reviewed including policies, grievances, and occurrence reports.

All medical records documented medications were ordered in response to patients' needs. All medical records documented patients' requests were considered. No records documented patients were given medication they were allergic to.

For example, 1 medical record documented a patient who was admitted to the hospital on 8/23/11 and was discharged on 9/15/11. Her diagnosis was bipolar disorder. Prior to admission, she was involuntarily committed to the hospital.

A Discharge Summary, dated 10/30/11, stated when admitted, the patient was delusional, paranoid, had threatened others, was not sleeping, had pressured speech, and seemed to have a great deal of anger.

An untitled admission assessment, dated 8/23/11 at 2:24 PM, stated the antipsychotic medications the patient was taking when she was admitted included Ziprasidone (Zyprexa) 80 mg daily and Haloperidol (Haldol) as needed.

Several physician and nursing notes stated the patient claimed she was allergic to the antipsychotics Haldol, Chlorpromazine, Latuda, and Geodon. Physician notes stated she did not believe she was mentally ill and told staff she was allergic to all antipsychotic medication. Both physician and other clinical notes documented her delusional status and behaviors, such as frequent calls to the FBI to report people were trying to kill her. A physician progress note, dated 8/25/14 at 8:10 AM, stated the patient was not allergic to any antipsychotic medications. The note stated he believed the patient's mental illness was serious enough that she required antipsychotic medication against her protests. He placed her on Latuda, with Haldol IM if the patient refused the Latuda. The case was reviewed and upheld at an "Override Hearing." On 8/30/14, the patient requested to be placed on Abilify, another antipsychotic medication, in place of the Latuda. The physician agreed to this request even though he documented he did not believe Ability was the best choice.

No allergic reactions were documented. The patient's condition improved. She was eventually discharged home.

A History and Physical (H&P) was completed on 8/24/14. The patient's medical diagnoses included Chronic Obstructive Pulmonary Disease (COPD), ongoing tobacco abuse, Type II Diabetes, and Fibromyalgia. The H&P stated "Continue current COPD regimen, providing DuoNeb nebulizer if Albuterol inhaler not adequate, and attempt to obtain Q-VAR ...Will offer oxygen for room air saturation levels below 95%."

Nursing records documented the patient complained of shortness of breath during her stay but her oxygen saturation levels were monitored and did not go below 95%. The patient was treated with inhalers and nebulizer treatments. The Q-VAR was not ordered. No reason was documented but an internet search revealed national shortages of the medication occurred during that time.

The H&P stated the patient took Glucosamine/Chondroitin although this was not included in the list of medications she was taking when she was admitted. She was initially treated for pain with Ibuprofen. On 9/01/11, Glucosamine/Chondroitin and Tramadol were ordered for pain. She was medicated for pain in response to complaints.

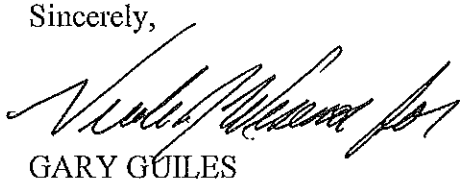
Seven current patients were interviewed. They all stated staff were responsive to medication requests. They all stated staff were responsive to their medical problems and complaints of pain.

It could not be proven through the investigative process that patients were given medications they were allergic to or that patients' medical needs were not appropriately managed.

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,



GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
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State Hospital North
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Orofino, ID 83544

Provider # 43506

Dear Mr. Hurt:

On **September 18, 2014**, a complaint survey was conducted at State Hospital North. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006102

Allegation: Staff mistreated patients while they were in the safety area.

Findings: An unannounced visit was made to the hospital on 9/17/14 and 9/18/14. Medical records for 12 patients, including 6 current patients, were reviewed. Seven current patients were interviewed. Patients were observed. Facility documents were reviewed including policies, grievances, and occurrence reports.

A tour of the nursing unit was conducted on 9/17/14 beginning at 3:15 PM. The unit included a large main patient area and a smaller area called a Safety Area that included a foyer and 2 seclusion rooms. It was located behind the nursing station. It had large windows to provide maximum visibility for patients and staff. The Safety Area provided a low stimulus area for patients separate from the main patient floor. It allowed unstable patients more freedom of movement than being placed in seclusion. Unless the interdisciplinary team so ordered, patients in this area had unfettered access to a restroom.

All of the medical records reviewed documented the individualized treatment of patients in response to their needs.

One medical record documented a 48 year old female who was admitted to the hospital on 1/24/13. She was discharged on 4/09/13. Her diagnoses included schizoaffective disorder, delirium, polydipsia (excessive water intake), and alcohol dependence. In extreme episodes of polydipsea, the patient's kidneys will be unable to deal with the fluid overload, and weight gain will be noted. Primary polydipsia can be life-threatening as serum sodium is diluted to an extent that seizures and cardiac arrest can occur.

The patient's record stated she had polydipsia and staff were to limit her fluid intake to 1 glass per hour.

The patient's record documented ongoing hallucinations and delusions. The patient had numerous documented episodes of verbal and physical assaultive behavior to other patients and to staff. Nursing notes documented she destroyed property and urinated and defecated on the floor when she was delusional.

One nursing progress note, dated 2/18/13 at 1:21 PM, stated the patient was allowed onto the main unit. The note stated she was loud and verbally aggressive. The note stated she "...pushed forward at the nurse and a psychiatric technician to attempt to move forward towards the A/B day hall, causing staff to step backwards. She then raised her hands at staff, her arms were then secured by staff using a (Crisis Prevention Institute) hold, this nurse on one side of the patient and a (psychiatric technician) on the other side. (Two other staff assisted)while the patient was walked to the Safety Area. She was physically resistant and kicked the Safety Area door as she was escorted into the Safety Area."

Another nursing progress note, dated 2/23/13 at 4:07 PM, stated the patient walked out of the Safety Area while making delusional statements. When the nurse went to the patient, the patient "...hit me numerous times in the chest with her fist. She attempted to hit me in the face but I blocked her arm. It took 3 staff to get her back in the Safety Area. She attempted to go through the door that does not open from the outside and slammed herself into the door. She then attempted to slam the other door but it has an arm on it which is slow to close and she kept pushing it and when it closed she had her thumb in the way and it shut on her. She was not in pain from this but extremely agitated that her thumb was caught in the door. 'My (Expletive) finger is stuck in the door let it go.' She finally pulled hard enough to get it out. The doors do have a gap in them ...He thumb was in the gap of the door so it was actually easy for her to pull it out." The note stated the patient was extremely psychotic, disorganized, and angry. The note stated the patient was held in place briefly and did not struggle after that. She was placed in seclusion at that time and released when she was in control of her emotions.

An incident report documented the event was investigated. There was no injury.

A nursing progress note, dated 2/18/13 at 11:45 AM, stated the patient had kicked the Safety Area door as she was being escorted to seclusion. No injury was documented and subsequent nursing notes did not document injury or difficulty ambulating. A Discharge Summary, dated 4/09/13, stated the patient was ambulating without difficulty and without assistance.

The nurse who wrote the above progress notes was not available for interview.

Six current patients were interviewed on the morning of 9/18/14. These patients all had been in the safe area during hospitalization. They verbalized being well treated. They stated they had not observed any mistreatment of other patients. They stated staff treated them well and no one voiced concerns with staff when they were put in the safe area. They stated their needs were met and they were given food and fluids. They stated they had access to toilet facilities.

Three observations of staff and patient interactions were conducted on 9/18/14. Staff were attentive and patient with patients.

Occurrence reports for 2014 were reviewed. No patient injuries were noted in the safe area.

No evidence of staff mistreatment of patients was found.

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,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
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